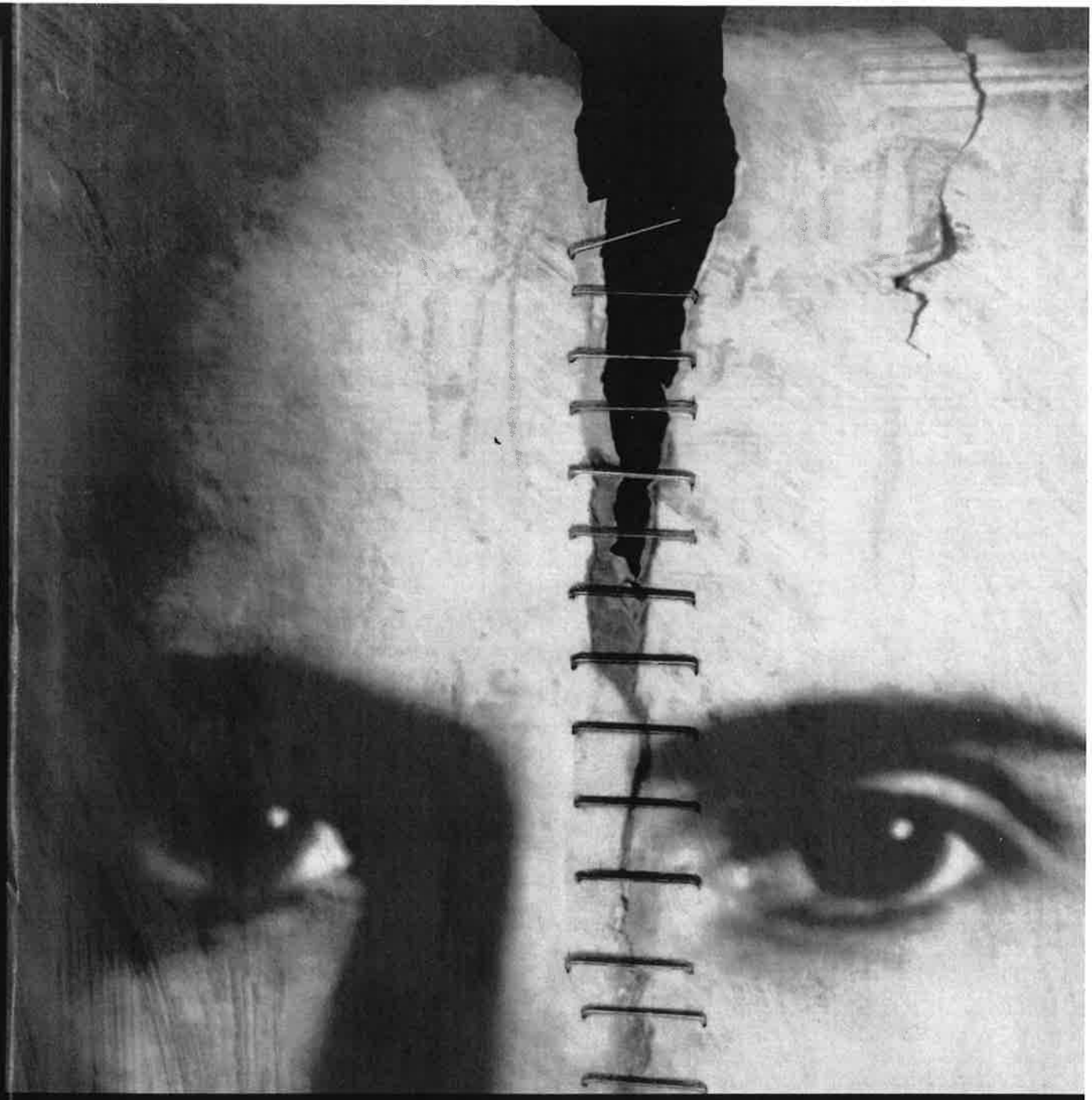

European **Clinical Psychiatry**

An historical perspective from selected scientific papers
by **Pierre Deniker**

Foreword

Pierre Deniker's name will live forever in the history of psychiatry as the key name on a series of articles about the discovery of chlorpromazine and the invention of the concept of the neuroleptics. While Jean Delay also made significant contributions, his name would have been on these papers automatically simply by virtue of being head of department. Deniker's was there by right. It was Deniker who was most clearly robbed of the Nobel Prize following the controversies about the discovery of chlorpromazine.

Deniker and Delay did not just discover a drug they charted a new terrain. This can be seen most clearly in Deniker's article "Who invented the neuroleptics?". And this mapping of a new country stood the test of time. It was more than 40 years before the framework put in place by Deniker and Delay began to be eroded.

This collection contains three set of papers. One group comes from the years 1952 to 1956 detailing the earliest observations from Deniker and his colleagues on the effects of chlorpromazine. These make compelling reading now, as the original observations are so much at odds with the tenor of much of modern psychiatry. Chlorpromazine and its successors have become "anti-schizophrenic" agents, whereas in the opinion of Deniker and his colleagues the role of these drugs in schizophrenia was likely to be quite limited. The true benefits of neuroleptic therapy lay elsewhere in manic, confusional and transitory delusional states. One is tempted to suggest that the developmental trajectory of psychiatry has been perverted.

We are now very aware of the role of pharmaceutical companies in shaping the perceptions of clinicians, but there were other factors at play in the 1950s and 1960s. One of these was French resistance to the German concept of schizophrenia. This comes through most clearly in the 1966 article included here on chronic hallucinatory psychoses. While the French resisted the Germans, America was on an entirely different developmental trajectory, leaving a vacuum at the heart of psychiatry. The profession was not in a position – noted by Deniker and colleagues – to explore the implications for psychopathology of the efficacy of the neuroleptics. This is a task that remains unfinished today.

A second set of papers, stemming from the early 1950s through to the late 1970s, deal with issues that are still of pressing importance today. Classic hysteria has vanished as Deniker notes but illness behaviours of various sorts are the substance of liaison psychiatry and many liaison psychiatrists will find his comments on hysteria with minimal symptoms very perceptive. Drug abuse and personality disorders are among the greatest problems facing both society and psychiatry at present. Deniker's contributions on these clinical issues reflect an organised and systematic approach to problems that eschews simple solutions; an approach that offers data in place of argument, and pragmatism rather than speculation.

Finally there is a third set of papers also. In this group are papers dealing with other states that in the mid-1950s were typically called perversions. While one might have thought that, at the time, Deniker would have had his hands full with attendance at international meetings reporting on the effects of chlorpromazine, we find him also writing articles on transsexualism and transvestism. Although the

first reports on transsexualism had appeared over 50 years earlier, this condition was still in the mid-1950s a relatively rare phenomenon. Deniker's views on this, as he and his colleagues grappled with a new phenomenon, provide a window on a changing culture. The views expressed display an openness to new entities as well as clinical acumen and an awareness of the new culture into which he and colleagues were moving – what would become of a clinical condition like transsexualism in our new media age?

In contrast to new conditions like transsexualism that were emerging in mid-century, this third group of papers also links back to one of the conditions that was celebrated more in French psychiatry than in any other national psychiatry – the grand fugue. Since the 19th century, French psychiatrists have catalogued the journeys that patients can take in the course of fugues or related multiple personality states. This phenomenon and its literature has been captured wonderfully in Ian Hacking's Mad Travellers. Here Deniker and colleagues outline a new case to add to the literature, one that demonstrates that this was not simply a 19th century condition.

It is impossible to imagine a Pierre Deniker today. No-one now has the capacity to stamp their mark on the fields of psychiatry and psychopharmacology in the way that he did. For this reason, the work of Deniker on some of the key issues in psychiatry from the 1950s through to the 1970s is of historical importance and the efforts of his colleagues to make this work available to Anglo-American audiences are welcome and opportune.

Clearly given the change in society from the 1950s through to the present day as well as the transformation of psychiatry effected by the psychotropic drugs many terms and concepts have changed dramatically. As a result, not only were there the usual difficulties associated with translation from French to English, there was also a need for an extra layer of translation from the dominant paradigms of 1950s and 60s thinking to a language which would make sense for the reader in the first decade of the 21st Century – 50 years after the discovery of chlorpromazine. These articles all written in the first quarter century after the discovery of chlorpromazine still however have relevance to the psychiatry of today. Few will be able to read these articles without wondering how much progress we have actually made. Few will be able to read these articles without thinking that it would be helpful if a major figure could put their imprint on the psychiatry of the present day in the way Pierre Deniker once did.

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Asking for a change of sex: transsexualism

J Delay, P Deniker, R Volmat and J-M Alby

From: *L'Encéphale.* 1956 (1: 41-80.)

In recent years, some male subjects[1] have requested surgical intervention to remove their sexual organs, with the associated requirement for hormone treatment and plastic surgery, with the aim of obtaining a feminine anatomy that this entails. These are men of normal constitution and are neither pseudohermaphrodites nor true hermaphrodites. Nonetheless, these subjects consider themselves to be women who have male bodies and sexual organs as a result of an error of nature.

We have had the opportunity to observe some such cases[2] and we compare these patients with cases that have been published in the medical literature and we report here on one of the most curious cases.

This feeling of being a woman, or 'konträre Sexualempfindung' (Westphal[3]) has long been included in the category of transvestism or homosexuality, but such cases are in fact in a class of their own. The fact that some of these subjects have undergone the desired interventions leads us to consider the distinctive classification of these cases and to make a special study of them. Some surgeons, endocrinologists and psychiatrists seem to have decided to intervene because of the pitiful psychological state of these subjects rather than taking into account rational considerations whose scientific, ethical and legal implications merit consideration as a whole.

We shall first narrate our case, and then, aided by our observations, we shall attempt to define the clinical symptomatology of these subjects, discuss their disease classification, discuss possible psychological and biological determinism and clarify possible therapeutic options and their consequences.

Henri, who is 40 years old and has no stable profession, entered our clinic on 23 April 1952, following referral by Dr P Sizaret, for observation. He asked for a psychiatric opinion favouring surgical intervention that would enable him to resemble as far as possible the woman that he says he is. He would thus rediscover the feminine condition that he had believed since adolescence was his true state, despite his undeniably masculine appearance.

The few memories of his childhood that Henri retains show that this period of his life was deeply troubled. He was born on 14 (or 16) June 1916, and was declared, seemingly after some hesitation, to be a girl, and was named Anne-Henriette[4].

At the age of one year, when he was not yet weaned, he lost his mother. She died suddenly of an unknown cause. Henri knows very little of her, she was 'good and charming' and seems to have had fairly liberal habits, and was thus not made very welcome by Henri's father's family who were more strict. The subject did not know his maternal grandparents, he only knows that his grandfather, who was a journalist, married several times. Of his mother's two sisters, one was divorced, and the other worked in the theatre.

His father seems to have been unbalanced, of weak and gentle character, and sometimes impatient. He

married for love. He was an engineer, and then director of an armaments factory when war started in 1914, and he seems to have had a downturn in fortunes in 1928. He went to the races, had a 'good time', had mistresses, was rarely at home and seems to have had little interest in his son.

When he was at home he seemed withdrawn and refused to see friends. He remarried ten years after the death of his first wife (the patient's mother). After the deathof Henri's great-aunt, who managed the household, he married her maid. He died in 1937, aged 57, from uraemia.

Henri has two elder brothers who are normal, from his father's first marriage. From his father's second marriage he had a half-brother who died at the age of 4 from typhoid, and a half-sister. It seems that there were also difficulties in identifying this child's sex at birth. The young lady is 25 years old and perfectly feminine in appearance.

The subject's life may be divided into three periods:

1) before he was 16, during which time he was treated as a girl even though those around him knew he was a boy;

2) from 16 to 34, during which time the subject apparently led the life of a normal man;

3) the current period, when the subject can no longer tolerate his condition and is seeking to have it altered using several therapeutic options.

At birth, he was very slight, and an aunt seems to have said of him: 'he will not survive, it's not worth taking care of him'. However, he survived and, no doubt because of his cryptorchidism, was declared to be a girl.

He was brought up by his great-aunt, whom he called grandmother, after the death of his mother, and she treated him as a girl, dressed him in dresses, kept his hair long, directed him towards girls' games (dolls), and complimented him as the 'pretty little girl that I was'. He lived surrounded mainly by women.

Those around him, particularly his father, must have realised the error that had been made, but did not alter their attitude towards Henri.

We only know that the family doctor said when Henri was around 6 years old that it would be necessary to 'do something, a little procedure on that, before he offered 'that' to a young lady'. This doctor 'burst out laughing and couldn't stop' when he saw the subject dressed as a girl, and this experience has led to the subject refusing all medical examination since then.

When he was 9 years old he was taken to the hairdressers to have his hair cut in a boy's style, but the hairdresser was only able to cut his hair in a bowl cut, as he cried so much.

Henri went to a mixed school until the age of 15, and was always treated as a girl, as he had a girl's behaviour and bearing, although he still enjoyed racing with the boys. He always sat down to urinate, however, and only when he began national service did he begin to urinate standing up, so as not to be singled out. He has never been in a men's urinal. His results at school were mediocre and his attendance was irregular because of a series of illnesses (headaches, abdominal pains, fevers) he complained of whenever he was confined to a room.

The subject was very attached to his great-aunt, although she was very severe and strict. He practically never left her side. He received a religious education. He was shy and unsociable, and was afraid of the dark. Henri seems to have chosen to forget everything relating to sexuality. He says that he remained ignorant for a long time, was very modest, and does not remember any sexual games; he thinks that he only began to know the difference between the sexes from the age of 12 or 13. He remembers

being scolded by his aunt for 'looking at himself'. His father's re-marriage led to a deterioration in the family situation. He was 12 years old at that time.

He tells us in an autobiography written for us: 'my father married this servant, who was a pretty woman from a peasant family, who was hard, calculating, and incapable of improving herself. As soon as he married, my father's attitude towards me changed. My step-mother took a dislike to me. (I had surprised her in the arms of her sister's husband and I did not speak about this). I revealed my mistrust of her in my attitude but never in my words. I was outraged to see her in my mother's place and I judged her with the intransigence of youth. She realised this, and had her revenge by cutting off the electricity to my room on the pretext that I read too late into the night (this was sometimes true), depriving me of food, which was completely unjust ... my step-mother would throw me outside and give me a late time to come back, and I would then find a plate of soup on the floor of my room, just like dog-food. In spite of my hunger I did not eat it, and sometimes spent whole nights crying.'

At the age of 15 or 16, the subject experienced a strong sentimental attraction to a friend of his brother, who was two years older than himself. This attraction remained platonic and hidden. He contented himself with fantasies and vague plans of marriage. His family must have realised what was happening, as his father suddenly decided to dress him as a boy: 'you have to play your part' he said. He was sent to Enghien to one of his mother's sisters. The subject received this transformation with apparent indifference and a lack of astonishment, which still surprises him today. 'He had already realised that he was not like everybody else'.

A very difficult period began now for Henri: 'I was leaving a period of psychological suffering with no possibility of trusting anyone ... I was completely indifferent to everything, I kept the initial appearance of my feminine soul to myself, in this environment. I believed that I was an absolutely unique case, and psychological suffering completely diverted me from my grandmother's religious example. I was unaware that homosexuality could exist between men and between women, until my uncle and aunt warned me of it.'

His aunt displayed an exuberant affection for him, which increased his isolation and brought him no comfort. He was introduced into cinematic circles, but his 'natural shyness' distanced him from the practice of production and direction; he nonetheless learned typing and various screenplay techniques.

When he was around 16 years old, his testicles dropped, and he found 'that' disgusting and made them 'go back up' as much as he could. He recognised his masculine attributes for what they were, but still hoped that 'things would sort themselves out and that this thing would go back up and disappear forever'; and he prayed that his wish would be granted. He did not start wearing women's clothes again.

His father called him back to Marseilles when he was 18 years old. Relations with his step-mother calmed when his half-brother was present, and hostility restarted after the latter's death. Living conditions for the family became insecure, and the subject was left to his own devices.

His passion was to read anything he could find, and he passed his days in the town library. He looked for work, but was unable to find any, and was 'starving hungry'. However, he was to find material support with a relative to whom he had been advised by his grandmother to go for support if he was in difficulties. She granted him a small income, which continued until recently - the subject never knew why. He was given a room, and left his parents' house permanently. He was not called up for military service because of his female civil status.

In 1936, an older sister of his father, who had been widowed, offered to help him, and called him to Lyon where he then lived for over 15 years. He worked for a businessman who employed him to perform office duties: data processing, accounting and writing reviews of shows backed by his boss. He edited screenplays, acted as understudy to radio actors, did 'donkey' work, wrote short stories and humorous novels, worked 'as much as possible' in order to avoid thinking about his troubles. But he was unable to fill the solitude or avoid the impression of being useless and the emptiness of his existence.

In spite of everything, he maintained 'good morale', he had men and women as friends, was entrusted with feminine confidences, gave advice, and did make-up for amateur performers. Women felt safe with him, and he tried to help them emotionally.

He had a female friend with whom he stayed fairly often, but never felt any sexual attraction to her, although they occasionally slept in the same bed. He adopted the habit of drinking heavily when he was too unhappy, in the company of this friend who was a 'strong woman, who didn't blanch at his drinking'.

During this period he experienced his first episodes of bleeding from the rectum, accompanied by abdominal pains. Henri tried to recognise patterns, as these episodes occurred every 3-4 months with accompanying pains, Henri thought that these could be periods, until he was disabused by his doctors – although he remains partially convinced of this view.

Although his first erections and nocturnal emissions occurred when he was 26 years old, he felt himself to be more and more feminine and his physical problems increased.

He was tempted (and still is) to dress as a woman, but found this ridiculous 'because of his physical attributes'. 'I kept my underwear clean, but didn't care about my outer clothes for the good reason that I hate men's clothing. I was well-dressed when I had to buy something new (from the boys' department). My employer, happily, did not judge me on my state of dress (this is one advantage of people from Lyon) and it did not prevent me from having friendly relationships, but this made my aunt despair, as she did not understand that I took care of my underwear, that I was tidy and that I wore old suits with no creases in the trousers, I didn't care and I did not want to explain the real reason to her'.

In 1943, when taken by his friends to a brothel, he experienced a sharp revulsion towards a prostitute who kissed him on the lips. Although he was pushed into it, he avoided looking at himself in the mirror because of the horror that his face inspired in him. He had always been modest, and only took baths in private, not permitting himself to bathe in the sea despite the liking he might have had for it.

After a 'neutral' period that lasted until 1939, he felt more and more attracted to men, and experienced fleeting feelings for men whom he met casually, about which he subsequently dreamed. He found his perfect ideal in a young officer of his own age, to whom he was physically and emotionally attracted. He fantasised about having sexual relations with him, but always in a passive feminine position. He never went further. He would in any case have rejected any advances made towards him, unless he had been able to look like a normal woman.

Towards the end of the war, anxiety about his sex increased. Furthermore, a series of events made his life difficult: in 1943, he had false papers made, and the Gestapo searched his lodgings and stripped them. Nauseated and disgusted, he had, he says, his 'only weak moment' and attempted suicide by ingesting barbiturates. He was admitted to the Grange Blanche hospital, and was discharged at his own request to avoid his sexual difficulties becoming known. Shortly after this attempt he found hope that there might be a solution when he discovered the book 'The

unknown sex' at a bookshop, translated from the German, in which a similar case was described - that of 'Lily Elbe', a painter and father who was transformed into a woman by a German doctor.

'I now knew that I could ask the medical profession for help; it did not occur to me that solutions to this problem were not well developed in France, but it had been proved to me that this change could be performed on a virile man, and I did not doubt that it could be done much more easily to me. I was quite inexperienced, but I was certain that there was a physical cause in me, of that I had no doubt'. However, he was unable to ask for 'the thing that preoccupied him'. He saw two psychiatrists, without talking to them about his sexual troubles.

Only in 1950 did he travel to the Tours area to seek advice from a doctor whom he had known as a student in Lyon. He was then prescribed testosterone (December 1950 to January 1951) – a treatment which made him 'physically and psychologically ill' and which he therefore stopped taking. He became more and more depressed and tormented, and went to see a surgeon in Isère to ask for emasculation.

This surgeon sent him to a psychiatrist. In 1951, he was forced to stop work because of his depressive state. He went back to the Tours area, and consulted another surgeon who requested 'lengthy psychological treatment' before any surgical treatment could be considered. He received treatment with Cycladiene in the meantime (December 1951-January 1952) which led to subjective improvement and he was sent to see Dr P Sizaret who referred him to our clinic. He only decided to be admitted after his financial situation worsened.

In April 1952, on entry to this clinic, the subject wanted to be admitted to the women's ward because of the difficulty he experienced in undressing in front of men. It is noted that the subject is very thin, depressed, feeds himself with difficulty and complains of multiple pains, particularly in the abdominal, chest, back and genital regions. His presentation hardly changed during his long stay, apart from variation in his depressive and hypochondriac state.

His anatomical appearance is masculine, and his skin, muscle and fat distribution are in no way abnormal (see fig. 1), his height is 1.64m, which is normal on the Decourt and Doumic masculinity table.

His hair is fine, and he is starting to develop baldness on the forehead and at the crown. His beard is quite stiff, and he has normal amounts of hair in the armpits

Chest measurement	Height of greater trochanter	Height (cm)	Bitrochanteric diameter	Bihumeral diameter
918.8	905.6	174.0	328.6	445.6
903	890	171	323	438
87.2	874.4	168	317.4	430.4
871	858	165	311	422
855	***853***	***164.5***	306	415
839	827	159	300	407
824	842	156	295	**401**
808	796	153	289	392
792	780	150	***285***	384
772	765	147	278	377
760	749	144	272	369
745	734	141	267	362

FIG. 1 – Dimension chart (in millimetres).
Bold line represents normal threshold. Bold italic figures are the patient's measurements

and on the upper chest, which he shaves. His lower chest and abdomen are hairless. He has a triangle of pubic hair, and he has only occasional hairs on his body. He has *keratosis pilaris* of the thighs.

His penis is normal, as is his scrotum, and the testicles in the normal position are of the size of a small plum. Very slight bilateral gynaecomastia is noted at the beginning of his stay, with a brown areola, a small nipple and a very small breast, which is larger on the right. This gynaecomastia subsequently disappeared; Henri had undergone oestrogen treatment prior to admission. Finally, his tongue is noted to be fissured, he has a small xyphoid process and foveola coccygea. Results from various instruments are negative, as is skull X-ray and electroencephalogram.

From an endocrinological viewpoint, the levels of urinary 17-ketosteroid is relatively low at between 7 and 10 mg per 24 hours on repeated measurement. The adrenal gland was investigated using an ACTH test, which raised the 17-ketosteroid measurement from 7 to 14 and even 17 mg per 24 hours (in March 1954). The testicles, however, may well have impaired function: aspermia was noted in March 1952, but it could be that only prostatic liquid was obtained at that point, and the patient subsequently refused to be examined.

From the point of view of the pituitary, in June 1954 the FSH levels were positive at 50 U.S. and negative at 100 U.S. over 24 hours. Furthermore, it was noted in April 1952 that his urine folliculin level was elevated: 684 UI, associated with pregnandiol level of 2.5 mg, which was a little elevated, as one sees in cases of gynaecomastia.

But we should recall that at the time of these initial examinations Henri had recently undergone oestrogen treatment (Cycladiène). On 20 June 1954, his urine folliculin levels were 180 U.I./24 hours (H. Delaville). It is known that such folliculin levels may be found in normal men.

Apart from aspermia and moderately low levels of 17-ketosteroids, his test results were not very significant. Testicle biopsy shows histologically normal appearance (Tourneur) which means that Klinefelter syndrome can be eliminated and allows consideration that this may be simple hypogonadism, which would confirm the idea of ectopia in childhood and delayed puberty.

In June 1952, an episode of severe abdominal pain led to laparotomy, during which an exploration of the pelvis revealed nothing abnormal, which greatly disappointed the patient. In January 1953 the episodes of rectal bleeding recommenced, and complete investigation of the digestive system was performed, which was negative. In December 1953, a haemorrhage of red blood led to the discovery of internal haemorrhoids, which were operated on in Beaujon in 1954. The persistence of lower back pain radiating to the genitals cannot be explained as a vertebral anomaly, nor as a mild osteophytic reaction.

However, renal investigations (intravenous urography and retrograde ureteropyelography) in October 1954 showed mildly delayed emptying of both kidneys, a kinked right ureter, abnormal appearance and position of the left kidney, which had a very long pelvis and calices that turned inwards, which was suggestive of a congenital abnormality (according to Dr Kapanji). Kidney function tests were normal, and blood pressure was maintained at 150/90. It should be noted that his persistent pains in various sites are likely to be of, at least in part, a cœnesthopathic nature. Variations in pain levels usually coincide with unpleasant events that the patient experiences.

Henri presents himself naturally with lowered eyes with a slightly effeminate gait, his attitude is reserved and self-effacing; he has a habit of smoothing his hair, which he wears quite long. His attire is deliberately neglected. He speaks fluently, his voice has normal timbre, his gesticulations are a little exaggerated. He sometimes talks about himself in the feminine, he chooses his expressions with some care, and

deliberately uses euphemism: 'sometimes ladies or young ladies have experienced the desire to alleviate my loneliness, which embarrassed me greatly ... when I made my retreat she had difficulty hiding her scorn. I apologised, claiming that I had been disappointed in love, and fled, disoriented.'

He is always very polite and appreciates care shown towards him, such as not examining him in front of other people. He becomes firmly and gratefully attached to doctors who show an interest in him. But he is unable to imagine that these doctors may not grant his wish for a sex change. He avoids all aggressive display, and expresses any discontent in very subdued tones. He is intelligent, and his verbal level is above average on vocabulary testing – I.Q. = 121 (J. Perse). He has something of the autodidact about him, and tells us that he has read Balzac, Mérimée, Anatole France, Zola and Dickens, and confesses with greater difficulty that he liked Delly's novels very much. He cannot stand pornographic novels 'such as those by Boris Vian'.

He has recently become fascinated by astronomy and has written a documentary screenplay about the moon. He likes chamber music, opera (Thaïs), has a fairly eclectic knowledge of cinematographic works. He continues to write to some friends and family members, but neglects other people who could be of help to him and refuses to renew some relationships (in particular, he refuses to visit his pharmacist brother) and says that he would not dare to go and see them in his current pitiful state, but this will all change, naturally, after his sex change. His work activities are reduced, but he willingly offers his services at the Clinic; he wrote a script in the form of a fairly childish fairytale, as well as three short stories, one of which, *'Femmes Lyonnaises'*, is a self-portrait of the author as a woman, another 'En silence' is a romanticised narration of his 'case', and the third is the tale of the disputes between a dreadful couple, seen from the woman's point of view. The three stories appeared to be a conventional depiction of men and women rather than a story of a lived experience.

One has the same impression of his autobiography; the action unfolds as though he had a 'role' to play. He is calm and rather self-effacing and gets on well with staff and patients, with whom he remains a little distant; he has nonetheless become attached to some of them, tries to 'improve their morale' demonstrating particular patience with some difficult patients 'whom no-one could tolerate'.

How does he view the problem of his sexuality? He felt at one with himself when he was able to consider himself as a girl. Since the 'catastrophe' he has been unable to tolerate his masculine condition. He has had great difficulty coming to terms with the physical side of this, and has never come to terms with the emotional side. 'I have a feminine soul, I am psychologically like a woman, I do housework, I love to cook ... I have often been asked 'why not stay this way?' Well if it was necessary to have doctors for this, I would have done that by myself, and I might have developed differently, but as that is not the case, it's natural that I should be horrified by all the masculine aspects of me, from physical appearance to clothes.' As we have said, he has no desire to cross-dress. He denies a diagnosis of homosexuality and says he cannot stand effeminate homosexuals!

'I have never been attracted by homosexuality, on the contrary, I remember one evening in the cinema, a young man came in, made-up, slicked back hair, perfumed, and the man next to me (a big man) said 'I'd like to give him a good thrashing' and I was thinking exactly the same thing, but isn't that the kind of thing a healthy woman would think? I was given this diagnosis, homosexual, and I was shocked, because I don't think it's right, it's not the same as the diagnosis of being intersexual that I was given at first. What's homosexuality got to do with wanting to be a normal woman – a homosexual wants, I assume, relations with someone of the same sex, and does not want

relations with someone of the other sex (or someone who has become the other sex).' He also feels nothing but embarrassment and aversion for the women who have made advances to him, which rules out female homosexuality.

In his dreams, Henri often sees himself as a normal woman, but he immediately has a sense of how impossible this is and wakes up feeling anxious. Several times he has seen himself crossing a bridge that abruptly ends in front of him, and he cannot rejoin the people who were with him. In another dream, he sees himself going into a grocer's shop, and in place of the food, he sees precious stones, for example diamonds; he asks the grocer and his wife for something to eat; his request is refused, he takes a piece of fruit and eats it; he is troubled because he stole it, and leaves, leaving some money, and in the distance he hears the noise of a party, it's a ball that he is unable to go to.

A nightmare has remained in his memory and is still vivid: he hears a noise of galloping, it's the skeleton of a horse ridden by a masked man, the man removes the mask to reveal a death's head; the man lances him in the face (in the precise place where a dentist had broken off the point of a drill in the root of one of his teeth). In his sexual fantasies, he only imagines himself in the position of a woman being penetrated by a man. Finally, this subject's sexual life can be summarised in the infrequent erections and nocturnal emissions he experienced between the ages of 26 and 30. In addition, in Tours he had an erection during narcoanalysis.

His Minnesota Multiphasic Personality Inventory (MMPI) shows that he has a sub-normal profile with considerable latent anxiety; the dominant component is on the Mf scale (Masculinity-Femininity).

The Rorschach test shows a strongly extratensive profile. Badly controlled affectivity, underlying anxiety, attempts at rationalisation most frequently in the form of vague idealisation, poor assimilation of affects. When faced with sexual images, he felt ill, and this masked his refusal due to anxiety to consider plate IV. He had a similar reaction to forms signifying the male sexual organs. On plate VII, the female forms were obscured by masks and clothes. There were no structured neurotic defence mechanisms. His personality was generally deeply disturbed, and his intellectual and affective reaction mechanisms are inadequate. The profile is closer to that of a psychopathic patient than to that of a normal or pathological case.

Murray's Thematic Apperception Test: his answers were quite conventional and affected, and seemed to have the underlying intention of conforming to the image of himself that the subject seeks to project. As a result, his answers were content-poor and the affective tone was quite cold. Denial of sexuality and suppression of aggression are apparent. For some plates, he clearly identified with a feminine image, but in a very ambiguous way. He moulds himself on conventional feminine models that are constructed and not experienced. The feminine images are all idealised - powerful and cold women who dominate the situation. For him, masculine images are an object of identification and not of admiration; his attitude to them is essentially passive. He experiences male-female relationships on an exhibitionist and voyeuristic, but non-genital, level.

The desire for transformation is expressed in several plates; whereas one might expect such a transformation to be terrifying, this aspect does not appear. The magical significance of a sex change is clear. At plate 16 (a blank plate) he explains how this preoccupation defines his personality and his relationships with others; an extension of this is that he identifies with 'part of suffering humanity'. The pathological character of such a projection can be deduced from the lack of criticism associated with it. His desire appears to be an archaic defence mechanism accompanied by an infantile affective structure, which is

incapable of assimilating the harrowing affects awakened by confrontation with situations of conflict involving parental images.

Which solutions does he envisage?

He has read whatever came to hand about this problem. Apart from 'Le sexe inconnu' he has read popular articles on sex change operations, 'a speech by the Pope' on medicine (*Carrefour,* August 1952) concerning radical operations 'to repair serious damage', a review of a publication on experimentation in medicine and from which he has remembered the following sentence in particular: 'the practitioner has the duty to attempt everything to cure the patient, *and there are neither laws nor rules that can restrict their experiences or limit their effects'.* Henri asks: 'why not go down the route (which is easier, despite appearances) of physical modification? Even if the person is condemned to a sterile life, he can be given the appearance of his new sex and the benefits of the hormones required for a balanced organism and the possibility of coupling with a person of the opposite sex (following a series of plastic surgery procedures accompanied by hormone injections).

It is not possible biologically to change sex completely, but in this way errors of nature may be repaired, by removal of the unwanted glands and improving physical appearance.' The subject is therefore requesting castration with amputation of the penis, plastic surgery to transform the scrotum into the form of a vulva, creation of an artificial vagina and female hormone treatment. To complete the process, electrical removal of the beard will be required. He would give his testicles to a man who had lost his own testicles accidentally or due to illness, if transplantation is biologically possible. He would accept simple castration, but he does not see why the doctors would stop there; his condition would certainly be improved by this, but he considers such a procedure to be merely the first step. If his desire to change sex were satisfied, he would rediscover joy in life through a rediscovered unity between body and mind, and he would have the possibility of a social and sexual life.

The question of civil status would arise, he recognises, but this seems to him to be secondary and easy to resolve (which, in his case, may well be true). If the doctors refuse to intervene, he thinks that they would be failing in their duty, that this would be an error and that he would have been wronged by having to spend four years in treatment to no avail. He says that through this process he has lost all material possibility getting help. Another opportunity is available to him in the form of an operation abroad or, clandestinely, in France, but he would need many months to obtain the required money. That is, unless he decides that his life is finally ruined and that he will go back to the 'hellish life' that he had previously renounced. However, he is not currently thinking of committing suicide, and neither is he considering self-harm, although the idea has occurred to him.

During his stay in the clinic, between 1952 and 1954 he underwent psychotherapy with Dr Lacan, with on average one session per week. Henri says that he found in Dr Lacan 'unparalleled understanding', but they both agree that pursuit of a change to a condition that the patient never seems to have accepted is useless.

In spite of the length of his observation period, and in spite of the fact that the end result was contrary to his wishes, Henri still retains hope that he will convince us. He is obstinate in his plans, and it almost seems as though the pursuit of his chimera is more important than attaining it.

Transsexualism

We have attempted to compare our case to those that we have found in literature[3]. We have only seen cases in males. Hamburger bases his study on 5 cases of which one case, who was operated on, is narrated

in the study. He also alludes to a German patient of Huelke, who was operated on in 1943. Neither Benjamin nor Gutheil state the number of cases on which their studies were based. They propose the term 'transsexualism' to denote the feeling of belonging to the opposite sex and the accompanying desire for body transformation.

Worden and Marsh base their work on 5 cases, but we do not learn which cases were operated on. Aubert, in his thesis, which is influenced by Steck and Riggenbach, describes 3 cases of which 2 were operated on. Earlier cases of transsexualism appear in literature: Krafft-Ebing, Hirshfeld and Havelock-Ellis all reported cases. Likewise, Büurger-Prinz and colleagues report 9 cases of transvestism without noting that two of these were cases of transsexualism, one of whom had been operated on, and one of whom was requesting surgery. We did not have the impression that these cases were clearly differentiated from transvestites. Only the subject's knowledge of the possibility of a sex change procedure, it seems to us, brings out these particular characteristics.

Recently, HP Klotz and colleagues have reported a case of 'habitual heterosexual transvestism' and they ask whether, for the first time in France, plastic surgery would be a possibility. Likewise Heuyer and colleagues have reported a case, which is of particular interest, among other reasons, because of the young age of the patient[5].

1. Clinical Features

These subjects have some clinical features in common, which we shall try to define, following the work of Worden and with the aid of our observations of our patient. The initially striking thing is that these subjects are psychologically remarkably similar, and the following elements are almost always found.

1. First, there is the overriding idea according to which they define themselves. The transsexual patient has a female soul in a male body, following an inexplicable error of nature. This conviction of being a woman resists all evidence to the contrary. The image they have of themselves is the only correct one. Society is 'perversely' attached to the notion that they are men. This results in a constant struggle to prevent others from recognising their masculine appearance.

Our patient, for example, asked to be admitted to the women's ward of our clinic. Some patients refuse mail addressed to their masculine name; others wear women's clothing so that they may be mistaken for women. They only keep good relations with those family and friends who seem to accept their assertions or who are kept ignorant of the anomaly.

This overriding idea is fixed and irreducible, much like something which (if not exactly a delusion) has all the features of what classical texts would have called monomania, a term that includes neurotic as well as psychotic disorders. Maintaining this notion narrows the subject's field of awareness, and devalues all other affective investments. Such a subject will therefore eventually break familial connections, abandon his social situation and leave his profession.

The 'sensational' sections of the press have reported the tribulations of some such cases. As soon as the possibility of sex change is raised, they enter into a kind of 'quest', collecting documents about their condition, and willingly seeking publicity. They consult multiple doctors, endocrinologists, surgeons and psychiatrists, and they take along all this documentation. Our patient, who is normally very reserved, only asserts himself when speaking of his desire for surgical intervention; we have already described some of the documents that he produced in support of his ideas. This overriding idea is accompanied by numerous and invasive pathological rational-

isations, such as the belief that rectal haemorrhages or feelings of sickness are regularly occurring phenomena and therefore that they are periods. Such ideas form themes for their imagination: they delight in fantasies in which they see themselves metamorphosed into women.

This overriding idea is accompanied by a genuine distortion of memory. Along with their conviction that they are women, there is a parallel selection of memories and a reconstruction of their own life story which attempts to prove that they have been 'feminine' from childhood. Some special memories are easily evoked: girls' clothing and decoration, blonde curls, girls' toys and games, feelings of envy towards them, sentimental attraction to boys. Any evocation of other aspects of childhood, however, tends to be vague, and releases of anxiety have been noted when elements of a patient's life story that are contrary to their own convictions are sought.

2. Second there is the pursuit of an ideal of perfection. Such a pursuit is rarely lacking in these cases, and although the goal is principally an idealised image of woman, the pursuit encompasses the subject's entire ethical constitution. The same is true for the idea these subjects form of women: one of Aubert's patients was devoted to the Virgin Mary although he was Protestant; women, for him, were purer than men, because of their more elevated feelings: 'a woman can be extremely pure of soul, even if she is a prostitute'.

   Another of Aubert's patients wanted to be a 'deaconess'. Similar efforts are observed when patients attempt to overcome sexual difficulties; some patients have attempted to marry, when they have not yet concentrated all their activities on fulfilling their desire to be transformed. They are seeking to escape from their wish to cross-dress and, undoubtedly, from their homosexual tendencies; such attempts are rarely satisfactory and often lead to increased certainty on the part of the subject that he wishes to cease being a man. To this ideal we compare the significance of the aesthetic preoccupations shared by most of these subjects. This is not unique to them, and has already been observed in transvestites by Havelock-Ellis and was found in a case of transvestism that we have reported. Painting, theatrical and cinematic work, music hall and even literary work are means of expression commonly adopted by these subjects.

3. Third is a refusal of sexuality prior to sex change. The attitude of these subjects towards their masculine sexual characteristics seems to us to be crucial. These attributes disgust them. They want to see in them the cause of all their problems: our patient said to us 'everything would be so much better if all that was removed – I would finally feel clean'. Masculine clothing attracts a similar level of repulsion.

   All manifestations of male sexuality are dreaded. Erections provoke true panic, as they constitute a denial of their feminine image, and often lead subjects to demand castration or even to risk self-mutilation. Our patient tries to erase his memory of the spontaneous erections that he seems to have had between the ages of 25 and 30, as well as the event that occurred during narcoanalysis carried out before he was admitted to our clinic. One of Worden's patient's said: 'It's not worth loving someone, as sooner or later an erection will spoil everything'. Masturbation is used by some to get rid of erections, or even to try to destroy their genitals. None say they derived pleasure from doing this.

   Our patient has never been tempted to 'touch this organ'. He did so once, and this was at our request so that we might examine his sperm; this experience was very difficult for him and he has refused to do it again since then. Nocturnal

emissions of semen do not hold this level of terror for him; they are more easily likened to female secretions.

The libido of these patients is considered by some authors to be low. It would be more correct to say that it is not directed at the usual sexual object. We shall later see the precise nature and intensity of these subjects' libidinal investments. This being the case, they do not display very well developed sexual needs, in the strict sense of the word. They generally seem to be terrified by any manifestation of sexuality, whether hetero- or homosexual, masturbation or, for some, cross-dressing.

They consider everything concerning sexuality as dirty and dangerous, while they are burdened with male genitals: 'sex is in the mind, you can either control it or let it drive you mad'. Some patients have nevertheless had a heterosexual life, which usually ends in failure, which may consist of impotence, fear of masculine behaviour, fear of initial sexual contact, indeed of unconquerable revulsion at 'the smell' or body of the woman. At best, they are able to have sexual relations in a passive feminine position. These attempts at heterosexual contact sooner or later cease and are replaced with the wish for surgical intervention, which will leave them without sex.

Homosexual experiences can sometimes be found in the life stories of these subjects; these are usually transitory and always passive. However, homosexual attraction is always present. As a rule, this is not accepted at face value: 'it's a mistake to consider me to be homosexual, it's natural that I should be attracted by men, as I am a woman'; in their opinion, being attracted to a woman would be a perversion.

Thus our subject, while recognising that he is attracted to men, cannot conceive of having sexual relations with a man before surgical sex change. He therefore only imagines, and only distantly, having a sexual life as a woman. These subjects' knowledge of female sex organs is very limited. The idea of these organs is a source of anxiety and disgust. Our patient has only become familiar with them with the aid of anatomical plates.

A need for transformation can be found in all these subjects. Benjamin confirms this observation. This need may become apparent very early in life: as children, they borrow their sisters' or mothers' clothes, with their knowledge or in secret. Later, some are content to cross-dress in private, and others appear in public dressed as women. In these subjects' histories, the requirement to dress in masculine clothes is a real catastrophe. Our patient has not dressed in women's clothing since his father first forced him to dress as a man. Only in his fantasies does he see himself dressed as a woman. He feels satisfaction from this that he does not dare allow himself in reality: 'I would be a laughing stock, and it would be in very dubious taste'.

4. This brings us to the principal characteristic shared by these subjects, the narcissistic component. This is the origin of their mannerisms and the pleasure they take in the images of themselves in women's clothing in the mirror. It can also be observed in the representations they have of the women that they would like to be; an aesthetic idealisation which flatters their self-esteem.

   One of Worden's patients imagines, when looking at the blank plate of the TAT, that he has been transformed into 'a women with long hair, with my shape changed so that I am attractive and so that everyone pays attention to me (pretty dress ...) and everyone would look at her if she were at the theatre or in a restaurant ... She pictures herself alone on the stage; people are complimenting her on her beauty and apparel ...'

We should note here that the notion of femininity in this patient is both childish and superficial. They only accept relations with others if the relationship is unidirectional: admiration of themselves, by others.

Moreover, this narcissistic attitude is linked to significant voyeuristic and exhibitionist tendencies. One patient who had been operated on was able to fulfil his ambitions on the stage, and others have contented themselves with the publicity that they are guaranteed to receive from the press or various other circles that are fond of this kind of spectacle. One patient was not asked to help with a charity gala! As with transvestites (Hirschfeld) we were struck by the masochistic behaviour of these subjects; this behaviour is linked to the adoption of a passive feminine position. Conversely, sadistic behaviour is generally not displayed.

5. A fifth point of distinction is their attitude towards society. All these patients present themselves to a greater or lesser extent as victims of society: they are misunderstood and badly treated. Difficulties in obtaining the surgical intervention they want arise from cultural prejudices, in their view.

   Our patient found it incomprehensible that French doctors were so far behind their colleagues in some other countries. He criticised us for the wrong done to him by admitting him to hospital for such a long period, which was for nothing as surgical intervention had been refused. He had therefore been backed into a corner and was despairing.

   At the very least, his social integration would be irreparably damaged, despite the fact that all the efforts we had made in this direction had been in vain, as the patient would not co-operate. Just one possibility was open to him; to make enough money to be able to have the operation clandestinely in France or to contact a foreign surgeon.

   These patients do display, however, co-operation with research; they freely tell doctors their life stories and will undergo any kind of medical experiment in exchange for a change of sex. Let us remember that our subject offered his testicles to a man who had lost his in an accident. Worden gives the example of one of his patients: 'I would like to offer my mind, heart and soul in exchange for surgery, hormone treatment and cosmetic surgery, anything they would like to do to me for research in exchange for a sex change. I know that I would be much happier and that I could serve humanity much more easily in any environment I might have to live in'.

   For transsexuals, changing to a female appearance is the only way in which they can be accepted and admired. In effect, they need people to look after them: they desire attention, approval and acceptance, which is linked to a deep feeling that they have been rejected and, for some that they have been ignored. For example our patient, whom we had given secretarial work and whose help we sought when putting on an exhibition of patients' art, felt much better when we did so; his obsessions, particularly his hypochondria, reappeared as soon as we were no longer seeking his help. Generally, these subjects present themselves as isolated.

6. Other characteristics should also be pointed out. There is a compulsive tendency, a need for immediate satisfaction of desires that bears no relation to the subjects' real needs - this seems to us to be linked to the difficulty these subjects have in tolerating frustration. This results in instability and problems with social integration. As a result, their obsessive desire for a sex change can appear to be a flight reaction, rather than the reaching of a positive goal that is desired by the patient (Worden).

There is usually a depressive aspect. Hamburger emphasises the piteous state in which he found his patients. This state resulted from a constant background of anxiety, with apragmatism, world-weariness, vague, and apparently sincere, ideas of suicide. This state is a result, for Hamburger, of the fact that the subject finds it impossible to follow the inclinations of his true self. Without wishing to prejudice the significance of his symptoms, we were struck by this depressive state in our patient, and his accompanying hypochondria. It is also very clear that he has trouble with social integration: this improves during periods when he is busy with personal projects, but attempts at temporary discharge with a view to reintegration have failed so far, and he says he can attempt nothing while he is still in this situation.

The degree to which these subjects are socially integrated varies greatly; it depends on their individual aptitudes and their prior conditioning, as well as on the various defence mechanisms that subjects use to combat their inner conflicts and anxiety. Our patient's refuge seems to have been passivity and hypochondria, and for one of Aubert's patients it was hysterical behaviour combined with masochistic tendencies. Another case described by the same author is interesting as the patient developed paranoid sensory delusions, which were heightened, it would seem, by intercurrent blindness.

7. Some particular characteristics should also be emphasised: the conditioning of the subjects, their constitutional weaknesses and the chronology associated with their sexual attitudes.

In terms of conditioning it should first be said that, in the case reported by Hamburger, the family history is not recorded other than a note that the family was normal. Similarly, in Klotz' observations, relations within the family are not made explicit; however, allusion is made to a strict father and the subject's excessive attachment to his mother as 'she [the subject] only lived for her [the mother]'. In all other cases in which the childhood history is recorded, all pathogenetic phenomena are noted; none of these histories contains memories of a happy childhood in a happy family. They all feel as though they were isolated and solitary children.

The image of the father cannot serve as an identifying model. In some cases, the father is dead, usurped or unknown, in others he is brutal or authoritarian, and often alcoholic. In one case, the father had committed suicide. Relations with the mother are always troubled: in Aubert's case B the mother is even a psychopath. Similarly for one of Heuyer's cases: the natural mother who brought up her child for ten months before being locked up fed him on asparagus tips! Furthermore, this boy subsequently lived with a wet-nurse, and was surrounded entirely by women before being adopted by a couple when he was 7, which is when he started to be hostile towards his adoptive father.

In three of Worden's cases, affective relations between mother and child are abnormally close, which is complicated by a desire, to a greater or lesser extent, on the part of the mother to seduce the son. One mother used to solicit the help of her 7-year-old son when putting on her bra, and another slept in the same bed as her 14-year-old son. We also sometimes see that the mother had deeply desired a daughter instead of a son, with the associated behaviour. The history of our patient is typical in this respect. It is certain that the feminine conditioning in his childhood must be taken into consideration when assessing the pathological nature of his demands.

The chronology of the development of sexual attitudes needs to be clarified in these subjects. The desire to be a girl appears early in the fantasies and behaviour of these subjects. The need to cross-dress, to whatever extent this is fetishised, is

also early and seems, at least partly, to be a result of these fantasies. Homosexual attraction comes later but usually precedes puberty. Whether this attraction is acted upon seems contingent on external factors. The aggression normal in boys does not appear. Puberty brings little change apart from the awareness that one is not normal, and the feeling that one is different from others and separated from them by an insurmountable obstacle.

Their aversion to their masculine characteristics increases as these characteristics become more apparent. They become solitary and often desire to mask their tendencies, which continue to make themselves felt. Seeking a sex change happens later, following unhappy experiences of sex and social integration. In Heuyer's patient, however, this desire developed as early as during puberty.

Generally, it is the knowledge that plastic surgery has been performed on some subjects that leads these subjects to demand such procedures for themselves.

Self-castration is not unknown in these subjects. Attempts have been recorded (in the work of Wyrch, Benjamin and Hamburger). We should also consider Mayr's case, reported by Deshaies: a homosexual with hypospadias hid his testicles behind a corset and earned a living as a 'prostitute'. He was troubled by these inconvenient signs of his sex, and attempted to castrate himself. He asked a surgeon to make him a 'respectable vagina'. The idea of castrating oneself often occurs to these subjects; this can also be a way of putting pressure on doctors and on family and friends, as can ideas of suicide. But it would be a mistake to consider this as simple blackmail, as the ideas are sincere and followed up by action.

Finally, most authors point out the constitutional weakness of some of these subjects, and they note physical infirmity in some cases, sickliness, short status and low weight, effeminate appearance, varying degrees of malformation in particular of the genitalia (for example hypospadias, small penis and testicular ectopia); we shall discuss the possible pathological role of these anomalies.

2. Diagnostic problems

We shall now consider the classification problems posed by these subjects and, along with this, the legitimacy of a separate disease classification of transsexualism. How should these subjects be considered in relation to transvestites, homosexuals or in relation to sexual perversions? Should they be considered as normal subjects, neurotics or psychotic patients?

1. *Cross-dressing and Transsexualism:* At the Symposium of the Association for the Advancement of Psychotherapy (December 1953), Benjamin defined 'transvestism' and 'transsexualism' and studied the relationship between them. Transsexualism is the feeling that one belongs to the opposite sex and the intense desire to change sex, including a change in anatomy if this is possible. 'Transvestism' or cross-dressing is the perversion consisting in dressing in the opposite sex's clothes. (Hirschfeld).

   It is notable that these conditions each represent the symbolic fulfilment of a deep desire, of varying intensity, which presupposes a generalised disharmony of the personality. Klotz, Borel and Colla include transsexuals in the category of 'habitual cross-dressers' whom they put, rightly, in a separate category from homosexuals and occasional cross-dressers, and whose condition they presume to be genetically determined.

   We shall see that it seems to be difficult to conceive of a purely genetic explanation that can separate transsexuals from conditioned anomalies.

Furthermore, our patient, who evidently belongs in the category described by Klotz, has never cross-dressed.

Havelock-Ellis calls transvestism 'eonism', which refers to male subjects. Hamburger reserves the term 'eonism' for cases of 'genuine transvestism' which he calls 'psychological hermaphrodism' and these cases are precisely the transsexuals described by Benjamin and Gutheil. Benjamin, moreover, emphasises that 'transvestism' necessarily includes prior emotional, and indeed compulsive, tension, and the existence of some kind of sexual satisfaction from the act, without which the cross-dressing is a simple masquerade with no deep affective significance.

Cross-dressing can be a form of fetish when it involves wearing a loved one's clothes. It can also be a compromise between instinctive urges and social pressure. This form of transvestism is clandestine, or only the partner knows about it. In all cases, there is frustration, as the subject wishes to be accepted in society as a member of the opposite sex. The subject, whether male or female, tries to play, as completely and successfully as possible, the role of the opposite sex.

For the transsexual, it is not a case of simply playing a role, but of satisfying an overwhelming desire to change sex entirely. A male cross-dresser plays the role of a woman, but the transsexual feels like and wants to be a woman by adopting as many feminine characteristics as possible. The transsexual is always a transvestite, at least in his imagination, but the converse is not true; the transvestite is usually horrified at the idea of emasculation, while the transsexual lives in hope that his male sexual organs will be removed.

The latter seeks medical help, while the transvestite wants to be left alone. The fundamental distinction between the two groups, which has definite value in diagnosis, is that the sex organs are a source of pleasure for the transvestite, and a source of disgust for the transsexual. There is nevertheless no clear separating line between the two, as one state results from the other, and there is necessarily some inter-connection between them. Moreover, the publicity generated by sex change procedures may lead to collapse, or destabilisation, of some already unstable transvestites.

2. *Transsexualism and Homosexuality*: Some subjects have had homosexual relations (one of Aubert's cases and one of Heuyer's). They all experience attraction to those of their own sex and in most cases they envisage such relationships after their sex change. They do not accept being labelled as homosexual; this would be tantamount to accepting their masculine position, no matter how feminised and passive this position. Homosexuality is nonetheless an essential component of their personalities insofar as they are attached to any other object than themselves: they are homosexual in as far as their narcissism permits it.

   Homosexuality and transvestism are two principal aspects of these subjects' sexual deviation, but these two tendencies are not sufficient to characterise and summarise their disorder; neither are the exhibitionist, fetishist or sado-masochist tendencies that can be found in these subjects to varying degrees. Should we consider them as affected by a sexual perversion? If we regard sexual perversion as the result of regression linked to fixation of the libido on archaic forms, it seems difficult to interpret the feeling of being a woman in any other way than as a special and extreme case of passive homosexuality, but the subject denies that this is the case. Perversions could also be classed as psychological imbalance; this hypothesis is considered later in the context of imbalance.

3. *Transsexualism and psychopathology.* Are transsexuals normal subjects, as Hamburger and Klotz imply? This position does not seem to us to be tenable. The main feature of these subjects is the negation of a reality that could easily be controlled. They express no doubt as to their feminine identity, and no regret that they are unable to play male roles, but they appear to be convinced that what is obvious to everyone else is not true, and demand that their feelings be recognised unconditionally by others. Female chromosomes, which are hypothetical in any case, would not alter the pathological nature of this attitude.

It would be more consistent to consider these patients as neurotic cases, as Ostow and Worden do to a certain extent. Congenital sickliness, anomalies in education and psychosexual trauma are often found. They present during particular periods of their lives, particularly adolescence, with neurotic symptoms and features: adaptation problems, a feeling of being unlike others, inhibition, hysterical symptoms. However, if we admit the neurosis hypothesis, we have to accept that these cases are most often serious neuroses or psycho-neuroses. Because it is so profound and extensive, and because it progresses so inexorably and is not responsive to ordinary psychotherapeutic methods, the progress of this disorder is similar to that of an obsessive psychoneurosis or hypochondria.

If we now recall the main characteristics of the overriding idea – its strength, the unshakeable con-viction, the systematisation and rationalisation that accompany it, the active demands that arise from it, the selectiveness of memory and narrowing of the field of awareness – we can legitimately ask whether these subjects are not bordering on psychosis or, more precisely, delusions. Our patient's hypochondriac complaints can be seen against this background. Krafft-Ebing, narrating the case of a man who feels he is a woman (obs. 354) makes this story into a transitional stage on the journey towards 'paranoiac sexual metamorphosis'. Progress of a case of sensory delusions is noted in Aubert's case.

Büurger-Prinz's patient W, despite temporary alleviation of his condition following surgery, demonstrates his primordial dissatisfaction as he develops a demanding and querulent attitude, with the idea that he has been wronged. The young transsexual observed by Heuyer is interesting as he develops schizophrenia. It seems to us to be useful to note that this conviction that sex change is necessary is quite often noted in the clinical data for cases of schizophrenia or paranoid psychoses. For example, one case from our clinic is Bernard, who is 19 and affected by an imaginative delusional system: he has delusional ideas about his parentage, about reincarnation and possession; moreover, he has hypochondriac delusions that have led him to request surgical treatment for an imaginary cancer of the digestive system, of a kind that had recently caused the death of his father.

This patient had demonstrated homosexual tendencies and felt that he had a feminine soul (he was the reincarnation of a princess of the Medici family) and he also requested castration 'which would alleviate certain tendencies that disturbed his balance'.

In the majority of cases we have come across, the relative integrity of the patients' mental state distinguished them from cases of common psychosis and psychoneurosis. This was the case for our patient, whose case was interesting because the subject assured us that he had consistently been brought up as a girl and believed that he was a girl until adolescence. If one accepts the subject's version of events (some details might lead one to believe that he had reason to suspect earlier than this that he was not a girl, and we know how these patients tend to alter their memories to suit their

convictions), one has to accept his current demands as legitimate, if one believes that sexual attitudes are primarily psychologically determined.

This is why teratologists agree to provide pseudo-hermaphrodites with the sexual identity they wish for, and to which they have believed themselves to belong since childhood. Deducing the normal situation from an abnormal example would otherwise be paradoxical, but here the legitimacy of the demand is not in question; rather, the question is whether these demands are psycho-pathological or not. The fact that this psycho-logical anomaly results or does not result from an understandable reaction does not tell us anything about whether the pathological symptoms that we have described are reversible.

The extent and duration of these frustrations – which are all the greater because they are real – could lead one to believe that a request for emasculation is merely a first step on a route that could lead to complete sex change with a change in civil status, legal access to marriage, and so on. In any case, surgical and hormonal treatment cannot genuinely change the sex of the subject, and are just a stratagem, a biological form of cross-dressing, which must necessarily leave the patient more dissatisfied, especially since he feels that he was led to pursue his desires with the encouragement of his doctors. But the depth and intractability of the problem is proof of its seriousness. Its similarity to the 'partial insanity' described by authors in the past raises the question of the nature of some perversions.

However, it seems that classification of this condition can only be considered as a function of the subject's future. The primary element of the condition may be neurotic, perverted or even psychotic, depending on the subject's psycho-logical structure and the particular period of the subject's life that is under consideration. Possible surgical intervention – strictly theoretically – must only be considered if this fact is taken into account, and the question of surgery should only arise in the context of acceleration or slowing of a process that has spontaneously become harmful. What is certain is that we are faced with a profound disorder of self-image, and we need to study its genesis.

3. Hypotheses regarding aetiology and pathogenesis

Three hypotheses have been put forward: one invoking biological intersex, the second, which is also constitutionalist, holds that this condition is a manifestation of congenital psychological imbalance. The third, which is more psycho-genetic in nature, sees the cause of this disorder in problems with libidinal and personality (self) development under the influence of environmental conditioning, which is behind 'this way of feeling in the manner of the opposite sex'.

We shall only outline the terms for a possible discussion.

1. The biological intersex hypothesis was outlined in Hirschfeld and described in works by Hamburger, Benjamin and Klotz, and was used in justification of a therapeutic approach that relied on two explanatory modes: genetic and hormonal. The problem would be the same in transsexualism and homosexuality. This genetic explanation is based on various experimental studies. Goldschmith, having found intermediate, genetically undetermined structures in insects, proposed an intersex theory of homosexuality.

   We should note, as Kammerer does, that there would seem to be difficulties if one attempts to liken, as Goldschmith does, human behaviour with morphological characteristics and assign them the same genetic determination. Lang proposes a

hypothesis whereby male homosexuals might have a female genotype. Such people according to him were masculinised by male hormones. This hypothesis was based on statistical data and was proven false subsequently[6]. Kallmann studied male homosexuality in twins, and despite a high level of correlation, concluded that homosexuality, like any other sexual behaviour, was not determined by a gene. In his view, homosexuality resulted from two sets of correlating factors; biological factors, involving sexual maturation, and psychological factors, involving personality adaptation.

This position was restated in recent studies on chromosomal determination of sex. This restatement resulted from initial work by Barr and Bertram. Could this position, as Klotz and Benjamin think, provide an argument in favour of a hypothetical female chromosomal sex that determines whether or not a subject feels like a woman, and thus provide evidence for 'the most complete form of sexual anomaly in women, the caricatured form of pseudo-hermaphroditism in which the individual has every appearance of a male subject, including the histology of the gonad'. (Klotz).

It does not seem as though, in subjects with male constitutions, even in cases of pseudo-hermaphrodite men (11 cases) and habitual transvestites (5 cases), Barr succeeded in finding female cell nuclei. Klotz's case is an exception that needs to be discussed in this context.Wilkins concluded from his chromosomalstudy of Turner syndrome that chromosomal proof of sex is not a determining factor when assessing the behaviour of an individual and does not exclude the coexistence of highly feminine psychology and tendencies in a chromosomally male subject.

One could ask whether a hormonal mechanism could be involved in the genesis of transsexualism, as it might be in homosexuality, by applying the results of the classic work by Marañon on hormonal somatic bisexuality to psychology. Direct action of hormones on character has been supported by work of authors such as Nobecourt. Numerous studies have attempted to establish a correlation between sexual deviation and hormonal regulation; the results are disparate and contradictory.

It seems, Hamburger admits, that there is no direct hormonal determination of the choice of sexual object in animals and, *a fortiori,* in humans. Hormone action affects morphogenesis, and can reinforce psychosexual 'models of behaviour', but cannot promote such models (Broster and Allen).

Many facts appear to demonstrate this; administration of androgens to female rabbits causes female or male behaviour, depending on environmental factors (Klein and Mayer). Homosexual tendencies can be exaggerated under the influence of androgens (Glass and Johnson). Conversely, children who go through early puberty maintain infantile psychosexual behaviour (Henry) just as sufferers of endocrine conditions causing loss of virility or masculinity do not have altered libido, though this might be reduced.

It seems to us useful to compare behaviour of transsexuals with that of cases of intersex, namely hermaphroditism and pseudo-hermaphroditism. In these cases the precise masculine or feminine orientation develops, according to the attitude of their family and friends during childhood. The role that is accorded to them (Rocheblave-Spenle) is more important than the morpho-physiological aspects of their sex, although there can be a certain amount of correlation. Some androgynous subjects who were raised as girls develop a masculine libido at puberty and therefore wish to become men; this can result in serious conflicts, but adoption of such a masculine attitude can be explained by psycho-social determinism (A. Ellis, Rocheblave-Spenle).

Most of these subjects behave in a consistently female manner throughout their lives after they are declared to be girls and educated as such. Feminoid states in boys (who were raised as boys) are usually accompanied by neurotic disorders, but homosexuality does not appear in a statistically significant proportion of these cases when compared with the normal masculine population (Kammerer).

So morphological and endocrine anomalies in transsexuals (feminoid morphology, genital dysgenesis such as hypogonadism, testicular ectopia, hypospadias, micropenis) could play a role, not as evidence for a hypothetical intersex state, but perhaps as a contributory cause of anomalies in psychosexual behaviour in so far as they lead to alterations in body image.

This representation is determinative in that it leads to an awareness of the self. The appearance of the subject also conditions the attitude of those around him, which has an additional impact on the subject's self-image.

2. Can transsexualism be considered as a manifestation of a congenital psychological imbalance? It is true that we find in our subjects clinical features that would seem to justify this way of viewing the condition. As for sexual perversion in general, it seems to us that there are difficulties with the position that holds that these are cases of specific and deep-rooted warping of instinctive impulses that are similar to the 'tendency to do wrong' in perversity, which is attached to sexual deviation (Ey). Conversely, it would seem reasonable to consider the existence in our subjects of constitutional elements which do not specify that the subject's natural tendencies will shift towards vice, but which are structural and which are involved in the integration of impulses, the capacity for narcissistic and object investment, and the organisation of defences of the Self. As Hesnard emphasises about homo-sexuality, 'any predisposition of this type is only an aptitude for being influenced by environmental factors'.

3. Taking this aptitude into account, which psychogenic determining factors are involved? Adopting the work of Gutheil, we shall distinguish six such factors:

a) ***the passive homosexual component***, which can be latent or manifest, would be related to a continuing maternal identification: either the paternal image has been erased, or it is so dangerous that the child cannot identify with it; or the mother-son relationship is so positive that the child identifies with the mother in order never to lose her. It is immediately necessary to sacrifice one's virility if one's mother wishes to see her child as a daughter and models the child as such. Similarly, abandoning a masculine position can be a way of arming oneself against the fear that a malicious mother can inspire, as indeed can the image of a dead mother.

b) The ***narcissism*** of these subjects constitutes a primitive structural element. A corollary of this is the absence of a real choice of object. The way in which the subject relates with others is speculative. These subjects' goal is 'not to be women, but to see themselves – and be seen by others - as women'. (Gutheil).

c) ***Voyeurism and exhibitionism*** are present in imagination as well as in symbolic realisations. These 'partial tendencies' are closely linked to these subjects' narcissism and to their persistent identification with their mothers.

d) ***Fetishism*** can be associated with this condition, as an indication of the erotic symbolism of women's clothing, in some cases, and in all cases as an indication of the emotional charge obtained by dressing as the other sex. Psychoanalytical studies have shown that a cross-dresser identifies with an

image of 'phallic mother' not as the object of sexual desire but as a representation of 'femininity'. As with fetishism, the dress seems to be a magical symbol of the force of phallic nature, and displaying oneself in women's clothes makes display, or even possession, of a penis useless (Fenichel).

e) For the transsexual, possession of male genitals, which is an obstacle on the path to a passive feminine identification, involves, it seems, such a vital danger that causes such anxiety that he must be rid of them at any price. This ***masochistic component*** is on the scale of the aggressive impulses that this mutilation is supposed to erase.

Hirschfeld has provided a good assessment of the eroticisation of this masochistic behaviour. To this can be added the derision to which the transvestite is naturally subject, and the need to expose himself to being hunted down by society. Castration would therefore be a mark of an unconscious desire to deny sexual culpability.

Clinical improvement noted in subjects who have been operated on can be considered as a secondary benefit obtained to their narcissistic needs.

Nothing proves that the reason for feelings of culpability has been removed in this way. Thus, respite could well be only temporary. Realisation of profound imaginary fears of castration can also develop into a serious narcissistic injury, whose consequences could exacerbate the subject's previous symptoms.

4. Therapeutic problems

Of the proposed treatments, some conform to the patient's wishes. Hirschfeld asked for legal authorisation for transvestites to dress as women when their psychological condition required it. Such permission was also granted in Sweden and Denmark. Even in England, understanding authorities have agreed to grant the civil status of a woman to two subjects despite their masculine sexual characteristics. This 'permissive' attitude is not enough for the transsexual: he demands emasculation, and Hamburger describes a typical observation.

After careful clinical examination, he agreed to undergo hormonal castration using oestrogen which was followed by physical modifications in the form of testicular atrophy and breast enlargement, and psychological modifications in the form of reduction in libido and erections, improvements in depression and anxiety, and better performance at work.

When treatment was stopped because of the risk of cancer, the patient demanded surgical sex change; this was performed with the agreement of the Danish Ministry of Justice. This was carried out in several stages: castration, removal of the penis, remodelling of the scrotum into labia majora, joining of the urethra to the perineum; feminine appearance was completed by low-dose hormonal treatment and electrolysis of the beard.

The result was a female body that satisfied legal requirements and gave the subject the legal right to present himself as a woman. In this case formation of a vagina by plastic surgery was not carried out; the subject did not request it, but it has been done in other cases (Worden, Aubert).

Other treatments have aimed to persuade the patient to accept his condition. It has been attempted to increase the virile libido using hormonal treatments (gonadotrophin, male hormones). These attempts have been ineffective or have resulted in subjective worsening of the subjects' condition; sometimes such treatment is refused by the patient. Likewise, it is rare that a patient will agree to undergo classical psychoanalysis that might change his personality in unwanted ways, and this problem is so acute that even now one cannot use psychoanalytic treatments, which would otherwise be used.

Other therapeutic options have proved to be necessary: hospitalisation during depressive episodes, when the subject demonstrates suicidal ideation or self-castration or when failure to integrate into society is too great. If psychotic symptoms develop, confinement can be a problem. Supportive psychotherapy is required in such cases, as is occupational therapy. These measures are palliative, of course, but they can be the only possible avenues if surgical intervention is not considered.

On what are these various therapeutic approaches based?

Those who are in favour of surgical intervention do not base their views on genetic justifications, but rather on the need to help subjects who are suffering when no other option is offered to them. They consider the proposed sequence of interventions, which would only be performed after careful psychiatric observation and attempts at feminising hormone treatments, to be the only treatment method that could provide relief for these subjects. However, they do not know what the long-term future holds.

This attitude attracts criticism: it follows the patient's point of view entirely, that they are affected by a cruel destiny which imposes sexual organs on them that are inappropriate to their psychological nature, and their neurosis results from this. No satisfactory explanation has been given for the hypothesis that their psychological state arises as a consequence of their frustration in not being able to become women. This desire should, rather, be considered as a symptom of their mental state. Their suffering arises mostly from their feelings of culpability and the anxiety inherent in their own neurotic components.

Surgical intervention gives them neurotic gratification connected with their masochism, and alleviates their feelings of culpability, but it is still probable that this gratification is only a transitory effect and that the psychopathological process will resume, and will perhaps worsen more rapidly. Some examples of cases that have been operated on show that these subjects need to find exhibitionist solutions that are not compatible with satisfactory adaptation (for example Jorgensen's case) or find themselves in an ambiguous condition with no further hope for modification (for example MacLeod's case). Others move towards a demanding or delusional state.

As for psychotherapeutic treatments, it seems that these come up against a great many difficulties when attempted on subjects whose condition has become crystallised in their own minds. Perhaps much earlier psychotherapeutic intervention could result in the hope of effective treatment, as in Aubert's observations of the son of a transsexual (case C) who himself wanted to be a girl and who was successfully treated using psychoanalysis.

In conclusion, it does not seem to us as though a hypothetical chromosomally female sex in transsexuals would deny the pathological character of their psychological makeup and behaviour. In terms of medical practice in the true sense, the only real problem seems to us to be to determine whether or not it is possible to obtain real improvement in their condition by agreeing with their 'monomania' and if such an action would be likely to produce sustained results. We do not feel that a precise answer can be given to this question at the moment.

We should remember that transsexualism, in its phase of active demand for a sex change, is the direct consequence of the fact that patients have been informed about therapeutic possibilities in surgery and endocrinology: opening the path to these treatments would mean causing increased demand for mutilation, and sexologists are currently receiving such requests in increasing numbers.

Despite their unceasing quest for information,which is designed to strengthen their own opinion, these subjects are less preoccupied with the exact nature of

the intervention than with the satisfaction of their desire for emasculation and to have a feminine appearance. However, surgical intervention is only justified in so far as it enables a genuine change in sex, while in reality it is just an illusion, which enables neither sexual satisfaction nor procreation. Even if such a procedure provides temporary relief, such a measure risks leaving the patient all the more dissatisfied and demanding because he has had the legitimacy of his request confirmed.

6. Ethical, social and legal consequences

We shall not over-emphasise the problems in medical ethics posed by castration performed for therapeutic reasons with the patient's consent when no pathological process affects the sex organs. It is difficult to consider that these sex organs constitute a direct danger for the subject himself and thus to consider that their removal is lawful. Moreover, affecting the bodily integrity of a subject whose mental health cannot be confirmed is a serious matter.

To take an extreme example, Ostow wonders whether doctors would help a mentally ill patient to prepare for suicide. One could also ask whether psychological and surgical intervention would be less well founded and more hazardous.

Turning to the social consequences, publicity given to intervention possibilities by the press carries the risk, as we have seen, of compromising the equilibrium of some patients who are predisposed to such problems, and we have already seen a considerable increase in the number of requests of this kind: Hamburger has received many hundreds of requests, of which around 50 seem to him to have come from genuine transsexuals; one subject had no hesitation in having himself castrated by a butcher in order to force the surgeon's hand.

Denmark has had to limit access to intervention for Danish citizens. One could ask whether there is a risk that some neurotics will seek masochistic satisfaction even though they are not genuine transsexuals.

As for legal consequences, quite apart from the fact that this intervention is illegal under French criminal law, there exists the problem of the legal identity that would be granted to these subjects. Some countries have had no hesitation in granting these subjects new legal identities, but it is not difficult to imagine the difficulties such changes could cause, particularly in terms of the marriage of the person in question; this possibility was foreseen in the case of Aubert's case A in Switzerland, and a change in identity for this patient was made dependent on a set of restrictions including loss of civil rights and the right to marry.

Conclusion

Transsexualism can be distinguished from homosexuality and transvestism within the classificatory group of sexual anomalies. This group includes subjects who are usually male and who ask to be changed into an individual of the opposite sex with the help of the medical profession.

This condition is familiar to classical sexologists, and numbers seem to have multiplied since modern possibilities involving surgery and hormone treatments have been developed, creating the possibility of realising their hopes. Publication in the press of results achieved in some subjects has seemed to cause an increase in the number of requests.

The psychology of these cases is very distinctive and those cases that we have observed – of which we report one of the most curious here – seem to have so many similarities to other reported cases that they can be considered as having the same characteristic syndrome. This is dominated by the overriding idea that these subjects have of being victims of an error of nature, that they are women in men's bodies. This unshakeable conviction brooks neither doubt nor discussion, it invades ideation, reduces the subject's

field of awareness, is supported by dangerous rationalisations, memory is selective to such a point that the subject's attitude becomes very demanding of society and of doctors who do not share the subject's certainty.

Very obvious homosexual tendencies are denied stubbornly, while the narcissistic, fetishist, masochist and even exhibitionist components become clear on observation. It then becomes obvious that this is a distinctive psycho-pathological condition which can be classified, depending on the particular case and the stage at which the condition developed, as a psychoneurotic disorder, a perversion or even a partial psychosis. Even when the patient seems to have maintained mental integrity, and even when the patient's demands seem to be explicable in terms of an erroneous upbringing, if not by nature, it is none the less clear that there is psychological damage and that it is doubtful whether this damage is reversible.

One feature that can be found in our patient shows how far logical capabilities can be altered; whatever the age or physical appearance of the subject, his only goal is to be transformed into a pretty woman who will attract attention, admiration and love.

Development of this theme soon relegates all other ideo-affective activity to the background, with the quest for information and positive opinions erasing any memory of things that oppose the subject's wishes, and distancing the patient from any who do not share his point of view. The patient will refuse any discussion of even the most formal evidence.

Such a process, in its progress, structure and end point, is evocative of states of partial insanity, as in the monomania cases described in classical texts.

Therapeutic options must be considered in this context. Certainly, doctors who have come to pity the real distress suffered by these patients have acted according to their conscience by 'relieving them' of their male attributes and attempting to alter their morphology, even if it means confronting new requirements concerning changes in civil status, social integration, marriage and so on.

However, what subsequently happens to these subjects has not been sufficiently studied. The least that one can currently say is that most may have declared that they have obtained partial relief, but some display behaviour that is at the very least worrying from the social and psycho-pathological point of view.

We should not hide from the fact that granting transsexuals' requests means embarking on a journey in psychopathological development, which may be satisfied for the moment but may well not stop at this point.

References and notes

[1] There are also cases in women, which we shall not consider here.

[2] These can be found in J-M Alby's thesis

[3] While specific papers or publications are not directly cited in the text, a very complete bibliography was provided with this paper. It is reproduced below. A more detailed bibliography on transvestism can be found in Delay J., Deniker P., Lemperière T. and Benoit J.C., Histoire d'un travesti: l'éonisme. *Encéph.* 1954 : (5) 385-398.

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[4] The patient initially hid from us that he had been declared to be a girl, as he is living under the false identity of a brother, whom he tells us exists.

[5] This is also the case for the patient studied in R. Dorey's thesis 'L'inversion psychosexuelle avec travestissement chez l'homme', Strasbourg 1955, of which we became aware as this article went to press.

[6] **Translator's note:** This sentence is equally ambiguous in the original French