

**XIV Harry Benjamin International
Gender Dysphoria Symposium**
Gender Dysphoria: Transcultural Perspectives
Transsexualism: State of the Art Treatment
Kloster Irsee, Bavaria, Germany
September 7-10, 1995

**The Harry Benjamin International Gender Dysphoria
Association, Inc.**
&
**Department of Psychotherapy, Ulm University,
Ulm, Germany**

Chairs
Friedemann Pfäfflin, Ulm & Wolf Eicher, Mannheim

Program-Committee
Wolf Eicher, Joris Hage, Donald R. Laub, Friedemann Pfäfflin,
Leah C. Schaefer, Alice Webb

Program & Abstracts

Ulm, September 1, 1995
Friedemann Pfäfflin (Ed)

Sponsored by
Deutsche Forschungsgemeinschaft
Supported by
Lilly Deutschland GmbH
Rhone-Poulenc Rorer Pharma GmbH



**XIV Harry Benjamin International
Gender Dysphoria Symposium**
Gender Dysphoria: Transcultural Perspectives
Transsexualism: State of the Art Treatment
Kloster Irsee, Bavaria, Germany
September 7-10, 1995

**The Harry Benjamin International Gender Dysphoria
Association, Inc.**
&
**Department of Psychotherapy, Ulm University,
Ulm, Germany**

Chairs
Friedemann Pfäfflin, Ulm & Wolf Eicher, Mannheim

Program-Committee
Wolf Eicher, Joris Hage, Donald R. Laub, Friedemann Pfäfflin,
Leah C. Schaefer, Alice Webb

Program & Abstracts

Ulm, September 1, 1995
Friedemann Pfäfflin (Ed)

Sponsored by
Deutsche Forschungsgemeinschaft
Supported by
Lilly Deutschland GmbH
Rhône-Poulenc Rorer Pharma GmbH

BY Harry Frankfurt International Center, Frankfurt, Germany
 German Department, The University of Maryland, Germany
 Department of the Arts, The University of Maryland, College Park, Maryland, U.S.A.
 Study Year, January, December, April, July, 1963

By Harry Frankfurt International Center, Frankfurt, Germany
 and Department of Psychology, The University of Maryland, Germany
 Chair Department, Florida, U.S.A. and Center, U.S.A.
 Program Committee, The University of Maryland, College Park, U.S.A.
 David S. ...
 Lee C. ...

Program

Thursday, September 2, 1963

- 1200-1230 pm Registration
- 1230-1300 Lunch
- 1300-1330 Lecture
 David S. ...
 Center Department, U.S.A.
- 1330-1400 Lecture
 ...
 ...
- 1400-1430 Presidential Lecture
 Harry Frankfurt and the Philosophy of the Mind - a paper which
 ...
 ...
- 1430-1500 ...

Friday, September 3, 1963

- 7:00-7:30 am Registration
- 7:30-8:00 am ...
- 8:00-8:30 am ...
- 8:30-9:00 am ...
- 9:00-9:30 am ...
- 9:30-10:00 am ...
- 10:00-10:30 am ...
- 10:30-11:00 am ...
- 11:00-11:30 am ...
- 11:30-12:00 pm ...
- 12:00-12:30 pm ...
- 12:30-1:00 pm ...
- 1:00-1:30 pm ...
- 1:30-2:00 pm ...
- 2:00-2:30 pm ...
- 2:30-3:00 pm ...
- 3:00-3:30 pm ...
- 3:30-4:00 pm ...
- 4:00-4:30 pm ...
- 4:30-5:00 pm ...
- 5:00-5:30 pm ...
- 5:30-6:00 pm ...
- 6:00-6:30 pm ...
- 6:30-7:00 pm ...
- 7:00-7:30 pm ...
- 7:30-8:00 pm ...
- 8:00-8:30 pm ...
- 8:30-9:00 pm ...
- 9:00-9:30 pm ...
- 9:30-10:00 pm ...
- 10:00-10:30 pm ...
- 10:30-11:00 pm ...
- 11:00-11:30 pm ...
- 11:30-12:00 am ...

Thursday, Sept. 4, 1963, 8:00 am to 11:00 am, and Friday, Sept. 5, morning

XIV Harry Benjamin International Gender Dysphoria Symposium
Gender Dysphoria: Transcultural Perspectives
Transsexualism: State of the Art Treatment
Kloster Irsee, Bavaria, Germany, Sept. 7-10, 1995

Harry Benjamin International Gender Dysphoria Association, Inc.,
and Department of Psychotherapy, Ulm University, Ulm, Germany
Chairs: Friedemann Pfäfflin, M.D., Wolf Eicher, M.D.
Program-Committee: Wolf Eicher, M.D., Joris Hage, M.D., Ph.D.,
Donald R. Laub, M.D., Friedemann Pfäfflin, M.D.,
Leah C. Schaefer, Ed.D., Alice Webb, M.S.W., LCSW

Thursday, September 7, 1995

- 2:00-10:00 p.m. Registration
- 4:30-6:30 **HBIGDA Board of Directors Meeting**
- 7:00-7:15 **Call to Order**
Leah C. Schaefer, Ph.D., President Harry Benjamin International
Gender Dysphoria Association, Inc., New York, U.S.A.
- 7:15-7:30 **Welcome Address**
Friedemann Pfäfflin, M.D., Ulm, Wolf Eicher, M.D., Mannheim,
Germany
- 7:30-8:00 **Presidential Lecture**
*Harry Benjamin and the beginning of the history of gender identity
disorders and conditions.*
Leah C. Schaefer, Ed.D., New York, U.S.A.
- 8:00-10:00 Buffet and Cash-Bar Cocktails

Friday, September 8, 1995

- 7:00-8:00 a.m. Registration
- Male-to-female Surgery**
Chair: Donald R. Laub, M.D., Stanford, U.S.A.
- 8:00-8:15 *Vaginoplasty in male transsexuals using pedicled penile skin with
composite urethral flap.*
Sava Perovic, M.D., Ph.D., Belgrade, Yugoslavia
- 8:15-8:40 *Video: Sex reassignment in male-to-female transsexuals.*
Christa Spehr, M.D., Augsburg, Germany

- 8:40-8:55 *A sixteen year review of colovaginoplasty in male-to-female transsexuals.*
Michael G. Royle, F.R.C.S., N.S.B. Tanner, N.H. Porter, Brighton, U.K.
- 8:55-9:10 *Extended groin flap phalloplasty in the female-to-male transsexual.*
Alan N. Wilson, M.B., B.S., F.R.C.S., Detroit, U.S.A.
- 9:10-9:30 *Rectosigmoid neocolpopoiesis: Thailand Experience.*
Preecha Tiewtranon, M.D., Bangkok, Thailand
- 9:30-9:55 Coffee Break
- 9:55-10:15 *Video: Genital transformation in male-to-female transsexualism.*
Wolf Eicher, M.D., Mannheim, Germany
- 10:15-10:30 *Silicone autoimmune disease.*
Gail S. Lebovic, M.A., M.D., Stanford, U.S.A.
- 10:30-11:30 **Poster Session I: Male-to-Female Surgery**
Chair: Wolf Eicher, M.D., Mannheim, Germany
- 10:30-11:00 Poster Presentation
11:00-11:30 Poster Discussion
- Refinements of postoperative care to optimize neovaginal depth and width in male-to-female transsexuals.*
Refaat B. Karim, M.D., J. Joris Hage, M.D., Ph.D., Amsterdam, The Netherlands
- A custom-made silicone mould to improve vaginal reconstruction in male-to-female transsexuals.*
Stan J. Monstrey, M.D., Jan De Cubber, Piet Hoebeke, Koen Van Landuyt, Griet De Cuyper, Robert Rubens, Guido Matton, Gent, Belgium
- Surgical technique in male-to-female transsexuals: A new method of clitoral hood formation, a new method for formation of anterior labial „Fourchette“. Clitoris construction with internal pudendal deep penile nerve flap avoids neuroma formation.*
Donald R. Laub, Sr., M.D., Gail S. Lebovic, M.A., M.D., Donald R. Laub II, M.D., Judy Van Maasdam, M.A., Stanford, U.S.A.
- A study of vaginal depth in postoperative GDS patients - comparing methods of surgery.* Donald R. Laub, Sr. M.D., Gail S. Lebovic, M.A., M.D., Stanford, U.S.A.
- A study of erotic spots in the postoperative male-to-female GDS patient.*
Donald R. Laub, Sr., M.D., Donald R. Laub II, M.D., Gail S. Lebovic, M.A., M.D., Stanford, U.S.A.

Raising the medium speaking voice pitch by surgical means in male-to-female transsexuals.
Kerstin Neumann, M.D., Alexander Berghaus, M.D., Halle, Germany

The plan of surgical treatment of transsexuals.
Julia Kruk-Jeromin, Ph.D., Lodz, Poland

11:30-12:00

Debate

Penile inversion versus rectosigmoid vaginoplasty.
J. Joris Hage, M.D., Ph.D. versus Donald R. Laub, M.D.

12:00-1:30 p.m.

Lunch

Quality of outcome

Chair: Michel Seghers, M.D., Brussels, Belgium

1:30-1:45

Transsexualism: General outcome and prognostic factors. A five year follow-up study of nineteen transsexuals in the process of changing sex.
Owe Bodlund, M.D., Gunnar Kullgren, M.D., Ph.D., Umea, Sweden

1:45-2:00

Psychosocial and treatment factors contributing to favorable outcomes of gender reassignment.
Marsha C. Botzer, M.A., Bryant Vehrs, M.A., Seattle, U.S.A.

2:00-2:15

Factors influencing postoperative 'regrets' in transsexuals.
Abraham Kuiper, Ph.D., Amsterdam, Peggy Cohen-Kettenis, Ph.D., Utrecht, The Netherlands

2:15-2:45

Coffee Break

Female-to-Male Surgery

Chair: Joris Hage, M.D., Amsterdam, The Netherlands

2:45-3:00

A new concept of phalloplasty with one rectus abdominis muscle flap and two groin flaps - experience with 123 cases.
Klaus Exner, M.D., Frankfurt/Main, Germany

3:00-3:15

Microsurgical alternatives of phalloplasty.
Jiri Vesely, M.D., J. Válka, M.D., P. Ganti, M.D., P. Berrino, M.D., C. Dominici, Brno, Czech Republic

3:15-3:30

Phallus, made in Switzerland.
Paul Daverio, M.D., Lausanne, Switzerland

3:30-3:45

Penile prosthesis implantation in total phalloplasty.
David A. Gilbert, M.D., G.H. Jordan, S.M. Schlossberg, G.J. Alter, Norfolk, U.S.A.

3:45-4:00

Metoidioplasty: an alternative phalloplasty technique in transsexuals.
J. Joris Hage, M.D., Ph.D., Amsterdam, The Netherlands

4:00-6:30

Poster-Session II: Female-to-Male Surgery

Chair: Wolf Eicher, M.D., Mannheim, Germany

4:00-5:30

Poster Presentation

5:30-6:30

Poster Discussion

Breast Amputation

The estimation of methods of surgical reduction of breasts in female-to-male transsexuals.

R. Bratos, M.D., J. Kruk-Jeromin, M.D., Lodz, Poland

An anatomic study of the position of the male nipple: Useful information for mastectomy with GDS patients.

Donald R. Laub, Sr., M.D., Gail S. Lebovic, M.A., M.D., Donald R. Laub II, M.D., Stanford, U.S.A.

Subcutaneous mastectomy in female transsexuals: Basic considerations on positioning of the areolar complex.

J. Joris Hage, M.D., Ph.D., Amsterdam, The Netherlands

Groin flap phalloplasty

Phalloplasty in female transsexuals using pedicled extended island groin flap.

Sava Perovic, M.D., Ph.D., D. Stanojevic, M. Djordjevic, Belgrade, Yugoslavia

Construction of the neophallus in female-to-male transsexuals using the lateral groin flap.

Cezary Peszynski-Drews, M.D., Tomasz Zielinski, M.D., Julia Kruk-Jeromin, M.D., Lodz, Poland

Free flap phalloplasty

Ulnar forearm phallic construction.

David A. Gilbert, M.D., Deborah M. Gilbert, R.N., Norfolk, U.S.A.

A.M.S. Dynaflex implantation as part of the phalloplasty: Preliminary results.

J. Joris Hage, M.D., Ph.D., Amsterdam, The Netherlands

Technical refinements to optimize function and cosmesis in female-to-male gender reassignment surgery (mastectomy, phalloplasty).

Stan J. Monstrey, M.D., Piet Hoebeke, Koen Van Landuyt, Griet De Cuyper, Robert Rubens, Guido Matton, Gent, Belgium

Interdisciplinary concepts for gender reassignment surgery in female-to-male transsexuals.

Michael Sohn, M.D., Sven van Saldern, Euphrosyne Gouzoulis-Mayfrank, Hermann Ebel, Aachen, Germany

6:30-8:00

Dinner

8:00-

Beer & music

Neo-personality & suffering

Tendency
to
somatization -
obstacle -
dominance
high
ego def.

marked
social
isolation
strong need -
persistence
high
impulsivity

significant
psycho pathology
and relational
disorders

no significant
psycho pathology
strong need - persistence,
denial of
obstacle

Journal Nervous
Disease - 1946
Geo Brown Study
"Traits vs States"

Narcissism

46 x ✓
46 x x

Saturday, September 9, 1995

Typology and Personality

Chairs: Eva-Maria Niehus, M.D., Münster, Germany, George R. Brown, M.D., Johnson City, U.S.A.

8:15-8:30 *Self and gender: Narcissistic pathology and personality factors in gender dysphoric patients. Results of a prospective study.*
Uwe Hartmann, Ph.D., Hinnerk Becker, M.D., Claudia Rüffer-Hesse, M.D., Hannover, Germany

8:30-8:45 *Personality characteristics and sexual functioning of 188 American transgendered men: Comparison of patients with nonpatients.*
George R. Brown, M.D., Johnson City, Thomas N. Wise, Falls Church, Paul T. Costa, Baltimore, U.S.A.

8:45-9:00 *Schizophrenia and transsexualism: Defining the boundaries.*
Sharon G. Dott, M.D., David P. Walling, Ph.D., Eric N. Avery, M.D., Collier M. Cole, Ph.D., Walter J. Meyer III, M.D., Galveston, U.S.A.

9:00-9:15 *Dissociation and gender dysphoria.*
David Seil, M.D., Boston, U.S.A.

9:15-9:30 *Dissociation and gender dysphoria: Exploring the relationship.*
David P. Walling, Ph.D., Jean M. Goodwin, M. D., M. P. H., Collier C. Cole, Ph.D., Galveston, U.S.A.

9:30-10:00 Coffee Break

Developmental Aspects

Chair: Peggy T. Cohen-Kettenis, Ph.D., Utrecht, The Netherlands

10:00-10:15 *Post-operative functioning in adolescent transsexuals.*
Peggy T. Cohen-Kettenis, Ph.D., Stephanie H. van Goozen, Utrecht, The Netherlands

10:15-10:30 *Gender identity change from female-to-male in classical CAH: four cases.*
Heino F.L. Meyer-Bahlburg, Dr. rer. nat., R. S. Gruen, P. Trautman, M. T. New, M. Shimshi, A. Morishima, New York, U.S.A.

10:30-10:45 *Evidence of a female-type brain differentiation in male-to-female transsexuals.*
Jiang-Ning Zhou, Dick F. Swaab, Amsterdam, The Netherlands, presented by Louis J. Gooren, M.D.

W. J. Meyer III, M.D., Galveston, U.S.A.

wrote for

A central part of human experience
to explain the human experience,
John Taylor, 1995

Saturday, Sept. 9, morning

Dissociation Experiments
Sera

Absorption
Repersonalization
Anesthesia

Sample Characteristics

Living situation = married
divorced
etc.

Narcosis

10:45-12:00

Panel: Endocrinology

Chair: Louis J. Gooren, M.D., Amsterdam, The Netherlands

Venous thrombosis and pulmonary embolism in estrogen-treated male-to-female transsexuals remains a major problem.

Henk Asscheman, M.D., Paul van Kesteren M.D., Jos Megens,
Louis J. Gooren, M.D., Amsterdam, The Netherlands

Effects of androgens in female-to-male transsexuals: Shift towards a male cardiovascular risk pattern.

J.M.H. Elbers, Henk Asscheman, M.D., J.C. Seidell, Louis J.
Gooren, M.D., Amsterdam, The Netherlands

Side effects of cross-sex hormonal treatment: An update of mortality and morbidity in 1109 transsexuals.

Paul van Kesteren, M.D., Henk Asscheman, M.D., Jos Megens, Louis
J. Gooren, M.D., Amsterdam, The Netherlands

Effects of long-term cross-sex hormone treatment on the prostate of aging transsexuals.

Paul van Kesteren, M.D., W. Meinhardt, P. van der Valk, A. Geldof,
Jos Megens, Louis Gooren, M.D., Amsterdam, The Netherlands

Discussion

12:00-1:30 p.m.

Lunch

1:30-2:30

Poster Session III: Clinical and Related Issues

1:30-2:00

Poster Presentation

2:00-2:30

Poster Discussion

Chair: Ulrich Clement, Ph.D., Heidelberg, Germany

On the relationship between gender-identity/role, personality traits and cognitive abilities.

Reinhard Arndt, Hartmut A. G. Bosinski, M.D., Reinhard Wille, Kiel,
Germany

Transsexuals and HIV/AIDS risk behaviors.

Eric N. Avery, M.D., Collier M. Cole, Ph.D., Walter J. Meyer III,
M.D., Galveston, U.S.A.

Gender identity disorders in psychiatric practice. Design and preliminary results of a prospective study.

Hinnerk Becker, M.D., Uwe Hartmann, Ph.D., Claudia Rüffer-Hesse,
M.D., Hannover, Germany

Personality traits/disorders and self-image among transsexuals and gidaant patients.

Owe Bodlund, M.D., Gunnar Kullgren, M.D., Ph.D., Kerstin
Armelius, Torvald Höjerback, Umea, Sweden

Outcome and prognostic factors in sex reassignment.
Owe Bodlund, M.D., Gunnar Kullgren, M.D., Ph.D., Kerstin
Armelius, Torvald Höjerback, Umea, Sweden

How successful is speechtherapy in male-to-female transsexuals?
An Greven, M.D., Amsterdam, The Netherlands

*Workshop model for the inclusion and treatment of the families of
transsexuals.*
Randi C. Ettner, Ph.D., Evanston, U.S.A.

*Gender dysphoria: Clinical, sociocultural, and psychosexual data of 134
patients.*
Adriana Godano, M.D., Damiana Massara, Ph.D., M. Cavaretta,
Torino, Italy

*Psychological and social follow-up of reassignment surgery in 67
female-to-males after SRS.*
Klaus Exner, M.D., Birgit Schermitzky, M.D., Frankfurt/Main,
Germany

A Gender coordinator's job.
Deborah M. Gilbert, R.N., Norfolk, U.S.A.

Adrenal enzyme activities in individuals with transsexualism.
R. Krähner, R. Sachse, J. Hensen, G.K. Stalla, T.A. Moesler, C.
Maser-Gluth, Erlangen-Nuremberg, Munich, Heidelberg, Germany

*Analysis of the CYP21B gene in female-to-male transsexuals.
by PCR-SSCP method.*
Richard Sachse, M.D., X.J. Shao, R. Krähner, Erlangen, G.K. Stalla,
Munich, T.A. Moesler, J. Hensen, Erlangen-Nuremberg, Germany

*Counseling Center for Gender Dysphoric Persons
(„Beratungsstelle für Menschen mit Geschlechtsidentitätsproblemen“
BfTS)*
Kai Staupe, Iris Donaubaauer, Hamburg, Germany

2:30-3:00

Coffee Break

Transcultural Clinical Issues

Chair: Alice Webb, M.S.W., LCSW, Sonoma, U.S.A.

3:00-3:15

*Experience of organisation in Russia of a complex of medico-social help
of persons with transsexualism.*
Lubov Vasilenko, M.D., Aron Belkin, M.D., Ph.D., Nikolai Kibrik,
M.D., Moscow, Russia

3:15-3:30

Holistic psychotherapy treatment model: Highlights and controversies.
C. Christine Wheeler, Ph.D., Leah C. Schaefer, Ed.D., New
York, U.S.A.

3:30-3:45

The growing rent in the fabric of western society.
Marjorie A. Schützer, M.A., Copenhagen, Denmark

3:45-4:00 *Orchidectomy as a first stage towards gender re-assignment - A positive option.*
Fran Springfield, R.G.N., Russell Reid, Ph.D., London, U.K.

4:00-4:15 *Transgender coming out. Implications for the clinical management of gender dysphoria.*
Walter O. Bockting, Drs., Minneapolis, U.S.A.

Interactions

Chair: Sharon Satterfield, M.D., Minneapolis, U.S.A.

4:15-4:30 *The processes of appraisal and self-verification in transsexualism and some of the consequences.*
C.D. Doorn, Louis J. Gooren, M.D., Amsterdam, Peggy T. Cohen-Kettenis, Ph.D., Utrecht, A.M. Verschoor, A.J. Kuiper, Jos Megens, Amsterdam, The Netherlands

4:30-4:45 *Transsexual and non-transsexual patients together at the ward: The Amsterdam experience.*
Yvonne Kuipers, R.N., Mariska Butterman, R.N., Amsterdam, The Netherlands

4:45-5:00 *Masked vulnerabilities of the gender dysphoric patient and his partner.*
Pat Rubin, M.Ed., Marilyn Wilchesky, Ph.D., Montreal, Canada

Epidemiology

Chair: Walter J. Meyer III, M.D., Galveston, U.S.A.

5:00-5:15 *Incidence and sex ratio of transsexualism.*
Mikael Landén, M.D., Bengt Lundström, M.D., Ph.D., Mölndal, Sweden

5:15-5:30 *Transsexuals within the prison system: An international survey of correctional services policies.*
Maxine Petersen, M.A., Judith Stephens, M.Ed., Robert Dickey, M.D., Wendy Lewis, B.A., Toronto, Canada

5:30-5:45 *Empirical data on application of the German transsexuals' act during its first ten years.*
Cordula Weitzel, M.D., Susanne Osburg, M.D., Berlin, Germany

Sociology of Transsexualism

Chair: Judy van Maasdam, M.A., Stanford, U.S.A.

5:45-6:00 *Gender identification and sexual orientation among genetic females with gender-blended self-perception in childhood and adolescence.*
Ann E. Eyster, M.D., M.P.H., Ann Arbor, Kathryn L. Wright, D.O., Detroit, U.S.A.

6:00-6:15 *Feminist and/or lesbian opinions about transsexuals.*
Nancy Strapko, Ph.D., Plymouth, U.S.A., Holly Devor, Ph.D., Monica
Kendel, Victoria, Canada

6:15-7:15 **Panel: Sociology of Transsexualism**

The medicalization of gender migration.
Stefan Hirschauer, Ph.D., Bielefeld, Germany

*Blending genders - some social aspects of cross dressing and sex
changing.*
Richard Ekins, Ph.D., Ulster, Dave King, Ph.D., Liverpool, U.K.

8:00 Dinner

Sunday, September 10, 1995

8:00-9:00 a.m. **Panel: Group Psychotherapy**

Chair: Christine Wheeler, Ph.D., New York, U.S.A.

Group Psychotherapy of gender dysphoria.
Don Montgomery, M.D., London, U.K.

Doing group psychotherapy with female-to-male transsexuals in Turkey.
Sahika Yüksel, M.D., Dogan Sahin, M.D., Nuray Karalt, M.D., Isin
Baral, M.D., Istanbul, Turkey

*The Cross-Roads Group - designed for the rejected, but not dejected,
gender candidate.*
Marilyn Wilchesky, Ph.D., H el ene Cot e, M.A., Montreal, Canada

Discussion

9:00-10:00 **Panel: Psychotherapy**

Chair: Hertha Richter-Appelt, Ph.D., Hamburg, Germany

Psychodynamic aspects in two cases of gender identity disorders.
R.-P. Beigel, M.D., Hinnerk Becker, M.D., Claudia R uffer-Hesse,
M.D., Hannover, Germany

Reflections on the aspect of hostility in transsexual symptoms.
Karin D esirat, Ph.D., Bochum, Germany

*The relevance of sexual and/or physical abuse in the treatment of
transsexual patients.*
Karin Renter, M.D., Hertha Richter-Appelt, Ph.D., Hamburg, Germany

Discussion

10:00-10:15 Coffee Break

10:15-12:15

**Panel: Legal Issues of Transsexualism
Marriage, Parental Rights, Adoption, and Employment**

Chair: Michael R. Will, J.D., Geneva, Switzerland

Maria S. Augstein, Lawyer, München, Germany
Maria Draskic, J.D., Belgrade, Yugoslavia
Richard Green, M.D, J.D., London, U.K.
Lima Marques, J.D., Porto Alegre, Brasil
Lopez-Galiacho, J.D., Madrid, Spain
Louis H. Swartz, Ph.D., Buffalo, U.S.A.
Stephen Whittle, M.A., Manchester, U.K.
Michael R. Will, J.D., Geneva, Switzerland

12:15-12:45

**Panel: The Harry Benjamin Standards of Care: The
Hormonal and Surgical Sex Reassignment of Gender
Dysphoric Persons. Update**

Leah C. Schaefer, Ed.D., New York, U.S.A.,
President HBGDA 1991-1995
Friedemann Pfafflin, M.D., Ulm, Germany,
President HBGDA, 1995-1997
Richard Green, M.D., J.D., London, U.K.
President HBGDA 1997-1999
Alice Webb, M.S.W., LCSW, Sonoma, U.S.A.
Executive Director HBGDA, 1992-present

12:45-1:00

Farewell

1:00-2:00

Business Meeting (for members only)

Abstracts

Abstracts Table of Contents

Arndt R, Bosinski H, Wille R	1
<i>On the relationship between gender-identity/role, personality traits and cognitive abilities.</i>	
Asscheman H, Kesteren P van, Megens J, Gooren L	2
<i>Venous thrombosis and pulmonary embolism in estrogen-treated male-to-female transsexuals remains a major problem.</i>	
Avery E, Cole C, Meyer III W	3
<i>Transsexuals and HIV/Aids risk behaviors.</i>	
Becker H, Hartmann U, Rüffer-Hesse C	4
<i>Gender identity disorders in psychiatric practice. Design and preliminary results of a prospective study.</i>	
Beigel R-P, Becker H, Hartmann U, Rüffer-Hesse C	6
<i>Psychodynamic aspects in two cases of gender identity disorders.</i>	
Bockting W	7
<i>Transgender coming out. Implications for the clinical management of gender dysphoria.</i>	
Bodlund O (Co-workers: Kullgren G, Sundbom E, Armelius K, Höjerback T)	8
<i>Personality traits/disorders and self-image among transsexuals and gidaant patients.</i>	
<i>Outcome and prognostic factors in sex reassignment.</i>	
Bodlund O, Kullgren G	9
<i>Transsexualism: General outcome and prognostic factors.</i>	
<i>A five year follow-up study of nineteen transsexuals in the process of changing sex.</i>	
Botzer M, Vehrs B	10
<i>Psychosocial and treatment factors contributing to favorable outcomes of gender reassignment.</i>	
Bratos R, Kruk-Jeromin J	11
<i>The estimation of methods of surgical reduction of breasts in female to male transsexuals.</i>	
Brown G, Wise T, Costa P	12
<i>Personality characteristics and sexual functioning of 188 American transgendered men: Comparison of patients with nonpatients.</i>	
Cohen-Kettenis P, Goozen S van	14
<i>Post-operative functioning in adolescent transsexuals.</i>	
Dahl A, Guldberg C, Hansen H, Kjelsberg E, Grünfeld B	15
<i>The Norwegian follow-up study of patients treated for transsexualism.</i>	
Daverio P	16
<i>Phallus made in Switzerland.</i>	
Désirat K	17
<i>Reflections on the aspect of hostility in transsexual symptoms.</i>	
Doorn C, Gooren L, Cohen-Kettenis P, Verschoor A, Kuiper A, Megens J	18
<i>The processes of appraisal and self-verification in transsexualism and some of the consequences.</i>	
Dott S, Walling D, Avery E, Cole C, Meyer W	20
<i>Schizophrenia and transsexualism: Defining the boundaries.</i>	
Draskic M	21
<i>Transsexuals and marriage, parental rights, adoption: Perspectives for the legislator in Yugoslavia.</i>	
Elbers J, Asscheman H, Seidell J, Gooren L	22
<i>Effects of androgens in female-to-male transsexuals: Shift towards a male cardiovascular risk pattern.</i>	
Ekins R, King D	24
<i>Blending genders - some social aspects of cross-dressing and sex-changing.</i>	

Ettner R	25
<i>Workshop model for the inclusion and treatment of the families of transsexuals.</i>	
Exner K	26
<i>A new concept of phalloplasty with one rectus abdominis muscle flap and two groin flaps - experience with 123 cases.</i>	
Exner K, Schernitzky B	27
<i>Female-to-male-transsexualism - psychological and social follow-up of reassignment surgery in 67 patients.</i>	
Eyler A, Wright K,	29
<i>Gender identification and sexual orientation among genetic females with gender-blended self-perception in childhood and adolescence.</i>	
Gilbert D	30
<i>A gender coordinator's job.</i>	
Gilbert D, Jordan G, Schlossberg S, Alter G	31
<i>Penile prosthesis implantation in total phalloplasty.</i>	
Gilbert D, Gilbert D	32
<i>Ulnar forearm phallic construction.</i>	
Godano A, Massara D, Cavarretta M	33
<i>Gender dysphoria: Clinical, sociocultural and psychosexual data of 134 patients.</i>	
Green R	34
<i>Formerly the orphans of medicine, transsexuals are currently the orphans of the law.</i>	
Hage J	35
<i>A.M.S. Dynaflex implantation as part of the phalloplasty: Preliminary results.</i>	
Hage J	36
<i>Metaiodoioplasty: An alternative phalloplasty technique in transsexuals.</i>	
Hage J	37
<i>Subcutaneous mastectomy in female transsexuals: Basic considerations on positioning of the areolar complex.</i>	
Hartmann U, Becker H, Rüffer-Hesse C	38
<i>Self and gender: Narcissistic pathology and personality factors in gender dysphoric patients. Results of a prospective study.</i>	
Hirschauer S	40
<i>The medicalization of gender-migration.</i>	
Karim R, Hage J	41
<i>Refinements of postoperative care to optimize neovaginal depth and width in male-to-female transsexuals.</i>	
Kesteren P van, Meinhardt W, Valk P van der, Geldof A, Megens J, Gooren L	42
<i>Effects of long-term cross-sex hormone treatment on the prostate of aging transsexuals.</i>	
Kesteren P van, Asscheman H, Megens J, Gooren L	43
<i>Side effects of cross-sex hormonal treatment: An update of mortality and morbidity in 1109 transsexuals.</i>	
Krähner R, Sachse R, Hensen J, Stalla G, Moesler T, Maser-Gluth C	44
<i>Adrenal enzyme activities in individuals with transsexualism.</i>	
Krajka K, Mikszewicz A, Lukianski W	46
<i>Large intestine as an alternative for creation of neo-vagina in male-to-female transsexuals.</i>	
Krajka K, Mikszewicz A, Matuszewski M	47
<i>Surgical conversion of sex in male-to-female transsexuals.</i>	
Kruk-Jeromin J	48
<i>The plan of surgical treatment of transsexuals.</i>	
Kuiper A, Cohen-Kettenis P	49
<i>Factors influencing post-operative 'regret' in transsexuals.</i>	

Kuipers Y, Butterman M	50
<i>Transsexual and non-transsexual patients together at the ward: The Amsterdam experience.</i>	
Landén M, Lundström B	51
<i>Incidence and sex ratio of transsexualism.</i>	
Laub D, Laub D II, Lebovic G	52
<i>A study of the erotic spots in the postoperative male to female GDS patient.</i>	
Laub D, Lebovic G	53
<i>A study of vaginal depth in postoperative GDS patients - comparing methods of surgery.</i>	
Laub D, Lebovic G, Laub D II	54
<i>An anatomic study of the position of the male nipple: Useful information for mastectomy with GDS patients.</i>	
Laub D, Lebovic G, Laub D II, Maasdam, J van	55
<i>Surgical technique in male-to-female transsexuals: A new method of clitoral hood formation.</i>	
<i>A new method for formation of anterior labial "Fourchette".</i>	
<i>Clitoris construction with internal pudendal deep penile nerve flap avoids neuroma formation.</i>	
Lebovic G	56
<i>Silicone autoimmune disease.</i>	
Meyer-Bahlburg H, Gruen R, Trautman P, New M, Shimsi M, Morishima A	57
<i>Gender identity change from female to male in classical CAH: Four cases.</i>	
Monstrey S, De Cubber J, Hoebeke P, Landuyt K van, De Cuypere G, Rubens R, Matton G	58
<i>A custom-made silicone mould to improve vaginal reconstruction in male-to-female transsexuals.</i>	
Monstrey S, Hoebeke P, Landuyt K van, De Cuypere G, Rubens R, Matton G	59
<i>Technical refinements to optimize function and cosmesis in female-to-male gender reassignment surgery (mastectomy, phalloplasty).</i>	
Neumann K, Berghaus A	60
<i>Raising the medium speaking voice pitch by surgical means in male-to-female transsexuals.</i>	
Perovic S, Stanojevic D, Djordjevic M	61
<i>Phalloplasty in female transsexuals using pedicled extended island groin flap.</i>	
Perovic S	62
<i>Vaginoplasty in male transsexuals using pedicled penile skin with composite urethral flap.</i>	
Peszynski-Drews C, Zielinski T, Kruk-Jeromin J	63
<i>Construction of the neophallus in female-to-male transsexuals using the lateral groin flap.</i>	
Petersen M, Stephens J, Dickey R, Lewis W	64
<i>Transsexuals within the prison system: An international survey of correctional services policies.</i>	
Renter K, Richter-Appelt H	65
<i>The relevance of sexual and/or physical abuse in the treatment of transsexual patients.</i>	
Royle M, Tanner N, Porter N	66
<i>A sixteen year review of colovaginoplasty in male-to-female transsexuals.</i>	
Rubin P, Wilchesky M	67
<i>Masked vulnerabilities of the gender dysphoric patient and his partner.</i>	
Ruggieri V, Ravenna A, Iacoella S, Stranieri S	68
<i>Body image gender identity and narcissism in transsexualism.</i>	
Sachse R, Shao X, Krähner R, Stalla G, Möslers T, Hensen J	69
<i>Analysis of the CYP21B gene in female-to-male transsexual individuals by PCR-SSCP method.</i>	

Schaefer L.....	71
<i>Harry Benjamin and the beginning of the history of gender identity disorders and conditions.</i>	
Schützer M.....	72
<i>The growing rent in the fabric of western society.</i>	
Seil D.....	73
<i>Dissociation and gender dysphoria.</i>	
Sohn M, Saldern S van, Gouzoulis-Mayfrank E, Ebel H.....	74
<i>Interdisciplinary concepts of gender reassignment surgery in female-to-male transsexuals: 5-year experience.</i>	
Spehr C.....	76
<i>Sex reassignment in male-to-female transsexuals (Video).</i>	
Springfield F, Russell R.....	77
<i>Orchidectomy as a first stage towards gender re-assignment -</i>	
Staupe K, Donabauer I.....	78
<i>Counselling center for gender dysphoric persons. (Beratungsstelle für Menschen mit Geschlechtsidentitätsproblemen - BfTS).</i>	
Strapko N, Devor H, Kendel M.....	79
<i>Feminist and/or lesbian opinions about transsexuals.</i>	
Swartz L.....	80
<i>Legal responses to transsexualism: Scientific logic versus compassionate flexibility in the U.S. and U.K.</i>	
Tiewtranon P.....	81
<i>Rectosigmoid neocolpopoiesis: Thailand experience.</i>	
Vasilenko L, Belkin A, Kinrik N.....	83
<i>Experience of organisation in Russia of a complex of medico-social help of persons with transsexualism.</i>	
Vesely J, Válka J, Ganti P, Berrino P, Dominici C.....	84
<i>Microsurgical alternatives of phalloplasty.</i>	
Vujović S, Penezić Z, Stojanović M, Drezgić M, Beleslin B, Slijepčević D.....	85
<i>Effects of hormone replacement therapy on gonadotropins pulsatility in male-to-female transsexuals.</i>	
Walling D, Goodwin J, Cole C.....	86
<i>Dissociation and gender dysphoria: Exploring the relationship.</i>	
Weitze C, Osburg S.....	87
<i>Empirical data on application of the German Transsexuals' Act during its first ten years.</i>	
Wheeler C, Schaefer L.....	88
<i>Holistic psychotherapy treatment model: Highlights and controversies.</i>	
Whittle S.....	89
<i>Employment protection for the transsexual and sex discrimination law.</i>	
Wilchesky M.....	90
<i>Sexoanalytic approach to a reluctant dysphoric: a case study.</i>	
Wilchesky M, Côté H.....	91
<i>The Cross-Roads Group. Designed for the rejected, but not dejected, gender candidate.</i>	
Will M.....	92
<i>Marriage, parental rights, adoption, and employment.</i>	
Wilson N.....	93
<i>Extended groin flap phalloplasty in the female-to-male transsexual.</i>	
Yüksel Ş, Şahin D, Karali N, Baral I.....	95
<i>Doing group psychotherapy with female-to-male transsexuals in Turkey.</i>	
Zhou J-N, Swaab D (presented by Gooren L).....	96
<i>Evidence of a female-type brain differentiation in male-to-female transsexuals.</i>	

On the relationship between gender-identity/role, personality traits and cognitive abilities.

In contrast to common psychometric tests (MMPI, FPI) the concept of androgyny postulates the independence of masculinity and femininity on different measuring scales (Bem-Sex-Role-Inventory/BSRI). Due to this concept 4 subgroups of gender related traits can be discriminated: (1) feminine, (2) masculine, (3) androgyne and (4) undifferentiated. An androgyne personality (i.e. co-existence of masculinity and femininity in one subject) is supposed to be beneficial for psychological well-being.

The paper deals with BSRI-findings in 127 subjects with different gender-identity/role and/or sexual orientation: 18 heterosexual females (hsF; mean age: 23 yrs.), 19 heterosexual males (hsM; 23 yrs.), 30 homosexual females (hoF; 35 yrs.), 30 homosexual males (hoM; 30 yrs.), 18 gynephilic female-to-male-transsexuals (FM-TS; 28 yrs.) and 6 androphilic and 6 gynephilic male-to-female-transsexuals (MF-TS; 27 yrs.). Moreover general personality traits were investigated in hsM, hsF, FM-TS and MF-TS by Freiburger Personality Inventory (FPI), Gießen Personality Self-concept (GTs), Aggression-Questionnaire (FAF) and Draw-a-Person Test (DAP). Cognitive abilities were measured by Wechsler Adult Intelligence Scale (WAIS-R), Raven Progressive Matrices and Cube Perspective Test for Mental Rotation.

Results: Most of hsF and hsM had a self concept in accordance with their gender identity, i.e. high rates of femininity or masculinity, respectively. HoM described themselves mainly in terms of high femininity while hoF and FM-TS showed mostly androgynic values. The gender related self-concept of MF-TS differed with sexual orientation: Gynephilic MF-TS fall mostly into the undifferentiated category while androphilic MF-TS saw themselves in a feminine or undifferentiated manner.

With regard to general personality traits androgyne as well as masculine hsM showed higher values of self-esteem, self-security, and social resonance and lower rates of depression and emotional distress compared to feminine hsM. Among hsF highest rates of aggression, emotional distress, depression and irritability were found in androgynes and feminines, while masculine hsF seem to be more stable. The corresponding comparison in MF-TS and FM-TS interestingly showed tendencies more in accordance with the biological sex than with gender identity. There were some relationships between gender related self-concept, biological sex or gender identity and cognitive abilities, but they did not show consistent tendencies.

Asscheman H, Kesteren P van, Megens J, Gooren L

Department of Andrology/Endocrinology, Free University Hospital, Amsterdam, The Netherlands

Venous thrombosis and pulmonary embolism in estrogen-treated male-to-female transsexuals remains a major problem.

In a previous study on side effects of cross-sex hormone treatment (Metabolism 1989) we found venous thrombosis and/or pulmonary embolism in 19 patients (6.3%, n=303), a 45-fold increase of the expected number. In particular, treatment with ethinyl estradiol in patients > 40 years of age was associated with a prevalence of thromboembolic events of 12%. This prompted us to change our estrogen prescription to Estraderm TTS, a transdermal delivery system that bypasses the liver, in all new patients > 40 years and to offer this treatment to all male-to-female patients regardless of age. However, the majority of our younger patients opt for ethinyl estradiol because of its higher dose and faster action.

Recently we updated our experience with side effects of cross-sex hormone treatment (P. van Kesteren, at this meeting). Venous thrombosis and/or pulmonary embolism was observed in 45 patients (5.5%, n=816), still a 20-fold increase of the expected number. It occurred in 17 patients within the first year of estrogen treatment. In none of the Estraderm-treated patients venous thrombosis was diagnosed (1 patient had a recurrence of thrombosis during Estraderm when she prematurely discontinued oral anticoagulants). In the group of patients > 40 years the risk of thromboembolic events was no longer increased.

In conclusion, venous thrombosis remains a major problem in estrogen-treated male-to-female transsexuals. The risk is high (2%) in the first year of treatment and remains increased during estrogen use. Transdermal estrogen administration with Estraderm TTS reduced the risk of thrombosis in patients > 40 years of age. The peri-operative thrombotic risk can be reduced by discontinuing estrogens 4 weeks before the operation and the use of subcutaneous low-dose heparin prophylaxis peri-operatively. In view of the increased risk of thromboembolic events in estrogen-treated male-to-female transsexuals the use of Estraderm TTS in all patients at risk (> 40 years, previous thrombosis or strong family history) is mandatory and should be stimulated in all age groups.

Avery E, Cole C, Meyer III W

Department of Psychiatry & Behavioral Sciences, The University of Texas Medical Branch,
Rosenberg Clinic, Galveston, TX, USA

Transsexuals and HIV/Aids risk behaviors.

The risk factors for HIV disease in gay men and women, heterosexual men and women, and intravenous drug users have been well documented. In our large university-based HIV clinic we follow five male-to-female transsexuals who are infected with HIV disease. The risk factors for those patients include intravenous drug abuse, prostitution, and multiple sex partners without using protection. Co-risk factors include lower socioeconomic status, limited family and social support, histories of childhood sexual/physical abuse, and psychiatric problems (e.g., personality disorders, major depression). Similar HIV disease risk patterns have been described in transsexual prostitutes in Italy, India, Israel, Australia and Singapore.

One wonders, however, if such risk factors are characteristic of the transsexual population at large. Our clinical experience with such individuals over the last 15 years suggests an empirical hypothesis that transsexualism is not, per se, a risk factor for HIV disease. We propose to survey this larger group of transsexuals (e.g., middle-class individuals from a number of states currently involved in treatment at a Texas-based gender clinic) for known possible risk factors for contracting HIV as well as their general knowledge about HIV disease transmission. Based on this survey, education, testing, counseling and other intervention strategies could be developed. Our presentation will report in detail the original five patients as well as on the findings representative of the larger group. We will highlight both shared and divergent characteristics of these groups and what education/intervention strategies might be appropriate for the transsexual population.

Becker H, Hartmann U, Rüffer-Hesse C

Department of Clinical Psychiatry and Psychotherapy, Medical School of Hannover (MHH), Hannover, Germany

Gender identity disorders in psychiatric practice. Design and preliminary results of a prospective study.

In recent years there has been a small but discernable number of clients asking for further advice and/or treatment for gender dysphoria in the MHH psychiatric outpatient clinic (I). In 1992/93 we collected case reports of more than 30 self-labelled transsexual patients who were considering sex reassignment procedures although they didn't fulfill the diagnostic criteria for transsexualism. Hereby we tried clinically to characterize and categorize the heterogeneity of their problems leading to this repudiation. Additionally, we performed a literature review on this topic. Our impression is that most of these clients suffer from a variety of underlying or concomitant mental health conditions which have to be considered in regard to proper further management (see Becker H., Hartmann U.: Gender Identity Disorders in Psychiatric Practice on the Need for a Clinical Perspective. *Fortschritte der Neurologie Psychiatrie*, 8 (1994) 290-305).

To meet the demand for scrupulous screening, careful and competent differential diagnosis and to enhance the specificity of prognosis and outcome we started a systematic prospective investigation involving this population:

In the study design patients labelling themselves as transsexuals are seen several times in the MHH psychiatric outpatient clinic by a team of psychiatrists of both sexes and a clinical psychologist, all with special experience in sexual issues. The patients demographic variables and past history are assessed in detail. Clinical interviews are performed as well as psychological testing with a set of self developed questionnaires and standardized instruments. Emphasis is laid on cognitive functioning, personality traits, sexual history and fantasies, types and levels of adaptation and coping strategies, identifications, conflicts, psychodynamics, clinical course, psychopathological classification and psychiatric differential diagnosis. If possible endocrinological parameters are collected and relatives or friends are also interviewed. Patients are generally encouraged to participate in psychotherapy, and access to further counselling in our institution is optional. Follow-up assessments to cover their longterm outcome are strived for.

According to our preliminary results these patients require two differential diagnostic processes - one to determine the type of gender identity disturbance, and the other to identify the associated psychopathologies which often require specific treatment. Our experience has shown that the whole personality is affected, therefore extensive (presurgical) psychiatric evaluation and ongoing psychotherapy should be provided routinely.

With this presentation the authors implore for the adherence to a clinically oriented approach and a careful reconsideration of the "standards of care" in "transsexual wishes".

Psychodynamic aspects in two cases of gender identity disorders.

The wide range of clinical subtypes of gender identity disorders is illustrated by two case presentations exemplifying the psychopathology, psychodynamic aspects, course of treatment as well as theoretical implications.

The first case refers to a 30-year-old white caucasian male (Mr K.) who consulted our outpatient department in 1988 about his wish to undergo sex reassignment surgery (SRS). In his family he was "nestled" by the mother and suffered from his father's masculine oriented education. Juvenile sexual development was marked by non-intimate friendship to girls. His first intimate experiences occurred during a 2 years lasting homosexual partnership, in which Mr K. took the feminine role. Presumably in 1987 Mr. K. was HIV infected by this partner. Neurologic examination, magnetic resonance tomography and psychometric evaluation did not reveal any pathologic cerebral process. We understand this history as a secondary gender dysphoria according to *Levine* and *Lothstein*. Presumably the fragile ego of the patient was shattered by the HIV-diagnosis, the wish for SRS then serving as an attempt of regressive stabilization after the traumatic diagnosis.

Case 2 presents a 32-year-old white caucasian male (Mr. S.) originating from a family with a dominating mother. Having had no heterosexual orientated contacts but a one time homosexual experience he describes the intermittently present wish for SRS in a stressful environment. We established a regular contact with a female therapist. Being of passive-dependent personality, Mr. S.'s ambivalence did not allow him to separate from his parents. In the course of the therapy, Mr. S. fell in love with his therapist, aggressively following her in her private life. At this point the patient was recently admitted for psychotherapy.

These cases favour *Beitels* concept of a continuum of gender identity disorders and DSM-IV concepts which abandon the term "transsexualism" as a clinical entity (*Bradley*) and give support for a subtyping of these phenomena according to etiologic-psychodynamic aspects. Strategies for differential diagnosis will improve therapeutic approaches and prognostic assessment.

References:

- Beitel A. The Spectrum of Gender Identity Disturbances. In: Steiner, W.B. (ed) Gender Dysphoria. Plenum Press, New York 1985
- Bradley, S.J. et al. Interim Report of the DSM-IV Subcommittee on Gender Identity Disorders; Arch. Sex. Behav. 20, 333-343, 1991
- Levine S.B., Lothstein L. Transsexualism or the Gender Dysphoria Syndromes; J. Sex Marital Ther. 7(2), 85-113, 1981

Bockting W

Coordinator Gender Dysphoria Program, Program in Human Sexuality, Department of Family Practice & Community Health, Medical School, University of Minnesota, Minneapolis, MN, USA

Transgender coming out. Implications for the clinical management of gender dysphoria.

After a brief historical and crosscultural overview, recent developments in conceptualization and expression of transgender identities in North America are presented. There is a paradigm shift occurring in this field signified by an emerging transgender consciousness, that includes changes on a sociocultural, interpersonal, and intrapsychic level. Socioculturally, the prevailing gender schema of Western culture is challenged by transgender identities that transcend the gender dichotomy. Interpersonally, transgendered individuals are coming out to their families, friends and workplaces, and no longer hide their unique identity. Intrapsychically, affirmation of one's identity as transgender alleviates shame and is experienced as liberating. A growing transgender community provides the necessary support.

This paradigm shift has tremendous implications for the clinical management of gender dysphoria. Treatment is no longer limited to assisting gender dysphoric individuals to adjust in one and/or the other gender role, but includes the possibility of affirming a unique transgender identity. Transgender identities are diverse, and may or may not include partial or complete changes in primary or secondary sex characteristics. The merits of physical changes are evaluated in the context of the individual's identity development with an emphasis on personal comfort and well-being.

In order to exchange perspectives and enhance treatment effectiveness and satisfaction, a forum for a dialogue between health care providers and transgender community representatives is proposed. The role of research in facilitating this paradigm shift and in empowering transgender persons and their communities is discussed.

Bodlund O (Co-workers: Kullgren G, Sundbom E, Armelius K, Höjerback T)

Department of Psychiatry, University of Umeå, Umeå, Sweden

Personality traits/disorders and self-image among *transsexuals* and *gidaant* patients.

Outcome and prognostic factors in sex reassignment.

The focus of the study is personality traits and disorders, self-image and outcome in Gender Identity Disorders. *Transsexuals* (n=19) and GIDAANT patients (n=11) were assessed according to axes I, II and V (DSM-III-R). Clinical axis II diagnoses were compared to personality disorders and traits according to the SCID screen-self-report. Self-image was described by means of the SASB. All transsexuals were followed-up after five years and were evaluated as regards changes in social and/or psychological functioning.

Axis II diagnoses according to SCID screen showed fairly good agreement with clinical assessment ($\kappa = 0.77$). Among transsexuals 33% received a clinical axis II diagnosis versus 73% among GIDAANT patients. Personality traits (SCID screen) revealed frequent subthreshold personality pathology, especially among GIDAANT. The total amount of fulfilled axis II criteria (GBI) for GIDAANT was 40%, 29% for transsexuals versus 17% in the control group. GBI was inverse correlated to axis V - GAF value (62, 70 and 83 respectively).

Transsexuals' self-image was positive as the controls', while GIDAANT patients had a negative self-image with self-hate and self-blaming. Overall, transsexuals showed significant less pathology in all studied aspects, which clearly differentiated them from GIDAANT.

At five year follow-up, 70% of the transsexuals had improved in at least two areas of social and psychological functioning, 16% were worsened and only one of them regretted the sex change. Powerful prognostic factors for negative outcome emerged to be personality pathology (according to SCID screen) and disturbed self-image (SASB) and in some degree also male sex.

In summary the results show that the outcome for sex reassigned transsexuals is fairly good and that the SCID screen and the SASB are useful diagnostic instruments with capacity to predict the outcome.

Bodlund, O et al.: Personality traits and disorders among Transsexuals. *Acta Psychiatr Scand*, 1993, 88: 322-327.

Bodlund, O et al.: Self-image and personality traits in GID: An empirical study. *J Sex & Marital Ther*, 1994, 20: 303-317.

Bodlund, O et al.: Transsexualism - general outcome and prognostic factors. A five year follow-up study of 19 transsexuals in the process of changing sex. *Arch Sex Behav*, in press.

Bodlund O, Kullgren G

Department of Psychiatry, University of Umeå, Umeå, Sweden

**Transsexualism: General outcome and prognostic factors.
A five year follow-up study of nineteen transsexuals in the process of
changing sex.**

Nineteen genuine transsexuals, approved for sex reassignment, were followed up after five years. Outcome was evaluated as changes in seven different areas of social, psychological and psychiatric functioning. At baseline the transsexuals were evaluated according to axis I, II, V (DSM-III-R), SCID screen, SASB (Structural Analysis of Social Behavior) and DMT (Defense Mechanism Test).

At follow-up all but one were treated with contrary sex hormones, twelve had completed sex reassignment surgery and three females were waiting for the final phalloplasty. One male transsexual regretted the decision to change sex and had quit the process. Two transsexuals had still not undergone any surgery due to high age and ambivalence, respectively.

Overall 68 % (n=13) had improved in at least two areas of functioning. In three cases (16 %) outcome were judged as unsatisfying and one of those regarded the sex change as a failure. Another three patients were mainly unchanged after five years, according to the outcome measures.

Female transsexuals showed a tendency for a slightly better outcome, especially concerning establishing and maintaining partnerships and improvement in socioeconomic status compared to male transsexuals.

Baseline factors associated with negative outcome (unchanged or worsened) emerged to be presence of a personality disorder and a high number of axis II criteria. SCID screen assessments had in general high prognostic power. Negative self-image according to SASB clearly predicted a negative outcome whereas DMT variable were not correlated to outcome.

In conclusion, overall outcome was as favorable as shown in previous studies. SCIDF screen and SASB added further diagnostic and prognostic information useful for the selection of candidates for sex reassignment surgery.

Botzer M, Vehrs B

Ingersoll Gender Center, Seattle Counselling Service, Union Institute, Seattle, USA

Psychosocial and treatment factors contributing to favorable outcomes of gender reassignment.

Using both intake and 6-to-12-month follow-up data, a range of factors were examined for their effects upon development and outcomes for gender reassignment clients. These factors include client characteristics, psychosocial histories, therapist evaluations, response to the course of gender reorientation, motivations, expectations, treatment choices, and physical results. Data were analyzed from 326 male-to-female surgical patients of Dr. Stanley H. Biber, with the most complete files from 1987 to 1993. Three matching groups of pre-operative transsexuals, gay males, and lesbian females provided comparisons across factors of psychosocial characteristics, development and outcomes.

Results of descriptive data, discriminant function analyses, and ANOVA's support earlier findings that successful real-life tests, good work/school adjustments, and physical outcomes correlate with client satisfaction and rated success of surgery. In addition, greater activity involvement, social relations histories, family support, and realistic expectations are all significantly correlated with positive outcomes. Multiple episodes of physical harm to self or others, breaks in life-test, and certain signs of inconsistencies and internal conflicts related to less satisfying outcomes.

The Harry Benjamin requirements for evaluation, treatment, and life-test are strongly supported by the result of this study. Composition data further validate surgery as a treatment for gender dysphoria for a substantial proportion of transgendered, male-to-female clients, while suggesting additional evaluation, therapy, or alternative choices for others.

Bratos R, Kruk-Jeromin J

Department of Plastic Surgery, Medical University of Lodz, Lodz, Poland

The estimation of methods of surgical reduction of breasts in female to male transsexuals.

For 7 years (1984-1990) 166 female-to-male transsexuals were surgically treated at the Clinic of Plastic Surgery of the Medical Academy in Lodz. At the first stage of the operative change of sex breasts (N=154) were reduced. Methods used in treatment of hypertrophy of male breasts were applied as well as in reducing female breasts. Methods were chosen according to a size of breasts which were classified in groups: "A" - small breasts, "B" - medium breasts, "C" - large and "CC" - very large breasts.

Webster's method was applied in 22 patients with small breasts ("A") and in 11 patients with medium breasts ("B").

In 56 other patients, also with medium-size breasts ("B") Webster's method was extended by additional "fold" cuts on the lateral and/or paracentral side of the areola of nipple in order to achieve better reduction of the skin and adipose tissue. In the case of large breasts ("C"), 24 patients were treated with methods applied in reduction of female breasts: Maillard's, Mc Kissock's, Skoog's, Weinett's and Strombeck's methods.

In 41 patients with very large breasts Convaye's amputation method was applied, with the transmission of nipples with areolas in the form of free transplants. In 23 patients (15 %) we had to revise the operated region.

In the estimation of the results of the operation after at least 6 months, the shape of the anterior surface of chest, nipples with areolas and the appearance of cicatrices were taken into account.

The best and most satisfying results occurred after the application of Webster's method, also with our modification, and Convaye's method. After adapting the methods of reduction the results were good, satisfying and bad in equal proportions that proves their doubtful usability in breast surgery in transsexuals of F-M type.

¹Montain Home VAMC, East Tennessee State University, Johnston City, TN, USA.

²Department of Psychiatry, Fairfax Hospital, Falls Church, VA, USA.

³Natinal Institutes of Health, Laboratory of Personality and Cognition, Balitmore, MD, USA

Personality characteristics and sexual functioning of 188 American transgendered men: Comparison of patients with nonpatients.

Introduction: Most of the literature on crossdressing men has been limited to self-identified patients in distress presenting at psychiatric clinics or those brought in for treatment under duress by spouses. Prior work with these clinical populations has suggested that transvestites had more negative affect, poorer body image, less sexual satisfaction, and more general psychopathology than male "norms." Others, including Paul Walker, Ph.D., reported very high rates of personality disorders in transsexuals seen in gender clinics. However, results from these settings cannot be generalized to the larger population of crossdressers (CD), the majority of whom never report for psychiatric treatment.

Methods: To further understand the phenomenology of crossdressing, we utilized nonclinical settings in four American cities over a three year period of time to recruit 188 anonymous male CD respondents. Participants completed a background questionnaire, the Derogatis Sexual Functioning Inventory (DSFI; includes the Brief Symptom Inventory), and the NEO Personality Inventory (NEO). Respondents were classified as transvestites (TV; N=83), transgenderists (TG; N=61) or transsexuals (TS; N=44) based on self-report and the extent of crossgender activities. The sample was also divided into four treatment groups: no mental health treatment (N=81), treatment for psychological problems (N=49), treatment for crossdressing-related issues (N=41), and treatment as part of gender transition/sex reassignment (N=17). Groups were compared to each other and to normative data from non-CD male samples using MANOVA's and univariate ANOVA's (where appropriate).

Results: The sample was predominantly white (95%), educated (15.5 years avg.), married (48%), and employed (95%). Thirty percent were taking female hormones at the time of the study. The group as a whole fell within the average range on four of five broad domains on the NEO and high on the Openness domain. The psychological treatment group had significantly more symptoms (e.g., anxiety, depression) than the other groups, consistent with the clinical populations studied by others. In contrast, the other groups did not have elevated symptom scales on the DSFI and were generally indistinguishable from normative samples. Last, the three diagnostic subgroups were indistinguishable on the NEO; the TS group experienced less sexual drive and a greater feminine gender role than the TV or TG groups on DSFI scales, but otherwise few intergroup differences emerged.

Discussion: This study suggests that crossdressers who are not seen for clinical reasons are indistinguishable from noncrossdressing men using a personality assessment instrument, a sexual functioning inventory, and measures of psychological distress with the possible exception of increased openness to experience in all crossdressers and decreased sexual drive and satisfaction in transsexuals. These results emphasize the importance of utilizing clinical significance criteria as required by DSM-IV guidelines before diagnosing men who crossdress with an Axis I disorder.

Cohen-Kettenis P, Goozen S van

Department of Child and Adolescent Psychiatry, University Hospital Utrecht, Utrecht, The Netherlands

Post-operative functioning in adolescent transsexuals.

Starting hormone treatment before the age of 18 is a subject of much debate among professionals. They are generally reluctant to begin these rather invasive procedures when the adolescent is still developing. Because of this ongoing development, it is felt that adolescents cannot make a sensible decision and that the risk of post-operative regret is high. However, one important argument for commencing the administration of cross-sex hormones earlier - for example, during adolescence - is that the physical outcome can be expected to be more satisfactory by comparison with starting later, at an age at which the body has already been fully developed into woman or man. Thus an early start could be expected to have positive effects on feelings of psychological well-being and social adaptation.

Since 1987 adolescents with gender identity disorder are diagnosed and treated at the gender clinic in the Academic Hospital in Utrecht. In our paper background data and diagnosis of the first 33 patients will be presented. Of this group 19 patients, 14 female to males and 5 male to females were referred for hormone treatment and sex reassignment procedure.

The aim of the study was to examine how this relatively young group was functioning physically, psychologically and socially. An extensive structured interview and a battery of psychological test was administered by someone not involved in the diagnosis and treatment of transsexuals. Important domains of inquiry were: satisfaction with the outcome of the surgical operations, effects of hormonal treatment, psychological functioning, social functioning and gender role adaptation. These post-treatment data concerning each of these domains will be compared to the patients' own pre-treatment data.

The implications of our findings for the issue of when to begin the gender reassignment process will be considered.

Dahl A, Guldberg C, Hansen H, Kjelsberg E, Grünfeld B

Department of Psychiatry, University of Oslo, Research Unit, Gaustad Hospital, Oslo, Norway

The Norwegian follow-up study of patients treated for transsexualism.

Since 1963 65 Norwegian patients with transsexualism have been with hormones and surgery. The patients were selected according to the diagnostic and treatment criteria laid down by Lundström & Wålinder, and 40 Patients were converted to females and 23 to males. The 63 patients still living in Norway had a personal follow-up examination by blind raters at a mean of 8.3 years after surgery. The follow-up was done with SCID-interviews for axis I and II disorders, and with a special form for sexual and social adaptation that was rated according to the scheme of Hunt & Hampson.

One patient (1,6%) committed suicide some time after follow-up. Twenty-five per cent of the patients had an axis I disorder before and after their operation, while 22% developed an axis I disorder after operation, mainly anxiety disorders. Twenty-five per cent of the patients had an axis II disorder mainly paranoid and avoidant personality disorder. The mean GAF score was 71.6 (range 38-90). On Hunt & Hampson scale the mean total score was 36.9, and 28% of the sample had a total score of 34 or less which was seen as an unsatisfactory result. Seventy-two percent had a good total outcome after treatment.

Daverio P

Centre Médico Chirurgical, Lausanne, Switzerland

Phallus made in Switzerland.

The first microsurgical one stage phalloplasty has been performed in Lausanne in November 1984.

The technique changed according to complications. This report covers now 84 cases. The urethroplasty was built up with a reversed vaginal flap in continuity with the female meatus in the first 5 patients. But the vaginal skin was not safe enough, so we changed the technique of urethroplasty using the labia minora for the proximal part of the neo-urethra. The penile urethra is then constructed with the ulnar strip of the forearm free flap.

The arterial anastomoses also changed from previous epigastric artery end to end with radial artery to end to side anastomose radial artery to femoral artery.

The innervation of this neophallus has been insured by the right and left ilio-hypogastric nerves. The pudendus branches giving the dorsal nerves of the clitoris remain attached to this orgasmogenic organ, sutured deepithelized in the midline under the neo-scrotal skin.

Subcutaneous mastectomy, hysterectomy, ovariectomy and colectomy are done in the same operating session.

The donor side of the forearm is covered with a full thickness skin graft gathered from mammary or inguinal skin.

8 to 12 months after the phalloplasty, the sensitivity of the penis allows to go ahead with implants of testicules and erectile prosthesis as AMS Dynaflex, now completed with a soft silicone glans protecting from protrusion, and giving a better aesthetic aspect; tattooing the glans brings a must to the swiss phallus.

Early and late complications are discussed: arterial thrombosis; vaginal bleeding; complication after hysterectomy; post-operative infections; fistulae and urethral stenoses.

Désirat K

Evangelische Fachhochschule RWL, Bochum, Germany

Reflections on the aspect of hostility in transsexual symptoms.

The originally rather stereotypical description of transsexual symptoms has been replaced recently by a more discriminating view. The author will discuss the symptom of hostility on the basis of two selected case presentations of transsexual patients. Long-term experience in psychotherapy with transsexual patients has shown that the intensity of hostility may not only be important regarding patient-psychotherapist-relationship but also have major implications regarding the patient's prognosis.

The processes of appraisal and self-verification in transsexualism and some of the consequences.

Until now transsexualism has almost exclusively been studied intrapersonally. The contribution of social processes in the development of (the awareness of) one's cross-gender identity is the issue of the present paper.

One of the most difficult tasks for transsexuals is to sort out and to come to terms with the contradiction between the awareness of their gender identity and the reality of their physical body. In spite of this contradiction they need to integrate the cross-gender identity in their self-system. In order to achieve this, it is very important for them to be recognized and treated in accordance with their gender identity. Anatomical sex characteristics as perceived by the social environment play a decisive role in this process. For the present investigation it was hypothesized that the appraisal of their secondary sex characteristics by others would have a direct relationship with the self-seeking behavior of transsexuals and on their chances of developing a stable personality in which the cross-gender identity is well integrated.

To test these hypotheses all applicants for SRS were classified as feminine or masculine of appearance. This classification was based on subjective, but nevertheless highly reliable ratings by external judges. In an analyses of variance design male-to-female and female-to-male applicants, thus classified, were compared on a number of personality tests and questions regarding their sexual history.

The most salient finding of the study is that the simple, arbitrary and very subjective appraisal of how feminine or masculine transsexuals presenting at the Gender Clinic look at first sight indeed appeared to relate impressively strong with their lives and personalities. An appraisal consistent with their gender identity leads to a more stable personality, which is more extraverted and agreeable (less incentive). Transsexuals who were appraised as such presented less borderline characteristics, were less sensitive to the criticism of others and reported much less psychological and physical symptoms. These clear relationships between external appraisal and personality were predicted, because it was hypothesized that they reflect a process in which others' appraisal leads to self-verifying feedback and enables the person to integrate the cross-gender identity in the selfsystem. An appraisal not consistent with the cross-gender identity leads to a much more problematic personality. One of the reasons that appraisal has this impact lies in the fact that it guides (and in the case of inconsistency: manoeuvres) them into specific behaviors. This was investigated with respect to sexual relationships. Regardless of anatomical sex it was shown

that transsexuals appraised as feminine were more likely to engage in sexual relationships with heterosexual males and enjoy this. Only for male-to-female transsexuals this can be considered a self-verifying experience. Those appraised as masculine were more likely to engage in sexual relationships with heterosexual females and enjoy this, which is only self-verifying for female-to-males transsexuals. As a consequence of the effect of appraisal on this self-seeking behavior and of the beneficial impact it has on the stability and integration of the self it was expected that those who were appraised in line with their cross-gender identity would have a more positive view of their body and would have a higher probability to start sex reassignment treatment. This is precisely what was found.

In the paper the theoretical outlines that were tested will be summarized and the results will be presented. Some implications will be discussed.

The study presented here is part of a large prospective study which was made possible by a grant of the Ziekenfondsraad (the Dutch Health Insurance Council).

Dott S¹, Walling D¹, Avery E¹, Cole C^{1,2}, Meyer W¹

¹Department of Psychiatry & Behavioral Sciences, University of Texas, Medical Branch, Galveston, TX, USA, ²Rosenberg Clinic, Galveston, TX, USA

Schizophrenia and transsexualism: Defining the boundaries.

Transsexualism as defined by the DSM-IV is unrelated to the diagnostic category of schizophrenia. However, until recently many professionals considered transsexualism to be a presentation of schizophrenia resulting in the misdiagnosis of many transsexuals. This paper explores those individuals who present as dually diagnosed with schizophrenia and transsexualism. To date their coexistence has been recognized in only isolated case reports. We have identified and will present six additional cases.

Additionally, the issue of pseudo-transsexualism arises in the treatment of persons diagnosed with schizophrenia. This pseudo-transsexual behavior is secondary to the psychotic and delusional thinking associated with schizophrenia. The authors are currently conducting a survey of individuals with schizophrenia (n=500) to determine the incidence of co-morbid transsexualism and pseudo-transsexualism in this population. Final results of this study will be presented.

Draskic M

Faculty of Law, University of Belgrade, Belgrade, Yugoslavia

Transsexuals and marriage, parental rights, adoption: Perspectives for the legislator in Yugoslavia.

Belgrade's team for treating gender dysphoric patients separated 78 transsexuals in the period of January 1986 to January 1993: 38 females and 40 males. Only 22 of them (2 females and 20 males) were indicated for sex reassignment and operated. The follow up study of 20 male operated transsexuals, now females, shows that all of them were dissatisfied before the indication for treatment and that 16 (80%) were satisfied after the acceptance for hormonal preparation. Finally, 12 (60%) transsexuals were satisfied six months after the operation. The discontent of the remaining 8 (40%) transsexual persons was not connected with the sex reassignment itself, but with the failure in interpersonal relationships.

With regard to legislation for transsexual persons, Yugoslavia can be named as a country which has not adopted special legislation. The prevailing viewpoint is that the very small percentage of transsexuals in the population as a whole renders the problem statistically insignificant, so that recourse to legislation is unnecessary. On the other hand, not a single transsexual case ever came before the courts in Yugoslavia. This is to say that the administration authorities allow change of sex and change of forename in the birth register after the medical intervention.

Elbers J¹, Asscheman H¹, Seidell J², Gooren L²

¹Division of Endocrinology/Andrology, Free University Hospital, Amsterdam, The Netherlands

²Department of Chronic Disease & Environmental Epidemiology, R.I.V.M., Bilthoven, The Netherlands

Effects of androgens in female-to-male transsexuals: Shift towards a male cardiovascular risk pattern.

An increased accumulation of fat in the abdominal cavity, the visceral fat, seems responsible for the metabolic disorders observed in obesity, such as hypertension and an unfavourable lipid profile. Generally, it is shown that males have larger amounts of this hazardous visceral fat and a more unfavourable lipid profile than females. Because of these sex differences, the role of the male sex steroid hormones (androgens) in these metabolic processes has been studied in both sexes. Cross-sectional studies showed that high levels of androgens in females were associated with a predominance of fat in the abdominal depots and decreased HDL-cholesterol levels. However, the cause-effect relationship between these associations remains unclear.

In the present study, the effects of androgen administration (Sustanon 250 mg/2-3 weeks intramuscularly) on serum lipids and fat distribution was studied prospectively in 9 female-to-male transsexuals (mean age: 24 ± 5 yrs, mean body mass index: 23.0 ± 3.0 kg/m²). At 0, 2, 4 and 12 month of treatment blood samples were taken for determination of serum lipid and hormone levels. Fat distribution was assessed by the imaging technique based on magnetic resonance (MR) before (T=0), after 1 year (T=1) and after 3 years testosterone treatment (T=3). MR images were obtained at the level of the waist, hip and thigh for quantification of subcutaneous and visceral fat depots.

HDL-cholesterol and HDL₂-cholesterol levels decreased significantly: a decrease in HDL₂-cholesterol of 45 % was reached after 4 months and stabilized at this level. Data on body fat distribution are presented in the table below.

	T=0	T=1	T=3
Weight (kg)	66.4 ± 7.5	66.2 ± 7.6	68.5 ± 9.5
Fat depots (cm ²)			
Hip S	186 ± 39	131 ± 47*	169 ± 69
Thigh S	264 ± 51	200 ± 64*	241 ± 101
Waist S	182 ± 76	137 ± 69*	177 ± 88
V	31 ± 15	33 ± 10	44 ± 15#

*P<0.05 T=1 vs T=0, #P<0.05 T= 3 vs T=0 (paired Wilcoxon Test)

These data show that exogenous testosterone in female-to-male transsexuals has a direct, unfavourable effect on HDL- and HDL₂-cholesterol levels. The decrease of subcutaneous fat observed after 1 year is no longer present after 3 years. However, longterm androgen administration in female-to-male transsexuals increases the accumulation of the hazardous visceral fat thereby inducing a shift towards a male cardiovascular risk pattern.

Ekins R¹, King D²

¹University of Ulster, ²University of Liverpool, United Kingdom

Blending genders - some social aspects of cross-dressing and sex-changing.

This paper discusses the limitations for social scientists of the medical categories of transsexualism and gender dysphoria. The remainder of the paper considers five areas of what the authors see as gender blending: the experiences of those who cross-dress and change sex; the way in which these phenomena have been socially patterned over the past few decades; the significance of the medicalisation of gender blending; the enormous popularity of gender blending in the mass media; the various debates concerning the political role of those who blend various aspects of gender. Taken together, these five areas may be seen as the basis for a newly emerging field of transgender studies.

Ettner R

Evanston, Ill., USA

Workshop model for the inclusion and treatment of the families of transsexuals.

Objective. - Present clinical management and counseling of gender dysphoric individuals is directed exclusively at the individual. Very little work has been done on educating and treating parents, relatives and spouses of gender dysphoric persons. Family members have no access to reliable information or support. Often they are not knowledgeable about the condition itself.

As gender conflicts impact not only individuals, but everyone in their family systems, we have developed a workshop model for the purpose of inclusion of the family. This paradigm attempts to disseminate practical information, education and meaningful emotional support for the families of the transgendered.

Setting and Participants. - The workshop was conducted during a single day, in a comfortable and non-imposing conference room which accommodated thirty participants. Seating was movable to allow for flexible room topologies depending on the exercise or presentation. Participants were 50% family members (mostly mothers, no fathers) of transsexuals, 10% professionals, and 40% transsexuals.

Format. - The family physician moderator outlined the format and scope of the seminar, and introduced the speakers. The psychologist gave an overview of the psychological and social implications of the condition of gender dysphoria. These presentations were followed by the participants introducing themselves, in turn. This was the most important and powerful segment of the program, as each participant shared personal experiences and concerns relative to gender. It allowed family members to change existing beliefs about the condition. Two physicians spoke about the medical management of the condition. Role-playing exercises were conducted following these presentations. A question and answer session concluded the workshop.

Results. - The results of this workshop are a greater understanding by the family members involved, and networking and peer support between the participants who had previously not known anyone else in a similar situation. The participants were able to take what they had learned back to the non participating family members.

Conclusions. - We propose that this workshop model be employed, wherever there is a substantial transgendered community.

Exner K

Department of Plastic Surgery, St. Markus-Hospital, Frankfurt/Main, Germany

A new concept of phalloplasty with one rectus abdominis muscle flap and two groin flaps - experience with 123 cases.

In the last 14 years 123 female-to-male patients were operated in our unit at St. Markus Hospital in Frankfurt. We developed a one stage phalloplasty by use of one unilateral pedicled rectus muscle flap in combination with bilateral groin flaps. The rectus abdominis muscle flap with a stripe of the anterior sheet is elevated through an abdominoplasty incision. Bilateral groin flaps are turned over to cover the newly created phallus. The muscle covers a rigidity prosthesis fixed to the symphysis. The ideal stiffener has been found wrapping a silicone rod in a Dacron velour prosthesis.

At the same stage, mastectomy, ovariectomy and hysterectomy may be done. Secondary procedures are the scrotal construction inserting testicular prosthesis, the vaginal resection and the closing of the female perineum. The clitoris is transposed to the base of the scrotum preserving the erogenous sensibility. The construction of a neourethra extending to the tip of the phallus remains a complicated procedure. Lengthening of the urethra to the tip of the transposed clitoris is a safe method by the use of the hairless labia minora.

As techniques developed to improve the cosmetic appearance and the function of the newly created phallus, the complication rate has decreased markedly. In obese patients we prefer the delay of the groin flaps and the transposed clitoris enables the patient to have erogenous sensation. The new phallus may be individually sized and the wrapped stiffener enables sexual intercourse. One patient reported functional disturbance of the donor site. The scars are hidden under the swim suit.

The results in our 123 cases demonstrate a high satisfaction rate. In our hands the method has become a proven surgical reassignment for female to male transsexuals.

Exner K, Schernitzky B

Department of Plastic Surgery, St. Markus Hospital, Frankfurt/Main, Germany

Female-to-male-transsexualism - psychological and social follow-up of reassignment surgery in 67 patients.

Introduction

The following retrospective study encompasses the after effects of plastic surgery on female-to-male-transsexuals. It concentrates on psychological and social developments of the transsexuals who have undergone these complicated operations. The developments specifically concentrated on are mental stability of the patients and the interaction with their respective environments.

Method

This study includes 67 female-to-male patients with transsexual symptoms. The patients were handled between 1985 and 1993 in the clinic for plastic and reconstructive surgery in St. Markus hospital in Frankfurt. The goal of each set of operations was the transformation from female to male.

All patients received psychological treatment and observation for a minimum of one year. The approval for the operation was first given after two psychological or psychiatric expert opinions indicated that the transsexual symptoms were permanent. All patients received the same standardized operation program. A collective homogeneous group of patients were evaluated by this study. The evaluation included patients, whose operations were completed no less than 10 months and no longer than 8,5 years before the study began.

In order to objectively evaluate the results of this study, a questionnaire was created based on existing literature. The development of the questionnaire was influenced by experts in the field of transsexualism, former and current operation candidates and transsexual self help groups.

The questionnaire contains categories broken down in three time periods (before, during and after the operations). The categories deal with the following: physical aspects, psychological changes, relationship developments, changes in sexual behaviour, changes in social aspects of the patients' lives, and changes in the living standards based on occupational developments.

The questionnaire includes mostly multiple choice questions. Further questions requiring direct patient response were posed in order to give the patients the opportunity to express their most important internal developments.

Results

72.7 percent of the questionnaire were returned, although strict anonymity was guaranteed to all respondents.

physical aspects

- the patients satisfaction with the appearance of each set of operations was varied
- the construction of the neo-urethra was indicated to be the most problematic aspect of the set of operations
- in many cases patients believed further enhancement to the neo-phallus and breast were necessary
- 92.5 percent of the patients believed themselves to be seen as masculine

psychological results

- an increase of psychological stability after the operations
- problems encountered in the patients day-to-day routine were decreased
- suicidal tendencies decreased from 72.5 to 5 percent
- the points most important for reaching psychological balance were in the following order: mastectomy - hormonal therapy - name change

relationship developments

- there were no significant changes in the manner and duration of patients' relationships
- many of the patients exhibited the tendency towards stable, long term relationships during *all* three times periods
- after the operations many patients married and expressed a desire to adopt children

sexual behaviour

- a statistically significant increase in pleasure from sexual experiences
- the number of sexual encounters increased
- more patients experienced an orgasm

social aspects

- the interaction with family, friends and new contacts showed a significant improvement

socio-economic improvements

- the attitude towards personal living conditions improved
- a statistically significant increase in job placement
- no significant change in financial situation
- job satisfaction grew

Eyler A¹, Wright K²,

¹University of Michigan, Ann Arbor, MI, USA, ²Wayne State University, Detroit, MI, USA

Gender identification and sexual orientation among genetic females with gender-blended self-perception in childhood and adolescence.

Research attention has to date been focused on the transsexual or transgendered person who presents for clinical services during the course of his or her efforts toward gender reassignment or acquisition of chromosomally-opposite gender characteristics. However, much less is known regarding persons who experience gender identifications elsewhere on the theoretical continuum, such as those who exhibit a blended self-perception (1). Uncertainty regarding future gender or gender qualities is especially common during childhood and adolescence, yet may be followed by stable adult identifications of either gender, or a blended identification. This paper presents the results of qualitative interviews conducted with three individuals which illustrate the spectrum of adult gender identification and sexual orientation which can emerge from gender dysphoric childhood or adolescence among genetic females: female-to-male transexualism (heterosexual), and two gender-blended identifications, one lesbian and one heterosexual. A theoretical construct encompassing these outcomes is also presented.

1) Devor, H. Gender Blending. University of Indiana Press, 1989

Gilbert D

The Center for Gender Reassignment, Norfolk, VA, USA

A gender coordinator's job.

The needs of the transgendered population cut across psychological, hormonal, surgical and life style spheres. During the patient's metamorphosis, he or she touches all of these disciplines and requires an advocate for support.

Likewise, the coordination of many busy and diverse professionals to focus on the problems and needs of the patient population requires someone who can relate well to all.

Finally, many of these activities are carried out in an ambivalent and occasionally hostile atmosphere while interfacing with fellow professionals, health care workers, health insurance personnel, and the general public.

The "gender coordinator's" job in this milieu is demanding, tiring and often thankless. It takes a strong-willed person with a commitment to the transgender phenomenon to stick with the job for an extended period of time. Indeed, the demands of patient and professional education of the transgender phenomenon is the overriding obligation of the coordinator. Gender coordinators give their time to teaching, coaching, or just giving something back to somebody. They understand that you're not just your own universe, you're part of a larger universe. Without educating patients and the public, understanding will not be forthcoming.

The gender coordinator's compensation for a job well-done is the realization of their patient's happiness. Coordinator pitfalls and pragmatic solutions will be discussed.

Gilbert D, Jordan G, Schlossberg S, Alter G

Eastern Virginia Medical School, Norfolk, VA, USA

Penile prosthesis implantation in total phalloplasty.

Over the past five years, we have acquired a series of 15 patients who underwent prosthetic implantation following total phalloplasty. Nine of these patients were transgendered.

Our experience with prosthetic implantation is reviewed. Fifteen patients underwent 17 attempts at implantation. Thirteen of the 15 patients (86%) of attempted implants currently have prostheses in place. In four patients, infection necessitated removal of the prosthesis. Two of the four patients have been successfully reimplanted.

Our experience with semi-rigid and inflatable prostheses will be reviewed, including indications, current surgical technique, and postoperative complications.

Gilbert D, Gilbert D

Eastern Virginia Medical School, Norfolk, VA, USA

Ulnar forearm phallic construction.

We have modified our approach to phalloplasty with the goals of improved functional and aesthetic results. Over the past two years, we have completed 21 ulnar-based forearm phalloplasties with no failures. Twelve patients were transgendered.

Flap designs included ten "Beimer" flaps, six "cricket-bat" flaps and two modified "Chang" (Chinese) tube-in-a-tube flaps. Complications included three patients who required re-operation to relieve arterial thrombi, three patients who had postoperative stenoses that required internal urethrotomies, and four patients who had postoperative urethrocutaneous fistulae (one resolved spontaneously, one was successfully closed with an intra-oral mucosal graft, and two others await fistula repair.)

This poster will demonstrate improvements in functional and aesthetic results as a result of our experience with phallic construction.

Gender dysphoria: Clinical, sociocultural and psychosexual data of 134 patients.

Only recently have gender dysphoria and particularly transsexualism, been studied and thoroughly investigated, but epidemiological and clinical data, referring to the incidence and characteristics of this phenomenon are poor, both in the international scientific issues, and especially in the national ones.

Therefore in our work we are going to present our experience in such a field, dealing with 134 patients (115 males and 19 females) who requested our attention first at the Sexological Advice Bureau at the Mauriziano Hospital in Turin, and the at other public and private structures in the same town, for gender dysphoria-related problems, or more specifically requesting surgical sex reassignment, from 1983 to 1995.

According to the Standards of Care of the HBGDA we suggest to all the patients consulting us for such a problem, an endocrinological, psychological and psychiatric evaluation, and for that reason the drop out is rather high, because many patients don't complete nor start their suggested evaluation, representing so a first selection in the group.

Several at the clinical and sociocultural data we usually try to systematically investigate in all the patients: first the distribution for sex and age group at the time of first consulting, who sent them to us, the initial request, state whether single-married with children, how long they have been in charge; then we usually try a birth-place (North, Middle, South and Islands; abroad) and residence geographical area analysis in order to evaluate the discomfort depending on the transfers, often from South to North, with sociocultural uprooting, and then prostitution addiction; present and past family membership with particular regard to brothers' and sisters' number, often very high; family features relationship; education and social level, particularly considering their job; alcohol and drug addiction, and last the possible psychiatric-related pathology.

As regards psychosexual data, we evaluate the beginning and the history of their gender dysphoria; the pattern of their emotional ties and of their sexual attitudes, and last former doctor's advice and medical and psychological therapies for the gender dysphoria.

Green R

Gender Identity Clinic, Department of Psychiatry, Charing Cross Hospital, London, United Kingdom

Formerly the orphans of medicine, transsexuals are currently the orphans of the law.

In the US the Americans with Disabilities Act, a handicap protection law, specifically excludes transsexuals from coverage against employment discrimination. The US anti-gender discrimination employment statute, Title VII, has repeatedly failed the transsexual. UK protection is equally toothless.

Nearly half of American states do not permit birth certificate change for post-operative transsexuals. The UK, with its unitary law, steadfastly adheres to the medically and psychologically flawed Corbett case of 30 years ago. The Englishman's (nee woman's) or Englishwoman's (nee man's) "court of last resort", the European Court of Human Rights, has too, turned away. Deferring to the UK's anaemic rationale for not changing a birth certificate, it has rejected all transsexuals' appeals.

Without birth certificate change, marriage is impossible. Consequently, parenting is obstructed. Adoption of a child by an unmarried couple (co-adoption) in the UK is not allowed. Formerly married transsexual parents who change sex fare no better. Courts are even less sympathetic than former spouses toward permitting the transsexual continuing contact with children.

Harry Benjamin adopted the transsexual orphan into the family of medical rights. The Association bearing his name should now adopt the transsexual orphan into the family of legal rights.

Hage J

Department of Plastic and Reconstructive Surgery, Academic Hospital of the Free University, Amsterdam, The Netherlands

A.M.S. Dynaflex implantation as part of the phalloplasty: Preliminary results.

In phalloplasty, obtaining sufficient rigidity allowing for sexual penetration is difficult. Resorption, curving, and fracture of autologous cartilage and bone transplants are reported, and rigid implants have a tendency to erode and extrude. On the other hand, hydraulic prostheses may show mechanical failure. For these reasons, the Amsterdam surgical team until recently refrained from the use of rigidity prosthetic implants.

Because promising results have been obtained using the one-cylinder A.M.S. Dynaflex, these have now been implanted in several female-to-male transsexuals. For insertion of a stiffener, intact neophallic sensibility is regarded a *conditio sine qua non*. Hence, insertion of a stiffener will only be contemplated in cases of free flap phalloplasty. To further try and prevent erosion, the implant is wrapped in a Dacron vascular prosthesis.

The surgical experience and preliminary postoperative results applying A.M.S. Dynaflex implants in several female-to-male transsexuals are presented.

Hage J

Department of Plastic and Reconstructive Surgery, Academic Hospital of the Free University, Amsterdam, The Netherlands

Metaidoioplasty: An alternative phalloplasty technique in transsexuals.

The various techniques for phalloplasty in female-to-male transsexuals produce results that are more or less acceptable, both aesthetically and functionally. However, all of these techniques will lead to extensive scarring of the donor area.

Metaidoioplasty uses the clitoris, overdeveloped by hormonal treatment, to construct a microphallus in a way comparable to the correction of chordae and lengthening of urethra in male pseudohermaphrodites and in cases of severe hypospadias. It will not leave any scars outside the perineum.

The surgical and longterm postoperative experiences applying a combination of the techniques of both Bouman and Laub in 30 female-to-male transsexuals are presented. At best, metaidoioplasty will provide a small phallus hardly, if at all, capable of sexual penetration. Still, we consider it to be a method of choice in cases where the clitoris seems large enough to provide a phallus which will satisfy the patient.

Hage J

Department of Plastic and Reconstructive Surgery, Academic Hospital of the Free University, Amsterdam, The Netherlands

Subcutaneous mastectomy in female transsexuals: Basic considerations on positioning of the areolar complex.

In order to obtain favorable results after subcutaneous mastectomy in transsexuals, the surgeon should be aware of the differences between the female mammary anatomy and its male counterpart, as well as of the possible techniques to overcome them.

Both nipple and areola should be reduced in female-to-male sex reassignment surgery. For the re-positioning of the reduced areolar complex, young adult male and female nipples alike are said to be located approximately at the superior quarter point of body height on the line passing from the pubis to the acromioclavicular joint or in perpendicular line with the anterior iliac spine and the medial corner of the infraclavicular fossa. One should be careful applying these anatomical landmarks for the female thorax is shorter and more conical. Moreover, in males the nipples are separated by nearly one head-length and, hence, in a subject whose chest and shoulder development is extensive the nipples will appear to be closer as usual.

In our opinion, one should not adhere to fixed measures. Rather, the nipple is placed on the line going straight upwards from the native site of the nipple, at the crossing of the 4th to 5th rib over the inferior of the major pectoralis muscle.

Self and gender: Narcissistic pathology and personality factors in gender dysphoric patients. Results of a prospective study.

In recent years, the clinical heterogeneity as well as the etiological and psychopathological diversity of gender dysphoric patients have increasingly come into the focus of attention. In view of the remarkably different gender and orientation developmental backgrounds of individuals with gender identity problems, DSM-IV has changed its nosological classification and has done away with the term 'transsexualism' as a diagnostic category of a specific type of gender disorder with distinct boundaries to other types of gender dysphoria. While basically serving the purpose to uncouple the diagnostic classification of gender disorders from criteria for approving patients for sex reassignment surgery, these nosological changes should also increase clinical perceptions of gender problems and improve the precision of differential diagnosis. Recent efforts for subtyping gender disorders (e.g. Blanchard 1989) are important for clinical management and research purposes but have mainly been confined to variables relating to gender development and sexual orientation whereas personality and psychopathological factors associated with the inhibition of an adequate gender identity development have rather been disregarded.

This contribution will concentrate upon the relationship of self and gender in patients requesting or seriously considering sex change. Specific attention will be paid to pathological features in regulatory processes of the self-system as well as on personality factors associated with different types of gender disorders. Based on the results of a retrospective analysis of all patients that have consulted the gender dysphoria team of the psychiatric outpatient clinic of Hannover Medical School during a one year period (Becker & Hartmann 1994), a prospective study was designed to identify subtypes of gender dysphoric patients based on a scrupulous psychiatric and psychopathological evaluation. All patients consulting our gender dysphoria team are included into the study. The evaluation procedure consists of the following components:

- Clinical interviews addressing differential diagnosis of gender dysphoria, patient history and psychiatric status. Patients are usually explored independently by all members of the team over an extended period of time.
- A structural interview according to the concept of Kernberg (1984) covering relevant aspects of self-pathology, narcissistic regulation and object relations.

- A set of psychometric and self-developed questionnaire instruments including the MMPI (short version), 16PF, Rosenzweig Picture-Frustration-Test, Narzißmusinventar (narcissism inventory), the Androphilia-Gynephilia-Index and Cross-Gender Fetishism Scale developed by Blanchard (1985) and an erotic imagery questionnaire.

Preliminary results indicate significant psychopathological aspects and narcissistic dysregulation in most of our gender dysphoric patients. Among biological males different subtypes of self-(dys-)regulation and corresponding MMPI-profiles seem to emerge. Results of the narcissism inventory indicate that of the 4 main dimensions (the threatened self, the traditional narcissistic self, the ideal self, the hypochondriac self) scales covering aspects of the "threatened self" show the most significant deviations while a number of patients do not have a negative body-self. The implications of these results will be discussed with special reference to differential diagnosis and prognostic factors.

References:

- Becker, H., Hartmann, U. (1994): Geschlechtsidentitätsstörungen und die Notwendigkeit der klinischen Perspektive. Ein Beitrag aus der psychiatrischen Praxis. Fortschritte der Neurologie Psychiatrie, 62:290-305.
- Blanchard, R. (1989): The concept of autogynephilia and the typology of male gender dysphoria. The Journal of Nervous and Mental Disease, 177:616.-623.
- Kernberg, O. (1984): Severe Personality Disorders. New Haven: Yale University Press.

Hirschauer S

Faculty of Sociology, University of Bielefeld, Bielefeld, Germany

The medicalization of gender-migration.

The paper will outline a sociological notion of gender and gender change which contradicts both a common confusion of gender change with transsexuality and the distinction between sex and gender. This distinction does not make sociological sense any more. In a second step the paper will analyse how surgeons, psychiatrists, and endocrinologists are involved into the social conflicts surrounding a change of gender, and how they deeply shape the phenomenon itself. The medical 'solution' of transsexuals' 'problems' have become an integral part of the cultural phenomenon of transsexuality.

Karim R, Hage J

Department of Plastic and Reconstructive Surgery, Academic Hospital of the Free University, Amsterdam, The Netherlands

Refinements of postoperative care to optimize neovaginal depth and width in male-to-female transsexuals.

In the period 1980 - 1992, primary genital reassignment surgery was performed for 200 male-to-female transsexuals aged 18 to 71 years. For this, the penile and scrotal skin inversion technique was employed. Because, apart from minor complications in 32 patients, partial sloughing of the inverted penile skin was observed in only 2 of the 200 patients, our postoperative measures appear to be worthwhile reporting.

We feel this favorable result is realized through the use of the soft and pliable Vaseline® tampon instead of a firm mould. If as much as possible of the penile fasciae is left adherent to the penile skin, inclusion of the dorsal neurovascular bundle has been proven not to be necessary to prevent sloughing.

Furthermore, intermittent daily neovaginal dilatation may successfully ensure neovaginal depth and width and, in our opinion, is superior to a long-term continous intravaginal stent. After examination in the out patient clinic, the patients are instructed to dilate the vagina as of 21 days postoperatively, applying a 3 cm wide dildo daily for 15 minutes. This is to be continued for half a year. Since we started advising our patients to do so, the mean depth and the mean diameter of the neovagina examined between 6 and 12 months were found to be 10 cm (range 6 to 14) and 28 mm (range 19 to 35) respectively.

Mean neovaginal depth at operation was 11 cm (range 8 to 15 cm), and so, it appears that an average of 1 cm of depth is lost as compared with the intraoperative measurements.

k

As an alternative, sexual intercourse is permitted. We found that the long-term width may depend on sexual activity. In the cases perpetrating sexual intercourse the neovaginal width averaged 30 mm, while in those that were otherwise - or not at all - sexually active, an average width of 27 mm was found. Depth in both groups on average was 10 cm.

Kesteren P van¹, Meinhardt W², Valk P van der³, Geldof A⁴, Megens J¹, Gooren L¹

The Departments of ¹Andrology, ²Urology, ³Pathology, and the ⁴Laboratory of Experimental Endocrinology, Free University Hospital, Amsterdam, The Netherlands

Effects of long-term cross-sex hormone treatment on the prostate of aging transsexuals.

In aging males, the prostate is subject to two bothersome and frequently seen diseases, namely: 1) enlargement of the prostate (benign prostate hyperplasia, BPH) and 2) prostate cancer. Recent studies revealed that estrogens may play a role in the development in both diseases. During sex reassignment surgery in male-to-female transsexuals, the prostate is not removed, reducing operation time with its concomitant risks, and incontinence, often seen after prostatectomy. Therefore, aging, long term treated transsexuals have prostates which are exposed to years of estrogen administration and this consequently may put them potentially at risk to develop enlargement or cancer of the prostate.

We studied 9 male-to-female transsexuals, mean age 60.2 (51-71) years. The average time of estrogen treatment was 15.8 (13-19) years and on average 13.4 (7-22) years ago they had undergone sex-reassignment surgery. Subjects were asked to fill in the World Health Prostate symptom score (WHOPS score) to reveal urinary discomfort at the time of our study. Transrectal or transneovaginal ultrasound was performed to measure prostate volume. 1-3 prostate biopsies were taken and studied by light microscopy. The remaining tissue was studied by immunohistochemistry for prostate specific antigen (PSA), prostate specific acid phosphatase (PAP), cellular proliferation by Ki-67, androgen receptors (AR), estrogen receptors (ER) and progesterone receptors (PR).

On the WHOPS score, subjects reported to suffer not at all or slightly from urinary discomfort. At ultrasound measurements all prostates were found to be small. Light microscopy showed squamous metaplasia of the prostate cells, which is a well known phenomena after estrogen exposure, but is not a sign of malignancy. There was still PSA and PAP detectable. Few cases showed weak positive Ki-67 staining, indicating only little cell proliferation. Sex steroid receptor content was markedly changed with a predominance of ER and PR in both epithelium and stroma.

In conclusion: long-term estrogen exposure in aging transsexuals did not lead to signs of hyperplasia or malignancy of their prostates.

Side effects of cross-sex hormonal treatment: An update of mortality and morbidity in 1109 transsexuals.

Transsexuals use supraphysiological amounts of sex steroids in order to adapt their body to the opposite sex. Sex steroid treatment may be associated with serious and sometimes life-threatening side effects. Asscheman et al reported in 1989 mortality and morbidity figures in a group of 425 transsexuals. In the last 5 years, the population of transsexuals consulting our clinic for hormonal treatment expanded to the number of 1109. It is therefore timely to review once more the files of all patients seen in our outpatient department in order to collect a large amount of updated data on side effects.

The number of deaths and morbidity cases in 816 male-to-female (m-F) and 293 female-to-male (F-M) transsexuals treated with cross-sex hormones were compared with the expected number in a similar reference group of the population. In contrast with our previous report, the number of death in M-F (38) was not higher compared to the number expected. However, the number of deaths due to suicide and AIDS was increased. Combined treatment with estrogen and cyproterone acetate in M-F was associated with increased prevalence of thromboembolic events, hyperprolactinemia, depressive mood changes, weight increase, and transient elevation of liver enzymes. Two F-M deceased, which was not higher than the statistically expected number. Androgen treatment in F-M was associated with transient elevation of liver enzymes, weight increase, and acne. In both groups persistent liver enzyme abnormalities could be attributed to other causes than sex steroids (hepatitis B and alcohol abuse).

In view of the high prevalence of side effects, continuous and accurate clinical evaluation remain the cornerstone of cross-sex hormone administration.

Adrenal enzyme activities in individuals with transsexualism.

Besides from psychosociological factors and brain alterations, deficiencies in enzyme activity in adrenal steroid-biosynthesis are discussed as the cause of establishment of transsexualism. Based on elevated basal plasma levels of dehydroepiandrosterone sulfate (DHEAS) and androstenedione a partial lack of 3 β -hydroxysteroiddehydrogenase (3 β -HSD) was hypothesized to be responsible for development of male-to-female transsexualism (m'f). In the maternal placenta these precursors of adrenal steroids are converted to estrogen, which suppresses gonadal androgen production. In addition estrogen is discussed to influence sexual development of the male fetusses brain via estrogen receptors of brain tissue. Both lack of gonadal androgen and increased level of estrogen may contribute to irritation of gender identity. In a similar way 21-hydroxylase deficiency may cause female-to-male transsexualism (f'm), since f'm transsexuals are reported to have increased ratios of 17-hydroxyprogesterone/cortisol (17-OHP/F) and androstenedione/cortisol as well as 21-deoxycortisol/cortisol after ACTH stimulation. Even in cases with a slightly diminished 21-hydroxylase activity without obvious virilisation of the external female genitalia or salt loss, e.g. commonly known as the adrenogenital syndrome (AGS), increased levels of 17-OHP are found. Therefore 21-hydroxylase deficiency might lead in an analogous way to the 3 β -HSD deficiency to masculinization of the female brain.

In case of inherited enzyme deficiencies the excessive amount of adrenal androgen secretion is not limited to fetal stages, it goes on in the postnatal period, unless cortisone replacement therapy is started. So elevated plasma levels of the precursors of cortisol should be measurable postpartally. Therefore we performed standardized ACTH tests in 65 transsexual individuals to evaluate adrenal enzyme activity. Among these 37 were m'f and 24 f'm transsexuals. In addition we tested 25 transsexuals by standardized CRH tests to evaluate hypothalamic-pituitary-adrenal axis. We determined the following parameters: basal and stimulated cortisol, 11-deoxycortisol, DHEA, androstenedione, 17-OHP, 21-deoxycortisol, 17-hydroxypregnenolone and basal DHEAS before and after injection of 0.25 mg synacthen and basal and stimulated ACTH, cortisol and 17-OHP before and after hCRH. Results so far have been completed in 39

cases (18 f'm, 21 m'f, mean age 33+11 years). Two transsexuals individuals (1 f'm, 1 m'f) showed evidence of a slightly reduced 3 β -HSD activity, in one m'f transsexual 21-hydroxylase activity was slightly diminished. Thus our data suggest that adrenal enzyme deficiencies do not play a major role in the etiology of transsexualism. We rather believe in the power of postnatal social environment to shape gender identity. That means gender identity follows the sex of assignment in spite of opposite genetic and fetal determinants.

Large intestine as an alternative for creation of neo-vagina in male-to-female transsexuals.

Introduction

Necrosis of penile skin used for creation of neo-vagina or its misplacement under a skin of a perineum is a serious complication after operation of converting sex in male-to-female transsexuals. It can subsequently cause their deep disillusion and prevent them from achieving full social adaptation.

Sample, Methods and Results

Five male-to-female transsexuals (age 23 to 28 [medium age =26]) had an operation after having had an unsuccessful procedure done in other centres. Period of time after first procedures varied from 2.5 to 5 years. The main complains in all patients were: complete lack of vagina or a very short one not exceeding 3 cm in length.

We created the neo-vagina with a 15 -18 cm segment of rectal-sigmoid part of the colon. In one case this part of the colon was positioned in an anti-peristaltic way in order to secure a better blood supply. The canal for the neo-vagina was formed under intraoperative transrectal ultrasound control. In a short post-operative period before full recovery and healing enabling sexual activity the vagina was dilated using oesophageal Sengstaken balloon. In two cases, during preparing a site for the new vagina the rectal wall was damaged. Two-layer sutures and divulsion of rectal sphincter secured uncomplicated healing of this defect. In two cases a limited necrosis of a distal part of intestine occurred, but was healed without any complications. One patient described very intense peristaltic cramps of the neo-vagina that pushed out a penis or vibrator during sexual activity. All patients were fully satisfied with the final cosmetic and functional result.

Conclusions

Results of second operation for unsuccessful conversion of sex in male-to-female transsexuals is burdened by the great risk of serious complications. Using a distal segment of large intestine to create the neo-vagina as presented above enables achievement of full patient satisfaction despite slight problems of excessive mucous secretion and possible infection.

Krajka K, Mikszewicz A, Matuszewski M

Department of Urology, Medical Academy in Gdansk, Gdansk, Poland

Surgical conversion of sex in male-to-female transsexuals.

Introduction

Surgical treatment of male-to-female transsexuals is an essential part of the complex approach to this complicated entity. Decision whether to perform an operation was proceeded by: close psychological and medical evaluation, test of living in a new social role and legally authorised changes of sex.

Sample and Methods

We have treated 20 male-to-female transsexuals (19 to 48 years of age [medium age 24]). In the first 15 cases we did a one-stage operation using mixed perineo-abdominal approach. In the perinael phase of this procedure corpores cavernosae and testes were removed and a canal for the neo-vagina was created. After that the urethra was positioned in the perineum and labiae majores were formed. In the abdominal part of the procedure a distal segment of the canal for the neo-vagina was done. Penile skin with glans penis preserved at its end was subsequently invaginated, inserted inside and attached to the peritoneum. In the latest five cases we formed the vagina using penile-scrotal skin flaps, and the glans penis was utilised to create a clitoris.

Results

Medium hospitalisation time was 14,5 days. In the first group we observed one case of vagino-urethral fistula and five cases of limited skin necrosis in a region "commisura posterior". In the second group there was one case of limited necrosis of neo-clitoris. All but the first of operated patients are fully satisfied with the effects of the treatment.

Conclusions

One stage operation of sex conversion in male-to-female transsexuals using a perineo-abdominal approach resulted in functional and cosmetic results satisfying patients and hence helping them to achieve social adaptation and self-acceptance.

Kruk-Jeromin J

Department of Plastic Surgery, Medical University of Lodz, Lodz, Poland

The plan of surgical treatment of transsexuals.

During the past ten years (1984-1993), 196 patients with female-to-male transsexualism and 27 with male-to-female transsexualism came to the Department of Plastic Surgery, Medical University of Lodz. The main condition for acceptance for surgical treatment is the legal statement of birth certificate rectification and the identity card issued on the basis of this certificate. The author introduces the plan for complex treatment of transsexuals. In female-to-male transsexuals breast reduction, hysterectomy and adnexectomy, and penis formation were performed. In male-to-female patients the penis and testes were removed and the vagina and labia maiora were formed. Plastic surgeons, gynaecologists and urologists participated in planning and surgical treatment, pioneer in Poland. In over 70% patients both cosmetic and functional results were evaluated as positive.

Kuiper A, Cohen-Kettenis P

University Hospital Vrije Universiteit, Department of Medical Psychology, Amsterdam, The Netherlands

Factors influencing post-operative 'regret' in transsexuals.

More than 70 follow-up studies about the effect of Sex Reassignment Surgery (SRS) have been carried out the past 30 years. Despite the heterogeneity of these studies in, among them, their research questions and methodology, the researchers are almost unanimous in their conclusion that SRS is a therapeutic effective method. By far the most important positive finding is an increase in subjective well-being. Over three-quarters of those questioned felt happier as result of the SRS, felt inwardly liberated, were more satisfied with their own body, and experienced greater self-acceptation. The number of people who expressed regrets after SRS and/or committed suicide or tried to do that, turns out to be small. One estimates that postoperatively about 2% of the male-to-female transsexuals (MFs) and 0,5% of the female-to-male transsexuals (FM) ever attempts suicide.

Systematic research into factors which influence the success of treatment positively or negatively, still remains to be done. Knowledge about such factors is of great importance considering the complexity of diagnostic procedures and the irreversibility of the medical interventions. It is without saying, that false positive decisions must averted. In particular those who postoperatively regret, or seriously doubt the justness or realizability of their live as a member of the other sex, can shed light on this matter.

Because of the foregoing consideration, 10 MFs who postoperatively openly expressed regret in one or the other way about their transformation, were extensively interviewed by the two of us. In our presentation we first will discuss the way in which the concept 'regret' is and can be operationalized. Secondly, some results of our study will be presented.

Kuipers Y, Butterman M

Department of Plastic and Reconstructive Surgery, Academic Hospital of the Free University, Amsterdam, The Netherlands

Transsexual and non-transsexual patients together at the ward: The Amsterdam experience.

At the plastic surgical ward of the Academic Hospital of the Free University in Amsterdam, six out of 27 beds are usually occupied by transsexual surgical patients. These patients are in no way restricted to mingle with the non-transsexual patients.

During a three month period, an inquiry using exit interviews and questionnaires was held among all transsexual and non-transsexual patients to find out whether the unrestricted mixing of the two groups presented any problems for either of these groups.

It is concluded that with proper pre-admittance information to the non-transsexual patients, no problems are to be expected. Some advice on how to coach both groups is provided.

Landén M, Lundström B

Department of Clinical Neuroscience, Section of Psychiatry and Neurochemistry, Mölndal, Sweden

Incidence and sex ratio of transsexualism.

The question of incidence and whether more men than women are transsexual is two important issues to address because of their implications in the discussion whether transsexualism is a disease invariant of culture and timespirit or merely a phenomenon of our time and the western world societies. In order to further analyse to what extent societal pressures and variations over time influence the incidence and sex ratio of transsexualism, it is important to provide comparative data to previous reports.

Since all requests for sex reassignment in Sweden requires permission from , and is registered at, the Bureau of Social Welfare; we have in Sweden a unique possibility to find out the frequency of transsexualism. In this investigation, we calculate incidence and sex ratio of transsexualism with access to all files processed regarding sex reassignment in Sweden from July 1, 1972 to July 1, 1992. Our material has in addition been processed in a similar manner to earlier Swedish figures (Wålinder, 1971) and may therefore be compared and analyzed.

During the study twenty-year period 233 requests for sex reassignment were processed and the incidence figures is computed on the basis of this group. This means the average annual frequency was 11,65 cases which gives an annual incidence for request for sex reassignment of 0,17 per 100.000 inhabitants. The sex ratio male/female is 1,38:1.

Since all medical records are kept in file it was possible to distillate those with the diagnosis primary transsexualism and put the other aside. That gave us 188 cases with definitive diagnosis, i.e. 9,4 annually. This corresponds to an *incidence of primary transsexualism* of 0,14 per 100.000 over 15 years of age. The most important observation is however, that *primary transsexualism is equally common in females and males.*

Laub D, Laub D II, Lebovic G

Division of Plastic & Reconstructive Surgery, Stanford University Medical Center, Stanford, CA, USA

A study of the erotic spots in the postoperative male to female GDS patient.

A not uncommon question of the male to female GDS patient is regarding postoperative sexual function and capabilities. Information regarding erotic stimulation is helpful in the counsel given to patient by coordinators and practitioners, and is of interest to researchers. In order to answer the question regarding the anatomic sites of erotic stimulation in the postoperative male to female patients, 12 patients were studied. They were questioned regarding auto and all sexual stimulation and were examined by two experienced physicians.

Five spots were identified by pinpoint digital pressure; these were rated 1 to 4 according to erotic stimulation and were also ranked 1 to 4 according to the same criteria:

- G spot (or prostate remnant)
- clitoris (or glans penis remnant)
- corpora covens (distal end)
- urethral mucosa
- rectal pressure

These results were compared against the study made on 2 previous occasions and the surprising results were compared against similar data from 5 genetic females.

Laub D, Lebovic G

Gender Dysphoria Program of Palo Alto, Division of Plastic & Reconstructive Surgery,
Stanford University Medical Center, Stanford, CA, USA

**A study of vaginal depth in postoperative GDS patients - comparing
methods of surgery.**

One of the criteria for a successful outcome of male to female GDS surgery is the depth of the vagina,. Indeed, the symptoms associated with the short vagina are a not infrequent source of concern in the post operative patient.

A random selection of 20 post operative patient is compared according to type of operation using depth as the one variable.

The results show that more depth is achieved with a certain method using a flap transfer than the penile inversion or the skin graft technic.

Laub D, Lebovic G, Laub D II

Gender Dysphoria Program of Palo Alto, Division of Plastic & Reconstructive Surgery,
Stanford University Medical Center, Stanford, CA, USA

An anatomic study of the position of the male nipple: Useful information for mastectomy with GDS patients.

Bilateral mastectomy is an important surgical step in the reassignment of the external genitalia in female to male GDS patients. The male nipple position, though important, has been studied infrequently.

15 genetic males were studied and a formula for nipple position was identified. Data regarding measurements from landmarks, and relationship to topographic anatomic structures were collected. Photos were taken for study. It was found that absolute metric measurements from the landmarks such as midline, suprasternal notch of Burns, acromio-clavicular joints, clavicle, and lateral torso are not as accurate as the method which relates to the lateral border of the pectoral muscle and the 14th rib, and also to the direction in which the nipple areola complex (NAC) faces.

Laub D, Lebovic G, Laub D II, Maasdam, J van

Gender Dysphoria Program of Palo Alto, Division of Plastic and Reconstructive Surgery,
Stanford University Medical Center, Stanford, CA, USA

Surgical technique in male-to-female transexuals: A new method of clitoral hood formation.

A new method for formation of anterior labial "Fourchette".

Clitoris construction with internal pudendal deep penile nerve flap avoids neuroma formation.

Clitoral hood formation is not an infrequent request in the male to female GDS patient. Therefore, a technique was designed and applied to 5 patients.

It consists of a 4 layer adherence of the surrounding tissue in the midline in upside down "U" shaped fashion.

Postoperative complications are reported and they were treated with change in the technique.

Anatomic precision is desired in surgical formation of the external genitalia in male to female GDS patients. A not uncommon postoperative request is to narrow the space between anterior labia, and to place them together to more closely simulate the genetic female.

Dr. Biber has designed a double x-plasty and performed this operation routinely as a second stage procedure in a large number of cases.

A procedure is presented for the scrutiny of the audience. The technique consists of a diamond shaped skin incision. No subcutaneous tissue is excised in order to preserve vital vascularity to surrounding tissue.

The construction of the vagina with the rectosigmoid flap has been associated with painful neuroma at the cut end of the penile flap in the scar which connects it with the colon.

The "exquisite" sensation of the glans of the clitoris is preserved and neuroma formation is avoided.

Lebovic G

Gender Dysphoria Program of Palo Alto, Stanford University Hospital, Stanford, CA, USA

Silicone autoimmune disease.

Silicone, once touted as the most biologically inert substance known to man, has become the center of widespread debate. Laboratory and clinical data accumulated over the last 20 - 30 years suggest that silicone and/or its related chemical compounds may act as an immunogen within the human body. Retrospective epidemiologic studies both support and reject this hypothesis. Review of the world literature seems to support the theory that silicone plays a role in autoimmune disorders, however, opinions are strong, and often differ by 180°.

Despite the controversy, enough suspicion exists to have prompted the withdrawal of these products from the market. Presentation of anecdotal case reports and inflammatory news coverage relating to this topic has caused many patients with silicone breast prostheses to request explantation (surgical removal of the implants) and financial remuneration for personal damages. Since many gender patients have silicone breast or testicular implants, physicians specializing in gender dysphoria must become familiar with the clinical presentation, evaluation and treatment of women or men with autoimmune disease.

Meyer-Bahlburg H^{1,4}, Gruen R^{1,4}, Trautman P², New M², Shimsi M³,
Morishima A⁴

¹New York State Psychiatric Institute, ²New York Hospital-Cornell Medical Center,
³Elmhurst Hospital Center, ⁴College of Physicians & Surgeons of Columbia University, New
York, NY, USA

Gender identity change from female to male in classical CAH: Four cases.

Change of gender identity in patients born with ambiguous genitalia (somatic intersexuality) has been described in numerous case reports in the literature (Meyer-Bahlburg 1994), but the causes are not well understood and have been ascribed in varying degrees to biological and psychosocial factors. As advocated by John Money and the pediatric endocrine group from Johns Hopkins Hospital in Baltimore, MD, USA, sex of assignment based on expected sexual functioning in adulthood and early surgical corrections of the genitalia in conformity with the sex of assignment have become the policy of the choice in most major medical centers of the US. This policy of sex assignment in patients with intersexuality is based on a very small database as far as psychological outcome is concerned, and there are very few long-term follow-up data available, the recent literature mostly on cases from Money's own files.

In the past three years, our team has evaluated a total of four 46, XX individuals with CAH with atypical gender identity. All four entered an 8-hour psychological research protocol including systematic interviews regarding gender role, sexual and psychiatric history, and self-report inventories. Data from clinical interviews and medical records were also evaluated. Some of the data on gender and sex variables could be compared to those of small samples of CAH women with female gender identity and those of medically normal control women.

The four patients (age 28, 35, 35, 38 years at exam) represented three different subtypes of classical early-onset CAH: 21-OH deficiency, simple virilizing (SV); 21-OH deficiency, salt wasting (SW); 11- β -OH deficiency.

Detailed analysis of the psychological and medical data lead to the conclusion that female-assigned 46, XX individual with classical CAH are at increased risk of cross-gender identity development, if the genitalia are not successfully feminized in neonatal age and glucocorticoid replacement therapy is lacking or inconsistent. Behavioral self-image, sexual orientation, and body image in combination with symptoms of atypical development of primary and secondary sex characteristics appear to play a role in such cross-gender development.

Monstrey S, De Cubber J, Hoebeke P, Landuyt K van, De Cuypere G, Rubens R, Matton G

University Hospital, Gent, Belgium

A custom-made silicone mould to improve vaginal reconstruction in male-to-female transsexuals.

Vaginal reconstruction in male-to-female patients is traditionally considered as a rather simple operative procedure. However, many surgeons still have problems with the peri-operative filling of the newly reconstructed vagina and how to keep this vagina widely expanded without compromising the normal wound healing process.

We have developed a specially designed silicone mould with the form of a phallus consisting of a hard inner core (with central air escape) which is covered with a soft and mouldable silicone prosthesis. The device is held in position with a system of three adjustable belts.

Our preliminary results with this silicone mould, used in three patients, have been impressive: we not only obtained an extremely easy and clean handling of the vagina in the immediate post-operative period but, more important, we obtained a 25% longer and wider vagina on long-term evaluation compared to previous techniques.

Monstrey S, Hoebeke P, Landuyt K van, De Cuypere G, Rubens R, Matton G

University Hospital, Gent, Belgium

Technical refinements to optimize function and cosmesis in female-to-male gender reassignment surgery (mastectomy, phalloplasty).

Gender reassignment surgery in the female-to-male transsexual patient is notorious for its high complication rate and its less than optimal functional and aesthetic results. In some centers, the frequent and major post-operative complications have resulted in an abandonment of this surgery. We hereby present 18 refinements and tricks to improve the functional and aesthetic results in the mammoplasty and the phalloplasty procedure as performed in our University Hospital in female-to-male transsexuals. These include pre-operative preparations, positioning of the patient, reduction of operation-time, incisions, aesthetics of the penis, improved techniques of vascular and neural anastomosis, reduction of donor morbidity, easy post-operative positioning and monitoring, and precise instructions on assessment of late fistula formation and stenosis.

Neumann K, Berghaus A

Martin-Luther-University of Halle-Wittenberg, Medical School, E.N.T. Department, Halle, Germany

Raising the medium speaking voice pitch by surgical means in male-to-female transsexuals.

On completion of sex reversal in male-to-female transsexuals the woman is likely to be psychologically affected by the deep, typically male, speaking voice. Besides, in some cases the starkly protruding laryngeal prominence (Adam's apple) constitutes another male characteristic. The paper reports on 3 cases in which, by means of a special surgical technique aimed at approximating the thyroid and cricoid cartilages with resulting tensioning of the vocal cords, the medium pitch of the speaking voice could be raised by at least one fifth. By request in two of the cases at the same time the thyroid cartilage was reduced by partial resection of the laryngeal prominence. The operation was performed under local anaesthesia so that desired level of the speaking voice could be checked intraoperatively. Post-operative voice training over a period of three months ensured stabilization of the speaking voice. The described operation is an integrated part of the complex concept of treatment following surgical sex reversal, which includes epilation, mammoplasty and hormone therapy. One year after the operation the patients could no longer be distinguished by a male timbre of voice, their average speaking voice pitch ranging between f and g, as female voices.

Perovic S, Stanojevic D, Djordjevic M

University Children's Hospital, Belgrade, Yugoslavia

Phalloplasty in female transsexuals using pedicled extended island groin flap.

The authors present the operative procedure for phalloplasty using pedicled extended island groin flap. Forming a combined groin and lower abdominal flap based on the superficial iliac and epigastric vessels is the main characteristic of this technique. The flap consists of three parts: 1) lateral, narrow and hairless part - for the neourethra, 2) medial, wide part - for the neophallus shaft reconstruction, and 3) the base of the flap - whereon, performing deepithelization of the skin we form and lengthen a flap pedicle. The pedicle includes subcutaneous tissue with blood and lymph vessels. The neourethra and neophallus shaft are reconstructed using a tube within a tube technique. The size of the flap depends of the patient's build. The flap is transferred to the recipient area, i. e. to the level of the lower margin of symphysis. Anastomosis of the new and native urethra may be done simultaneously or during the second stage procedure. The donor site skin defect is closed by direct approximation. During a 3-year period (1991-1993) this flap was applied in 29 patients, aged from 18 to 42 years. Follow-up period ranged from 6 to 41 month (average 29 months). A new phallus of satisfactory dimensions was achieved in all cases. Complications were: partial necrosis of flap in 2 patients, fistulas in 2 patients and stenosis of urethral anastomosis in 3 patients. These complications were successfully resolved by corrective surgeries. The method is simple, time-saving and it has few complications. This technique could be the available alternative to the most commonly used procedure today - microsurgical free tissue phalloplasty.

Perovic S

University Children's Hospital, Belgrade, Yugoslavia

Vaginoplasty in male transsexuals using pedicled penile skin with composite urethral flap.

The author presents the operative technique for one-stage male to female sex reassignment surgery. The main and original procedure of the technique presents construction of a vagina. The new vagina consists of two parts: a long vascularized urethral flap and pedicled island tube skin flap, formed from the penile body skin. The urethral segment of the vagina increases its depth and width and provides moisture. In the period from 1989 to 1993, subjects were 56 transsexuals with a mean postsurgical follow-up of 3.2 years. Satisfactory cosmetic and functional results were obtained in 49 patients.

Peszynski-Drews C, Zielinski T, Kruk-Jeromin J

Department of Plastic Surgery, Medical University of Lodz, Poland

Construction of the neophallus in female-to-male transsexuals using the lateral groin flap.

The work presents operative techniques and results of single-stage phalloplasty with the lateral groin flap based on arteria circumflexa ilium superficialis. In the years' 1991-93, 64 female to male transsexuals had been operated by this method at our hospital. Good functional and aesthetic results were observed in 51 patients (79,6%). In 16 patients we observed ischemic necrosis of flap tip that made us shorten it about 2-4 cm. Complete loss of the phallus has occurred in 4 patients. We have not attempted to make a urethra through the penis in transsexual patients. Rigidity for coitus has been obtained by inserting silicone or polyester, nonhydraulic semirigid implants 6 months after the first operation.

Petersen M, Stephens J, Dickey R, Lewis W

Gender Identity Clinic, Clarke Institute of Psychiatry, Toronto, Canada

Transsexuals within the prison system: An international survey of correctional services policies.

This paper extends the preliminary data presented at the Second Conference of the European Network of Professionals on Transsexuals (September, 1994). To facilitate the process of developing appropriate standards of care for incarcerated individuals diagnosed with Gender Identity Disorder (DSM-IV), questionnaires were sent to representatives of correctional systems within the European Community, as well as Australia, North and South America targeting issues pertinent to the transsexual inmate. Respondents were asked to delineate policy regarding identification of inmates classified as manifesting Gender Identity Disorder; provision of medical services such as hormone treatment, hormone replacement treatment, and sexual surgical reassignment; dress codes affecting cross-dressing; and placement and safety of the transsexual in the prison population. If formal written policy was lacking, the existence of informal guidelines was noted as was a total lack of policy. Results thus far are suggestive of a degree of consistency in the management of transsexual inmates. It is hoped that the compilation of results will provide a basis for an attempt to rationalize and standardize policies of care comparable to those developed by the Harry Benjamin International Gender Dysphoria Association for gender disordered individuals in the community. This will benefit the incarcerated transsexual as well as enabling corrections staff to maintain a secure milieu.

Renter K, Richter-Appelt H

Department of Sexual Research, Hamburg University, Hamburg, Germany

The relevance of sexual and/or physical abuse in the treatment of transsexual patients.

Taking the case of a 35 year old female-to-male transsexual patient as an example, the authors trace how the dynamics of sexual and/or physical abuse are reflected in the transference relationship. The patient had already been living as a man for 5 years before psychotherapy began, but had neither undergone a change of name nor had he any hormone treatment. After the patient had been in psychotherapy for a year hormone therapy was discussed and then begun.

The early stages of psychotherapy were largely taken up with coping with the patient's rage and aggressive impulses. The therapist was confronted with a barrage of negative criticism and fantasised assaults which revealed a paranoically tinged grandiose self and repeatedly tested her resilience and dependability. Only after the patient had made sure that the therapist could and would survive (i.e. the patient felt accepted in her transsexual wishes) and a stable working relationship had been established was it possible to approach the underlying feeling of impotence and helplessness. In the course of this process the patient's overpowering guilt feelings - often described in the literature on sexual abuse as introjects of the assailant (perpetrator) - came increasingly to the fore. In the light of the patient's markedly disturbed personality development two aspects became apparent: on the one hand the autoaggressive element in transsexuality and on the other the constructive form of defence involved in establishing a new identity.

Royle M, Tanner N, Porter N

Brighton, United Kingdom

A sixteen year review of colovaginoplasty in male-to-female transexuals.

Out of approximately 500 cases of gender reassignment surgery performed over the last sixteen years some thirty have been colovaginoplasties. These operations using sigmoid colon have been either primary procedures where there was limited penile skin or secondary following failed initial surgery.

The operative procedure including clitoroplasty will be reviewed and the results analysed.

Rubin P, Wilchesky M

Montreal General Hospital, Montreal, QC, Canada

Masked vulnerabilities of the gender dysphoric patient and his partner.

Our Centre has been consulted by a number of gender-disturbed individuals who have been in a relationship for many years. What brings them to us? Once in front of us how do we understand the relationship? What is their expressed wish compared to our own objectives?

We will explore the unconscious dimensions of these couples. Material will be presented with some case vignettes. This will be linked with contemporary theoretical formulations such as those of Jörg Willi, Cliff Sager, and Marion Solomon.

Ruggieri V, Ravenna A, Iacoella S, Stranieri S

University of Rome "La Sapienza", Psychology Department, Chair of Psicofisiologia Clinica, Roma, Italy

Body image gender identity and narcissism in transsexualism.

In the present work we examine the problem of transsexualism in the framework of the narcissistic development of personality. We suggest that during this development a central role is played by the construction of the body image.

Our psychophysiological integrated model considers the body image not a simple mental phenomenon but a psychophysiological construction in which the sensorial information of the periphery of the body plays an important role.

In this work we examine at first the weight of different sensorial bodily 'messages': visual, tactile, cutaneous, proprioceptive in constructing the body image.

We hypothesize that transsexual subjects have a different sensorial modality, than a control group, in the selection and integration of bodily information suggesting that the sexual theme is a part, even if the most important, of a more general aspect of the self acceptance and, in particular, acceptance of the body. This mechanism, we think, is the basic structure of the process of identity. Then we suppose also that this topic is related to the narcissistic development of the subjects.

In order to examine these questions we will measure the body image (through the new test S.I.B.I.T., Prof. Ruggieri) and the narcissistic development (through the test Q.D.N. Italian adaptation, Prof. Scilligo) of 30 transsexual subjects of a matched control group. The subjects are people who carry out their medical and surgical procedure at the Department of Plastic and Reconstructive Surgery, San Camillo Hospital, Rome-Italy, directed by Prof. A. Felici.

Sachse R¹, Shao X¹, Krähler R¹, Stalla G², Möslers T¹, Hensen J¹

¹University of Erlangen-Nürnberg, Erlangen, Germany, ²Max-Planck-Institute for Psychiatry, Munich, Germany

Analysis of the *CYP21B* gene in female-to-male transsexual individuals by PCR-SSCP method.

Increased ratios of 17 α -hydroxy-progesterone/cortisol and androstenedione/cortisol after ACTH stimulation in female homosexuals and especially in female-to-male transsexuals have been reported. Furthermore, 21-deoxycortisol as direct precursor of cortisol and 21-deoxycortisol/cortisol ratios were found to be significantly increased after ACTH stimulation in female homosexuals and transsexuals and even before ACTH stimulation in female-to-male transsexuals. Based on these findings it was hypothesized that 21-hydroxylase deficiency was a genetic predisposition to female homosexuality and to female-to-male transsexualism. As a result of the 21-hydroxylase deficiency, cortisol secretion decreases with a compensatory rise in ACTH output, which in turn stimulates the production of cortisol precursors and adrenal androgens.

Female patients with congenital hyperplasia due to 21-hydroxylase deficiency are exposed to adrenal androgens during fetal life, resulting in masculinization of their external genitalia. Both brain and genital cells have receptors for androgen and for estrogen and both have the enzymes necessary to metabolise arriving testosterone to form its contrasting metabolites, indicating that they are target tissues for sex steroids. In brief, the brain has the same potential as the genitalia to respond to sex steroids. The question of whether girls with congenital adrenal hyperplasia have "masculinized brains" is discussed controversially. There are accumulating data that females with congenital adrenal hyperplasia marry with a lower frequency, have fewer children when they do marry, and have a higher incidence of lesbian behaviour. Also it was found that females with congenital adrenal hyperplasia tend to have more negative body image, less sexual activity and less interest in sexual activity.

Mutations in the *CYP21B* gene resulting in deficiency of the 21-hydroxylase enzyme are the major cause of congenital adrenal hyperplasia. The vast majority of these mutations are transferred from *CYP21A* pseudogene to *CYP21B* gene by gene conversion-like events, but there are also a few de novo mutations described. However, complete characterisation of the genetic lesions of *CYP21B* gene including non-pseudogene-derived mutations has been hampered by the

complicated structure of CYP21 locus. In this study we developed a sensitive, rapid and simple method which is capable of analysing specifically the *CYP21B* gene using single-strand conformation polymorphism analysis of polymerase chain reaction products (PCR-SSCP analysis) to screen for mutations in the *CYP21B* gene in female-to-male transsexuals. After cutting *CYP21A* pseudo-gene with Taq 1 restriction endonuclease we amplified the whole *CYP21B* gene specifically by PCR. Then all 10 exons including parts of the flanking intron sequences were amplified into 10 DNA fragments. Mutations can be detected by SSCP analysis and consequently by direct sequencing of DNA fragments with mobility shift.

Schaefer L

HBIGDA, New York, USA

Harry Benjamin and the beginning of the history of gender identity disorders and conditions.

For the past ten 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, the authors, 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 reputable 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.

Schützer M

Copenhagen, Denmark

The growing rent in the fabric of western society.

More and more transsexuals around the world are appearing on court room dockets. We are demanding our rights as equal members of society and of the Human race. Our demands are for recognition, not approval, and not in spite of our transsexuality ... but because of our transsexuality!

The discussions which we are met with in court, in cases of sexual and gender discrimination in the work place, are both extremely dangerous while at the same time exciting, refreshing and promising. But difficult and emotionally demanding all the same. In the first, the danger lies directly in the path of the individual with-in society.

The dismissal case which was recently before the European Court in Luxembourg concerns a person who, while working for a public teaching institution in Cornwall, England, began her period of transition. Her case is similar in detail to my dismissal case against the city of Copenhagen. The legal discussion has focused on the issue that equal rights laws refer to 'men and women', not 'transsexuals'. By taking up this discussion the legal community has stated that these "equal rights laws" do not apply to this group of people. 'Equal Rights' laws are based on Human Rights ideals, The danger here lies in the possible legal conclusion ... "Transsexuals have ceased to be legally human". Can we as a race and at this level of our sociological development, afford the creation of a class of non-human 'humanoids'?

While in the second instance, and by demanding that equal rights laws stipulate ... "men, women and transsexuals", the conclusion could lead to the legal recognition of transsexualism as a "third gender"! This discussion is refreshing and promising, exciting and innovative. Especially to my thinking as a Native American. I am Sihasapa, Lakota ... Blackfoot, Sioux. The 'third gender' solution snakes into the past and connects with Native American societal structure from more than one thousand years ago. These societies existed and functioned quite well, long before the white race ever thought of challenging the 'monsters' which lived in their fears and which swam in the middle of the Atlantic!

Working ourselves into these corners, western society is in danger of beginning to pick itself apart destructively. By attacking this minority instead of protecting them we destroy ourselves. While on the other hand, through an awareness of the collective unconscious, these discussions have the possibility of being the fertilization which affords western society continued growth. The real danger is faced by those we are treating ... as the 'real-life-test' becomes a 'real-life-war' ... everyday ... all the time for them.

Seil D

Boston, Massachusetts, USA

Dissociation and gender dysphoria.

Secondary transsexuals employ a variety of coping mechanisms to deal with their unwanted ego-dystonic gender yearnings. The use of dissociation by the ego as a defense mechanism against gender dysphoria has been rarely described. Four cases are presented in which various degrees of dissociation, including Dissociative Identity Disorder, were the means used by the egos of these individuals to avoid the experience of gender dysphoria. In all four cases, dissociative experiences either ceased or lessened during treatment when the individuals accepted their gender wishes and began to transition.

Transsexuals may also use the process of dissociation to deny their anatomic gender and achieve comfort, particularly when crossdressing. Two vignettes which illustrate this are presented. An examination of the mental configuration in transsexuality reveals it to be a dissociative state in itself.

Discussion focuses on the need to include gender identity disorder as an underlying cause for pathological dissociation. For these individuals, therapy should focus on uncovering the unwanted gender yearnings and assisting the ego to integrate them so that this at times devastating defensive operation is no longer necessary.

Sohn M¹, Saldern S van², Gouzoulis-Mayfrank E³, Ebel H³

¹Department of Urology, ²Department of Plastic and Reconstructive Surgery, ³Department of Psychiatry, University Clinics of RWTH Aachen, Germany

Interdisciplinary concepts of gender reassignment surgery in female-to-male transsexuals: 5-year experience.

In 1989 an interdisciplinary gender identitee committee has been founded at our institution. Until 1994, 165 patients with suspected or confirmed transsexualism have been seen by the authors. Only 40 patients fulfilled all criteria for gender reassignment surgery during the same period. Of 15 patients with confirmed female-to-male transsexualism 12 patients were selected for a complex one stage operation including radical vaginectomy, scrotal reconstruction and neopenis-formation from a modified radial fore-arm flap. The 9-11 hour operation was performed by two surgical teams in a parallel session. While the plastic surgeon developed the radial fore-arm flap for neo-penis- and neo-urethra formation, the urologist performed the vaginectomy, bulbar urethra reconstruction, neo-scrotum formation and preparation of recipient vessels for the microsurgical flap transfer. The last part of the operation was done by both surgeons under the microscope, including superselective nerve-anastomoses between both dorsal clitoral nerves and correspondent cutaneous nerves from the flap. During the last 4 procedures a newly developed flap design, recently presented by Gottlieb et al. (Plastic and Reconstructive Surgery 92:276-284, 1993) has been used. This flap permits the development of a longer cutaneous penile urethra, reducing the length of the vaginal-flap urethra to only 2-3 centimeters and thus reducing the usually high fistula rate for urethral reconstruction.

The cosmetic and functional results were excellent, no loss of transplanted tissue was noted. Fistula formation was repaired by two-step Johansson-procedures. After complete return of sensibility and complete urethral healing, testes and penile prosthesis placement was performed, using a single cylinder AMS-700 CX hydraulic multicomponent device. Prosthesis implantation was done in a two-step procedure, first implanting a Dacron[®]-sock, fixed to the pubic bone and filled with a soft silicone-placeholder which was replaced by the functional device after capsular-formation.

5 patients completed the whole procedure up to now. They all have a sensible neopenis, regular sexual intercourse and are able to void in the standing position.

Interdisciplinary co-operation between plastic surgeon and urologist permits better functional and esthetic results, preoperative psychiatric selection and perioperative consulting protects candidates for sex reassignment surgery from inadequate timing of operative sessions and helps in postoperative care. The recently introduced flap modification permits better functional and esthetic results.

Spehr C

Department of Urology, Zentralklinikum Augsburg, Augsburg, Germany

Sex reassignment in male-to-female transsexuals (Video).

Since 1984 we performed 101 operations (male-to-female), out of which 90 were controlled. Our technique of surgery is to be described here.

Method:

1. Ablation of the testes.
2. Excision of the penile shaft from the surrounding skin, which is to coat the neovagina.
3. Isolation of the vascular/nervous bundle and glans from the penile shaft, the glans forming the later clitoris.
4. Complete resection of the corpora cavernosa and shortening of the urethra to female length.
5. Undermining of the abdominal skin so that the base of the penile skin tube can be approached to the anal region.
6. Opening and widening of the recto-prostato-vesical space up to the recto-vesical duplication. The deep wound cavity is being coated with the penile skintube (or skin graft) and kept open by a stant.
7. After partial removal of the epithelium, the glans is placed as neo-clitoris into the pubic angle, and below it the urethra.
8. The scrotal spaces are transformed into labia.

Results:

With one exception, cosmetic and functional results were very satisfactory.

Complications:

Up to 1987 we saw three compartment syndromes of the lower leg. In one case a temporal abdominal anus had to be established because of a rectal lesion.

Conclusions:

An anatomically and functional acceptable transformation of male-to-female genitals is feasible. A satisfactory result of the operation is an essential requirement in the solution of psychological problems in transsexuals.

Springfield F, Russell R

The London Institute for Human Sexuality, Earls Court, London, United Kingdom

Orchidectomy as a first stage towards gender re-assignment - a positive option.

A study of 14 transsexual to female Gender Dysphoric patients - 13 of whom presented requesting orchidectomy as a first stage towards full gender re-assignment. Within the UK it has never been the accepted practice to offer orchidectomy in place of anti-androgen hormonal therapy. We have had an increasing number of patients who have found the side effects of Androcur® (cyproterone acetate) sufficiently unpleasant, that this combined with a wish to be completely free of their testes, resulted in a request for bi-lateral orchidectomy as a procedure prior to full gender re-assignment. Follow-up has demonstrated that those who were intrinsically transsexual have benefited from this surgery and leads us to believe that provided suitable care is taken in selection of patients that this procedure should be offered more frequently as a positive option.

Staupe K, Donabauer I

Counselling Center for Gender Dysphoric Persons, Hamburg, Germany

Counselling center for gender dysphoric persons. (Beratungsstelle für Menschen mit Geschlechtsidentitätsproblemen - BfTS).

The introduction will contain information on foundation, work and aims of the BfTS.

Having its origin in the work of a Hamburg self-help group for transsexuals, the BfTS was founded in 1994 advising people suffering from gender dysphoria, their relatives and others asking for information on these topics. To be able to do this work the BfTS receives financial support from Hamburg authorities.

The two advisers working at the BfTS -transsexuals themselves - are students of social education.

Apart from offering advice the BfTS seeks to be a link between people affected and professionals. Therefore we would wish to have more contact to and support from psychologists, doctors, surgeons and others working with people affected by gender dysphoria.

Strapko N¹, Devor H², Kendel M

¹Health Physical Education and Recreation, Plymouth State College, Plymouth, USA

²Department of Sociology, University of Victoria, Victoria, Canada

Feminist and/or lesbian opinions about transsexuals.

The aim of this research project was to investigate feminist and/or lesbian attitudes towards transsexuals. It is hoped that the results of this research project will increase the awareness and understanding of the participants, the scholarly community, and the general public about the ways in which transsexuals are perceived in society. The work will focus on feminists and lesbians, who will benefit from an increased public understanding of attitudes and opinions about transsexuals.

Procedures: To gather these opinions, a pen and paper mail-back survey was completed by self-identified feminists and/ or lesbians. The authors distributed the surveys at North American lesbian or feminist public events such as: women's music/comedy festivals, feminist conferences, lesbian dances, feminist rallies, lesbian sporting events etc. Specific distribution sites were chosen for their high attendance of lesbians and/or feminists (i. e. Michigan Womyn's Music Festival where 10,000 plus women attend, a large majority of whom are lesbian). However, respondents were solicited as individuals, and not as representatives of these events. Over 8,000 surveys were distributed with over 2,500 completed and returned. There was no further interaction between the researcher and the respondent after the initial distribution of the survey and there were no identifying marks on the survey which would link individual participants to their survey answers.

Findings: At present (January 1995), all surveys have been collected and the data is expeditiously being processed. It is the desire of the first author to report on these findings in September, 1995 at the XIV Harry Benjamin International Symposium in Bavaria, Germany. A report of the preliminary findings will be shared by the second author at the International Congress on Cross-Dressing, Gender, and Sex in Los Angeles, CA. USA. (February 1995).

The findings will have a useful effect on understanding the opinions of feminists/and or lesbians about transsexuals. It has been the experience of the first author that transsexuals in psychotherapy have encountered negative, inhospitable and often hostile responses to their desire to engage in feminist/and or lesbian activities and lifestyle. These research results will help to better understand these responses.

Swartz L

School of Law and School of Social Work, State University of New York at Buffalo, NY,
USA

Legal responses to transsexualism: Scientific logic versus compassionate flexibility in the U.S. and U.K.

Transsexuals' legal problems may include validity of marriage and revision of official records of identity, such as birth certificates. The paper argues that compassionate, piecemeal legal accommodation to the situation of transsexuals deserves recognition as a sound legal policy to be followed by courts, legislatures and administrative bodies. This is contrasted with attempted scientific deductive logical approaches to legal problems in this area. Court cases and statutes from the U.S. and U.K. are discussed to illustrate points involved in the argument.

Tiewtranon P

Chulalongkorn Hospital Medical School, Bangkok, Thailand

Rectosigmoid neocolpopoiesis: Thailand experience.

The use of rectosigmoid colon for vaginoplasty was first proposed by Baldwin in 1904. Since then several modifications have been presented by Markland and Hastings, Laub et al., Hage et al. etc.

In male to female sex reassignment surgery the penile skin inversion technique is generally accepted as the method of choice for vaginoplasty. The rectosigmoid neocolpopoiesis should be considered only for the insufficient penile skin length which can lead to unsatisfactory results. Due to such coloneocolpopoiesis can lead to disappointing results or even serious long term complication.

Sample (1987-1995)

1. 91 patients (9 with vaginal atresia, 82 male transsexuals).
2. 81 of the male transsexuals had had penile skin vaginoplasty resulting in vaginal stricture (vaginal canal only 0-5 cms). 4 patients had vaginal fistulas in addition. One patient was operated due to rectovaginal fistula.
3. 9 patients had congenital vaginal atresia, 4 with uterus, 5 without.

Surgical Technique

The bowels were prepared 48 hrs. before surgery by mechanical cleansing and antibiotics. The sigmoid colon was isolated about 15 cms in length with the vascular pedicle and delivered down into the newly dissected vaginal cavity and sutured to the vaginal penile skin remnant or perineal skin by 2-0 chromic gut interruptedly.

The peritoneal opening should be incised widely, the scarring along the dissected vaginal cavity should be completely irradiated to yield more elasticity. In case of rectovaginal fistula, it was closed by two hinged flaps of vaginal skin and reinforced second layer by the rectosigmoid colon wall. The vaseline gauze pack was inserted beyond the anastomosis and left for 3 days, the paraffin mold dilator exercise was used for 2 weeks, sexual intercourse was allowed thereafter.

Result

There was one skin woundinfection, 2 persisting strictures, one anastomosis disruption at the perineal level which was corrected by skin graft lining. There was no mortality, intraabdominal complication, mucosal bleeding, or inflammatory neovaginal contraction.

Early painful suture line between the mucosa and perineal skin.
The operative time ranges between 2-3 hours, the hospitalization is 4-8 days.

Conclusion

The rectosigmoid neocolpopoiesis can offer very satisfactory result to the patients. The risks can be minimized by the team of well experienced general surgeon and plastic surgeon.

Vasilenko L, Belkin A, Kinrik N

Moscow Research Institute of Psychiatry, National Research Centre of Psychoendocrinology, Moscow, Russia

Experience of organisation in Russia of a complex of medico-social help of persons with transsexualism.

The National Centre of Psychiatric Endocrinology during the last 15 years has been providing research in psychiatric and psychosomatic aspects of Transsexualism (TS). A complex of medical and social actions for TS patients was created in the Centre. It consist of several stages.

The first stage is a diagnostics and psychotherapeutic preparation for forthcoming sex change. The second stage is a sexual reorientation itself. The third one is rehabilitation.

The main methods used to help TS patients were psychocorrection (psychotherapy and psychopharmacotherapy), hormonal correction of sex, social and legal help in change of civic sex, surgical reconstruction of anatomical sex.

At the first stage the patient is to undergo complex observation including psychiatric (mental expertise, dynamic observation), sexologic (incl. dynamic observation of mental and sexual conditions within 2 years), genetic and somatic ones. The observation involves consultation of different specialists. The aim of the diagnostics is to exclude an endogenic mental illness, to confirm the diagnosis of TS, to exclude contraindications for sex change. Psychocorrection is oriented on sexual reconciliation.

The second stage consists of 3 steps. 1. Change of name in documents. 2. Substitutional therapy by using sexual hormones. 2. Surgical correction (complete or partial) after 1 year trial (adaptation) period.

The third stage includes postsurgical observation, somatic status control, medical, social and psychological help for patients.

2231 patients have got medical advice in the Centre. 480 of them were diagnosed as TS (m/f ratio is 1/3). 270 patients have got the sexual reorientation (191 female TS and 79 male TS, 190 patients - complete and 80 patients - partial). 44 patients limited themselves to civic change and hormonal therapy.

The TS patients were observed within a period of 1-12 years. The level of adaptation was controlled. A significant reduction of the suicide risk and frequency was reached.

Vesely J, Válka J, Ganti P, Berrino P, Dominici C

Klinika Plastické a Estetické Chirurgie, Brno, Czechia

Microsurgical alternatives of phalloplasty.

In our experience we use different ways of phalloplasty using muscular corpus of penis covered by microsurgical flap, one time also with microsurgical reconstruction of urethra. Because the muscle - part of pedicled rectus abdominis - has not brought supposed stiffness of penis we use now in our practice forearm flaps with urethra in central part of forearm.

Effects of hormone replacement therapy on gonadotropins pulsatility in male-to-female transsexuals.

In order to investigate gonadotropins pulse characteristics in male-to-female (m-to-f) transsexuals receiving different hormone replacement therapy (HRT) we have formed two groups.

I Group: 25 m-to-f transsexuals, 26 ± 5 years old, BMI 22.9 ± 2.7 kg/m², sex reassignment surgery was done 4.2 ± 2.3 years before. They were on oestradiol implant á 25 mg (crystalline 17 β oestradiol in a cholesterol base) and linestrenol (Endometril®) á 5 mg 24th, 26th and 28th day.

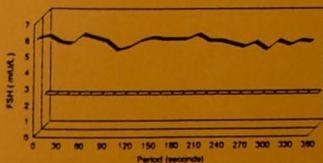
II Group: 27 m-to-f transsexuals, $24 \pm$ years old, BMI 23.4 ± 6.2 kg/m², operated 4.3 ± 2.4 years before. They received Trinovum® Cilag (Ethinyl estradiol á 0.035 mg and norethisterone 0.5; 0.75 and 1 mg orally).

Blood samples for follicle-stimulating hormone (FSH) and luteinizing hormone (LH) pulsatility were obtained by indwelling catheter one month after starting therapy, every 15 minutes from 2pm to 8pm. FSH and LH were detected by RIA method. Pulse characteristics (number, amplitude, length, interpeak interval and frequency) were analysed by Pulsar Peak Identification Algorithm. Gonadotropins pulse characteristics are shown in Fig. 1 & 2.

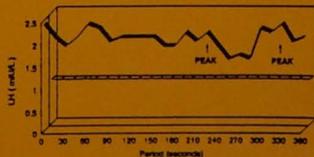
The amplitude of FSH and LH were two LH peaks, while there were no peaks in the first group. The shape of FSH pulse curve is more similar to normal in the second group. There were no FSH peaks in both groups.

It seems possible that gonadal steroids, neurotransmitters, catecholamins, β -endorphins and other factors have different influences on FSH and LH. Oestradiol implant á 25 mg inhibit gonadotropins pulsatility indicating higher oestradiol dose than it is necessary. Some advantages of this treatment are that it is pure, natural oestrogen and it avoids "first pass" effect. Under Trinovum® gonadostat work more physiologically. The fact that Trinovum® had not changed physiological rhythm of gonadotropins secretion in given period of time, with further investigation, could suggest the use in m-to-f transsexuals.

PULSATILITY OF FSH IN MALE-TO-FEMALE TRANSEXUALS DURING HORMONE REPLACEMENT THERAPY



PULSATILITY OF LH IN MALE-TO-FEMALE TRANSEXUALS DURING HORMONE REPLACEMENT THERAPY



Walling D¹, Goodwin J¹, Cole C²

¹University of Texas Medical Branch, Galveston, TX, USA, ²University of Texas Medical Branch, Galveston and the Rosenberg Clinic, TX, USA

Dissociation and gender dysphoria: Exploring the relationship.

Increased attention to dissociation has resulted in the study of a number of clinical subpopulations. The presence of dissociative features has been documented in populations of sexual abuse survivors and borderline personality disorders. The present study sought to explore the prevalence of dissociative disorders in a population of transsexuals.

This pilot study measured dissociation using the Dissociative Experience Scale (DES) in a group of highly functional transsexuals in surgical treatment. Research questions explored were: 1) Prevalence of significant dissociation; 2) Patterns in relation to other symptoms; birth gender, stressors, and dissociation subscales; 3) Association with only easily ascertainable childhood trauma, surgery and; 4) Suitability of the DES, developed after the intensive 1970's studies of transsexuals, for screening.

The DES, SCL-90R, and a brief demographic survey were anonymously sent to 120 transsexuals. A total of 64 (53%) usable questionnaires were returned.

The DES significantly correlated with the total SCL score and the paranoia subscale. In contrast to other populations, genetic females averaged a lower DES score than males. Dissociation was significantly lower in post gender reassignment subjects. Of the DES subscales, absorption was highest, followed by depersonalization and amnesia. Approximately 10% had elevations above 30 on the DES suggesting the possibility of significant dissociative disorders in this subgroup and the need for further research in this area. Ten subjects indicated that they had had childhood surgery and these individuals evidenced significantly higher DES, total SCL, anxiety, phobia, and depression scores than other subjects. In sum, this study suggests 1) The presence of a sub-population of gender dysphoric individuals with unresolved childhood trauma and clinical dissociation. 2) The importance of absorptive fantasy in coping with gender dysphoria. 3) Decreased dissociation and other symptoms post gender reassignment.

The authors will also present results of a more detailed study of dissociation and trauma in gender dysphoric individuals that is currently being conducted.

Empirical data on application of the German Transsexuals' Act during its first ten years.

In light of possible emulation of the German Transsexual's Act (TSG) in discussions taking place on the future legislation of other states, we took advantage of the tenth anniversary of the German TSG as an appropriate occasion to review the application of this law. In this context, questionnaires were submitted to all German courts of first resort (Amtsgerichte) which handle such cases. The goal of this study, the exhaustive examination of all decisions rendered on the basis of the TSG in West Germany during the initial ten years of its validity could be reached:

From 1981 to 1990, 1.422 judicial decisions were rendered in Germany on this basis: 683 of them related to the so called minor solution (change of first name), and 733 involving what is termed the major solution (legal change of sex status). One may conclude that the frequency of transsexual applications over these ten years lay between 2.1 and 2.4 per 100,000 German adult population. There was an initial peak of 162 applications during the first year followed by a decrease from 1982 to 1985 and a continually increasing number of applications from 1986 until 1990.

Those applicants who change their first names in the sense of a tentative accustomizing process waited an average of two years before changing their legal sex. Between 20 % and 30 % apparently go on further than the so-called minor solution. Only 3.6 % of the minor and 10.9 % of the major applications, respectively, were rejected by courts. The data revealed no significant trend over the years among the prevailing practices of adjudication during the data-collection period, but evidence does exist that the German courts or judges respectively apply the law differently. Over the ten-year period, only six persons requested to have their names changed back again to their former names and only one, to be reassigned to the former legal sex classification.

The results of our study refute the feared flood of applications, the legislators once voiced. A study covering a longer period of time would be required to determine whether the increasing number of applicants over the past five years is in fact a reflection of a general trend. The rarity of sex retransformation applications appears on the surface to evidence that there were extremely few erroneous judicial rulings, for us it also raised the question as to whether the diagnostic security perceived as apparent here may not in fact originate in an artificial framework of interrelated medical examination, therapy, and judicial measures -- and whether it may not actually be rigidly fixed on an iatrogenic bases.

Wheeler C, Schaefer L

New York, USA

Holistic psychotherapy treatment model: Highlights and controversies.

Like holistic medicine, we view psychotherapy for people with gender dysphoria as treating the whole person and all of their associates and associations and not simply addressing the question of when and where they will get their "surgery". This holistic treatment model, developed gradually over the past 20 years of treating over 1,000 clinical patients, has been recently published by the authors in the second edition of TREATMENT OF PSYCHIATRIC DISORDERS (American Psychiatric Press, 1995) which is the treatment companion to the DSM-IV (Diagnostic and Statistical Manual -DSM-IV of the American Psychiatric Association, 1994).

To be sure, all clinicians treating people with gender dysphoria in psychotherapy can be expected to deal with the obvious familiar, and yet very important, issues such as: the requirements of the HBGDA's Standards of Care, adequate and appropriate intake for evaluation, "true life test" considerations, concurrent diagnosis, prognosis, range of patient presentation (psychosocial history), questions regarding the necessity of psychotherapy, preparation of candidates for hormonal and surgical interventions, assessment of treatment outcomes, and therapy with life-partners and significant others.

Our special holistic treatment model was developed in an effort to adjust all psychotherapy treatment concerns to the unique needs that each individual's life circumstances require in dealing with all of the various levels of emotional adjustments, the complexity of interpersonal interactions, and life choices in learning how to live and love and work with this unique condition.

This presentation will focus on the more controversial issues, dilemmas, and decisions -- for both the patient and clinician -- in the psychotherapy treatment addressed in this model: therapy or not (timing, duration, frequency, content), post-op therapy needs, etiological theories and their consequences, multiple options and combinations of possibilities (timing/limitations) in learning how to live one's life with inner gender identity distress, terminology (who is, who isn't and what do you call them), immobilizing effects of gender guilt in interpersonal/relationship dysfunction, consumer demands - peer pressure - awareness group goals that influences therapy goals, referrals of reputable health-care providers, conflicts in sexual response and partner choice, therapy requirement for spouses and off-spring, prostitution, AIDS, professional preparation.

Whittle S

Manchester Metropolitan University, School of Law, Manchester, United Kingdom

Employment protection for the transsexual and sex discrimination law.

This paper will look at the employment rights and lack of them for transsexuals in the United Kingdom. Using survey results from 256 members of the United Kingdom's transsexual population and ethnographic research which involved free ranging interviews and participant observation, the changing nature of transsexual employment (and unemployment) will be considered, along with the implications for both transsexuals and potential employers, of meeting the need for protective legislation or case law.

Using an overview of decided cases from English Industrial Tribunals, the limits of sex discrimination law as a device will be discussed.

The paper will then go on to discuss a current application by an English transsexual to the European Court of Justice. This requests a clarification of gender status as it could be used by the Equal Opportunities Commission, which overseas applications for unfair dismissal or treatment on the grounds of sex.

Using decided case law, the chances of this producing a favourable result for all transsexuals will be discussed, along with any possible limitations for such people, particularly those about to transition, or in the process.

Finally the implications of a favourable decision for other indicators of civil status such as birth registers, passports etc. will be discussed along with the ramifications for English marriage law. This will involve looking at English Legislative procedure, and the ways forward for those campaigning for full civil rights to be accorded to transsexuals in their new gender status.

Wilchesky M

Psychotherapy, Sextherapy, Montreal, QC, Canada

Sexoanalytic approach to a reluctant dysphoric: a case study.

For many years, clinicians have had to deal with the increasingly complex classification of the gender dysphoria syndrome. One specific category is that of the self-styled male non-fetishistic transvestite, who experiences chronic reluctance regarding his sex reassignment, in spite of adequate presentation and psychosocial adjustment in the female role. The usual resistance to treatment is intensified as a result of the added opposition which preserves their confused state. Such a "transsexual" poses a problem from the standpoint of continued assessment during treatment, and of the effectiveness of current therapeutic intercession.

An alternative treatment modality to group psychotherapy is sexoanalysis, which is more circumscribed to explore this specific type of ambivalence. This therapy model uses erotic fantasy material to have a comprehensive understanding of the disorder, and to shed light on the anxieties and secondary gains of this particular problem. The four dimensions of the sexoanalytic approach will be discussed: (1) the nature of conscious versus latent sexual fantasy; (2) the intersexual dysphoria (3) the ambivalence of sexual orientation identity; and, finally, the gender split related to underpinning non-sexual anxieties. A clinical vignette will illustrate the important role played by sexual fantasy in eroticism, as well as in gender dynamic, both of which serve to lift the depression, and undo the person's confused state.

Wilchesky M, Côté H

Psychotherapy, Sextherapy, Montreal, QC, Canada

The Cross-Roads Group. Designed for the rejected, but not dejected, gender candidate.

At the 1993 HBIGDA meeting, we were given the opportunity to introduce the polarization effect resulting from the integration of rejected transsexual candidates into our programme's assessment/treatment therapy groups. As we have been screening increasing numbers of candidates who are gender disturbed, but clearly ambivalent as to the resolution of their condition, we conceptualized a treatment modality comprising a psychotherapy group running parallel, but not within the framework of the hospital setting. The Who, What, When, Where, and Why of this Cross-Roads group will be presented. The criteria for admission, differential diagnoses, goals, and methods of therapy will be discussed, with topics raised in this dynamic group unveiled. Reference will be made to the differences between the dynamics of the pre-grouper in the traditional hospital group, and the Cross-Roads group members.

Will M

University of Geneva, Faculty of Law, Geneva, Switzerland

Marriage, parental rights, adoption, and employment.

A number of countries have over the past 25 years opened the possibility for transsexual persons to have their first names and legal sex changed in their birth registers or at least in their personal documents: some by special legislation (Sweden 1972, Germany 1980, Italy 1982, The Netherlands 1985 and Turkey 1988), some by administrative decision (Norway, Austria), some simply by judge made law (Switzerland, Spain). In 1992 a decision by the European Court of Human Rights in Strasbourg has made the French Supreme Court of Cassation change its case law.

But some of the countries mentioned still refuse or hesitate to admit transsexual persons to getting married (England, Singapore, Spain, Portugal), to exercising parental rights, or - let alone - to proceed with adopting a child. Information on those issues remains scarce, the debate is just about to begin.

This is why the Panel welcomes any material or personal experience from any country.

Wilson N

Surgery Division of Plastic Surgery, Wayne State University School of Medicine, Detroit, MI, USA

Extended groin flap phalloplasty in the female-to-male transsexual.

The surgical technique is derived from that described by Puckette in 1978. The method has advantages over the radial forearm free flap in that it produces a larger phallus (17 - 18 cm x 12 - 14 cm in circumference) which will except penile prosthesis and a urinary tract "hook-up" with reliability. The scarring around the iliac crest and a skin after scar on the antero-medial aspect of the leg are more acceptable.

Method:

A 40 cm x 7 cm bipedicle groin flap is raised with direct donor area flap closure. A 40 cm x 7 cm split skin graft is cut from an antero-medial thigh and applied to the underside of the groin flap. After two delay procedures, the lumbar end of the flap, shaped as a "W", is transposed to the vulva. The clitoris is detached from its anterior tethering structures and transposed superiorly. The flap is inserted, each fork into each labium majus, with the glans clitoris on the dorsal surface. The hairless clitoral shaft skin is rotated superiorly and laterally to cover the ventral surface of the flap as far as the skin graft.

After a suitable time the ventral skin graft is then tubed around an 18 Fr catheter to form the urethra; the groin flap is tubed around this to form the phallus; prosthetic testes are inserted into the labia majora which are then joined in the mid-line to form the scrotum.

After a suitable time the tip is then detached via a two stage delay procedure and the tip of the phallus is formed by a vertical fishmouth incision and closure with the urethra opening onto the tip. The basic phallus and scrotum is now formed, the patient is then offered urinary tract "hook-up" and/or penile prosthesis.

Urinary tract "hook-up" is derived from the method described by Bouman with a difference that the whole anterior wall of the vagina is used not just a strip of it. The posterior wall of the vagina is excised. The vagina is closed.

AMS Dynaflex prosthesis are inserted into the shaft of the phallus via two lateral scrotal incisions over the ischiopubic rami. The rear tips are sutured into

the fascia overlaying the ischiopubic rami. The prostheses are left deflated so that urination can proceed without undo difficulty.

Some 40 patients have been treated so far over the last 8 years. The patients can stand to urinate. They can masturbate. They can engage in penile vaginal intercourse with no difficulty in obtaining orgasm. Protective sensation proceeds down the phallus and will provide protective sensation and erotic sensation in some cases to the tip of the phallus, in some cases half way down the phallus.

Yüksel Ş, Şahin D, Karali N, Baral I.

Istanbul University, Med Faculty, Psychiatry Department, Topkapi, Istanbul, Turkey

Doing group psychotherapy with female-to-male transsexuals in Turkey.

In this study, we examine the transsexuals who applied to the Psychotherapy Unit of the Department of Psychiatry, Istanbul School of Medicine, between 1987 and 1994. In Turkey, public prejudice about transsexuals and lack of relevant knowledge among physicians are accompanied by a similar lack of legal regulations.

The applicants, who were 17 to 39 years old, had different demographic characteristics and socioeconomocultural backgrounds. Although it is known that the worldwide prevalence of male to female transsexuality is higher than female to male, the cases who applied to our unit were mostly female to male transsexuals. We also discuss this paradox.

After the diagnosis of transsexuality, we propose the cases to join the transsexual group if they have no severe psychopathology.

The groups meet monthly. Drop out rates to date were low and group cohesion was high. During the group psychotherapy process, expectations after the predicted sex-reassignment surgery, problems the participants experience with their partners, families, and friends, and the problems at job arising from their "unusual" gender identity as well as coping ways are discussed.

Public intolerance to the groups who do not obey the conventional rules in our country also gives the members of the above-mentioned groups the advantage of sharing their experiences. This situation also gives to the groups a self-help quality.

Zhou J-N¹, Swaab D¹ (presented by Gooren L²)

¹Netherlands Institute for Brain Research, ²Free University Hospital, Amsterdam, The Netherlands (presenter)

Evidence of a female-type brain differentiation in male-to-female transsexuals.

Anatomical sex differences in the brain are beginning to be identified. A number of nuclei in the hypothalamus appear to differ in size and cell numbers between the two sexes. The central subdivision of the bed nucleus of the stria terminalis, which in lower mammals is involved in various aspects of sexual behaviour, appeared to be 378 % larger in men than in women. The volume of the above nucleus in five male-to-female transsexuals was only 54 % of the size in men and was not different from the volume found in women. This nucleus was not different in size between homosexual and heterosexual men. This is the first demonstration of an unambiguously female-sized brain area in male-to-female transsexuals. The administration of antiandrogens and/or oestrogens in adulthood does not influence the size of the bed nucleus, as could be shown from cases of men and women who had been exposed to endogenous or exogenous cross sex hormones in adulthood. It is presently not known at which stage of development this bed nucleus becomes sex-dimorphic neither is it known what is the driving force behind the sexual differentiation of this nucleus. Of another sex-dimorphic nucleus, the so-called Sex-Dimorphic-Nucleus, it is known that it becomes only dimorphic postnatally between the ages of 2-4 years. The present finding supports the hypothesis of the aetiology of transsexualism that purports that in transsexuals the sexual differentiation of the brain has not followed the course of sexual differentiation prognosticated by the other criteria of sex such as the chromosomes, the gonads, the internal and external genitalia. As yet there are no data on this nucleus in the brains of female-to-male transsexuals.

PROZAC[®]

fluoxetine hydrochloride

The only **1** indicated for both depression and obsessive-compulsive disorder

A broad spectrum of dosing flexibility

—an SSRI that offers dosing options that *do not* require breaking or cutting tablets

- Proven effective in treating depression
- Proven effective in treating OCD
- The only one indicated for both depression and obsessive-compulsive-disorder
- 20 mg once a day—The same starting dose in both depression and obsessive-compulsive disorder
- The safety of a favorable side effect profile

Discontinue immediately if rash or other possibly allergic phenomena appear for which an alternative etiology cannot be identified.

The most commonly observed adverse events associated with the use of Prozac in clinical trials were: nausea, anxiety/nervousness, insomnia, drowsiness, and headache. In OCD clinical trials, additional commonly observed adverse events were: tremor, diarrhea, and dry mouth.

Avoid using concomitantly with or in proximity to MAO inhibitors.

20-mg capsules
10-mg capsules
20-mg/5mL oral solution



Lilly



The Harry Benjamin International
Gender Dysphoria Association, Inc.

A Non-Profit Corporation

P.O. Box 1718
Sonoma, CA 95476

(707) 938-2871
FAX (707) 938-2871

XIV Harry Benjamin International Gender Dysphoria Symposium
Kloster Irsee (Germany), September 7 - 10, 1995.

Organized by The Harry Benjamin International Gender Dysphoria Association
and the Department of Psychotherapy, Ulm University, Ulm, Germany.

Registrations (Sept. 1, 1995)

Adelman	Kenneth	Ann Arbor	USA
Alley	Rhea	Norfolk	USA
Almas	Elsa	Grimstad	Norway
Asscheman	Henk	Amsterdam	Netherlands
Augstein	Maria-Sabine	Tutzing	Germany
Avery	Eric Nelson	Galveston	USA
Becker	Hinnerk	Hannover	Germany
Beigel	R.P.	Hannover	Germany
Benestad	Esben	Grimstad	Norway
Bergmann	Birgit	Ulm	Germany
Bockting	Walter O.	Minneapolis	USA
Bodlund	Owe	Umea	Sweden
Boer-Meisel	M.E.	Amsterdam	Netherlands
Bosinski	Hartmut	Kiel	Germany
Botzer	Marsha C.	Seattle	USA
Brassard	Pierre	Quebec	Canada
Brewer	Barbara	Cincinnati	USA
Brown	George R.	Jonesborough	USA
Butterman	Mariska	Amsterdam	Netherlands
Carpenter	George	Dallas	USA
Clement	Ulrich	Heidelberg	Germany
Cohen-Kettenis	Peggy T.	Utrecht	Netherlands
Cross	David P.	Galveston	USA
Daverio	Paul J.	Lausanne	Switzerland
Davidsson	Lars	Lund	Sweden
de Cuyper	Griet	Gent	Belgium
de Vriendt	Danny	Kortrijk	Belgium

Désirat	Karin	Hannover	Germany
Di Ceglie	Domenico	London	U. K.
Doorn	Kees	Amsterdam	Netherlands
Dott	Sharon G.	Galveston	USA
Draskic	Marija	Belgrade	Yugoslavia
Drunkenmölle	Claus	Halle/S.	Germany
Dufmats	Anneli	Möln dal	Sweden
Eicher	Wolf	Mannheim	Germany
Ekins	Richard	Liverpool	U. K.
Elbers	J.M.H.	Amsterdam	Netherlands
Ettner	Randi C.	Evanston	USA
Exner	Klaus	Frankfurt	Germany
Eyler	A.E.	Ann Arbor	USA
Fisseler	Kathrin	Düsseldorf	Germany
Floth	Andreas	Vienna	Austria
Fraser	Lin	San Francisco	USA
Frederiksen	Karin	Copenhagen	Denmark
Fuchs	Caroline	Deisenhofen	Germany
Garrels	Lutz	Münster	Germany
Gilbert	David A.	Norfolk	USA
Gilbert	Deborah M.	Norfolk	USA
Godano	Adriana	Collegno	Italy
Gooren	Louis	Amsterdam	Netherlands
Green	Richard	London	U. K.
Greven	A.M.	Amsterdam	Netherlands
Grigoriev	Andrei	Vancouver	Canada
Gummersbach	Walter	Berlin	Germany
Hage	J.Joris	Amsterdam	Netherlands
Harashina	Takao	Saitama	Japan
Hartmann	Uwe	Hannover	Germany
Heinrich	Michel	Stuttgart	Germany
Hense	Katharina	Hamburg	Germany
Hertoft	Preben	Copenhagen	Denmark
Hines	Melissa	London	U. K.
Hirschauer	Stefan	Bielefeld	Germany
Hoebeke	Piet	Gent	Belgium
Höjerback	Torvald	Lund	Sweden
Hoppenkamps	Gereon	Köln	Germany
Hornung	Nicole	Alsbach	Germany
Hundler	Connie L.	Mannheim	Germany
Jacob	Manon	Quebec	Canada
Jarolim	Ladislav	Prague	Czechia
Juran	Shelley	Brooklyn	USA

Karim	Refaat B.	Amsterdam	Netherlands
Karstens	Jan	Hamburg	Germany
King	Dave	Liverpool	U. K.
Klaassen	Uwe G.	Berlin	Germany
Klein	Cornelia	Offenbach	Germany
Klene	Petra C.	Amsterdam	Netherlands
Krappel	Anita-Daniela	Wien	Austria
Kuiper	A.J.	Amsterdam	Netherlands
Landén	Mikael	Möln dal	Sweden
Laub	Donald R.	Palo Alto	USA
Laub	Mrs.	Palo Alto	USA
Lebovic	Gail S.	Stanford	USA
Leusink	A.M.	Amsterdam	Netherlands
Lima Marques	Claudia	Heidelberg	Germany
Lombardo	Francesca	Rome	Italy
Lopez-Galiacho	Javier	Madrid	Spain
Lundström	Bengt	Möln dal	Sweden
Madeira	Rosa M.S.	Charneca de Caparica	Portugal
Massara	Damiana	Collegno	Italy
Master	Gert	Amsterdam	Netherlands
Megens	Jos	Amsterdam	Netherlands
Meyer	Olivia	Galveston	USA
Meyer III	Walter J.	Galveston	USA
Meyer-Bahlburg	Heino F.L.	New York	USA
Michel	Aude	Liège	Belgium
Mitchell	Arthur M.	Los Angeles	USA
Möhl	Bo	Copenhagen	Denmark
Monstrey	Stan J.	Gent	Belgium
Morris	Denise	Dallas	USA
Naumann	Johanna	Berlin	Germany
Neumann	Hans Jürgen	Halle/S.	Germany
Neumann	Kerstin	Halle/S.	Germany
Niehus	Eva-Maria	Münster	Germany
Pearson	Rosemary	West Yorkshire	U. K.
Perovic	Sava	Belgrade	Yugoslavia
Petersen	Maxine	Toronto	Canada
Petersen-Lee	Michelle	Scarborough	Canada
Pfäfflin	Friedemann	Ulm	Germany
Pfeifer	Hans-Werner	Berlin	Germany
Piesch	Elisabeth	Wien	Austria
Pimenoff	Veronica	Paihola	Finland
Preuss	Wilhelm F.	Hamburg	Germany
Purnell	Alice	Hove	U. K.

Ramos da Silva	Elaine	Freiburg	Germany
Reichhart	Christine	Homburg	Germany
Richter-Appelt	Hertha	Hamburg	Germany
Robertson	Bill	Petersham	Australia
Robinow	Oliver	Vancouver	Canada
Royle	Michael G.	Hove	U. K.
Rubin	Pat	Montreal	Canada
Rücker-Frensch	Eva	Berlin	Germany
Runte	Annette	Hamburg	Germany
Sachse	Richard	Erlangen	Germany
Satterfield	Sharon	Minneapolis	USA
Schaefer	Leah C.	New York	USA
Schaff	Jürgen	Dachau	Germany
Schernitzky	Birgit	Frankfurt a.M.	Germany
Schroer	Bernhard	Münster	Germany
Schützer	Marjorie	Copenhagen	Denmark
Seghers	Michel	Brüssel	Belgium
Seil	David	Boston	USA
Sjöström	Annika	Lund	Sweden
Slijper	Froukje M.E.	Rotterdam	Netherlands
Spehr	Christa	Augsburg	Germany
Spehr	Wolfgang	Hamburg	Germany
Springer	Kayla	Cincinnati	USA
Springfield	Fran	London	U. K.
Starke	Wolfgang	Wiesbaden	Germany
Staupe	Kai	Hamburg	Germany
Strapko	Nancy	Plymouth	USA
Strauß	Lisa	Halle	Germany
Stuurman	M.E.	Amsterdam	Netherlands
Swartz	Louis H.	Buffalo	USA
Tiewtranon	Preecha	Bangkok	Thailand
Timmerman	I.	Amsterdam	Netherlands
Toivonen	Eeva-Kaisa	Helsinki	Finland
van Kesteren	Paul	Amsterdam	Netherlands
van Maasdam	Judy	Palo Alto	USA
Vandemaele	Lydia	Merksem	Belgium
Veenhuizen	A.M.	Utrecht	Netherlands
Vehrs	Bryant	Seattle	USA
Vesely	Jiri	Brno	Czechia
von Saldern	Sven	Aachen	Germany
Vornik	Boris M.	Kiev	Ukraine
Vujovic	Svetlana	Belgrade	Yugoslavia
Walling	David P.	Galveston	USA

Watson	Diane	Vancouver	Canada
Webb	Alice	Sonoma	USA
Weitze	Cordula	Berlin	Germany
Wells	Ms. Marion	London	U. K.
Wesson	Sarah	London	U. K.
Wheeler	Connie	New York	USA
Whittle	Stephen	Manchester	U. K.
Wilchesky	Marilyn	Montreal	Canada
Will	Michael R.	Geneva	Switzerland
Will	Wiltrud	Saarbrücken	Germany
Wilson	Neal	Detroit	USA
Windgassen	Klaus	Münster	Germany
Wornik	Boris M.	Tübingen	Germany
Yüksel	Sahika	Istanbul	Turkey
Zucker	Ken J.	Toronto	Canada
Zukerman	Zvi	Petah-Tikva	Israel

Recto Sigmoid Colon

Leub
vs Hage

stapler, for Russia - we remove out

The mucorhea

Safety vs Lubrication

Vaginal Length

sensitivity

Neurona Formation
Grafinger

Leub - the
neurones - cut nerves

Vaginal Stenosis

Dilation
loss of Tissue
stricture

AIDS

and Cancer

Herpes Chancroid

Diversion
colitis

MALODOR

No malodor

No lubrication
may shrink a bit
less prausibility
Tough
less Introwaction surgen

Handwritten scribbles at the top of the page, possibly including the number '5'.

A small handwritten mark or scribble in the center of the page.

L. C. Schaefer, Ed.D.
285 Riverside Drive

New York NY 10025

USA