

Criteria for the evaluation of male-to-female transsexual patients

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The sensational publicity given to the 'sex change' of a former American G.I., George Jorgensen, made hundreds of transsexuals aware of the fact that the field of medicine offers a 'cure' for their problem. The result of this is that an ever increasing number of transsexuals approach physicians with the request for sex reassignment surgery. Besides possible moral and ethical objections to the reassignment of a biologically normal male to the opposite sex, the physician is also faced with the problem of having to amputate normal organs in order to create the image of the opposite sex.

Despite the objections to sex reassignment surgery the number of operations shows an

increase every year. The implication of this is that the sex reassignment operation has come to stay and that physicians will have to reassess their attitudes towards sex reassignment. In this connection Green (1975b) says that the reaction towards sex reassignment is usually subjective and based on emotional, moral and theoretical views that are not scientifically founded. Man is subjectively involved with his own sexual organs and therefore cannot comprehend why a person could express the need to be rid of his sexual organs and want to live as a member of the opposite sex.

Although physicians can be criticised for refusing sex reassignment on account of their personal views, Baker and Green (1970) emphasise that the sex reassignment operation should not be granted on request. In support of this, Kubie and Mackie (1968) state that cases were reported where it appeared after the sex reassignment that the patients were not transsexuals. In order to avoid this, both Benjamin (1975) and Ehrhardt (1973) stress the im-



* This article is based on material in the author's doctoral thesis of which the University of South Africa holds copy right.



portance of thorough evaluation prior to giving consent to have the operation performed.

Stone (1977) believes that the evaluation should not be the responsibility of one person alone. In order to make a meaningful assessment a team approach is necessary and the team members should be representative of various disciplines. Exner (1972) who supports this approach believes that the team should consist of a psychiatrist, urologist, gynaecologist, plastic surgeon, clinical psychologist, social worker and a legal advisor.

According to Money and Schwartz (1975), all team members should be familiar with the literature on transsexualism. In addition to this Green (1975a) believes that all team members should be unbiased towards transsexuals and that they should not be too strict or permissive regarding the approval of the operation. A further characteristic of the team members emphasised by Wollman (1975), is the ability to empathise.

Green (1975a) and Knorr, Wolf and Meyer (1975) see the evaluation of transsexuals as problematic because it is not

always clear what criteria should be used to distinguish effectively between true and pseudo-transsexuals. One way of overcoming this problem is to only accept those patients for sex reassignment who were recommended by all the team members. If the team cannot agree the patient should be evaluated for a further period. If no agreement can be reached after this period has elapsed, the patient's request should be refused. Refusal, however should not imply that the patient may not come back at a later stage and reapply for evaluation.

According to Knorr et al. (1975) the psychiatric interview is the most effective method of evaluation at present, provided it is supplemented by psychometric tests, and medical and social reports. Despite the effectiveness of the psychiatric interview it has various limitations. Its most negative characteristic is that it can very easily become subjective. Furthermore transsexualism is a very complex phenomenon that shows similarities to other sexual disorders such as homosexuality and transvestism. The psychiatric interview often fails to bring to light the subtle dif-

ferences that distinguish transsexualism from homosexuality and transvestism.

Most transsexuals have had psychiatric or psychological treatment prior to their evaluation for sex reassignment. This often contributes towards the transsexual's becoming sophisticated in psychiatric interviewing. Previous experiences in psychotherapy often leave them defensive and distrustful of any interviews as they see it as further attempts to persuade them to continue living as they are.

The majority of transsexuals are sensitive and very sharp to pick up any negative attitudes towards them. If they suspect that the psychiatrist or psychologist is in any way biased towards them they react negatively and try to manipulate the interview in such a way that the interviewer should feel guilty. A characteristic that is often observed in transsexuals is the tendency to create confrontations between team members. This can be extremely detrimental to the evaluation process. Team members should therefore have continuous communication with one another in order to devise strategies that will block the patient's manipulative behaviour and ensure the team's effective functioning.

A further factor that influences the effectiveness of the psychiatric interview is the average or above average intellectual abilities of transsexuals. This enables them to study the literature on transsexualism and to assess what information should be given or omitted. Contact with post-operative transsexuals also contributes towards a situation where the transsexual supplies the 'correct' information (Kirkpatrick and Friedmann, 1976; Pomeroy, 1975a).

According to Kubie and Mackie (1968) the transsexual is very unreliable in the psychiatric interview. It is not only the fact that retrospective information is often unreliable, but in the case of the transsexual it is striking that he only remembers facts that emphasise his transsexual tendencies. Block and Tessler (1973) believe that the transsexual is so desperate to get the operation that he either consciously or unconsciously distorts or represses all information that could have a negative effect on his qualifying for the operation.

Pomeroy (1975b) and Randell (1971) disagree with the

statement that transsexuals are unreliable. In support of their viewpoint they mention that parents and other family members often support the transsexual's recollections about his childhood. They also feel that the inability of others to confirm the transsexual's information is not confirmation of unreliability.

On the contrary it is a well-known fact that many transsexuals disclose their most intimate feelings for the first time when they approach a physician for a sex reassignment operation. Although Money (1972) agrees with this he argues that the operation should not be granted on the information supplied by the transsexual alone. Knorr et al. (1975) support this point of view and emphasise that even if parents or other family members cannot supply information regarding the transsexual's psychological condition they can supply valuable information about his early behaviour. Behaviour that was seen as quite normal or cute by parents may have a totally different meaning in the evaluation of the transsexual.

During the interview with the patient the focus should be on the duration of the condition; whether he is a homosexual or a transvestite*; to what extent his penis is a primary source of sexual gratification; whether he is willing to give up his ability to have orgasms; whether it is more important to him to please a man than himself; and if the need for love and care is more important than his need for sexual gratification.

According to Pomeroy (1975b) the psychiatric interview can be used very effectively to obtain information about the transsexual's sexual history. This information should include information regarding the transsexual's body image as an adult; fantasies he has during masturbation; sexual and interpersonal relationships; whether his behaviour is feminine or effeminate; and if he could or has lived among men (eg. during military training) for long periods.

Kirkpatrick and Friedmann (1976) believe that the person who applies for a sex reassignment operation because his sexual orientation and religious views are incompatible is a poor candidate for sex reassignment and should not be allowed to have the operation. This patient should rather be referred for psychotherapy with a view to

* Unlike the homosexual and the transvestite the transsexual rejects his primary male characteristics and believes that he has a feminine psyche that is caught in a male body due to a trick of nature.



helping him accept his sexual orientation.

Stoller (1973a, 1973b) feels that all married applicants who enjoy heterosexual coitus as well as severely depressed individuals, psychotics and those whose physical appearance is so masculine that they will never pass successfully as women, should not be considered for sex reassignment.

Walinder, Lundström and Thuwe (1978) believe that in addition to the above factors the following should also preclude individuals from the sex reassignment operation: mental retardation; a history of criminal behaviour; an unstable personality; an exceptionally strong libido; and having reached an age that will make adjustment to the female rôle difficult. Benjamin (1971), however, disagrees that age should be one of the criteria for selecting candidates for sex reassignment surgery. According to him, the transsexual who is over 40 has suffered for so long that he is entitled to the little happiness sex reassignment will bring.

Although criteria cannot be applied rigidly, the following has proved valuable in the evaluation of transsexual patients:

1. The candidate should at least be 21 years of age (Money & Schwartz, 1975).

2. At the first and subsequent interviews the patient should immediately give the impression of femininity (not effeminate behaviour) and have the ability to accept the feminine rôle with ease. This ability should be tested by insisting that the transsexual live full-time as a member of the opposite sex.

The value of this is to assess the transsexual's ability to support himself as a female; whether he is able to pass successfully; and whether he is happy in the rôle of the opposite sex. Baker and Green (1970) suggest that this period should be no less than one year while

the operation and help him to adjust post-operatively.

11. The transsexual must be prepared to be very truthful and willing to accept the fact that attempts will be made to verify the information he supplies during the interviews.

12. He must be motivated to undergo the operation (Knorr et al., 1975). If any evidence exists that indicates that his motivation is due to pressure from others, or that his request for the operation is based on the recommendation of others, it should be regarded as contra-indications for the operation.

In addition to the criteria used during the evaluation, it is advisable that the patient should undergo psychotherapy. Although existing evidence shows that transsexual tendencies are not changed by means of psychotherapy, it is true that psychotherapy can help to confirm the diagnosis of transsexualism. Furthermore it can improve the transsexual's insight into himself and serve the function of preparing him for his role after the operation.

4. According to Sabalis, Staton and Appenzeller (1977) the true transsexual cannot accept his biological sex. This means that the morphological sex and the gender identity must be incongruent. Furthermore it should be evident that the patient rejects his penis and avoids any sexual activities that require the use of his penis (Stone, 1977).

5. The tendency to cross-dress should be present from an early age. According to Baker and Green (1970) cross-dressing should occur without sexual stimulation. If cross-dressing causes sexual arousal or had even caused it on a single occasion, the patient should not be accepted for the operation as it is indicative of transvestism rather than transsexualism.

6. The transsexual should not have a criminal record. Only minor offences such as arrests for cross-dressing or traffic violations are acceptable.

7. If there are any indications of temporal-lobe epilepsy the patient should be referred for neurological treatment. If the neurological treatment proves ineffective in letting the gender identity disturbance disappear, the patient can be accepted as a candidate. (Money and Gaskin 1970-71).

8. All patients should be unmarried. Patients who were previously married should only be accepted after submitting legal proof that a divorce was granted (Money, 1972).

9. Not taking the patients transsexualism into account he should have a stable personality (Randell, 1971).

10. The transsexual's intellectual abilities should enable him to understand the implications of

the operation and help him to adjust post-operatively.

11. The transsexual must be prepared to be very truthful and willing to accept the fact that attempts will be made to verify the information he supplies during the interviews.

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