

**The Psychopathology of “Sex Reassignment Surgery”:
Assessing its Medical, Psychological and Ethical Appropriateness**
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Richard Fitzgibbons, Philip Sutton, and Dale O’Leary

Abstract

Is it ethical to perform a surgery whose purpose is to make a male look like a female or a female to appear male? Is it medically appropriate? Sexual Reassignment Surgery (SRS) violates basic medical and ethical principles and is therefore not ethically or medically appropriate. (1) SRS mutilates a healthy, non-diseased body. To perform surgery on healthy body involves unnecessary risks; therefore, SRS violates the principle “primum non nocere (first, do no harm).” (2) Candidates for SRS may believe that they are trapped in the bodies of the wrong sex and therefore desire, or more accurately demand SRS; however, this belief is generated by a disordered perception of self. Such a fixed, irrational belief is appropriately described as a delusion. SRS, therefore, is a “category mistake”—it offers a surgical solution for psychological problems such as a failure to accept the goodness of one’s masculinity or femininity, lack of secure attachment relationships in childhood with same sex peers or a parent, self-rejection, untreated gender identity disorder, addiction to masturbation and fantasy, poor body image, excessive anger, severe psychopathology in a parent, etc. (3) SRS does not accomplish what it claims to accomplish. It does not change a person’s sex; therefore, it provides no true benefit. (4) SRS is a “permanent,” effectively unchangeable, and often unsatisfying surgical attempt to change what may be only a temporary (i.e., psychotheapeutically changeable) psychological/psychiatric condition.

The desire to imitate the other sex or to pass for the other sex is not new, nor is the amputation of healthy body parts. In many cultures, men were castrated for various reasons, in some cases to preserve the pre-puberty boy-soprano voice, in others to serve as guards of harems. Such practices are now considered barbaric. Individual women have at various times in history passed as men. Only when surgical skills advanced to the degree that surgeons could construct artificial vaginas and something resembling a penis or scrotum did Sex Reassignment Surgery (SRS) develop as a surgical subspecialty. The materialist ethic of “if we can do something, we may do it” has created a climate where people see nothing wrong with surgeons destroying healthy reproductive organs and creating artificial organs for those who want them. Those who believe in the radically dualistic ethic of “it’s my body so I can manipulate it however I like,” are offended if surgeons refuse to grant their demands.

Use of the term “sexual reassignment surgery” is in itself problematic, it implies that the sexual identity is assigned at birth and can actually be surgically reassigned. Sexual identity is observed at birth and, except in rare cases, matches the genetic structure. It is written on every cell of the body and can be determined through DNA testing. It cannot be changed. Calling men who have had SRS

“women” does not change their genetic structure. It does not make them genetic women.

The use of “transsexual” is also problematic since it also implies that a person can move from their true genetic sex to the other sex. At one time, the word “sex” was used to describe everything that was included in being male or female. The word “gender” was used in reference to language; words were masculine, feminine, or neuter in gender. Controversial psychologist, sexologist, and promoter of SRS, John Money, introduced the idea of “gender identity,” defined as a person’s own categorization of themselves as male, female, or ambivalent. Radical feminists embraced the idea that sex—the biological reality—could be separated from gender, which they viewed as an artificial social construct imposed on male and female bodies. For them, sex may be a biological given, but gender is in the mind and because it is constructed by social interaction, it can be deconstructed.

Those calling themselves transsexuals took the separation of sex and gender in a different direction; for them, gender was natural and sex could be constructed—the body modified to fit the mind. Thus, a person could be male in sex (i.e., biologically, genetically), yet female in gender. This did not mean that a particular man simply had interests, talents, or other traits more likely to be found in women, but that at the core of his being he was essentially female and had been mis-assigned at birth. Therefore his desire to be reassigned surgically, and hormonally, was reasonable and should be accommodated.

Persons seeking SRS experience a disharmony between their bodies and their self image. The question is: Should this disharmony be reconciled by changing the body or changing the mind? Those applying for SRS strongly resist psychological probing into the origins of their feelings, demanding instead a surgical solution to their problem.

Those publicly promoting SRS insist that once SRS procedures are completed the client is no longer the sex to which he or she was born but has been surgically transformed into the other sex. However, SRS procedures only create an imitation of the organs involved in the sexual act, and in the case of women who wish to present themselves as men, are very poor, non-functional imitations. Surgery cannot change the DNA or reverse the effect of prenatal hormones on the brain. It can only create the appearance of the other sex. Persons who have undergone these procedures may engage in acts which simulate sexual intercourse between a male and female, but these acts are non-reproductive since the surgical procedures cannot create fertility. In effect, SRS is the most radical form of sterilization, and according to Catholic moral teaching, unethical on that ground alone.

We argue that the desire for SRS generally results from an array of psychological disorders. In defense of this view, we provide information on the background of the SRS movement, a review of the procedures involved, and data on typical psychological problems suffered by these patients. There is a discussion of the three types of people who apply for SRS. We then address the ethical, religious, and other objections to SRS and affect of a general acceptance of SRS on freedom of religion, speech and thought. We conclude that SRS does not serve the best interests of the clients and is a misuse of the skills of surgeons- and psychiatrists.

Background

Johns Hopkins University in Baltimore, Maryland, was once a center for SRS. However, when Dr. Paul McHugh became psychiatrist-in-chief in 1975, he decided to investigate what he “considered to be a misdirection of psychiatry and to demand more information both before and after [the]

operations.” He asked for a follow-up on clients from psychiatrist and psychoanalyst Jon Meyer. Meyer found that “sex reassignment surgery confers no objective advantage in terms of social rehabilitation” According to McHugh:

most of the patients he [Meyer] tracked down some years after their surgery were contented with what they had done and...only a few regretted it. But, in every other respect, they were little changed in their psychological condition. They had much the same problems with relationships, work, and emotions as before. The hope that they would emerge now from their emotional difficulties to flourish psychologically had not been fulfilled. We saw the results as demonstrating that just as these men enjoyed cross-dressing as women before the operation so they enjoyed cross-living after it. But, they were no better in their psychological integration or any easier to live with.

McHugh and others became convinced that SRS involved collaborating with mental disorder rather than treating it and the SRS program at Johns Hopkins was discontinued.

It is important to distinguish between SRS and procedures designed to restore organs that are deformed, whether from genetic abnormalities, congenital defects, injury or disease. The techniques currently used for SRS were developed for such patients and if no change of sex is intended, these are medically indicated and therefore ethically justifiable.

There are genetic and other abnormalities that can cause discordance between genetic sex, hormone receptivity, and external and internal sexual organs. These disorders of sexual development are very rare. While it is appropriate to test anyone desiring SRS, in order to be sure that they do not suffer from one of these rare abnormalities, those who seek SRS are virtually always genetically normal men and women with intact sexual and reproductive organs and hormones levels proper to their sex.

Sexual Reassignment Surgery requires the destruction of healthy sexual and reproductive organs. One of the surgeons at Johns Hopkins involved in the procedure expressed his feelings about the act of mutilation: “Imagine what it's like to get up at dawn and think about spending the day slashing with a knife at perfectly well-formed organs, because you psychiatrists do not understand what is the problem here but hope surgery may do the wretch some good.” In addition, candidates for SRS are administered hormones to create secondary sexual characteristics usually found in the other sex, such as growth of a beard for women and breast enlargement for males. Hormone treatments can cause serious health problems. For women, the effects of male hormones, as well as SRS surgery, can be permanent and irreparable.

Reassignment Process for Males

Sexual Reassignment Surgery is only one step in a long and expensive process. For *men* it involves:

- Dressing in public as a woman
- Electrolysis to remove facial hair
- Hormone treatment
- Breast implants
- Electrolysis to remove hair on genitals to prepare the tissue in these organs to be used to create

- a pseudo vagina
- Removal of the penis and testes
- Creation of a pseudo vagina
- Creating an opening for the urethra
- Cosmetic surgery—decreasing the size of the Adams apple, changes to other features
- Silicone implants in hips and buttocks

Those who begin the process are often dissatisfied with the initial cosmetic results. Some of those seeking SRS not only want to be women, they want to be stunningly attractive women and thus may become addicted to plastic surgery. Some also seek out back alley practitioners for silicone injections and other changes, risking infection and even death.

Some men present themselves in public as women, but have not yet chosen to have surgery below the waist. These are sometimes referred to as “shemales” since with breast implants and cosmetic surgery above the waist, they appear female, but below the waist, they are physically male. Some shemales work as showgirls in clubs that specialize in this kind of entertainment or as prostitutes in order to save up the money needed for genital surgery. Certain men seek out the sexual services of shemales.

Reassignment Process for Females

For *women* the process involves:

- Hormone treatments
- Removal of the breasts (often begun by binding them)
- Total hysterectomy
- Creation of a pseudo penis and testes

It is noteworthy that increasing testosterone levels in women—to stimulate facial hair growth and increase muscle—has the potential to cause a change in personality, including making a woman more aggressive. A hysterectomy is then performed to stop menstruation which, for many, removes the unwanted monthly evidence of womanhood and vulnerability. Relatively few women who undergo SRS, even those with severe gender dysphoria, choose to take the last step: the creation of a pseudo penis and pseudo testes. When this is done, the artificial organs often are small and are non-functional. A penis may be constructed to enable a mechanical erection and the simulation of sexual intercourse, but ejaculation is not possible. While the surgeons attempt to preserve sexual sensation in the pseudo organs, they are not always successful.

Recently, there was substantial publicity about a so-called, pregnant man. The pregnant person was in fact a woman who had undergone breast removal and was taking hormones to increase facial hair and muscle, but had not undergone a hysterectomy or surgery to create pseudo male external genitalia. When she and her female partner wanted to have a child but her partner could not become pregnant, she ceased taking the hormones and was artificially inseminated. Thus, a woman who looked male above the waist—but was, in fact, fully female—became pregnant.

Origins of the Desire for SRS

Ray Blanchard, of Clarke Institute of Psychiatry in Toronto (now part of the Centre for

Addiction and Mental Health), has spent years studying and treating transsexuals. He identified two distinct syndromes: homosexual transsexuals (HT) and autogynephilic transsexuals (AT). J. Michael Bailey's book *The Man who would be Queen* explored the difference between the two.

Homosexual Transsexual Males

According to this analysis, HT males are men whose appearance, gestures, and speech are perceived as feminine and who are attracted to masculine men rather than other homosexual men. HT males believe that if they can appear to be real women and can "pass" as such, they will be able to attract these men.

Almost all HT males experienced Gender Identity Disorder (GID) as children. They did not fully identify with their fathers, brothers, or peers and either believed that they were really female or wished to be female. They often expressed disgust at their male genitals, may have tried to hide them, refused to urinate standing, insisted on dressing in girls' clothes, and often chose only girls for playmates. These behaviors often resulted in rejection and teasing by male peers. Although some adult men with same sex attraction (SSA) exhibit some of these symptoms before age five, in later childhood the symptoms commonly disappear. HT males, however, persist in their identification with females, often presenting an exaggerated image of womanhood in their gestures, speech, and dress.

Many HT males at some point become sexually intimate with males with SSA, but they did not find these relationships satisfying. This is in contrast with a boy who moves from GID to SSA and engages in relations with other men with SSA. The HT male wants a relationship with a heterosexual man and believes that by presenting himself as a very attractive woman he can fulfill this desire. It should be noted that in the gay community, masculinity is favored and very feminine males are not considered as desirable.

McHugh characterized HT males as "conflicted and guilt-ridden homosexual men who [see] a sex-change as a way to resolve their conflicts over homosexuality by allowing them to behave sexually as females with men." While HT males may insist that their only motivation is to become the women they always knew they were, Anne Lawrence, a autogynephile who has undergone SRS, believes that sexual desire plays a bigger part than many HT's are willing to admit.

Homosexual transsexuals are not exactly devoid of sexual motivations themselves. Colleagues who have spent a lot of time interviewing homosexual transsexuals tell me that they can best be thought of as very effeminate gay men who do not defeminize in adolescence. Nearly all go through a "gay boy" period; and their decisions about whether or not to transition are often based in large part on whether they expect to be sufficiently passable in female role to attract (straight) male partners. Those who conclude they will not pass usually do not transition, no matter how feminine their behavior may be. Instead, they accept, perhaps grudgingly, a gay male identity, and remain within the gay male culture, where they can realistically expect to find interested partners. This self-selection process explains the intriguing observation that transitioning homosexual transsexuals tend to be physically smaller and lighter than their autogynephilic sisters. The bottom line is that in homosexual transsexuality, too, a sexual calculus is often at work. Transsexualism is largely about sex—no matter what kind of transsexual one is.

Gender Identity Disorder

There is general agreement that HT normally first manifests itself as childhood GID. Because the symptoms of GID (and therefore HT preceded by GID) appear very early in childhood, some assume that the condition is biological in its origin—either genetic or hormonal, and therefore unchangeable. But, there is no scientific evidence to support this conclusion.

A baby is conceived genetically male or female. Prenatal brain development is influenced by the same hormones that trigger the development of the reproductive organs. Babies discover there are two sexes, and to which sex they belong. This should lead to a positive self-awareness: “I am a boy. It is good to be a boy. I am like my Daddy and brothers. My parents are happy that I am a boy.” In the same way, a girl needs to feel that she is safe, accepted, and loved as a girl and that being a girl is a good thing.

Dr. Kenneth Zucker and Susan Bradley’s book, *Gender Identity Disorder and Psychosexual Development in Children and Adolescents*, represents years of work with clients with GID. According to their clinical model for boys with GID, the disorder begins in early childhood with an insecure mother-child relationship and tends to affect boys who are emotionally vulnerable:

The boy, who is highly sensitive to maternal signals, perceives the mother’s feelings of depression and anger. Because of his own insecurity, he is all the more threatened by his mother’s anger or hostility, which he perceives as directed at him. His worry about the loss of his mother intensifies his conflict over his own anger, resulting in high levels of arousal or anxiety.

When anxiety occurs at such a sensitive developmental period, the child may choose behaviors common to the other sex because in his mind these will make him more secure or more valued.

In her book *Affect Regulation and the Development of Psychopathology*, Susan Bradley classifies GID with internalizing anxiety disorders:

What makes GID different from anxiety disorders is that there are factors in the family making gender more salient. Specifically, boys with GID appear to believe that they will be more valued by their families or that they will get in less trouble as girls than as boys. These beliefs are related to parents’ experience within their [own] families of origin, especially tendencies on the part of mothers to be frightened by male aggression or to be in need of nurturing, which they perceive as a female characteristic.

The child’s first experiments of identifying with the other sex may be subtly or openly rewarded with smiles, particularly by the mother. She or other females in the family may exclaim, “Look how cute he is dressed up in his mother’s shoes. He would be a pretty girl” or something similar.

Zucker and Bradley explain a mother’s positive reaction to cross-sex behavior in her baby: “The mother’s need for nurturance and fear of aggression allow her to tolerate these behaviors, which may also be reinforced by her perception of her son as attractive; her tolerance may actually lead to a positive response to the initial cross-gender behaviors. The mother may be unwilling to make the child “unhappy” by discouraging cross-dressing, while the father may be convinced that his son is going to become homosexual. It is only later, when identifying with the other sex leads to teasing and rejection, that the mother becomes concerned. Zucker and Bradley have found that many parents of these boys when confronted with obvious symptoms of GID “profess a rather marked ambivalence,” ignoring the

problem until it is impossible to do so. Presumably, those with even more ambivalence never seek help.

Because of their own problems, parents are sometimes unable to meet their child's needs for security, acceptance, love, and for a positive image of his or her own sex. In contemporary culture, fathers often bond with their sons through sporting activities and may not know how to help boys to incorporate their special creative, artistic, or other non-athletic talents into their masculinity. Fathers with creative or artistic sons need to learn how to support and affirm these interests as authentically masculine. Parents may also fail to appreciate the importance of helping these boys in early childhood to develop strong male friendships with boys who share their interests.

In some cases, a parent may have wanted a child of the opposite sex, and dresses and treats the child as the opposite sex. Some parents pressure the school to allow the child to cross-dress in school, and may even take the child to a transgender support group. Family dysfunction leaves the child vulnerable:

The parents' ongoing difficulties in dealing with the child's cross-gender behaviors may intensify the child's anxiety and insecurity, but also permit the child to develop a fantasized but valued opposite sex self. With development and the repeated need to use this fantasized other self, the child may be very resistant to relinquishing this defensive solution.

Dr. Richard Fitzgibbons has found that children—particularly boys—with GID often experience rejection, teasing, and mistreatment. Boys who lack eye-hand coordination are often isolated or mercilessly teased because they cannot hit a pitch or properly kick a soccer ball. This rejection can cause an insecurely attached boy to believe that other people hate him. This in turn can lead to self-rejection that is focused on sex identity (e.g., “I hate being a boy” or “I hate being a girl”) or on particular body parts (e.g., boys may try to hide their genitals).

The experiences of girls with GID commonly differs from that of boys. Many girls with GID are noticeably *more*—not less—talented athletically, and more temperamentally suited for competitive (“rough and tumble”) sports than their female peers. This does not commonly lead to as much overt, peer rejection as boys who are *less* athletic or boys who are *less* competitive tend to experience. Yet, to the extent that girls with GID, for other reasons, experience an inordinate vulnerability or dysphoria about being “female”, they also may fear the biological hallmarks of their sex, such as the development of their breasts or the onset of menstruation. (See *Females Seeking SRS* section below for further discussion of the causes and effects of a girl's rejection by female peers.)

Overall, Fitzgibbons believes that this rejection of one's natural body, accompanied by self-hatred and masochistic tendencies, can lead to the desire for SRS. According to Fitzgibbons, if psychotherapists would focus on helping children and adult patients learn how to resolve their anger with themselves and with those by whom they feel rejected, these children and adults can become happy with their birth sex.

Other therapists have found that children with GID develop habits of self-pity, self-victimization, and complaining and exaggerating personal suffering—habits which are extremely difficult to break. Without a positive intervention, the majority of boys with GID develop SSA in adolescence. However, only a small percentage go on to seek SRS.

The failure to identify with the goodness of their own masculinity or femininity can lead to envying those who have the qualities which they perceive themselves to be lacking. One of the differences between a person whose GID is a path to SSA and one who is on a path to transsexuality, is

that the persons moving toward SSA may envy and even covet the characteristics of their *own* sex which they see present in others but lacking in themselves, while those on the path to transsexuality envy or covet the characteristics of the *other* sex. Those developing transsexuality commonly believe that being- and becoming- the other sex would achieve their goal of feeling safe, accepted, and loved.

It should be noted that there is controversy over the classification of childhood GID as a disorder. Some therapists insist that since childhood GID is a common—but not exclusive or invariable—first step to homosexual identification in adolescence and that since homosexuality is no longer considered a psychological disorder, GID in children should not be considered a disorder. Rather it should be accepted as healthy and normal for that child. Zucker and Bradley reject such an approach and point to the distress children with GID experience and to the high levels of psychopathology found among the parents of boys with GID. According to Zucker and Bradley, these are not happy well-adjusted boys who just happen to think they are girls. They are troubled children from troubled homes. As evidence, Zucker and Bradley presented a review of the families of ten consecutive GID boy clients who attended their clinic. All the families had serious problems. Eight of the mothers had at least one diagnosed psychological disorder. Of the remaining two, one was in long-term psychotherapy for family issues and the other suffered from severe debilitating migraine headaches.

Positive interventions are possible for pre-adolescent children with GID. Zucker and Bradley report: “It has been our experience that a sizeable number of children and their families achieve a great deal of change. In these cases, the gender identity disorder resolves fully.” Since the symptoms are obvious to everyone, including pediatricians and teachers, parents should be encouraged to seek help as soon as possible.

Unfortunately, parents are often unwilling to participate in the process. According to Zucker and Bradley, if the condition is left untreated in childhood, it is much more difficult to treat in adolescence, particularly if the adolescent believes that SRS is the solution:

Adolescents with gender identity disorder have poor anxiety tolerance. Seeking sex reassignment surgery is a defensive solution and a mechanism for control of anxiety. The thought of not having a “solution” for their distress increases their anxiety, thus making it very difficult to achieve a therapeutic alliance. Despite an understanding (at last at a superficial level) of why they have cross-gender wishes, these adolescents are often unable to relinquish their defense, as they feel too overwhelmed to face their anxiety without it. This leads to demanding behavior and impatience with the therapist as he or she tries to help them explore feelings and behaviors. Many adolescents who seek sex reassignment withdraw from therapy because of their inability to tolerate the anxiety connected with exploration of their wish for surgery.

Given the failure to achieve positive results with adolescents suffering from GID, Zucker and Bradley support hormone treatment for adolescents and SRS only when the person has come of age. The availability of SRS certainly encourages these adolescents to believe that their resistance to therapy will be rewarded and their desire for SRS granted.

Autogynephilic Transsexuals

According to Ray Blanchard, who named the syndrome, AT males are men in love with the image of themselves as women. Blanchard writes:

- (1) All gender-dysphoric biological males who are not homosexual (erotically aroused by other males) are instead autogynephilic (erotically aroused by the thought or image of themselves as females)
- (2) Autogynephilia does not occur in women, that is, biological females are not sexually aroused by the simple thought of possessing breasts or vulvas.
- (3) The desire of some autogynephilic males for sex reassignment surgery represents a form of bonding to the love-object (fantasized female self) and is analogous to the desire of heterosexual men to marry wives and the desire of homosexual men to establish permanent relationships with male partners.
- (4) Autogynephilia is a misdirected type of heterosexual impulse, which arises in association with normal heterosexuality but also competes with it.
- (5) Autogynephilia is simply one example of a larger class of sexual variations that result from developmental errors of erotic target localization.

Autogynephilia is classified with the paraphilia transvestism. Paraphilias are psychological disorders in which sexual excitement becomes obsessively associated with something other than the presence of a real, total person.

Some AT's object to the classification of their problem as a paraphilia because they are not (at least initially) restricted to enacting a single fantasy in order to achieve orgasm. Rather the heterosexual AT's find that their fantasies compete with their sexual relationship with their partners. According to Anne Lawrence, a post-SRS AT:

What makes the issue complicated is that autogynephilia does not necessarily preclude attraction to other people. That is why one can say that some transsexuals are autogynephilic, and simultaneously categorize them as heterosexual, bisexual, or anallophilic [not attracted to other people]. (If autogynephilia completely precluded attraction to other people, all autogynephilic persons would be anallophilic.) But autogynephilic arousal often does seem to compete with arousal toward other people. For example, autogynephilic persons who are heterosexual or bisexual often report that when they first become involved with a new sexual partner, their autogynephilic fantasies tend to recede, and they become more focused on the partner. But as the relationship continues, and the novelty of the partner wears off, they more frequently return to autogynephilic fantasies for arousal. (Perhaps for biologic males, novelty is an important factor in determining which of several possible sources of arousal receives attention.)

The power of the fantasy may, however, reduce the sexual partner to an actor in the fantasy. Lawrence continues:

Another common observation made by autogynephilic persons is that, while they like having partnered sex, there is sometimes a way in which their partner is almost superfluous, or merely acts as a kind of prop in an autogynephilic fantasy script. Blanchard has observed that this is especially characteristic of many autogynephilic fantasies involving male partners: often the male figure is faceless or is quite abstract, and seems to be present primarily to validate the femininity of the person having the fantasy, rather than as a desirable partner in his own right. In part because

autogynephilia seems to compete with attraction toward other people, but without precluding it, Blanchard has sometimes preferred to call autogynephilia an "orientation," rather than a paraphilia.

The fantasy life of an autogynephilic involves imagining himself being penetrated sexually. The majority of AT males consider themselves to be heterosexual. Many start out as transvestites, some may marry, and some may have children. Only later in life some may decide that they want to live full time as women. Some AT's continue to be attracted to women and insist after the surgery that they are lesbians.

Most heterosexual transvestites remain content to engage in cross-dressing while others desire SRS. Blanchard hypothesized that a man who can "satisfy his urges by periodically cross-dressing in private or in the company of other transvestites" probably will not seek surgery, while a man "whose primary fantasy is having a vulva" eventually will.

Autogynephilia takes a variety of forms. Some men are most aroused sexually by the idea of wearing women's clothes, and they are primarily interested in wearing women's clothes. Some men are most aroused sexually by the idea of having a woman's body, and they are most interested in acquiring a woman's body. Viewed in this light, the desire for sex reassignment surgery of the latter group appears as logical as the desire of heterosexual men to marry wives, the desire of homosexual men to establish permanent relationships with male partners, and perhaps the desire of other paraphilic men to bond with their paraphilic objects in ways no one has thought to observe.

AT Males commonly have decided to pursue surgery because they, according to McHugh, found intense sexual arousal in cross-dressing as females. As they had grown older, they had become eager to add more verisimilitude to their costumes and either sought or had suggested to them a surgical transformation that would include breast implants, penile amputation, and pelvic reconstruction to resemble a woman. Further study of similar subjects in the psychiatric services of the Clark Institute in Toronto identified these men by the auto-arousal they experienced in imitating sexually seductive females. Many of them imagined that their displays might be sexually arousing to onlookers, especially to females.

AT males are generally less convincing as women and less overtly "sexy" than HT males.

AT in males generally begins with transvestic fetishes and masturbatory fantasies in adolescence. AT males, in general, did not suffer from GID as children, rather during late-childhood or early-adolescence they began to secretly dress in women's clothing, particularly lingerie, and masturbate while looking at themselves in a mirror. Those seeking SRS are careful to deny their use of masturbation with fantasy. According to post-SRS AT, Sandy Stone, "Wringing the turkey's neck", the ritual of penile masturbation just before its surgical removal, "was the most secret of secret traditions" practiced by AT's. To admit the habit of masturbation would be to risk being disqualified as a candidate for SRS.

Lawrence acknowledges the erotic aspects of autogynephilia, but believes that focusing on the erotic misses other essential elements: "Autogynephilia can more accurately be conceptualized as a

type of sexual orientation and as a variety of romantic love, involving both erotic and affectional or attachment-based elements.” For Lawrence, the AT desires to become what he loves. Lawrence views this desire as comparable to the heterosexual desire to become one with the beloved. She says that “becoming what one loves usually becomes their first priority, while other elements of life—family, friends, employment—typically assume secondary importance at least temporarily. The sex reassignment process is often given first claim on the transsexual’s time, energy and resources. The kind of romantic love described by Lawrence has an unhealthy obsessive aspect even in a relationship between a man and a woman, but far more so when the “beloved” is a fantasy image of womanhood.

Lawrence also recognizes that AT’s are “probably at increased risk for the development of narcissistic disorder,” because they are “particularly vulnerable to feelings of shame and may be predisposed to exhibit narcissistic rage in response to perceived insult or injury.” Lawrence attributes this to the fact that AT’s are wounded because many people treat them as “men pretending to be women.” Rather than encouraging therapy to deal with the narcissism and accompanying rage, Lawrence suggests that clinicians avoid inflicting narcissistic injury. This may be difficult since Lawrence admits that many AT’s do not present themselves as convincing women. Even if someone expresses acceptance verbally, they will communicate their true feelings through facial expression and body language which may be perceived as rejection.

Females Seeking SRS

Although the desire for SRS was once relatively rare among women, the number of those seeking partial or complete SRS has increased, almost all originally identifying themselves as lesbian. Women with SSA can be divided into two groups: those with a strong masculine identification (“butch”) and those without (“femmes”). The majority of those with a strong masculine identification experienced GID as children. As children, they failed to identify with the goodness and beauty of their femininity and bodies. Like boys with GID, these girls often failed to establish close same-sex friendships. Many have a history of early insecure attachment to their mothers, whom they viewed as weak and vulnerable. They may have come to believe that if they were boys they could please their fathers or at least protect themselves and their mothers from male aggression. GID in girls differs from a more common “tomboyishness” in that GID girls vehemently resist wearing girls clothing or engaging in typical girl play. Tomboyish girls on the other hand might be atypical in their interests, but are more flexible.

According to Zucker and Bradley, the girl who develops GID is a “temperamentally vulnerable child who easily develops high levels of anxiety,” with a mother who has difficulty with feelings and who may have been depressed during the first year of the girl’s life. There is often family conflict in which the father expresses a lack of respect for the mother or for women in general. The girl “perceives the marital conflict as a situation in which the mother is unable to defend herself.” When the girl “tries out cross gender behaviors in an initial effort to decrease anxiety,” her mother reacts positively because the mother believes imitating males will protect her daughter. The father may also encourage cross-gender behavior. “This permits the child the fantasy of being the mother’s protector through identification with the aggressor.” In some cases women with GID recalled that their fathers constantly demeaned women in general, but in particular their mothers.

Psychological Disorders Associated with the Desire for SRS

Persons who desire SRS typically experience serious emotional conflicts often complicated by sexual self-rejection and depression. Because many therapists are not skilled in uncovering and addressing these serious conflicts, SRS is put forward as the best available solution—if not the only solution. The very availability of SRS motivates persons who see surgery as *the* answer to their problems to resist therapy. Those who desire SRS know that if they present themselves in a manner that meets the criteria set forth by SRS-affirmative therapists (i.e., if they claim they have always felt like women in men’s bodies or vice versa and if they hide their SSA, their homosexual behavior, their compulsive masturbation, and their paraphilias), then they may be allowed to proceed with SRS. This does not encourage an honest therapeutic alliance. The availability of SRS effectively prevents the patient from revealing anything that might lead to non-surgical (i.e., psychiatric and other psychotherapeutic) resolution of underlying problems. Some therapists too readily accept a client’s “I feel trapped in the wrong body” explanation and do not probe—let alone help the client to resolve—the client’s underlying narcissism, anger, and inability to embrace the reality of their sexual identity.

Once the SRS has been completed, treatment of the underlying psychological problems becomes even more difficult. According to psychoanalyst Charles Socarides: "There is no evidence that gender identity confusion—a gender identity contrary to the anatomical structure—is inborn. Therefore any attempt to change this through surgical means forever dooms the individual’s chances of overcoming his psychosexual and psychological difficulties." Generally, persons accepted for SRS are diagnosed with GID. According to the website of Gender Dysphoria Organization, advocates for those seeking SRS, gender identity disorder,

as identified by psychologists and physicians, is a condition in which a person has been assigned one gender, usually on the basis of their sex at birth...but identifies as belonging to another gender, and feels significant discomfort or being unable to deal with this condition. It is a psychiatric classification and describes the problems related to transsexuality, transgender identity and more rarely transvestism. It is the diagnostic classification most commonly applied to transsexuals. The core symptom of gender identity disorders is gender dysphoria, literally being uncomfortable with one's assigned gender.

The implication is that the “assignment” of an infant on the basis of sex was faulty in these cases and needs to be corrected.

Do persons seeking SRS really believe that they have been mis-assigned or have they learned that saying they are a woman in a man’s body (or vice versa) is the only way they can qualify for SRS? Are therapists who evaluate such persons too willing to take these claims at face value? Sander Breiner, in an article titled “Transsexuality Explained,” points out such a misperception is in itself a psychological problem:

When an adult who is normal in appearance and functioning believes there is something ugly or defective in their appearance that needs to be changed, it is clear that there is a psychological problem of some significance. The more pervasive and extensive is this misperception of himself, the more significant is the psychological problem. The more the patient is willing to do extensive surgical intervention (especially when it is destructive), the more serious is the psychological problem. It may not be psychosis. It may not require psychiatric hospitalization. But the significance of the psychological difficulty should not be minimized by a patient's seeming success socially and professionally in other areas.

While those who make these claims may wish to believe that they are really trapped in the body of the wrong sex, it may be that what they actually believe is that if they were the other sex they would be happy, safer, more accepted, and more loved—which is not quite the same thing. The belief that one's problems would be solved if one undergoes SRS can be thought of as an "idée fixe"—an obsession that dominates thinking and resists evidence. For various reasons, rooted in their psychological history, these individuals believe that SRS will make them happy and they are willing to do whatever is necessary to qualify for the treatment.

The intensity of the desire for change is presented as evidence of the reality of the "wrong-body claim". Some men seeking SRS say, "I will commit suicide if I am not allowed to have surgery" or "I will castrate myself." Some have actually done so. Suicidal ideation and self-mutilation are generally considered symptoms of mental illness. Therapists should explore whether the person seeking SRS is motivated by an irrational disgust directed at sex specific characteristics or a fantasy-driven desire for the sexual organs of the other sex or both. Socarides treated a young man who was forced into therapy by his father. The man admitted that he was sexually abused by an older brother from age seven to age fourteen. He expressed a strong desire for a vagina:

I will sacrifice everything to change. If you have a vagina, you can control people. You can control them sexually. The idea fascinates me and to use this vagina fascinates me. I think I'm scared of anal intercourse. I could do it with a vagina and I would not be harmed physiologically, but I already have been harmed through anal intercourse with men.

GID in children, which may be a precursor to the desire for SRS in HT males, is hardly a benign condition. It is associated with a number of psychological problems, which if left unaddressed affect adolescent and adult adjustment.

Childhood Sexual Abuse

Several studies have found that at least 40 percent of adults, both male and female, with SSA have a history that includes childhood sexual abuse (defined as sexual activity before age fourteen with a person five or more years older). It should be noted that the "abuse" may be regarded as "consensual", with a troubled child accepting whatever kind of affection or attention is offered. Although some people think that SSA is caused by sexual abuse, all persons who are sexually abused do not develop SSA. While such abuse can be a primary or at least a contributing cause, in most instances the foundation for SSA is laid before the abuse. The early initiation into sexual activity, however, may set a pattern for subsequent behavior.

The percentage of HT's with a history of abuse may be even higher than 40 percent. A small study found that 55 percent of the transsexuals experienced unwanted sexual acts before age eighteen. An article by Holly Devor explored the relationship between transsexualism and childhood sexual abuse. In one study of forty-five self-defined female-to-male transsexuals, 60 percent of the subjects reported physical, sexual, or emotional abuse:

While an experience with at least one of the conventional adult psychopathological sequelae symptomatic of child abuse (e.g. fear, anxiety depression, compulsive eating disorders, substance abuse, hyperaggression, suicidal behavior) was often cited, the exact source of these behaviors may be a combination of gender dysphoria and a history of child abuse. It is suggested that transsexualism may manifest in adulthood as an adaptive, extreme dissociative

survival response in individuals with a past of severe child abuse.

Childhood traumas can cause lasting damage. The extent of permanent damage depends not so much on the severity of the trauma as on the response of the adults around the child. If parents and other adults respond positively, they can help the child understand that whatever has happened (i.e., divorce, death, abuse) is not his or her fault. With positive adult input, a child's understandable sadness, anger, or feelings of guilt can be minimized. Unfortunately, the parents of children with GID are often unable to provide the support that their children need in order to deal with the trauma, forcing the child to develop his or her own strategy for coping.

Consider the case of a thirteen-year-old boy discussed by a panel of doctors in *Pediatric Annals*. The boy wanted to start hormone treatments with the goal of SRS when he came of age:

His medical history is significant for reported physical abuse warranting placement outside his home. He underwent psychiatric hospitalization one year earlier for suicidal ideation related to anger associated with gender issues. He has been diagnosed as having attention deficit disorder. ...He is sexually active with male partners only and considers himself a heterosexual female. He uses condoms 50 percent of the time for anal sex. He had one HIV test, which was negative approximately one year ago. He reported having few friends because "no one is like him."

The doctors evaluating this boy's request appear to have ignored the obvious: If this boy is not already HIV positive, he probably soon will be. One doctor quoted in the article expressed concern that "our society does not accept sexual ambiguity." It would seem more proper to recognize that this thirteen-year-old is the victim of ongoing sexual abuse and should be protected and treated rather than put on the fast track to SRS.

Same-Sex Attraction

"Homosexuality" as a separate diagnosis was removed from the *Diagnostic and Statistical Manual of Mental Disorders* in 1973; however, a number of large, recent well-designed studies have found that persons with SSA are far more likely to suffer from a wide range of psychological disorders, such as depression, substance abuse problems, and suicidal ideation, than the general public. For example, a 2003 study using data from a nationally representative survey of 2,917 adults compared persons with SSA to those without:

	Heterosexual Men	Gay/Bisexual Men	Heterosexual Women	Lesbian/Bisexual Women
Major Depression	10.2 percent	31.0 percent	16.8 percent	33.5 percent
Panic disorder	3.8 percent	17.9 percent	8.6 percent	17.1 percent
Drug dependence	2.7 percent	9.2 percent	1.5 percent	6.5 percent
Positive of at least 1 disorder	16.7 percent	39.8 percent	24.6 percent	43.7 percent

To the extent that persons with HT are similar to other persons with SSA, one would expect to

find similar or even higher levels of psychological maladjustment. Persons with SSA with a history of childhood GID may be more vulnerable than those without. Some claim that these problems are caused by societal rejection; however, if this were the case one would expect to see significantly fewer problems among those who live in tolerant countries such as the Netherlands and New Zealand, but levels are similar in these countries.

It should be noted that none of these studies include sexual addiction or paraphilias. Were these included the differences could be even more striking. Domestic violence is a serious problem for same-sex couples. Men with SSA are more likely to have engaged in high risk activities, sex with strangers, unprotected sex (often while using drugs or alcohol), and sex for money—all this in spite of the knowledge that this behavior could lead to infection of a number of serious diseases including HIV/AIDS. The percentage of men who have sex with men diagnosed as HIV continues to be high in spite of decades of prevention education. HT's going through the "gay boy" stage are more likely to engage in receptive anal sex, which is an extremely highest-risk sexual activity particularly for those who are young. It is possible that conscious or unconscious fear of infection might cause some to be attracted to heterosexual males since the risk of contracting HIV/AIDS or another sexually transmitted infection from a heterosexual male is far less.

A study of clients of HIV prevention centers found that 52 percent of the 107 transgender-identified clients, versus 22 percent of the 2,019 nontransgender-identified clients, were HIV positive. The authors concluded that "transgendered-identified individuals are at high risk for HIV infection because of reuse of needles and (prostitution) being paid for sexual intercourse.

Masochism

Sexual masochism involves experiencing sexual arousal or excitement from receiving pain, suffering, or humiliation. Jon Meyer and John Hoopes, in an article entitled "The Gender Dysphoria Syndrome: A Position Statement of So-Called Transsexualism," considered the possibility that masochism may play a part in the desire for SRS: The masochists find that sexual arousal is facilitated by the experience of pain prior to sexual activity; they look upon the surgical excision of the genitalia (albeit unconsciously) as a form of masochistic adventure with the surgeon. Similarly, Janice Raymond, in her book *The Transsexual Empire: The Rise of the She Male*, suggests that men who desire SRS may be suffering from a form of destructive masochism. She writes:

What has been scarcely noted in many commentaries on transsexualism is the immense amount of physical pain that surgery entails. Generally, this fact is totally minimized. Most postoperative transsexuals interviewed seldom commented on the amount of physical pain connected with their surgery. Are we to suppose no pain is involved? Anyone who has the slightest degree of medical knowledge knows that penectomies, mastectomies, hysterectomies, vaginoplasties, mammoplasties, and the like cannot be painless for those who undergo them. ...It seems that the silence regarding physical pain, on the part of the transsexual, can be explained only by an attitude of masochism, where one of the key elements of the transsexual order is indeed the denial not only of self but physical pain to the point "where it may actually be subjectively pleasurable, or at least subjectively negligible."

In an article on SRS in Thailand, a Thai surgeon said that he liked to do SRS work because other patients complained about the pain related to surgery, but "the sexual reassignment surgery

patients are *always* happy. They don't complain! They say they are born again here in Thailand and they are happy."

This suggests the possibility that some men seeking SRS may be using the process to fulfill masochist desires and to try to resolve self-hatred. On the other hand, SRS patients frequently do complain about the cosmetic effects of the surgery and about the treatment they receive by those who do not, in their opinion, sufficiently accept them as women.

Ethical Objection to SRS

The publicly promoted goal of SRS is to transform a person of one sex into the other sex. It is physiologically impossible to change a person's sex, since the sex of each individual is encoded in the genes—XX if female, XY if male. Surgery can only create the *appearance* of the other sex. George Burou, a Casablancan physician who has operated on over seven hundred American men explained, "I don't change men into women. I transform male genitals into genitals that have a female aspect. All the rest is in the patient's mind." Therapists may be unwilling to explore the erotic motivation of those seeking SRS:

Most therapists and surgeons would probably find it difficult to acknowledge that when they give approval for sex reassignment surgery, or perform it, they are sometimes simply helping a transsexual woman act out her own paraphilic sexual script.

Each person seeking SRS is a unique individual with his or her own history and particular psychological disorders and emotional problems.

The suffering of persons who desire SRS cannot be denied. In many cases, it began in early childhood. Many have been victims of various forms of abuse or neglect and of peer or parental rejection. Basic emotional needs for secure attachment relationships to same sex peers and to the same sex parent have often not been met. Gender dysphoria is rarely their only diagnosable psychological disorder. They are, however, united by the belief that SRS will solve their problems. They have created an erotic script in which, as persons of the other sex, they are able to overcome all difficulties. They may enlist the support of surgeons to make their fantasy come true, but such fantasies are not reality based. SRS may satisfy a fantasy wish but it cannot (re)create a person as a fully functioning member of the other sex, able to live honestly as the other sex in real world situations. Such persons always will be living in their fantasy, trying ever harder to make it more perfect. Fantasies may sooth anxiety temporarily but they cannot heal the wounds of childhood trauma and satisfy unmet early needs. Once persons receive SRS, they may be—and often are—even more reticent to admit that they are still struggling with serious emotional conflicts.

Therapists are often unable to overcome patient resistance and uncover the underlying problems—serious emotional weaknesses of low self-esteem, sadness, and anger associated with the failure to develop secure attachment relationships in childhood and adolescence. Rather than admit this, they may surrender to the patient's self-analysis and disorder-driven demands. Authorizing SRS allows the medical team to feel that they are doing something—their clients are grateful. But the team overlooks the fact that SRS mutilates a healthy human body, results in significant pain and suffering, incurs real, unjustifiable risks to patients, and does not address the real psychological problems.

This is not to deny the very human needs of these persons for acceptance and love. It is one

thing to honor each human person's need for acceptance as a being of infinite worth and value. It is quite another to accommodate a person's demand that others—including medical and mental health care professionals—overlook or deny the truth and accept a fantasy as reality. This kind of forced and false acceptance can only make those who demand it feel more insecure, since at some level they know that a forced affirmation is not sincere.

Our society has confused erotic satisfaction with love. This confusion springs from the widespread adoption of a sexual utilitarian ethic, under which pleasure becomes the measure of good; sexual pleasure is seen as the highest pleasure and therefore the highest good. Those who have adopted this ethical viewpoint regard all sexual pleasure—whether alone or with others, so long as no force is used—as good, and anything which inhibits sexual pleasure as wrong. Thus, if HT's desire to have sex with heterosexual men and can achieve that goal through surgery, there is no reason to deny them this pleasure. If AT's want their fantasy love of self as a woman to be more realistic, they should not be denied the medical and surgical means to achieve their wish. If those with transsexual desires find the pain of multiple surgeries sexually exciting, surgeons should oblige them. For sexual utilitarians, no sexual desire, no matter how compulsive or dangerous, should be denied.

In 1960, John Paul II (then Bishop Karol Wojtyła), in his book *Love and Responsibility*, explained how the utilitarian ethic applied to sexuality violated the fundamental law of love by treating the human person as an object. Reading through the autobiographical material and case studies on pre- and post-SRS patients, one sees that, although they insist that they are pleased with their decision to pursue SRS, these individuals also voice a sad dissatisfaction with the quality of their relationships. At some level they know that they are using others and being used and that they long for something more. Bailey found that HT's, either before or after surgery, often engaged in prostitution. According to Bailey, their ability "to enjoy emotionally meaningless sex appears male-typical." As they grow older, many admit living lonely, isolated lives. Fantasies can never meet the human need for authentic human love.

Partners in Deception

Those who undergo SRS want to be accepted as members of the other sex—legally, socially, and sexually -- to "pass." Surgery allays the fear of being exposed as a woman with a penis or a man without. The simplest form of passing is going out in public and having people assume that they are a person of the other sex. Some HT males—either before or after SRS—engage in sexual activity with a heterosexual male without informing him of their true sex. There have been tragic incidents in which their partners have reacted violently to the revelation. Some persons who have undergone SRS have married a person of the same sex, in some cases even without informing that person of their SRS. Obviously, this involves a massive deception. Such marriages are illegal in most states even if the partner is informed of the birth sex. Persons who have undergone SRS often try erasing their pre-SRS history by legally changing their names, cutting themselves off from those who knew them before, and creating a fictitious past.

Transsexual activists are working to change laws regarding sexual identity. They want persons who have undergone SRS to be able change their birth certificates and other records. Many states have allowed this. There is a push to allow persons who appear in public as the other sex, but have not had "bottom" surgery, to change their documents as well. Public officials object since this would affect, among other things, the placement in prisons. As one official pointed out "How can you send a person

with a penis to a women's prison?"

Is it ethical for physicians to participate in a procedure when the clear purpose of it is to deceive people? Should surgeons perform an operation where the goal is to hide crucial “facts” from innocent third parties? Does a potential sexual partner, or more importantly, a possible marital partner, have a right to know that the person with whom he or she is about to become intimate was not born the sex he or she appears to be, requires hormone treatments in order to sustain this appearance, and is not able to have children? The reaction of those who discover this fact *after* initiating the relationship strongly suggests that most people are not comfortable with engaging in what they perceive as a homosexual relationship.

Religious and Other Objections

The Catholic Church has made it clear that, since it is not possible for a person to “change” their sex, and a person who has undergone SRS cannot marry a person of the same or other sex. A woman who has undergone SRS cannot become a priest. The Church will not alter baptismal records to reflect the claim of a change of sex. Many other religious institutions also reject the claim of sex change as impossible and contrary to God’s plan. In England, the Evangelical Alliance, an organization representing more than a million British Christians, submitted a strongly-worded statement to the government opposing changing birth certificates to reflect SRS. It said, “We affirm God's love and concern for all humanity, including transsexual people, but believe that human beings are created by God as either male or female and that change from a given sex is not really possible.”

Arthur Goldberg, co-founder and co-director of JONAH (Jews Offering New Alternatives to Homosexuality), carefully documents and explains that the divinely created and revealed nature of human kind, as understood in the Old Testament and over 3,800 years of authoritative, Judaic oral and written Tradition, forbids the practice of SRS. In brief: “No published opinion by any Orthodox (Jewish) scholar permits sex change surgery for reasons of gender dysphoria.” Also, this prohibition of SRS—as well as the prohibition of other forms of sexual immorality (e.g., fornication, adultery, promiscuity, masturbation, incest, bestiality, homosexuality)—is understood by authoritative Jewish scholars as applying to all people, not just Jews. In summary, Goldberg writes:

SRS, for purposes of alleviating transsexual anxiety in a physically normal male or female, is forbidden, and no medical justification has yet been shown to exist. From so much as now is known, the procedure is dangerous, potentially harmful, of doubtful value or benefit, and emphatically contrary to medial ethics. Moreover, alternative and less drastic means of providing relief and a cure are available in gender-affirming processes (GAP) which...offer holistic approaches not only to resolving gender dysphoria, but to fully reintegrating the shattered personality of the affected individual.

Resistance to SRS is not limited to religious conservatives. Some lesbian and radical feminists, such as Janice Raymond, feel that men who have undergone SRS, were not born female and so have never experienced growing up as women, have no right to claim to be women, or as they do in some cases, claim to be lesbian women. Raymond is particularly offended that HT males who have undergone SRS promote demeaning stereotypes of women as sexual objects who exist for men’s pleasure. She is also offended that some HT males insist that they are better women than real women. As the number of women with SSA seeking surgery has increased, their feminist and lesbian friends see these women as betraying the cause or going over to the enemy. Some feminist and lesbian events

are now restricted to women born as women and living as women.

Many women regard the transsexual males' description of what it means to be a woman—weak and dependent, wanting only to be cared for by a man, addicted to gossip and clothes—as insulting. Dr. McHugh reports on his impression of men who have undergone SRS:

Those I met after surgery would tell me that the surgery and hormone treatments that had made them "women" had also made them happy and contented. None of these encounters were persuasive, however. The post-surgical subjects struck me as caricatures of women. They wore high heels, copious makeup, and flamboyant clothing; they spoke about how they found themselves able to give vent to their natural inclinations for peace, domesticity, and gentleness—but their large hands, prominent Adam's apples, and thick facial features were incongruous (and would become more so as they aged). Women psychiatrists whom I sent to talk with them would intuitively see through the disguise and the exaggerated postures. "Gals know gals," one said to me, "and that's a guy."

The cable television series *Sex Change Hospital* follows real patients through the process. Most of the men who insisted that the surgery made them women, did in spite of long hair and make-up, still look very much like men.

Those interviewing male applicants for SRS found that they did not understand the true nature of womanhood. Drs. Worden and Marsh felt that these individuals had no conception of the duties and responsibilities entailed by being a woman, but were rather, wrapped in fantasies of being beautifully dressed, embellished with sparkling jewelry, wonderful coiffures, cosmetics etc. Their aim was a narcissistic one rather than a normal adult feminine sexuality.

Testimonies of former transsexuals who underwent either total or partial SRS, and who subsequently chose to treat the underlying psychological bases of their gender dysphoria, document both the common causes of such perceived "needs" for SRS and the possibility of meeting those needs through non-surgical and non-hormonal means.

Freedom of Speech, Religion, and Thought

Those who believe that it is impossible to change a person's sex do not want to be insensitive to others, but neither should they be forced to lie by calling a man a woman or by calling a woman a man. Transsexual activists hope to force the public to use pronouns and designations of the sex the person wants to be rather than their true sex, even when the person has not undergone SRS. They want those who refuse to accept sex changes to be labeled as "transphobic"—and charged with discrimination. A flyer produced by a student group at the University of Massachusetts Amherst, lists attitudes condemned as transphobic, including:

Assuming that everyone is either male or female.

Continuing to use inappropriate gender pronouns for someone after being corrected or calling someone "it."

Believing that transgender people cannot be "real women" or "real men."

Considering transsexuality to be a mental illness or disorder.

Expecting all transgender people to be transsexual and want to transition completely or

at all.

Believing that transgender youths cannot be trusted to make decisions about their gender identities.

Dignity USA has even issued guidelines for media coverage of transgender persons. They condemn as “*extremely* offensive, referring to transgendered persons using pronouns and possessive adjectives appropriate to their birth sex.”

Colleges, including traditional women’s colleges, are accommodating the demands of students who want to be treated as the other sex. Activists are also pressuring schools to allow children with GID as early as kindergarten to cross-dress, change their names, and use the bathroom facilities of the other sex. Parents of these children’s classmates often strenuously object to programs which force children—some as young as six or seven—to pretend that a fully biologically male child is a girl.

Although some HT’s can deceive others as to their true sex, many people recognize that there is something wrong when they meet a person publicly presenting themselves as the other sex. People may be too polite to say so—they may even publicly say they support the idea that people can change sex—but they often unconsciously may communicate their lack of full acceptance. This unspoken lack of true acceptance cannot but affect the person claiming to be the other sex. It leads to layers of denial, feelings of insecurity, and need to constantly prove oneself.

Collaborating with Madness?

There is no question that SRS destroys healthy sexual organs, creates permanent sterility, and carries health risks. It cannot change sex but only creates the illusion of change. According to Anne Lawrence, “It is widely accepted that transsexualism represents a fundamental disorder in a person’s sense of self.” SRS does not treat this disorder, it surrenders to it. The desire for SRS is a symptom of a number of psychological disorders. Since these serious problems are difficult to treat in adolescents and adults, first priority should be given to prevention through education and early intervention. For the development of healthy masculinity and femininity, parents need to understand the critical importance of early secure attachment with each parent and siblings, positive support for sexual identity, encouragement for children with atypical talents and interests, and same-sex friendships in early childhood.

While the desire for SRS is presented as a problem of gender identity, there is substantial evidence that the defense mechanism of rationalization serves to cover up serious emotional and personality conflicts and the underlying sexual motivation, namely, the desire by some to live out their sexual fantasies. At the very least, health professionals should evaluate the role that strong anger towards oneself with self-destructive impulses and intense anger toward others, depression, self-pity, childhood trauma, addiction to masturbation and fantasy, and envy, play in the development of HT and AT. These persons also should be evaluated for personality disorders, particularly narcissistic and borderline types.

Efforts should be directed toward the development of effective therapy for adolescent and adults. The fact that such therapy is not described extensively in the literature and therefore is not widely available, and that these patients resist therapeutic interventions, does not justify giving in to the demand for surgical mutilation.

If SRS is neither medically nor ethically justifiable for adults, then starting hormone treatments on adolescents with GID in order to suppress puberty, with the promise of later proceeding to SRS is even less so. Surgeons, mental health professional, and those dealing with medical ethics would do well to follow the advice of Dr. Paul McHugh: “I concluded that Hopkins was fundamentally cooperating with a mental illness. We psychiatrists, I thought, would do better to concentrate on trying to fix their minds and not their genitalia.” He added,

As for the adults who came to us claiming to have discovered their "true" sexual identity and to have heard about sex-change operations, we psychiatrists have been distracted from studying the causes and natures of their mental misdirections by preparing them for surgery and for a life in the other sex. We have wasted scientific and technical resources and damaged our professional credibility by collaborating with madness rather than trying to study, cure, and ultimately prevent it.