

**Tenth
International
Symposium
on**



**Diagnosis and treatment
of transsexualism**

**Vrije Universiteit Amsterdam
The Netherlands**

June 9-12, 1987



IN MEMORY OF HARRY

It was almost 25 years ago when I first met Harry. I was a resident in psychiatry at the Payne Whitney Clinic at the New York Hospital. I had just seen my first transsexual patient, and ran across Harry Benjamin's name in the scant literature on transsexualism which was available in 1961. Fortunately for me, one reference gave Harry's address in New York City, so I simply gave his office a ring and his nurse put me right through to Harry. I introduced myself by phone, simply saying I was interested in meeting him and learning more about transsexualism. He graciously invited me to his office the next afternoon and explained that I would have the opportunity to meet several of his transsexual patients that day. And so I did, thereby enhancing my experience with transsexuals by 1000% in one afternoon. More importantly, I met Harry Benjamin!

How hospitable he was to a perfect stranger. Only my interest in transsexualism served as an introduction, and that was enough to warmly welcome me to the sanctity of his private practice and wealth of clinical experience with what was still, at that time, a very rare and little known about "transsexual phenomenon." And how gentle and warm he was. And what a superb teacher he was as he carefully gave me brief summaries about each patient's life history. And what a fantastic clinician he was as each and every patient had his individual attention. And simply because I was a friend of Harry's, each patient opened him or herself up to me, so I could peek into the fascinating world of what we have come to call gender dysphoria. So every Wednesday afternoon for many weeks I attended Harry's transsexual clinic, and was privileged to learn from the master. But it was far more than about transsexualism that I learned about on those Wednesday afternoons in 1961.

I consider myself fortunate to have attended medical school at UCLA where we had excellent professors in attendance. And similarly at Cornell University and New York Hospital we had good people to train us. But Harry gave me something I never had from those more academic types. How can I put this into words so that you will understand.

I never met anybody who seemed to care about his patients that way. It was almost as though they were all his family. How totally comfortable they were with him and thus with me, simply because I was somehow connected with Harry. During my previous four years with patients, I had always thought that it was important to achieve some professional distance from patients. Not to get too close was somehow the appropriate stance to seek vis a vis patients. Well Harry showed me that was certainly not the case. He epitomized what I consider to be the ideal doctor-patient relationship. From that moment forward he was my model and I strived to achieve that level of comfort, intimacy and caring which he so admirably demonstrated for me. His patients loved him and I am sure that many of you are nodding your heads in affirmation of what I am saying, if indeed, these words are read at Harry's memorial ceremony.

And what a teacher he was. He demonstrated the art of interviewing a patient with the student in attendance. From time to time he would excuse himself from talking with the patient and underscore some point for me. Yet never did the patient seem to mind or feel neglected as Harry taught me right there on the spot. How much better this was than anything I had ever experienced before in those meccas of medical education where I was fortunate enough to learn. I stumbled on to a real mecca of human kindness, and yes, of medical education there in Harry's office.

What more can I say. Over the next 20 years Harry and I saw each other infrequently. We exchanged manuscripts on our mutual topic. He was always very encouraging and supportive of my efforts. Harry opened for me that rather special arena of clinical research which has nourished me these many years. In these very demanding times of escalating mountains of data to learn in order to practice medicine, it is comforting to be able to retreat into a small corner of knowledge, sufficiently tiny so as to be consumed in toto. Such a tiny morsel was Harry's "transsexual phenomenon." And oh what fun it has been to add just a tiny little bit to what Harry's lead has given us. And what a distinct pleasure and honor it has been for me to become the President of the Harry Benjamin International Gender Dysphoria Association.

I last saw Harry exactly two years ago in this same place, as we celebrated his 100th birthday. We chatted briefly as he graciously made efforts to visit with all the impressive dignitaries there. We each knew that we would never see each other again and I will treasure the picture we took of Harry, Paul Walker, Dick Green, John Money and myself. He told me that he was pleased that I was to be President of his Association and I felt very special that day. I remember walking into the very cold January evening thinking of Harry Benjamin with tears rolling down my cheeks. Goodbye Harry, and my profound thanks for what you have given us.

Sincerely,

Ira Pauly, M.D.

A WORD OF WELCOME

Twenty years ago, it would have been impossible to organize a Symposium on gender dysphoria in Holland. At that time the word "gender" was hardly known in the Dutch language. Only the words sex and sexuality were understood. The word "gender" was used only to indicate the gender of words and objects, not of persons and psychological identities. "Gender problems" were at the time ignored by the Dutch medical press and medical profession. Only the boulevard press was interested in the subject.

In 1970, however, we succeeded to interest a few persons in the phenomenon of transexualism. We founded the "Stichting Nederlands Gender Centrum", the Dutch Gender Center.

In 1971, a plastic surgeon and a gynaecologist performed the first complete sex reassignment - or "detranssexualization" as we nowadays call it. We had at our disposal only one bed in a very small hospital.

Our first two probands had a very distinct chromosomal aberration, the 47,XXY or Klinefelter syndrome. The third one had an extra Y-chromosome. Prior to surgery these probands had been cross-dressing for years.

Much to our surprise the operations received no comments from the authorities. From then on it seemed to be accepted that sex reassignments were performed in Holland like in some other countries.

After 1977 interest in gender identity problems steadily increased, and today there are about 10 Dutch investigators who make contributions to this International Symposium. Their presentations deal with their own experiences with gender dysphoria in all its forms.

When my wife and I attended the 2nd International Symposium on Gender Identity in Elsinore, Denmark, 16 years ago, we were the only delegates from Holland. My presentation about "Genetic factors in transsexualism" did not attract very much attention. At the time biological factors were hardly considered to be of importance. In the program of today's Symposium you can see that things have changed and that ample attention is given also to biological factors.

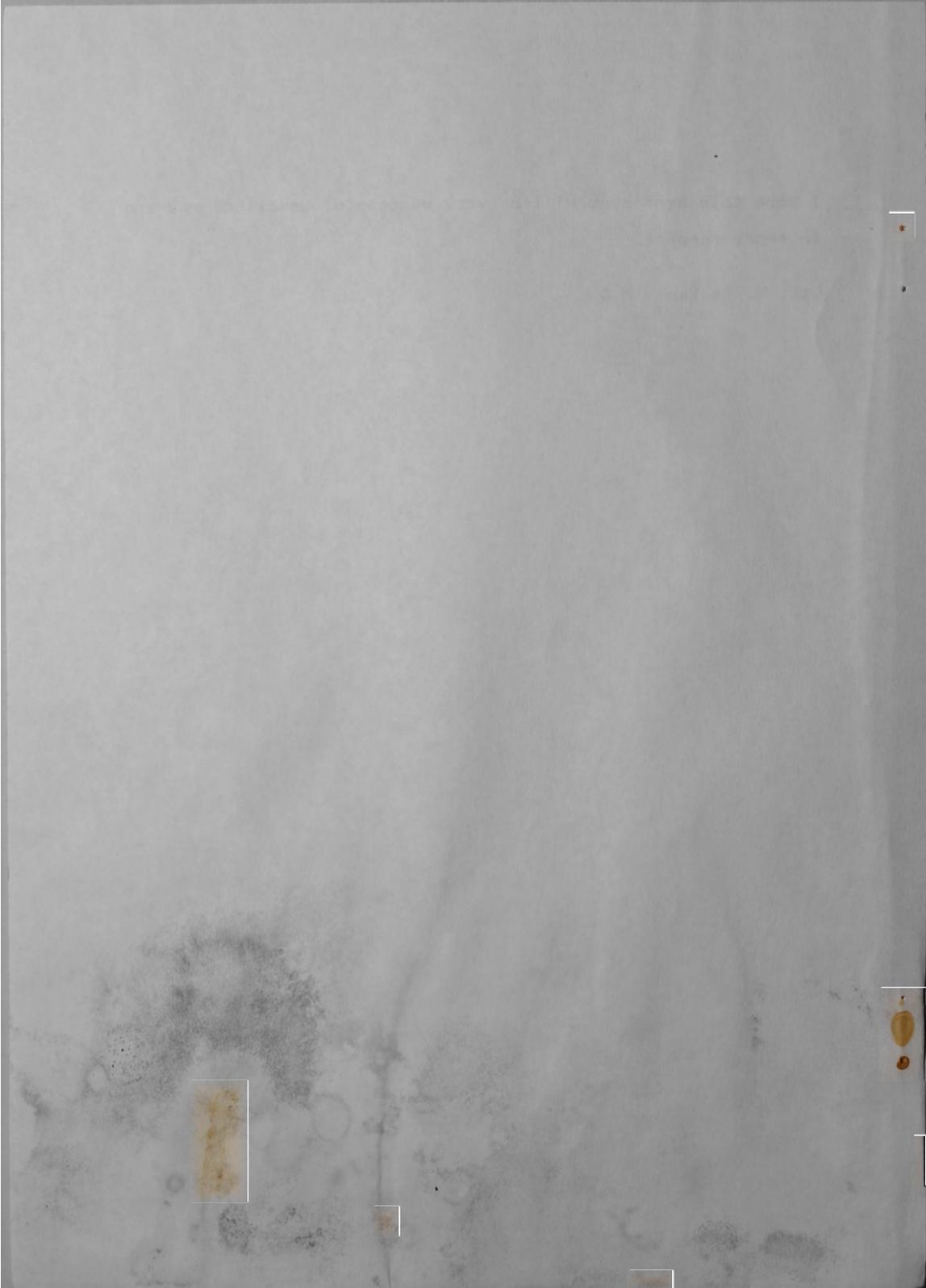
The progress made since 1971 is obvious: the number of speakers has almost doubled, and two workshops will be held.

Without the very valuable contributions from the American literature and the scientific work from American investigators, we could never have reached the present level of achievement in Holland. We are therefore very grateful for everything that has been done during the past 20 years. Your work has always been an example to us.

But I feel I should also mention the very dedicated and hard work of a few Dutch lawyers, who - with great efforts - drafted a law that was, after 11 years, accepted by the Dutch Government in August 1985. It is on the basis of this law that Dutch transsexuals can now finally have their legal status officially adjusted after they have been "detransexualized".

I hope this Symposium will be very successful to all of you and
in every respect.

Otto M. de Vaal, M.D.



MANNENGROEP NEDERLAND

This is a group of female-to-male genderdysphoric people.

A number of 140 people are members of this group.

Aims:

- Socializing
- Meeting people with identical problems,
- Exchange of experiences with medical help/societal problems.
- Self-help activities on the basis of experiences of others.
- Acting/negotiating on behalf of the group in relation with professional helpers and authorities.

Frequency of meetings:

Every three months at the home of one of the members.

Attendance: 40 - 70 members.

For further information contact:

- Jean van Aarle
(0) 4923-65336

Somatic side effects of cross gender hormone treatment of
300 M-to-F transsexuals over 2 - 10 years.

H.Asscheman

Hospital Vrije Universiteit, Amsterdam, the Netherlands.

This retrospective study investigated 300 M-to-F transsexuals treated
at our outpatient department between 1975 and 1986.

Treatment consisted of 100 µg ethinylestradiol and 100 mg
cyproterone acetate/day.

Of all patients physical complaints, general physical examination and
laboratory tests for liver functions and prolactin were recorded at
least once per year.

Our results show a very low incidence of complications of the above
hormonal treatment.

The most important complications are venous thrombosis + pulmonary
embolism, hypertension, depressive mood and hyperprolactinemia with
the potential of prolactinoma induction.

A. DE BOER, GRONINGEN - THE NETHERLANDS

How to measure a vagina after sex-reassignment surgery and what can be concluded from measuring.

In sex-reassignment surgery in male transsexuals the major problem is how to get a wide and deep enough vagina in the long run.

Most of the neovaginas have an adequate size immediately after surgery, but tend to constrict and get less deep. All newly made cavities in the body in places where there was no hole previously, will vanish if there is no mold in it for a certain period to keep the cavity open. It is in a way like digging a hole in the ground and leaving it as it is : After several days one will not find the hole back.

If a free skin graft is used in lining the newly made cavity, the tendency of the hole to shrink will be reinforced by the constriction of the skin graft itself, but even when the new vagina is entirely covered with a penile skinflap the dimension of the cavity tends to diminish.

In order to be able to judge the long term result of the operation it is important to get objective measurements of the vagina. Especially when there are functional problems due to an inadequate size of the vagina in the opinion of the patient it is important to know how big the vaginal cavity is.

In measuring the vagina there are three important measures: The depth, the circumference of the introit and the content of the vagina.

Measuring the depth can easily be done with some sort of a centimetre, the width of the introit is determined with probes and we have developed a new and simple instrument to measure the capacity.

This instrument and the measurements in transsexuals made three month after and one year after surgery will be presented. We will try to draw some conclusions on the relationship between the measures of the vagina and the sexual satisfaction or problems of operated transsexuals and their partners.

Prof. dr. F.G. Bouman, plastic surgeon
HOSPITAL VRIJE UNIVERSITEIT, Amsterdam The Netherlands

Abstract.

Construction of the neo phallus.

In the authors opinion the construction of a phallus. Like organ in female transsexuals should start with forming of the fixed part of the male urethra.

In view of the forming of the mobile part the urethra is in first operation now lengthened to the abdominal side of the clitoris. The clitoris with its erogenic zone can then be included in the exterior of the neo phallus. For the construction of the mobile part an island flap is used from the lower abdomen based on both superficial inferior epigastric arteries. The tube in the tube principle is used to form the urethra in this neo phallus. The problems with this procedure are mentioned.

Prof. dr. F.G. Bouman, plastic surgeon
HOSPITEL VRIJE UNIVERSITEIT, Amsterdam The Netherlands

Sex assignment surgery male to female.

Surgical follow up of 55 cases.

67 Patiënts are operated using the same method in which the vagina is formed with inverted penile skin on an abdominal pedicle.

The method is described.

In the follow up are all the data acquired from 55 patiënts. The data are presented. There are few failures. And nearly all the patiënts are satisfied with the results. There was only one who not succeeded living as a woman and regreted his decision.

64% Did not make use of the constructed vagina for different reasons but nevertheless were pleased with the operation. The conclusion is that this operation technique gives reliable and satisfactory results.

GEORGE BROWN, M.D., U.S. - AIR FORCE, DAYTON, OHIO, USA

TRANSSEXUALS IN THE MILITARY: FLIGHT INTO HYPERMASCULINITY

ABSTRACT

A sample of eleven male gender dysphoric patients meeting DSM-III criteria for transsexualism was seen over a three year period by a military psychiatrist. Eight patients had extensive military experience, including combat duty in some cases. At the time of evaluation three were on active duty, one was a Department of Defense employee, and four were veterans. Age range was 20 to 44 years. Evidence for a hypermasculine phase of development is presented, which coincides with the age of enlistment in nearly all cases. The psychodynamic underpinnings of the choice to enlist in transsexual males is discussed. Outcome of military service was premature discharge in over sixty percent. The military's management of gender dysphoric servicemen is described. Current military policies, in association with the proposed hypermasculine phase of transsexual development, may actually result in a higher prevalence of transsexualism in the military population than in the civilian populous.

KEY WORDS: hypermasculine, military, gender identity development, gender dysphoria, transsexualism

Note: The views expressed herein are those of the author and do not necessarily reflect those of the Department of Defense or the United States Air Force.

Prof. dr. F.G. Bouman, plastic surgeon
HOSPITEL VRIJE UNIVERSITEIT, Amsterdam The Netherlands

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TRANSEXUALITY : BORDERLINE PSYCHOPATHOLOGY ?

From September 1985 to January 1987, 9 transsexuals (7 male and 2 female) were referred to our out-patient clinic for hormonal and surgical treatment. One female transsexual who had already had sex reassignment surgery asked for psychosocial support. 5 Of these 10 patients were examined by the psychiatrist and by the psychologist; 4 patients by the psychologist only, 1 patient by the psychiatrist only.

The psychiatrist's task must be considered as two-fold :

1. Psycho-diagnostic :

To reach a diagnosis an assessment period is required of approximately 1 year with an average of 1 interview of 1 hour every 3 weeks. In this year further information is obtained from the parents or the partners.

During this period the client is asked to adopt the behaviour conform to the desired sex-role. Evaluation depends on the adequacy of this behaviour.

2. Psycho-therapeutic :

During the diagnostic phase as well as during hormonal and surgical treatment, the patient receives psychological support and coaching in his/her sex-reassignment process.

For 3 out of the 5 patients who desired treatment and were followed by the psychiatrist, the diagnosis of transsexuality, was made in accordance with the DSM III (302.5) criteria. After 1 year of follow-up in our out-patient clinic and integration in the desired sexual role, they started hormonal treatment.

Psychologist :

The psychologist's task is mainly diagnostic. Investigation of the personality-profile combined with the measure of intelligence, an image as complete as possible is constructed.

The following tests were used to investigate the personality-profile : Sentence completion, Frustration study by Rosenzweig, Coping-list by Sehreurs, N.V.M., N.P.V., Social Support-list) as well as non-verbal (Rorschach, Draw a Person, Wartegg) stimuli. Even problem solving capacities are assessed following the D.S.M. III classification.

Aim of our research :

Our interest in these interviews and tests went particularly to the diagnosis of transsexuality and its psychiatric classification.

1st phase :

Within this research, we looked for psychotic elements and a psychotic character structure. Since psychotics have a disturbed reality-testing, we believe that they cannot be considered for hormonal and surgical treatment. None of our patients showed psychotic features.

Patients were not excluded from somatic treatment on the basis of neurotic characteristics.

2nd phase :

We checked more specifically some recent views (Lothstein, Murray...) according to which these patients have an underlying borderline personality disorder. These authors also have their doubts about the fact that hormonal and surgical reassignment should be the therapy of choice. Accordingly psychotherapy is premised. We included this aspect in our research.

Results :

Through clinical interviews we checked the criteria for borderline-personality disorder, according to the D.S.M. III (301.83), namely impulsivity or unpredictability, a pattern of instable and intense interpersonal relations, unappropriate anger or lack of control of this anger, identity disturbances, affective instability, physically self-damaging acts, feelings of emptiness, intolerance of being alone.

All the patients who were examined by the psychiatrist, had not only the recognized identity disturbance but merely 1 or 2 other diagnostic symptoms which indicated a borderline-personality disorder.

It also struck us that 4 out of the 6 patients had a positive work-history, i.e. 4 of them had worked for almost 10 years in the same firm and were very stable and loyal in their love relation (10 years with the same partner). One cannot expect this from the other 2 patients, as they were respectively 24 and 20 years old.

The 24-year-old female transsexual is a university student and completes her studies without difficulties. None of the six subjects has ever had a psychotic phase, nor even in situations of stress.

In her psycho-diagnostic tests, the psychologist had comparable results (see diagram).

Dr. G. DE CUYPERE
M. VERVAET

TRANSSEXUALITY / BORDERLINE PSYCHOPATHOLOGY ?

1. SEX-REASSIGNMENT PROCESS :

----->

Diagnostic phase	Hormonal treatment	Surgery	Post-surgical phase
1 year	2 years		
Psychiatrist Psychologist Endocrinologist	Endocrinologist	Surgeon	Endocrinologist

----->

PSYCHOTHERAPY BY THE PSYCHIATRIST (SUPPORT + GUIDANCE)

----->

2. DIAGNOSTIC PHASE - CRITERIA DSM III (302.5) :

▣ psychiatrist : interviews with patient 1 h/3 w during 1 year
interviews with family, partner(s)

- psychologist :

Investigation area

Methods

IQ	W.A.I.S.
Personality profile Personality identification	NVM (Personality Inquiry of the Netherlands) NPV (short edition MMPI) Social Support list Sentence Completion Coping list of Schreurs Frustration study by Rosenzweig Wartegg Draw-a-Person Rorschach

- patient : integration into society in the desired sexual role

3. PATIENTS : 10

Period 01.07.85 to 01.01.87

M - F	F - M	F - M
7	2	1
9 asking for treatment		already treated
10		

Psychiatrist	1
Psychologist	4
Psychiatrist + Psychologist	5
10	

4. AIM OR OUR RESEARCH :

1st phase : screening for psychosis : - exclusion criteria for sex-reassignment surgery
- neurotic symptoms no exclusion

2nd phase : screening for borderline-personality disorder
Criteria DSM III (301.83)

(at least 5 of the following are required)

- (1) Impulsivity or unpredictability
- (2) A pattern of unstable and intense interpersonal relationships
- (3) Inappropriate intense anger, lack of control
- (4) Identity disturbance
- (5) Affect instability
- (6) Intolerance of being alone
- (7) Self damage
- (8) Chronic feelings of emptiness

When positive for borderline-structure :
therapy first choice : psychotherapie

When negative for borderline-structure :
therapy advised : sex-reassignment surgery

I. CRITERIA for Borderline Personality disorder investigated by the psychiatrist

Accor. to DSM III	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
DK.	-	x	-	x	-	-	-	-
DS.	-	x	-	x	x	-	-	-
VH.	x	-	-	x	x	-	x	-
A.	-	-	-	x	x	-	-	-
D.	-	-	-	x	x	-	-	-
G.	-	-	-	x	-	-	-	-

- (1) Impulsivity or unpredictability
- (2) A pattern of unstable and intense interpersonal relationships
- (3) Inappropriate intense anger lack of control
- (4) Identity disturbance
- (5) Affect instability
- (6) Intolerance of being alone
- (7) Self damage
- (8) Chronic feelings of emptiness

II. CRITERIA for Borderline Personality disorder investigated by the psychologist

Accor. to DMSIII	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
BK.	-	x	-	x	-	-	-	-
DS.	-	-	-	x	x	-	-	-
VH.	x	-	-	x	-	x	x	-
D.	-	-	-	x	x	-	-	-
G.	-	-	-	x	-	-	-	-
P.	-	-	-	x	-	-	-	-
D.	x	-	-	x	-	-	-	-
T1	x	x	-	x	x	-	-	-
T2	-	-	-	x	x	-	-	-

- (1) Impulsivity or unpredictability
- (2) A pattern of unstable and intense interpersonal relationships
- (3) Inappropriate Intense anger lack of control
- (4) Identity disturbance
- (5) Affect instability
- (6) Intolerance of being alone
- (7) Self damage
- (8) Chronic feelings of emptiness

THE HARRY BENJAMIN INTERNATIONAL GENDER DYSFORIA ASSOCIATION INC
TENTH SYMPOSIUM IN AMSTERDAM , NETHERLANDS , JUNE 10-12,1987

Abstract of a presentation of the book : LA QUESTION TRANSEXUELLE.

(Pasteur Joseph Doucé:"LA QUESTION TRANSEXUELLE" Paris - France 1986
Published by LUMIERE & JUSTICE, 32, rue Berzelius, 75017 Paris-France).

Written in French, published in Paris, fall 1986, this book contains some 20 chapters, written by as many authors, all specialists in one or another aspect of transsexuality.

Pastor Doucé, a baptist minister and psychologist, who has more than ten years of experience working closely with several hundreds of transeuxuals and advising them in many areas, has assembled the various chapters and taken the responsibility for their final editing and publication.

The foreword and the introduction are written by two Dutch physicians, both of the Free University of Amsterdam, where our Tenth Symposium will be held: Professor Dr. G.F.Bouman (surgeon) and Dr.Louis Gooren (endocrinologist and internist).

There are several chapters on the medical aspects of the " QUESTION TRANSEXUELLE ", as well as others dealing with this subject's legal, psychological and religious aspects. The book also contains a history of transsexuality since 1949.

A separate chapter deals with current situations in several countries including France, Singapore, India, Germany and Switzerland.

The book also contains the personal stories of two transsexuals who have undergone sex-change operations, one in each direction, as told in their own words. There is a long chapter about transsexuality and prostitution in France. Finally, the book ends with an impressive bibliography and list of audio-visual references pertaining to the topic of transsexuality. THE TRANSEXUAL QUESTION also contains the results of a study organised by a psychology student within the CENTRE DU CHRIST LIBERATEUR, the organisation for sexual minorities in France, founded by Rev. J.Doucé in 1976 in Paris.

You will find also a complete translation into French of the "STANDARDS OF CARE, The hormonal and surgical sex reassignment of gender dysphoric persons" of the Harry Benjamin International Gender Dysphoria Association. In this way, Europeans will easier come in contact with our organisation.

Let us now hope that we will find an English publisher and a good translator for the English-speaking world.

Rev. Joseph^hDOUCÉ (Paris, France).

cc Dr.Gooren and Dr.Bouman , Amsterdam.



ABSTRACT: PHALLOPLASTY-PAST, PRESENT AND FUTURE

MILTON T. EDGERTON, JR., M.D.
JOHN G. KENNEY, M.D.

UNIVERSITY OF VIRGINIA MEDICAL CENTER
GENDER IDENTITY CLINIC

The history of modern phalloplasty begins with the treatment of traumatic genital amputations derived from the 20th century military conflicts. These early reconstructive techniques involved the imaginative utilization of random tubed flaps and skin grafts. Multiple operative procedures were required, staged over prolonged time intervals. The final results were only moderately successful.

The female transsexual's goals of possessing a penis that is satisfactory cosmetically, psychologically and functionally can now be attained. The modern era of reconstructive phalloplasty began in the late 1970's and has continued to be refined into the late 1980's. Techniques such as the abdominal tubed flap, superficial inferior epigastric artery flap, groin flap, rectus abdominus flap, and gracilis flap have been modified and refined over the last 5 years leaning to improved functional and cosmetic results. For example, a silastic penile implant has been placed within a rectus muscle flap covered with a split thickness skin graft with excellent functional and cosmetic results. In addition, tissue expansion techniques have added a new dimension to the reconstructive options available for modern phalloplasty. The combined authors have 25 years of experience for modern phalloplasty. Its historical and future implications will be discussed.

PROPOSAL FOR PAPER PRESENTATION

HBIGDA Tenth Symposium
Amsterdam, June '87

"Anatomic Variation of the Corpus Callosum in Persons
with Gender Dysphoria"

Lee E. Emory, M.D.
Collier M. Cole, Ph.D.
Eugenio Amparo, M.D.

(Rosenberg Clinic and University of Texas Medical Branch,
Galveston)

It has been reported that there is a sex difference in the shape and volume of the posterior portion of the corpus callosum called the splenium (Lacoste-Utamsing, Science, 1982). This variation between male and female brains was, however, based on measurements taken at autopsy from a sample of 14 subjects. One might wonder if this observed difference in anatomic males and females would hold true in a larger *in vivo* sample and further would appear in a transsexual population, suggesting a neuroanatomical basis for the phenomenon of gender dysphoria.

The present study is designed to investigate this question and is being conducted in collaboration between the University of Texas Medical Branch, Galveston (Departments of Psychiatry and Behavioral Sciences and Radiology) and the Rosenberg Clinic Gender Treatment Program, Galveston. Institutional Review Board approval has been received and human subjects, between the ages of 20 - 45 years, are being screened via brain scans utilizing Magnetic Resonance Imagery (MRI) technology. The four subject groups being examined are comprised as follows: 20 anatomic males, 20 anatomic females, 10 male-to-female transsexuals, and 10 female-to-male transsexuals. (The latter two groups include individuals who have been diagnosed as transsexual, are cross-living fulltime, and have been undergoing hormone therapy for a minimum of 12 months in accordance with the HBIGDA standards of care.) All brain scans are being evaluated on a double blind basis without knowledge of whether they are male/female or normal/transsexual. One additional concern is that there have been reported differences in the corpus callosum based on handedness (Witelson, Science, 1985). Accordingly, all subjects have been screened and selected for right handedness using a test validated for this purpose (Crovitz and Zener, American Journal of Psychology, 1962). In addition, subjects have been excluded on the basis of

a medical history suggesting current pregnancy or problems involving hypertension, epilepsy, head trauma, or substance abuse.

At present nearly all of the scans have been completed and the data will soon be analyzed. It is anticipated that some conclusions will then be available as to whether or not neuroanatomical differences (in the corpus callosum) between males and females hold true and to what extent these differences may also be observed in transsexuals, possibly suggesting an anatomic basis for the phenomenon of gender dysphoria. (The data will be presented visually on slides in both table and photographic modalities.)

The Construction of Gender Identity
in Early Childhood

Beverly I. Fagot, Ph.D.

To be presented at the meeting of
the International Gender Dysphoria Association
Amsterdam, 1987

Abstract

Three-year-old children have well-developed gender categories. For the past five years, I have been studying children below the age of three, trying to discover just how three-year olds come to have so much information about gender. This work has forced me to a re-evaluation of the process of sex role development. The major portion of the work in the area of sex role development in the past 20 years has come from a framework of two theoretical approaches: social learning theory and cognitive development theory. We have learned a great deal from both approaches and hopefully have gained an understanding that these are not opposing theories but insights into different parts of the process of sex role development. The child's attempts to understand gender and the environment's role in shaping the content of the categories during the first two years allow us to examine the interface between the two theories. In this period when children are actively engaged in constructing gender categories, they are particularly open to environmental input about what it means to be a boy or girl, and they attempt to use all such information in developing their own style of gender. This, then, is a fruitful time to study sex role development, prior to the overlearning of sex role scripts that masks much of the relationship between cognitive understanding and behavioral performance.

Prevalence of transsexualism in the Netherlands.

Louis Gooren and Peter Eklund.

Hospital of the Vrije Universiteit, Amsterdam, the Netherlands.

Estimations of the prevalence of transsexualism have been made by Walinder (1967) for Sweden (1:37.000 men and 1:103.000 women), by Pauly (1968) for the USA (1:100.000 men and 1:400.000 women), and by Hoenig and Kenna (1974) for England (figures similar to those of Walinder).

Up to very recently almost all Dutch transsexuals were hormonally and surgically treated at the Hospital of the Vrije Universiteit in Amsterdam. There is no (financial) motivation for transsexuals for treatment abroad. The actual population of the Netherlands is 14.5 million. This situation allows an estimate of the prevalence of transsexualism in the Netherlands.

Only those gender dysphoric subjects actually starting hormonal therapy were included.

Our results show an increase between 1:50.000 in 1980 to 1:18.000 in 1986 of male-to-female transsexualism. For female-to-male transsexualism the rise is from 1:200.000 in 1980 to 1:54.000 in 1986. This is a 2.5-fold increase in men and a 4-fold increase in women.

Is the prevalence of transsexualism on the rise ?

Alternative explanations should be thought of.

Is the degree of "coming out" increasing ?

The age distribution did not change over the years which could evidence that the process of "coming out" is still in progress, but alternative explanations are possible.

It appears further that female-to-male transsexuals present themselves earlier in life for medical treatment.

Studies in other centers are needed to verify and to interpret the increase of prevalence found in this study.

HORMONES AND GENDER IDENTITY/ROLE

Louis Gooren, Free University Hospital, P.O.Box 7057, Amsterdam, the Netherlands.

It is now well established that androgen secreted by the mammalian testis during fetal development, plays a crucial role in organizing the internal and external genetical structures characteristic of the male.

In the absence of this androgenic stimulation individuals of either genetic sex develop phenotypically feminine internal and external genitals.

It has also been found that perinatal exposure of the male to testicular hormones permanently alters the structure of the mammalian brain and results in defeminization (reduced display of feminine coital behavior) and masculinization enhanced capacity to display masculine coital patterns.

In lower mammals defeminization is associated with the loss of the ability of the hypothalamic - pituitary axis to mediate estrogen-induced surges in luteinizing hormone, which is characteristic of females around the time of ovulation.

It has been assumed that in the human sexual orientation and gender identity/role depend on the above brain sexual differentiation induced by an appropriate sex-different endocrine environment.

Upon critical examination of this hypothesis in the human the evidence is still unconvincing for a hormonal determination of sexual orientation/gender identity, while gender role seems to be sensitive to prenatal hormonal influences.

MULTIPLE FAMILY GROUPS
FOR FAMILIES OF TRANSGENDER INDIVIDUALS

Kathy J. Harowski, Ph.D.
Assistant Professor
Program in Human Sexuality
Department of Family Practice
& Community Health
University of Minnesota Medical School
Minneapolis, Minnesota

Multiple family groups have proved a useful treatment modality for the families of many who present with mental health concerns. These groups--targeted for both families of origin and spouses/significant others--are particularly useful when long-term, complicated treatments are indicated for the patient. The groups provide information and support to family members during a time of transition, and serve to align both family and patient with health care providers.

This paper will discuss a multiple family group format developed for the Transgender Program at the University of Minnesota's Program in Human Sexuality. The group foci include providing information about gender dysphoria, support for family members, and presentation of coping models. The group also serves as a source for collecting more accurate information about the families of transgender individuals. The group model will be presented along with clinical excerpts and vignettes that arise in this setting. This group will have been in existence for one year by June of 1987, and it is the author's hope that indepth clinical information about one or two families can be provided along with the overview of the group model and process. The indepth assessment will focus on etiologic issues of the transgender phenomenon as well as the family's continuing ability to cope with this crisis and transition.

GENDER-ATYPICAL BEHAVIOR IN SCHOOL-AGED BOYS

Heino F.L. Meyer-Bahlburg, David E. Sandberg, and Richard R. Pleak,
New York State Psychiatric Institute and Department of Psychiatry, Columbia
University College of Physicians and Surgeons, 722 West 168 Street,
New York, NY 10032, USA

Gender-role behavior can be conceptualized as a continuum ranging from a gender-stereotypical pole through varying degrees of gender-atypical behavior to definite Gender-Identity Disorder of Childhood as defined by DSM-III. In boys, even only moderate degrees of gender-atypical behavior are often seen as "deviant" by the social environment and may lead to clinical referral. The conditions under which gender-atypical behavior develops are not well understood. Both social and biological, especially hormonal, factors are under consideration. An emerging association of gender-identity disorder with other psychopathology is probably also of importance in this context.

To the extent that gender-atypical behavior develops in association with other developmental psychopathology, there should be a general increase of the percentage of children with varying degrees of gender-atypical behavior among child psychiatric outpatients in comparison to the general population. If biological factors, especially male sex hormones, play a role, the prevalence of gender disorders among intersex patients should be increased, but the increase can be ascribed to hormonal factors only if appropriate other variables are controlled.

To evaluate these questions, we are studying three groups of samples of elementary-school aged boys: (1) a random sample of children aged 6-10 years from a metropolitan school district; (2) a nearly complete sample of hypoandrogenized boys of the same age range from pediatric urologists of three medical centers; (3) a sample of child psychiatric outpatients aged 5-12 years (not referred for gender identity disorder) from two hospitals.

The studies are conducted as survey studies with questionnaires being filled out by the consenting parents. All three studies include (1) the Child Behavior and Attitude Questionnaire (Bates, Bentler and Thompson, 1973); (2) The Child Game Participation Questionnaire (Bates and Bentler, 1973); and (3) The Child Behavior Checklist (Achenbach and Edelbrock, 1983). Current sample sizes range from about 40-100 boys per group. Data analysis will include the establishment of preliminary prevalence rates of varying degrees of gender disorder in these three categories of boys and their comparisons between categories, as well as the relationship of gender disorder to psychopathology scales. Initial analyses indicate results of both theoretical and practical relevance.

H

Draft for the 10th International Congress on Transsexuality to be held at the Free University, Amsterdam on 9-12th June 1987.

The permanent removal of superfluous hairgrowth in the case of transsexuals is carried out by skintherapists.

Several methods of electrical epilation may be applied:

1. Thermolysis (high frequency short wave diathermy current)
The current directed through the needle produces heat as its destructive force, thus cauterising the active areas of the follicle rendering it ineffective.
2. Blend Method (electrolysis and thermolysis combined)
Simultaneous use of high frequency current and direct electrical current. The merging of these 2 currents evokes several effects in the surrounding tissue.
In the case of thermolysis cauterisation takes place.
In the case of electrolysis the electrical current causes salt and water in the tissues to break down to form a lye, a highly caustic element that is effectively destructive in the hair follicle. This method appears to achieve a more adequate destruction of the follicle.

Treatment period

In view of the extent of the superfluous hairgrowth, treatment may amount to several years. The frequency and length of treatment sessions should be taken into account.

Financial Compensation

A maximum compensation of f. 7,500,-- for electrical epilation is afforded by the national insurance. Private insurance companies employ their own specifications.

(in the case of transsexuals)

Advice to patients during treatment

1. Plucking is forbidden: cutting or shaving is allowed.
2. Redness: cool the treated area with cold compresses or blocks of ice.
3. 24 hours afterwards or as long as treated area is irritated: sunbathing and sunbed treatment should be avoided. Hyperpigmentation may occur.
4. Mild cleansing of treated area with cleansing oil or protect with a neutral cream.

For information: Hazenkampseweg 17
6531 NA Nijmegen
tel: 080-569474
080-556368

THE EFFECTS OF SEX HORMONES ON INFLAMMATION OF THE PERIODONTIUM

M.G. Huisman, D.D.S. and M.A.J.H. Heydt, D.D.S.
Department of Periodontology, Free University, Amsterdam

In dentistry, it is distinctly understood that the periodontium is a total of functional units, as alveolar bone, blood vessels, lymph vessels, nerves and attachment fibres of the teeth, that guarantee the attachment of the teeth to the alveolar bone of the jaw. When an inflammation of the periodontium is manifest caused by several bacterium species, it is possible, with increasing of time, that teeth will be lost, caused by decrease of attachment level of the teeth in the surrounding bone of the jaw (alveolar bone).

The symptoms of periodontitis are:

- * increased plaque accumulation caused by swelling and the presence of deep pockets;
- * loss of alveolar bone and following decrease of attachment level, which results in a pathologic pocket;
- * increased mobility of teeth;
- * increased bleeding index (more bleeding sites after gentle probing of pockets);
- * increased gingival exudate;
- * swelling of gingival tissues;

With the current knowledge about the effect of sex hormones on periodontal inflammation, we cannot explain the pathogenesis of "hormonal stimulated periodontal disease". But we are able to imagine what will happen to the periodontium after using sex hormones.

In a healthy oral situation there will be no changes in the periodontium after using sex hormones. But nobody has a full 100 % healthy periodontium. Especially the gingival papillae will always be inflamed. As a result of the use of sex hormones (progesteron) there will be a vasodilatation. Also the permeability of blood vessels will increase. This result in bleeding after probing and in time increased tooth mobility. When oestrogens are used, oedema of the gingival papillae, as a result of water retention in the connective tissues, will occur.

So, the increase of permeability, dilatation of vessels and the water retention of connective tissues will enhance the general symptoms of periodontal inflammation.

Our small introductory study was concerned with the clinical effects of sex hormones used by transsexuals. With the use of standard dental clinical indices we investigated the oral situation.

The most important conclusions are:

- the changes in hormone concentrations result in an increase of periodontal inflammation;
- the gingival exudate, as general symptom, is an excellent nutrition for several bacterium species which are responsible for periodontitis;
- sex hormones only do not provoke periodontitis. They alone can exacerbate a present inflammation.

The Significant Other:
Sexual Orientation, Functioning and Satisfaction
with Partner Gender Reassignment -- A Previously Unstudied Aspect

David P. Hurley, Jr., M.D.
Milton T. Edgerton, Jr., M.D.
M. W. Langman, ps. dra.

Because of statements made by a few long term follow-up patients, we began to believe that in general post-operative male transsexual patients develop a quite satisfactory sex life.

We felt this to be particularly true if the patient formed his relationship following surgery, after gender identity had been surgically confirmed. Our interest was additionally drawn to the psychosocial and sexual orientation of the gender patient's significant other, an area which has remained largely unstudied. Therefore, we undertook this study.

Using questionnaires and individual interviews, the sexual orientation, functioning and satisfaction with partner gender reassignment was assessed. Basic demographic data was obtained, as well as data concerning the circumstances of relationship development and sexual history. The nature of the current relationship was explored in terms of sex role activities and social activities. In addition, the subjective assessment of the hormonal and surgical results of the partner's sexual reassignment was obtained and the significant other's assessment of the gender role satisfaction of their partner was explored. These data were compared with similar data obtained by a questionnaire from the sex reassigned partner.

PROPOSAL FOR PAPER AT THE 10TH INTERNATIONAL SYMPOSIUM ON GENDER DYSPHORIA
THE HARRY BENJAMIN INTERNATIONAL ASSOCIATION GENDER DYSPHORIA ASSOCIATION, INC.

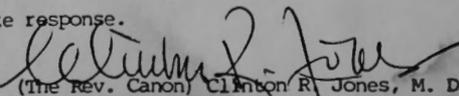
THEOLOGICAL QUESTIONS; PASTORAL RESPONSES REGARDING GENDER DYSPHORIA

Over the years that symposiums have been held regarding gender dysphoria, the primary focus has been on the surgical and psychological aspects of this identification. There has been some attention given to selected sociological data as well as a certain concern for "follow-up" studies. No doubt this has been a valid and understandable approach for the particular professions involved. However, one area that has been touched upon only slightly has been the theological, the religious, the pastoral.

Now that more than three decades have passed since broad public awareness surfaced by Christine Jorgensen's surgery and the subject of transsexualism has received wider attention, religious bodies and individual theologians have begun to grapple with issues which seem to rise regarding this subject. Some responses are positive, others are negative, and there are those which straddle and provide no specific determination. The traditionalists and conservatives are beginning to speak out as well as those who represent the evangelical "right". On the other hand more liberal theologians and moralists are adopting an opposing position.

What are some questions? If God is Creator, has man the right "to interfere" with His creation using the therapies embraced by this Association? Should such professionals support the dissolution of marriages and often the "breakup" of families which may be involved. Is sex reassignment surgery "mutilation" or is it "cure"? There are many others.

From a pragmatic standpoint perhaps the answers must come from experience. Is this really a situation in which "the end justifies the means". Is it possible that out of the pastoral relationship with such patients/clients that there can be some answers?? It is through such counseling which covers nearly a twenty-five year period that I feel ready to make response.


(The Rev. Canon) Clinton R. Jones, M. Div., S.T.M., D.D.
Christ Church Cathedral
45 Church Street, Hartford, Conn. 06103

EFFECTS OF RU 23.903 (ANANDRON) ON LATERALIZATION AND SPATIAL ABILITY IN MALE-TO-FEMALE-TRANSSEXUALS

Johannes F. L. M. van Kemenade, M. A. (1), Peggy T. Cohen-Kettenis, Ph.D. (1), Leo Cohen, Ph.D (2) and Louis J. G. Gooren, M.D. (2)

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ABSTRACT

Intelligence, spatial ability and hemispheric lateralization were investigated in 14 presurgical male-to-female-transsexuals, undergoing anti-androgenic treatment with RU 23.903 (anandron). Subjects were tested the morning prior to treatment onset and eight weeks into treatment. Subjects showed average intelligence on a short form of the Groninger Intelligentie Test (mean IQ = 103,2, SD = 8.0). Results on the Embedded Figures Test showed a dramatic improvement after eight weeks ($p < .01$). This is explained as a confirmation of the "Optimal Estrogen Theory" by Nyborg. Results on the dichotic listening test revealed the existence of two subgroups, i.e. one group ($n = 7$) with familial lefthandedness and one group ($n = 7$) without familial lefthandedness. Several between-group differences were found and the unusual high percentage of familial lefthandedness was commented.



nederlandse vereniging

humanitas

voor maatschappelijke dienstverlening en samenlevingsopbouw

Project Transsexualiteit

Centraal Bureau en
Regio Noordwest Nederland
p/a Centraal Bureau Humanitas
Sarphatistraat 4 Amsterdam
Tel. 020-262445
075-352917
postbus 71. 1000 AB Amsterdam

Abstract

PROJECT TRANSSEXUALISM

Project Transsexualism has the character of a self-help group of transsexual persons.

The Central Bureau Humanitas in Amsterdam is the national center of the professional counsellor, who is working on a 20-hour a week.

Furthermore there are six regionally volunteer counsellors.

The goal of the project Transsexualism is to assist and counsel persons with gender identity problems, and to aid in the transition process, in all its facets.

Besides professional counseling, there are also self-help groups where individuals with similar feelings can meet, socialize and exchange experiences.

Project Transsexualism is a branch from the Netherlands society "HUMANITAS", for social assistance and social growth. An organisation on Humanistic basis.

This is subsidized by the Ministry of Welfare, National Health and Culture.

Changes in bone turnover in transsexuals.

P. Lips, P. Uitevaal, H. Asscheman, J.C. Netelenbos, L. Gooren.

Department of Endocrinology, Academisch Ziekenhuis Vrije Universiteit, Amsterdam.

The effect of the change of hormonal environment on the skeleton in transsexuals is unknown. In order to study this effect, transillial bone biopsies were obtained in 23 male-to-female transsexuals (mean age \pm SD 38.0 \pm 11.7 year) after estrogen treatment for at least one year. The bone biopsies were processed without decalcification and analysed with histomorphometric techniques. Results were compared with data obtained from 11 healthy men (39.6 \pm 9.4 year). There was no difference in bone mass parameters between the transsexuals and the control group. The mean value of resorption surface and osteoclast count was similar in both groups, but osteoclastic bone resorption was increased in some transsexual patients. The relative ostoid volume and surface were significantly lower in the transsexuals than in the controls, but there was no difference in osteoid seam thickness. The mineralization rate was normal, but the active formation surface and the bone formation rate were less than half of the expected number.

Conclusion: Treatment of male-to-female transsexuals with estrogen leads to a decrease of bone formation. A change in bone mass parameters was not observed. The consequences of long term estrogen treatment in transsexuals are not yet known.

ABSTRACT

Development of Gender Self-Representation in Gender-Disturbed Children: A Genogram Analysis of One Family

Leslie M. Lothstein Ph.D. ABPP
Director of Psychology
Institute of Living
Hartford, Connecticut

The question of how gender meanings are transmitted from parent to child are investigated in this study. The process of identification is explored from the viewpoint of how intergenerational and intrafamilial gender images are formed and become an integral part of the gender identity confusion in the gender disordered child. It is hypothesized that a family's gender images are incorporated into their child's evolving awareness of his/her self system and becomes an integral part of his/her gender self-representation. The role of the parental dyad, the unique role of the mother, and the critical role of the myriad of intergenerational family members on the child's developing gender self-representation are explored.

In this study I chose to utilize the family genogram method to see how a child's gender identity conflict might be traced to a core family dynamic and an unresolved intergenerational family theme. The results suggest that the gender dysphoric child is viewed by the family as a natural target for bringing their unresolved conflicts out in the open where they can finally be resolved through treatment. I have used this method with 8 gender impaired children and their families and over 100 transsexual patients.

In this presentation I will focus on one family, Andy's family, in which a four year old boy presented with multiple gender symptoms, including genital abuse and threatened genital mutilation. The genogram served both as a diagnostic and therapeutic tool and enabled Andy's parents to understand the pathogenesis of Andy's gender disorder while also freeing them up to help treat their son and resolve his gender identity conflicts.

ABSTRACT

A Rorschach Analysis of Mothers and Their Transsexual Children

Leslie M. Lothstein Ph.D. ABPP
Director of Psychology
Institute of Living

In this study I have focused on one set of communications which arise between transsexuals and their mothers which may predetermine specific gender schemas in the child. Specifically, by analyzing the representational imagery of transsexuals and their mothers (as measured by Rorschach indices), I hope to show how an important part of the transsexual child's gender schema may have been derived from preexisting conflictual gender schemas in the mother and "transmitted" to the child.

Ten mother- "child" pairs participated in the study. The subjects were drawn from a larger number of transsexuals (n=200) who applied for sex reassignment surgery at a university gender identity clinic.

The results suggested that the mothers were more "disturbed" and conflicted than their transsexual children. The mothers Rorschachs suggested that their organizational level was inferior to that of their children. Moreover, the mothers were overreactive to stimuli; less reflective and introspective; had a weakened capacity for reality testing; evidenced more conflict over their self image and more turmoil over their gender identity and role; evidenced more impaired object relations; and had more malevolent and aggressive responses than their children. Overall they were more psychologically disturbed than their children on the Rorschach.

The study suggests that the transsexual's mother is also gender disturbed and, given her weakened ego capacity, may convey certain meanings about gender which are disorganizing to her children. These mothers also transmit their separation anxieties and weakened self structures to their children. In effect, they are the bedrock on which their child's gender identity disturbance rests.

In summary, the defective gender self representation of the mother forms the basis of the transsexual child's defective gender self representation.

ABSTRACT

IDENTIFICATION AND INTERNALIZED OBJECT RELATIONS:
A COMPARISON OF FEMALE-TO-MALE TRANSSEXUALS,
LESBIANS AND HETEROSEXUAL WOMEN

By

Terrie A. Lyons, Ph.D.

The proposed paper reports on a comparative study of female-to-male transsexuals, lesbians and heterosexual women conducted in the San Francisco Bay Area during 1985-1986. The primary study hypotheses were developed to test two psychological theories of etiology, social learning theory, which presumes that gender is learned through identification with parents and object relations theory, which suggests that gender dysphoria is a result of disturbance in the separation-individuation phase of development (age 18-36 mo.). Specifically, these hypotheses were that: 1) transsexuals would be more identified with their fathers than either the lesbians or heterosexuals and 2) transsexuals would show evidence of more primitive internalized object relations. It was also hypothesized that transsexuals would be male in gender and more masculine in their sex roles than the lesbian and heterosexual women.

Instruments used were the Block Q-sort, the Bem Sex Role Inventory, the Object Relations Technique, the Derogatis Symptom Check List and a Demographic questionnaire.

The subjects were 10 female-to-male post-op (at least mastectomy) transsexuals, ages 24-46. They were matched for age, race and socioeconomic status with 10 lesbian and 10 heterosexual women.

Contrary to expectations, the transsexuals were no more identified with their fathers than were the other groups, nor were they or any other group more identified with either parent. Similarly, transsexuals showed no more evidence of primitive internalized object relations than did the other groups. As was anticipated, the transsexuals were male in core gender, while the lesbians and heterosexuals were female. Transsexuals also tended toward more masculine sex roles than did their counterparts. However, they showed evidence of similar levels of feminine sex roles as did the heterosexuals. The lesbians were somewhat lower in measures of feminine sex roles than either other group. No differences were found on the psychopathology screening device, the Derogatis Symptom Check List.

It was concluded that core gender identity is an intrinsic part of identity and does not appear to be related to the psychological factors of identification with the parent of the same gender or internalized object relations. Rather, it was suggested that etiology may be due to complex factors involving multiple features.

GENDER DYSPHORIA: A NOSOLOGICAL PERSPECTIVE-1987

Judy Van Maasdam, M.A.
Paul A. Walker, Ph.D.

Various diagnostic terms have been used to define transsexualism; classic transsexual; primary transsexual; secondary transsexual; asexual transsexual; transvestite; aging transvestite; heterosexual transvestite; effeminate homosexual; stigmatized homosexual; gender dysphoria syndrome. Utility of these various terms and DSM-III nomenclature will be reviewed and discussed. A workable diagnostic paradigm will be proposed.

ONE-STAGE PHALLOPLASTY IN TRANSEXUALS

R.Meyer, P.J. Daverio, J.Dequesne

We show a one stage phalloplasty in female transsexuals with a modified Chinese forearm flap, including the cutaneous nerves anastomosed to the genital branches of the ilioinguinal and iliohypogastric nerves and the perineal branches of the pudendal nerve to obtain true genital sensibility. Immediate hysterectomy and vaginal closure are performed, providing vaginal skin to complete the neoscrotum built up with the labia and to cover the glans. A vaginal flap draped around the catheter provides the urethra, which is stripped through the dermal tube of the forearm flap acting as a corpus spongiosum. Autogenous costal cartilage is used as a stent for reinforcement, substituting for the corpora cavernosa. The donor forearm area is covered with split skin. The urethral catheter must be removed after six weeks, at the earliest. There is no incontinence and urination is possible in a standing position. Genital sensibility of the penis is achieved after eight months. The penis remains in a semierect position, as in individuals with noninflatable penile protheses. After one year, when all the scar tissue has become soft enough with good sensibility, erectile implants can replace the cartilage stent if desired, and at the same time testicular implants can be inserted. This is a one stage, 10-hour microsurgical plastic and gynecological procedure and requires a ten-day hospital stay with very simple follow-up.



ONE STAGE RECONSTRUCTION OF THE VAGINA WITH PENILE SKIN
ISLAND FLAP IN MALE TRANSSEXUALS

R.MEYER

A method of genital conversion in male transsexuals experienced in male transsexuals experienced in more than 15 years and more than 100 cases is presented.

The neo-vagina is created using the penile skin as an island flap.

The formation of the new vaginal cavity is begun by a horizontal incision in the perineum. We transect the fascia diaphragmatis urogenitalis inferior (Denonvillier), cut the rectourethral muscle and the levator ani muscle in the midline and enlarge the vaginal introitus created this way by blunt dissection between the bladder and the rectum, following the urethra up to the prostate.

The inverted penile skin is then pushed into the new vaginal cavity and held in position by packing.

To give a natural appearance to the labia majora a bilateral Z-plasty is performed in the lower inguinal zone. The anterior branches of the labia majora and minora converge in front of the site of the neoclitoris, which is emphasized by folding the "vestibular" skin with pinching mattress sutures while, beneath, a bud-like prominence has been shaped from the remaining tissue of the corpora cavernosa

JOHN MONEY, Ph.D. JOHNS HOPKINS UNIVERSITY, BALTIMORE,
MARYLAND, U.S.A.

Abstract

Under conditions of solitary confinement in prison, two men discordant for chromosomal sex, one 47,XXY and one 47,XYY, developed syndromes of gender transposition related to transexualism. The two cases are of theoretical significance to the differential diagnosis, prognosis, and treatment of transexualism. They exemplify inconstancy of gender dissociation, with the male/female pendulum swinging back and forth. In such cases, sex reassignment surgery is contraindicated until such time as there is evidence that the pendulum has quit swinging. Otherwise sex reassignment is likely to be regretted as a mistake. Both cases lend support to the thesis that transexualism, as well as other gender transposition syndromes, is fundamentally and phenomenologically a dissociative syndrome. The full implications of sexological dissociation have yet to become identified and incorporated into transexual theory, practice, and research, as well as into sexological medicine and research in general.

Specific Satisfying Results Among Patients Treated For Transsexualism at a Single Clinic

James M. Nachbar, M.D.
Milton T. Edgerton, M.D.
M.W. Langman, ps. dra.

Studies following patients who have undergone gender reassignment have consistently shown overwhelming patient satisfaction; however, we have often seen patients with more specific goals than a general consonance of gender identity and physical appearance. Some patients seem primarily driven by fear that their biologic sex will be discovered, while others state specific functional goals for the new genitals.

Since patient satisfaction has been so overwhelming, a detailed study of satisfaction with each aspect of the gender reassignment was undertaken. Patients presenting for evaluation at the University of Virginia Gender Identity Program over a ten year period were studied by questionnaire, and information concerning the patients' satisfaction with gender reassignment was obtained. Specifically, responses to questions concerning functional and cosmetic satisfaction with each aspect of hormonal and surgical results, as well as work history, social and interpersonal relationships, sexual orientation and practices, and overall gender role satisfaction were tabulated and compared among groups of patients stratified by biologic gender and extent of surgery.

ABSTRACT

J.-P.A. Nicolai and A.J.M. Huijbers

" SILICONE-RUBBER VAGINA STENT "

Neo-vaginas in transsexual men need a mold or stent in the postoperative period for a certain length of time. Several types of stents have been advocated, varying from gauze-filled condoms to vibrators commercially available in sex-shops. A simple way is presented consisting of filling the neo-vagina with fluid silicone-rubber which hardens within 5 to 10 minutes. The advantages include the ease with which the stent is manufactured, the fact that it is custom-made and is very resistant to wear and tear; moreover, irregularities may easily be cut off with a knife when necessary, and depressions filled with a new amount of fluid silicone-rubber.

Arnhem, 11.12.1986.

J.-P.A. Nicolai.

DEVELOPMENT FROM TRANSVESTISM TO TRANSSEXUALISM

Drs. J. Poortinga and Dr. A.M. Verschoor, Free University, Amsterdam

In this study so-called "secondary" transsexuals and transvestites are compared on a number of diagnostic criteria (i.e. pre-adolescent cross-gender behavior, transvestite history and sexual history). Moreover, it is tested whether changes in transvestites from fetishistic to gender-motivated cross-dressing is related to age, divorce and unemployment. Subjects were 36 transvestites (volunteers from the Dutch Club for Transvestites and Transsexuals) and 39 male transsexuals, applying for hormonal and surgical treatment at the Dutch Gender Foundation. The latter were diagnosed as "secondary" transsexuals on the basis of age of onset of transsexual feelings after the age of twelve.

Data were gathered with a pre-coded questionnaire.

As might of course be expected the transvestites and "secondary" transsexuals differed significantly with respect to both initial and current motivation for cross-dressing and sexual orientation. No significant differences were found with regard to pre-adolescent cross-gender behavior (measured by preferences for toys, plays and games and playmates). However, transvestites showed some noteworthy developments with regard to fetishistic arousal. Two third of them reported that the fetishistic arousal is currently of minor or no importance at all and for 44 % there had been a change toward more gender-motivated cross-dressing. Moreover, 23% mentioned the self-experience in sexual phantasy as gravitating toward transsexualism and 15 % reported a similar change in imagined sex-partner.

Early onset of transvestite behavior appeared not to be related ^{to} a greater intensity of genderdysphoria in later life; on the contrary, the transvestites started significantly earlier with cross-dressing than did the "secondary" transsexuals.

Seventy-five percent of the transvestites felt a growing urge to cross-dress. This held true for both the fetishistic subgroup (n=12) and a subgroup consisting of transvestites showing a change from fetishistic to gender-motivated crossdressing (n=16).

No significant differences between these two groups were found by comparing them on age, unemployment and marital status. Therefore it is suggested that development of transvestite behavior into a more transsexual direction is autonomous and not controlled by environmental factors.

ABSTRACT

Michael P. Small, M.D.
Clinical Professor of Urology
University of Miami School of Medicine

A technique of penile and scrotal inversion vaginoplasty for the male to female transsexuals has been used successfully in more than eleven (11) gender dysphoric patients. The depth of the neovagina is approximately 11 cm, a cosmetic and physiologic result which adds greatly to the patient's satisfaction with the operation. There were no complications of rectal or urethral fistulae. One patient developed vaginal stenosis.

W-2

RISK FACTORS FOR DEVELOPING HYPERPROLACTINAEMIA AND PROLACTINOMA IN
HORMONE-TREATED MALE-TO-FEMALE TRANSSEXUALS.

J.P.H.Smits, H.Asscheman, L.J.G.Gooren
Departement of Endocrinology/Andrology, Academic Hospital Free
University, Amsterdam, the Netherlands.

Since prolonged administration of estrogens, as given to male-to-female transsexuals, might induce prolactinomas, we evaluated all male-to-female transsexual patients treated between 1972 and 1986. We looked for the relation between PRL levels, age, duration of treatment and kind of hormone treatment.

We had sufficient data on PRL levels in 214 out of 303 patients. This group, aged 19 to 60 years, was treated for a period of 1 to 13 years with 100 mg cyproterone acetate (CA) and 100 µg ethinylestradiol (EE)/day or with long-acting estrogen esters (laE) 100 mg im. twice a week to once a month.

All patients had an increase in PRL levels. 46 out of 214 patients (21%) had PRL levels >1000 mU/l (normal upper limit 400 mU/l). In 37 (80%) this increase appeared during the first 4 years of treatment. There was no trend towards an increased prevalence with duration of treatment.

The occurrence of high PRL levels increases with increasing age at start of treatment, and the event rate of high PRL levels for the group treated with laE, for each age category, falls above that for the group treated with EE (Cox proportional hazard model).

In 8 patients, with PRL levels >1500 mU/l, CT-scanning of the pituitary gland was performed. It showed evidence of 1 macroadenoma and 4 microadenomas. 1 patient had a meningioma and 2 patients had no pituitary enlargement. 4 out of 5 patients with an adenoma had been treated with high dose laE.

In conclusion, the relation between these risk factors for developing high PRL levels, and the induction of prolactinomas remains to be elucidated. But follow-up of PRL levels in hormone-treated male-to-female transsexuals, especially when treated with high dose laE, appears necessary.

LE PULSE FREQUENCY AND AMPLITUDE IN
M-TO-F TRANSSEXUALS.

Spijkstra JJ, Spinder T, Gooren LJG.

Dept. of Internal Medicine (Division of Endocrinology)
Hospital of the Vrije Universiteit
1007 MB Amsterdam, The Netherlands.

ABSTRACT.

The LH pulse frequency and amplitude are indicators of the interaction of gonadal steroids with the neuroendocrine system governing the control of gonadotropin secretion. Transsexuals may differ from heterosexuals in some aspects of the regulation of the gonadotropin secretion.

In this study we tested whether a difference could be found between 8 m-to-f transsexuals and 22 heterosexual men concerning LH pulse amplitude, LH pulse frequency and mean serum LH concentration.

In this study no significant differences could be found. It was concluded that there are no indications that m-to-f transsexuals differ from heterosexual men in their neuroendocrine regulation of gonadotropin secretion.

L K G T & T

These letters stand for the contact association for transvestism and transsexualism, which attained its formal status in 1985. The object of the association, laid down by statute, is to contribute to the emancipation of the gender-dysphoric and to offer them support. In practice this means offering information and guidance, occasionally on an individual basis (at the present time we rely on voluntary effort), and producing our magazine "Transformatie".

Our organisation coordinates activities of our local "T and T" groups (as we call them). In 9 urban centres in The Netherlands, each of these groups organises one informal evening a month plus self-help activities. A wide variety of gender dysphorics and interested individuals visit our evenings.

Our address is:

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POSTBUS 11575
1001 GN AMSTERDAM
THE NETHERLANDS.

Rearrangements of the facial skeleton to match the sexual identity

The last decennium surgical interventions have been performed to correct facial disharmonies. Not only improvement of function but also from esthetical point of view were the objective's. In instances where a change of sexe is considered a masculine facial appearance does not always match to the overall bodychanges. In a poster some surgical technique and their effect on the facial appearance will be shown.

dr D.B.Tuinzing

AGE OF ONSET OF TRANSSEXUAL FEELINGS AND CROSS GENDER BEHAVIOR

by

Dr. A.M. Verschoor and Drs. J. Poortinga, Free University, Amsterdam

The hypothesis was that earlier onset of transsexual feelings was related to more clear-cut cross gender behavior. Subjects were 224 male and 121 female transsexuals, who requested sex-reassignment and being taken into treatment by the 'Dutch Gender Foundation'.

Some results are collected in tabel 1.

AGE OF ONSET TRANSSEXUAL FEELINGS

before 7 year after 12 year level of sign.
N = 108 N = 37

	younger	older	S	p	.05
age of onset of treatment					
married or divorced	--	--	NS		
employed in job or study	--	--	NS		
education level	--	--	NS		
cross gender toys	more	less	S	p	.001
cross gender plays and games	more	less	S	p	.001
cross gender playmates	more	less	S	p	.001
onset of cross dressing	younger	older	S	p	.001
sexual interest	less	more	S	p	.01
sexual phantasy fits TS-feelings	more	less	S	p	.001
aversion to own body	--	--	NS		

Tabel 1 : cross gender behavior and some other data in relation to age of onset of transsexual feelings : before 7 year, after 12 year.

Comparisons between the groups indicated that the hypothesis was confirmed. Interpreting these results the question was if the 'secondary' transsexuals would develop these feelings later or repress cross gender behavior stronger.

CONSIDERATIONS ABOUT THE USE OF ANTI-ANDROGENIC DRUGS IN
MALE-TO-FEMALE TRANSSEXUALS.

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Differentiation and development of male phenotypic characteristics are regulated by androgens of testicular origin. Genetic males who option for gender reassignment should be carefully monitored and the objective changes introduced gradually. This caution cannot be over-emphasized. Among the many presently available options to counteract androgen action considerations have to be paid to drug toxicity, time of initiation, effectiveness of drugs and their mode of action. Finally the possibility of reversing to pretreatment conditions with minimal damage has to be taken into account.

We evaluated the short-term effect of a pure anti-androgen Anandron (RU 23908) and the long term of a combination of estrogens and the anti-androgen Androcur (CPA) in 16 normal, healthy candidates for male-to-female gender reassignment. Serum T-, LH-, FSH- and prolactin levels were measured before and after 8 weeks of treatment with Anandron. In 6 patients prostate volume was measured by transrectal ultrasonography before and after the 8 week course of Anandron. In 6 other patients after 12 - 18 months of treatment with a combination of Estradiol and Androcur again prostatic volumes were measured, at the time of gender reassignment surgery. Biopsies from the prostates were also taken at that time. Testes removed were used for Leydig cell preparation.

A significant increase of serum T- and LH-levels was observed after Anandron treatment, while FSH and prolactin showed only minimal variations. All subjects showed signs of feminization, such as gynaecomastia and loss of hair growth. Remarkably there was no change in volume of prostates after 8 weeks of Anandron, nor after 18 months of estrogens and anti-androgens. Histologically however there was atrophy and disappearance of glandular

tissue and an increase in stromal tissue. From the removed testes, we were able to recover vital Leydig cells which could be cultured for a short time. These cells responded to stimulation by synthesizing testosterone in vitro.

These observations support the hypothesis that Anandron is a potent, pure anti-androgen in human beings. However the long term action on pituitary LH-secretion and testosterone production is not yet known. Estrogens are long known for their anti-androgenic action in patients with prostatic cancer. Drawback of estrogen use is the cardiovascular toxicity. Androcur is a potent anti-androgen but has also a weak progestational action. LHRH-agonists reduce testosterone synthesis without known side-effects, but feminization is minimal.

A combination of drugs in minimal, non-toxic doses which provide optimal effects should be the method of choice. In addition to the readily observable phenotypic changes, serum T- and LH-levels are indicators which could be used for monitoring treatment effect. Although prostate activity is androgen dependent, prostate size is not a reliable parameter for evaluating the anti-androgenic action with drugs.

The presence of vital Leydig cells, that were prepared from the testes of subjects treated for longer than 18 months with anti-androgenic drugs and that could be stimulated to synthesize testosterone in vitro, suggests the reversibility of the treatment procedures in vivo.

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ABSTRACT

Transsexualism and Character Disorders

75 MMPI profiles were obtained from applicants for sex reassignment surgery. All but 2 were clinically abnormal. Whether scored according to the norms for males or females, most evidenced signs of a character or personality disorder (DSM Axis II).

In dealing with sex reassignment applicants, clinicians often look for signs of gross psychotic functioning. The more subtle, but more pervasive and even, at times, more serious, personality disorders are often neglected or only commented upon. While not necessarily contraindicative of surgery, these personality disorders may be predictive of a patient's ability to cooperate with pre- and post-operative therapy, their ability to rationally approach and complete the real-life test, and the likelihood of post-surgical adjustment.

It is concluded that Axis II disorders almost always co-exist with the axis I diagnosis of transsexualism, and that these personality disorders need to be addressed as part of the total treatment plan for each patient.

Harry Benjamin International Gender Dysphoric Association
Tenth Symposium Amsterdam, Netherlands, June 10-12, 1987

Tina Wheeler and Leah Schaefer

Abstract

HISTORICAL OVERVIEW OF HARRY BENJAMIN'S FIRST 1,500 CASES

For the past five years the authors have been privileged to have the complete use for their research purposes of Harry Benjamin's entire medical files on gender dysphoria. Benjamin's files cover a unique practice which began with a singular chance referral from Alfred Kinsey in 1948, to over 1,500 patients by the time of his retirement in the late 1970's. For Harry Benjamin, treating the gender dysphoric person was ultimately the sum total of all of his previous interests and knowledge, primarily gerontology and endocrinology. Being a true physician, Benjamin treated each of his patients as people and by respectfully listening to each "self-diagnosed" individual, he learned from them what gender dysphoria was about.

Benjamin turned an idea -- a hunch -- into a professional discipline. In the course of researching his files and studying his writings, we have discovered that there is hardly a single idea used today, or still being researched, which was not initially suggested by the genius of his understanding. His contributions were without peer: among them were the development of a diagnosis of true gender dysphorias from other conditions presented; his recognition of the interweaving of the psychological with the physiological in those patients suffering with this condition; the development of resources of respectable practitioners from all over the world; plus his encouragement of gender clinics and networking systems.

An overview -- both empirical and sociological -- of the professional life of Harry Benjamin, "The Persistent Pioneer," will indeed describe the development of our unique profession.

SYMBOLIZATION PROCESSES IN GENDER DYSPHORIC MALES
PRELIMINARY FINDINGS

Marilyn Wilchesky, M.Ed., Montreal General Hospital

At the Human Sexuality Program of the Montreal General Hospital, a study was proposed to examine genital symbolization in male transsexuals. Results from a pilot study clearly indicated that, in fact, male transsexuals have a rich symbolic life. Investigation is currently centered on the form of symbolic representation that this particular group of individuals presents compared with two control groups - male heterosexuals, and male homosexuals. The instrument used in the ongoing research is the Rorschach ink blot test, scored by the Holt method, to which has been added a special genital symbol enquiry. This technique has been conceived to tap the wealth of symbolic productions related to the transsexual's intense castration anxiety. It is hypothesized that although this is experienced by all three groups, the transsexual will deal with it differently. The inability to represent the penis within the Ego will be bound to influence the transsexual's representations; the object rejected from his awareness will likely reappear in his conscious using primary process mechanisms. Initial findings show a tendency to support the hypotheses that the target group has a greater number of responses: symbolizing the penis; suggesting onslaught of this organ; symbolic representations of female genitalia; that these are seen with both pleasure and dread; instances of birth, mothering and motherhood; that these will also be conflicted; examples of men seen as primitive and threatening. These results will be illustrated from the protocols examined.

Harry Benjamin International
Gender Dysphoria Association - 10th Symposium

Abstract

Neal Wilson, M.B. B.S.,
F.R.C.S.

The Effects of Smoking on Arterialized
Skin Flap Phalloplasty - Case Reports

Rees et al reported on the effects of smoking in cervicofacial rhytidectomy; Anderson reports that smoking is an absolute contra indication to long flap face lifting procedures. Robson reports no effect of smoking on skin flap survival in the experimental animal.

Three case reports will be presented to illustrate some devastating complications during phalloplasty in heavy smokers and their eventual solution.

Harry Benjamin International
Gender Dysphoria Association - 10th Symposium

Abstract

Neal Wilson, M.B. B.S.,
F.R.C.S.

The Use of A.M.S. Hydroflex Penile Implants in the
Groin Flap Skin Tube Neo-phallus

The Hydroflex is a self contained inflatable penile prosthesis. The pump is at the tip, the resevoir of the base; the valve is behind the tip.

These rod-like structures can be fitted with 3 centimeters "rear tip" extenders which allow them to be sutured firmly in a fascial tunnel over the ischio-pubic ramis.

So far 8 units have been implanted. One has been lost due to skin flap failure. The remainder are functioning well.

It is expected there will be more than a series of 4 by the time of the meeting.

Harry Benjamin International
Gender Dysphoria Association - 10th Symposium

Abstract

Neal Wilson, M.B. B.S.,
F.R.C.S.

Revision Vulvoplasty and Urethroplasty

Urethral meatal stenosis and mal position are fairly common occurrences. This paper will illustrate the surgical technique of fashioning of glans clitoridis from the distal urethral remnant with transposition of the meatus to the anterior superior vaginal wall; also illustrated is the method of fashioning a clitoral hood and labia minora.

The above technique can be used in the presence of a remnant of inverted glans penis; this will be illustrated.

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... will be ...

STUDY ON THE
EFFECTS OF
SEXUAL
ACTS
ON THE
HEALTH
OF
INDIVIDUALS
IN
INDONESIA

By
Dr. H. S. S. S.
and
Dr. H. S. S. S.

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