

TransTasman Transsexualism

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Transsexualism is an important but a numerically small clinical matter that is claiming the attention of an increasing number of clinicians. It presents problems of assessment, some of which could be resolved were current concepts of gender identity and androgyny to be elaborated. But there are also legal issues to be resolved, not so much concerning the surgical intervention as the establishment and documentation of post-operative legal identity. New Zealand might concentrate some of its diffuse expertise were the professional people interested to form local groups to share their common concern.

The present article developed from a working paper given to the 1979 Melbourne Conference on Transsexualism, and its title reflected a concern of the conference organisers about the increasing number of New Zealanders, particularly Maoris, who seemed to be making requests for transsexual surgery in Australia. It therefore seemed appropriate to document the 'New Zealand experience' on the topic that had begun in 1953 (Taylor and McLachlan, 1962, 1963a, 1963b, 1964) and was reassessed in a survey of clinicians in 1979.

Transsexualism is the condition in which the members of either biological sex are impelled to seek hormonal and surgical intervention to change their anatomical shape and structures to conform to those of the opposite sex. Transsexuals believe that they belong psychologically to the opposite sex and are troubled by the dissonance between the two forms of sexuality—the anatomical and the psychological. Transvestites are similar, except that their desire for the physical alteration of shape and structures—usually mastectomy for the female, genital and facial surgery and breast augmentation for the male—is minimal. The groups are sometimes confused, and have been since Hamburger described the first clinical example of transsexualism as transvestism in 1953. Reliable statistics are difficult to obtain, but there has been a noticeable increase above the 1962 estimate of 1:50,000 in a population corrected for age (of Taylor and McLachlan, 1962). Every major city now has a group of trans-

sexuals, whereas once they might only have had a few on the periphery of larger groups of transvestites. It was also impossible to discover the number who were travelling to Australian 'Gender Identity Clinics' in Melbourne and Sydney for help. However, detailed attention could be paid to certain legal, general, sporting, assessment, professional and racial questions.

1. *Legal Questions*

Some transsexuals are under the impression that the law in other countries is less conservative than in New Zealand, and that by travelling abroad they might meet less stringent requirements before being able to marry and return with the reciprocal protection of International Law that obtained between the country in which the marriage was performed and New Zealand. At least one transsexual has married and returned to New Zealand under such hopes, but there has been no occasion for the marriage to be tested in the Courts, and until it is, the legal protection might be more apparent than real. It is thought that the Courts could take the view of marriage being a contract between parties of different biological sexes, the union of which would, in general, be capable of reproducing the species. Any transsexualism would therefore render the marriage contract inappropriate. But the most fundamental legal question concerns the legality of sex-change surgery, an answer to which was given to a surgeon by the Secretary for Justice as follows:

"... there is no specific legal sanction

for sex-change surgery but on the other hand neither is there an legal impediment as we see it . . . In the opinion of (the Director-General of Health) there should be no difficulties in such surgery being undertaken at a private hospital and indeed he sees advantages in that being done" (personal communication, 16 April, 1970).

A few months later, G. P. Barton (1971), then Professor of Jurisprudence and Constitutional Law at Victoria University, told an interdisciplinary Conference on Transsexualism in Wellington, that, apart from any matter of professional negligence, there could be no action in *civil* liability so long as an applicant was able to form a reasoned judgement on the question and was able to give proper consent to the operation. He also said that there would be no *criminal* liability for wounding, maiming or disfiguring (cf S188 (1) of the *Crimes Act 1961*), because of the special defence available under S.61 of the same *Crimes Act* which protects everyone . . . "from criminal responsibility for performing with reasonable care and skill any surgical operation upon any person for his benefit, if the performance of the operation was reasonable, having regard to the patient's state at the time and to all the circumstances of the case."

Barton's (1971) opinion was evidently insufficient to reassure all of the medical fraternity, because the sole surgeon in one city had to abandon his interest in transsexualism in the face of "general professional antipathy". He was allowed neither public nor private hospital facilities and also he met resistance from a group of anaesthetists. Other experienced clinicians purported to shelter under obscure mediaeval mayhem statutes that were created originally to prevent the maiming of potential bowmen should the need for such soldiers arise, and their influence, if not their argument, spread to the nursing staff who refused to become involved in the surgical treatment of transsexuals. It could be that the resistance of surgical personnel is more desirable than the uncritical enthusiasm of their forebears who for many years showed no such restraint in utilising castration and clitoridectomy for masturbators (Hamowy, 1977). To put the

resistance into perspective it should be said that it was not so marked in New Zealand as Pauly (1968) and Green (quoted in Mensch, 1972) encountered at a comparable stage in the treatment of transsexualism in the United States, and professionals are among the conservative on sundry medico/social matters. At least as far as sexuality is concerned, professionals have responded recently to the point of introducing sex education into the medical curriculum (Tyler, 1970) and of considering the sexual needs of patients (*Patient Management* 1974, 3:8). But transsexualism has still to emerge as an academic topic, despite the pioneering solo work of Benjamin (1966) and his collaborative work with Inlenfeld (Inlenfeld and Benjamin, 1973). However, references to transsexualism are beginning to appear in standard textbooks on psychosexual problems (e.g. Crown, 1976; Meyer, 1976; Money and Musaph, 1977), and a large bibliography on the topic is accumulating at the Kinsey Research Institute.

The resistance that remains today is probably more of an emotional response of distaste, revulsion and avoidance to the topic than a professional response to the clinical and ethical problems involved. The surgical procedures developed by Jones, Schirmer and Hoopes (1968) for males, and by Noe, Lamb and Schulz (1976) for females, seem to have become standard. Experienced plastic surgeons declare that transsexual surgery presents them with no more clinical problems than those experienced with any other kind of major abdominal surgery, and they say that their post-operative management is even less of a problem (Money and Walker, 1977). In fact one of the greatest difficulties after a sex operation has been performed, involves changing the name on a birth certificate. The initial entry cannot be construed as having been "an error of fact or substance" of the kind for which a correction is permitted by S37 *Births and Death Registration Act*, 1951. A ruling in the matter was given when a male transsexual, (designated Mr 'X'), petitioned the Supreme Court to order the Registrar-General to change his birth certificate. The sympathetic Judge ruled against the petitioner and held that he could

seek redress only through Parliament enacting legislation on his behalf (McMullen, J. R. v. Mr X, Auckland, 17.4.1975, M 362/73). But most transsexuals are content simply to leave their birth certificates intact and to change their names by deed poll rather than to campaign publicly for Parliament to change the offending statute. The Secretary for Justice considers that no Government would readily support the introduction of special legislation to permit the alteration of birth certificates, and that in any case there are too few transsexuals to justify the procedure (personal communication, 16 March, 1970).

General Knowledge of the Phenomenon

But there was one case of assault in which the Judge in his summing up confused the psycho-sexuality of the two defendants, both of whom were male transsexuals, and in which the Jury convicted them as if they were female (cf R. v. Rupe and Russell, Supreme Court Wellington, No. 8-9/74, Notes of Evidence, p. 46, 1.23-35). If the decision lacked authority for formal recognition of sexual status on other matters, it did suggest that the public at large was not unaware of the problems of identity in transsexualism. No doubt the Jury members were familiar with popular articles (of *New Society* 1973; *Honey and Vanity Fair*, 1973; *Guardian Extra*, 1976), books (Cowell, 1954; Morris, 1974), films and TV documentaries (Vidal, 1968; Granada "Trapped in the Wrong Body") and stage presentations of Danny la Rue, Barry Humphries and Frank N. Furter of the "Rocky Horror Show". And the public might also have noticed a relaxation of sexual stereotypes that was prompted by the women's movement (Greer, 1971; Millet, 1971; World Conference, 1975; Chesler 1978)—although that movement did not mention transsexualism specifically until quite recently when Raymond (1980) described it as an anti-feminist "socio-political programme" perpetrated by males. It so happens that the "programme" is not the exclusive concern of males, whether of applicants or of consultants, and also any psychopathological tendency can hardly arise when the applications are unsolicited and the sub-

sequent professional opinions are open to discussion.

Sexuality in Sport

If the Law Courts have dealt only with the occasional case in the determination of sexuality, the Olympic Committee has had to apply criteria to all of its women athletes. The application to women exclusively is presumably because masculinized females would have a muscular advantage over other females in certain athletic events, and that 'feminised' males would have no comparable advantage over males. Until 1964 the Committee was content to let the matter of sexuality be settled by a simple certificate from any medical practitioner, but then it decided to include gynaecological and hormonal evidence when required (*Life*, 30 October, 1966). The change came about because of the growing number of athletes from Zdena Koublova in 1934 to Sin Kim Dan in 1964 whose sexuality was in serious doubt (*Pix*, 21 August, 1971). Then there came a move to include Y chromatin studies of cell roots (Francis & Matton Van Leuven, 1973) and social criteria (Lennox, 1973), in determining the sexuality of athletes, but it did not succeed. The Committee seems to have hearkened to Harris' plea (1973) that pressure be taken off women to compete as physical equals of men, and that both sexes be given equal recognition for competing within their respective physical limits.

Meanwhile in tennis Dr Rene Richards, a male transsexual, was not allowed to compete with women in American Championships until players were satisfied that the difference in physique would confer no benefits and that locker-room relationships would not prove to be an embarrassment. Evidently they were satisfied because in 1979 Richards came to occupy the 23rd ranking for tennis on the Women's International Computer List (personal communication, N.Z. Lawn Tennis Association).

Assessment

It would be helpful if there were a set of internationally agreed criteria for the determination of sexuality and a set of indicators by which they might be demonstrated in

any given case. At present the criteria are both psychological and social, and they are determined more from clinical impressions and observations than objective tests. According to Wälinder (1969):

"ordinarily a person's appearance, clothing, carriage and mannerisms point clearly to one sex, and further clarification is seldom necessary because the presumed sexual identity almost always agrees with the sex assigned at birth."

And Money and Primrose (1969):

"Valid tests presently available do not provide an analysis of psychosexual status or gender identity (because) they assess the degree of conformity to a presented social stereotype of the male or female role but bypass the more subtle psychological traits and erotic indicators of gender identity . . . Interviews . . . are often more reliable . . . and must be relied upon, at least until more sophisticated tests are developed".

Perhaps some of the current tests of androgeny and emotional maturity could be adapted for present purposes (Bem, 1974; Rowland; 1977) but until they are, clinicians will be obliged to evaluate characteristics of gender identity and gender role. Money, Hampson and Hampson (1955) in their now classic studies of hermaphroditism were the first to postulate those psychosexual variables, and in a later elaboration Money and Erhardt (1972) defined them as:

(1) gender identity: "the sameness, unity and persistence of one individual as male, female or ambivalent, especially as expressed in self-awareness and behaviour", and

(2) gender role: "everything a person says or does to indicate to others or self that one is male, female or ambivalent".

In practice, a number of professionals have tacitly, if not explicitly, adopted the Pauly (1968) criteria for assessing readiness for transsexual surgery, i.e.:

"(1) psychiatric evaluation to determine that cross-gender identification is of long standing duration and irreversible and not the result of an acute psychosis;

(2) physical appearance, mannerisms and behaviour to indicate that the individual can simulate the opposite gender to such a degree

that he can 'pass', or preferably the indication that the individual has 'passed' and is already living and functioning as a member of the opposite gender;

(3) sufficient intelligence to understand the limitations and possible hazards of the operation;

(4) an agreement to participate in the pre-operative evaluation and long term follow-up studies necessary to evaluate the procedure more thoroughly; and

(5) an agreement not to involve the physician or hospital in any legal action (except for incompetence), nor to publicize, notarize or capitalize on his unique sexual status".

The first two of Pauly's criteria are assessed from case histories, school reports, documentary evidence and interviews that focus upon the following five features:

(1) the period of time that the applicant has cross dressed, partially and fully;

(2) the extent of supportive social relationships that have been established;

(3) the range of appropriate hobbies, vocational interests and any other activities that have been acquired during the preparatory period;

(4) the diligence and time over which the applicant has pursued enquiries for transsexual assistance, and;

(5) the degree of discomfort that the applicant has expressed about the transvestite condition. (A few patients might discover that transvestism alone might be sufficient to satisfy their cross sexual desires without the necessity for transsexual surgery).

Incidentally, if the transsexual desire is established it must be regarded as almost irreversible, and only the most optimistic would attempt to modify it (Money & Walker, 1977).

The problem for clinicians, particularly if they are isolated from more experienced colleagues of whatever discipline, is to calibrate their judgments and minimise the risk of making false positive and false negative assessments. False positives would be more serious an error, because mistakes cannot afterwards be rectified. Wälinder's (1978) series of 15 of such people suggests that they had developmental, criminal and

histrionic tendencies to which assessors had given insufficient weight. Perhaps regretably, such people are found in other clinical groups, and their numbers will not diminish when a set of criteria for transsexualism is established and published. If the deviant cannot be prevented from learning what they consider to be appropriate responses to achieve their own goals, assessors will need to exert greater care in searching for incongruities in their verbal and social behaviour.

There is the further point that some of the applicants who meet the criteria might subsequently have cause for disappointment. Meyer and Reter (1979) followed up 50% of their 32 transsexuals post operatively and 53% of their 66 'in waiting'. The researchers admitted that their research design had some deficiencies—the groups were not comparable, the wastage was too high, and the length of the follow up higher for the transsexuals than the others—but concluded that "sex assignment surgery confers no objective advantage in terms of social rehabilitation, although it remains subjectively satisfying to those who have rigorously pursued a trial period and have undergone it."

Current Professional Involvement

The extent of professional involvement with transsexuals in New Zealand was obtained from a survey of 25 general practitioners, psychiatrists, psychologists and surgeons. They were people who had either been known to, or were believed to, have been involved with transsexuals in different parts of the country.

They were asked to respond to questionnaires seeking information about the characteristics of their patients, the problems they presented, the extent of their intervention, and alternative sources of help¹. Those who had small individual practices had less difficulty in extracting the information from their records than those in large group practices. In the extreme case the respondent was unable to search 23,000 records diligently, but he did make some valuable general comments and offered research access to his files for a long term study later.

¹ Copies may be obtained from the author.

Eighteen professionals responded to the questionnaire. Between them they had been involved with 270 transsexual evaluations, but short of asking them to disclose the names it was not possible to discover the number of separate cases that were involved. The most experienced person had dealt with 40 cases, and the least zero, with the mean at 15. Some had been involved for 27 years, and the mean length of experience was 11.5 years. Two had retired from practice, one of whom expressed his strong opposition to becoming involved in "converting regressive bisexual fantasies into reality". Thirteen took the other extreme and were prepared to follow appropriate cases for as long as was necessary. The majority would countenance surgery as a last resort after hormonal and psychological support had proved insufficient to satisfy the needs. They had seen a male:female ratio of 9:1 transsexual applicants, the ratio of those married to never married being 1:3. The referrals came from medical, to self to other (mostly from social work and prison staff) in the ratio 10:2:1.

The surgeons required approved cases to remain in hospital for between 9-17 days. The costs were met by the taxpayer in the normal way if the operations were performed in public hospitals. Otherwise, they were paid by the patient. In 1979 the costs were approximately \$1,000 per patient in New Zealand, as compared to \$3,400 in Colorado, and \$8,000 in Singapore. There was no information supplied about the comparable costs in Australia.

In general the professionals regarded the post-operative follow-up patients as satisfactory, but two surgeons thought that some patients might benefit from specific sex-role training, and some psychiatrists and psychologists would have liked more detailed information about the hospital treatment their patients had received.

Thirteen professionals thought that the clinical services for transsexuals would be strengthened if *ad hoc* local meetings were arranged at which they could discuss their common concerns. It was clear from the replies that in one district the professionals operated so independently and discreetly that some of their colleagues were unaware

of their common interest. Nine thought that voluntary self-help societies for transsexuals such as Hedesthia, Transformation and Gay Aid, should be recruited formally into the referral and supportive network. Some said that such societies would compromise their freedom were they to associate more closely with any professional group. Others thought that the members of those groups tended to identify with the transsexual aspirants and to cloud the issues rather than to clarify them.

Racial Proclivities

The returns did not confirm the impression reported from Australia that transsexualism might be a feature of Maori life. From the largest sample of 40 transsexuals, seen mostly in public hospitals, only five were Maori. Yet, as transvestites form the pool of potential transsexuals, and a recent study reported "50 to 60 per cent" were Maoris (Waitai, 1979), it could be that Maori transvestites prefer to go abroad to Australia for transsexual assessment in conjunction with their employment. In an attempt to explain the disproportionate number of Maoris in his sample, Waitai suggested that (1) Maoris were more accepting of deviants than Europeans, and (2) their cross dressing was a function of the greater social dislocation and urban drift that they were experiencing compared to Europeans.

Conclusion

Transsexualism is a condition that is managed on an *ad hoc* basis in New Zealand by groups of professionals who have built up their informal ring of contacts. Their practice might be facilitated were they to establish themselves more formally into groups of the kind that have been operating in the United States and Australia, especially if the major Hospital Boards were prepared to endorse them. The endorsement would give wider recognition to those who have long been promoting the cause of transsexualism, allow for the dissemination of information about services available, and help some Hospital Boards to provide facilities for approved cases.

The regional groups could be left to work

out their own *modus operandi* and frequency of contact in accordance with the number and complexity of referrals that they will receive. The members would then be able to maintain and share their professional expertise as well as make general propositions about any clinical, legal and social impediments that might otherwise hinder their work.

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