Medical Research

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by Ken McGuire

It is vitally important that Christians understand the truth about sexuality issues. Political Correctness has clouded many of these issues to the point that it is almost impossible to get to the truth.

For the sake of people suffering gender confusion it is vital that we not only know the truth but also that the Church offers help and compassion to sufferers. Only the truth can set them free.

Transsexualism – Part one

The belief that transsexualism is a biological condition for which sex-change surgery is the only treatment is a total sham. This is the first part of a three part series on transsexualism in which we will expose some astonishing facts behind this deception.

There is no doubt that transsexuals suffer from psychologically-based gender-role distress, personality disorders, sexual deviancies and other mental illnesses. The psychological and situational factors which cause transsexualism have been known and well documented for decades.

During the 1950s and 1960s, however, US endocrinologist Harry Benjamin theorized that there was a subgroup of transsexuals apart from the main – “true transsexuals” – who had been born with a brain of one sex and a body of another. He speculated that this was due to some kind of hormonal fluctuations in utero and that it could be resolved surgically, by physically altering the patient’s body to resemble that of the opposite sex.

It was also supposed that the “true transsexual” could easily be distinguished from the mentally ill because, again in theory, a “true transsexual” would describe feelings of having belonged to the opposite sex from birth, of having experienced great distress during puberty and a persistent discomfort in their biological gender role consistently throughout life.

Although these ideas were almost universally rejected by mental health professionals and despite the complete lack of any kind of scientific or medical evidence in support of such theories, a few practitioners in various places around the world – including Australian practitioners in both Melbourne and Sydney – commenced clandestine experiments on their patients. One such practitioner stated that: “The first male-to-female surgery in Melbourne was cloaked in the deepest secrecy. It was the late 1960s and the public would have been in uproar. The surgeon and his staff operated on Sundays so his colleagues would not know and the whole procedure was kept firmly underground.”

Sex-change specialists published some initial follow-up studies that minimized complications and gave glowing accounts of post-operative adjustment and then used these to persuade responsible authorities to establish “properly supervised programs”.

In 1969 the Melbourne team established their sex-change experiments under the guise of a “Transsexual Consultative Service” (TCS). The University of Melbourne Department of Psychiatry and the Mental Health Authority endorsed the service, which was located at Royal Park Hospital and funded by the Office of Psychiatric Services (OPS) of the Department of Health Victoria (HDV).

Medical practitioners and nursing staff who became aware of what was going on questioned whether performing the surgery was morally acceptable and whether or not it was a dangerous collusion with mental illness. Many of those initially willing to assist the sex-change specialists soon became disillusioned and ceased further involvement.

Consequently, sex-change experiments in Australia had to be moved from one medical facility to another until, by

the late 1970s, there were no medical establishments left that were willing to host the sex-change surgeries.

Elsewhere in the world, more problems with the sex-change experiments were beginning to surface. Post-surgical complications were being reported in over half of the operations, including breast cancer in hormonally-treated males; the need for surgical reduction of bloated limbs resulting from hormones; repeated construction of neo-vaginal openings; infections of the urinary system and rectum; hemorrhaging; loss of skin grafts; post-operative suicides and suicide attempts; persistent post-operative depression, psychosis, and phobia; sexual dysfunctions; and pre- and post- operative prostitution, often necessitated by the high cost of treatment.

The patients themselves were often taken by surprise by the severe post surgical pain associated with the genital mutilations. Many patients were distressed that they did not come out of the anesthetic with the kind of “twice born” euphoric experience that had been glowingly reported by sex-change enthusiasts. Some patients questioned whether the surgery had been successful at all whilst others expressed early feelings of post surgical doubts and regrets.

Following surgery, the patient’s expectations of an immediately blissful, exciting and romance-filled life was replaced with the reality of a number of legal, social, economic and emotional problems. Many post-operative transsexuals attempted to solve these problems by demanding more and more cosmetic surgery in the hope of finally becoming the opposite sex, but never quite getting there.

In 1979 the largest “sex-change” program in the USA at John Hopkins was closed following an outcome study by Meyer and Reter which concluded that sex-change surgery had actually conferred no objective advantage to their patients.

Then sex-change specialists were shocked by another discovery: their patients had routinely and systematically lied about their life histories in order to match the prevailing theories about “true transsexualism”.

As it turned out, the kind of history that sex-change specialists had expected from true transsexuals was rarely encountered in practice. The concept of a “true transsexual” was abandoned and the medical profession’s worst fears about the sex-change experiments had been confirmed – collusion with mental illness.

In part two of this series, we will expose how sex-change specialists turned this situation around and how the Melbourne team managed to establish a government funded sex-change clinic at Monash Medical Centre. We will also uncover some shocking consequences.

Ken is happy to dialogue with anyone regarding the information in this article or any transgender issue.

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Transsexualism – Part 2

In part one of this series we saw how the concept of a “true transsexual” was discredited following the discovery that sex-change experiments had been conducted on mentally ill patients who had lied about their histories in order to fit the belief that transsexuals are born that way.

Despite such setbacks, sex-change specialists around the world maintained that sex-change surgery was still the best means of coping with an estimated 10% of transsexuals who remained unresponsive to psychotherapy, irrespective of the underlying cause.

In Australia, the Melbourne based sex-change team petitioned the government to re-establish a clinic that would provide a service for a broad range of gender identity issues and problems, not just transsexualism. They argued that there was an urgent need for research into the cause and treatment of the condition and that this was best done in a public setting.

In 1988, the Australian government acquiesced, establishing the Monash Medical Centre Gender Dysphoria Clinic on the proviso that any decisions by the team to administer sex-change procedures would have to be approved by an independent advisory committee.

The advisory committee established to oversee the clinic fell apart soon after it was formed and Monash Medical Centre refused to host any sex-change procedures. Control of the clinic was given to a psychiatrist on the sex-change team who arranged for her secretary to attend the clinic two days a week. The secretary appears to have played the role of a psychiatrist at the hospital, accepting patient referrals, requesting medical and hormonal tests to be conducted, summarizing clinical material, documenting her own conclusions about the diagnosis and condition of patients as if these were matters of fact and then referring patients on to the “private practice” of various team members for treatment. Unsupervised in this way, the Melbourne team was able to use the public hospital as a front for their continued sex-change experiments.

Internationally, sex-change enthusiasts set out to convince the world that transsexuals were born that way and cannot change. This was accomplished through the misuse and misunderstanding of scientific studies, political activism, litigation and manipulation of the media.

It is believed that genetic factors may predispose individuals to a number of mental disorders, anxiety, depression and substance abuse. It does not follow from this that people are “born that way” or that they cannot be helped with appropriate psychotherapy or psychotropic medications. Yet this is exactly what sex-change enthusiasts have repeatedly claimed about the findings of genetic studies into gender identity disorders.

Two such studies were published last year. One of these studies found that a particular gene in Male to Female transsexuals was slightly longer on average than that found in the general male population. The other study found that a completely different gene variant was slightly more prevalent amongst Female to Male transsexuals than it was in the general female population.

Even overlooking the small sample size of the studies, the fact that the results have yet to be verified, and the uncertainty as to the role that these genes might [actually] play in the development of transsexualism, one is still left with the fact that the gene variants in both studies are present in nearly half of the general population, and are absent in more than half of the transsexuals studied.

In other words, if there is a link between these genes and transsexualism, then it is at best an extremely weak one, which would lead good analysts to conclude that transsexualism is almost entirely due to psychological or situational factors, with genetics perhaps contributing no more than a slight predisposing role for some individuals.

The way in which sex change enthusiasts have misused such studies to promulgate their views is deceptively simple. Typically, a reporter with a vested interest obtains an opinion from one of the researchers that their findings [could] “support a biological basis for gender identity” together with a statement from a pro sex-change specialist that they believe transsexualism is a biological condition. Add to this mix a comment from a transsexual about how they have always felt that way from birth, and the reporter publishes the article under a headline such as “Transsexualism is in the genes”. Thus all those who read this article are deceitfully convinced because the newspaper said so and newspapers don’t tell lies!

Similar tactics have been regularly used to promote the legalization of illicit drugs and the normalization of homosexuality and lesbianism.

Using this kind of deception combined with public apathy, sex-change enthusiasts have managed to push through a number of legislative changes over the years that grant transsexuals legal recognition as the opposite to their birth sex and even special “anti-discrimination” rights. These new laws have then been successfully enforced through litigation, often encouraged by ‘Equal Opportunity Commissions’.

Peculiarities in the law have effectively prevented anyone other than sex-change ‘specialists’ from giving expert

witness. In the absence of any views to the contrary, the courts have invariably ruled in favor of the theories held by sex-change specialists and these judgments are then cited by sex-change enthusiasts as further proof of their beliefs.

Today it is psychotherapy and not sex-change surgery which is considered inappropriate. As for Australia, nearly every patient referred to the Monash Clinic over the past twenty years has been placed on their sex-change program and I could find no record of Monash treating anyone with psychotherapy as opposed to gender reassignment after reviewing the documents.

Consequently, a significant number of patients drop out part way through the sex-change process and many post-operative patients are left with a body that they feel is no longer recognizable as male or female because, despite all the rhetoric, it is still impossible to actually make a man a woman or vice versa.

Sex-change specialists, thriving on the conviction that people are “born that way”, have nothing further to offer. Left with a sense of betrayal by the professionals they had turned to for help, and faced with the prospect of living an isolated and lonely life on the outskirts of society without any real possibility of marriage and family, too many find suicide to be their only remaining option.

In the final part of this three part series on transsexualism, we will look at the true cause and appropriate treatment of this psychological condition.

Transsexualism – Part 3

In the first two parts on this series on transsexualism, we saw how transsexualism is a psychological condition and that sex-change operations are both inappropriate and ineffective in the long run. In this, the third and final part of the series, we answer the question as to what the actual cause of transsexualism is and how it can be treated.

The psychodynamic routes to gender dysphoria (discomfort with gender role) are different for boys than they are for girls and they do not necessarily all occur in childhood. Invariably, there is a complex interplay between different psychological and situational factors which cause a discomfort with, fear of, or rejection of, one’s biological sex and a corresponding desire to be the opposite sex. Over time, cross-sex wishes develop into cross-sex fantasies and feelings which culminate into the belief that one should be or really is the opposite sex.

Whilst transsexualism is sometimes associated with mental illness such as schizophrenia, transvestism, body dysmorphia or post-traumatic stress disorder, it is more usual to see gender identity issues in the context of personality disorders, often the result of childhood abuse or trauma or, in extreme cases, as a form of dissociative identity disorder consisting of a dual male/female persona.

Sexual abuse features prominently in the history of severe transsexualism. Girls may use a cross-gender identity as a form of self-protection against further abuse or it may arise as a form of “identification with the abuser”. Boys may suffer from confusion about sexual orientation following sexual abuse and this confusion can spill over into gender identity.

Transsexuals often entertain false ideas about gender roles and what it means to be a man or a woman. These ideas stem from inappropriate or absent sex-role models in childhood and social constructs and result in gender role discomfort or confusion. These feelings are exacerbated when the child’s role models put each other down in a verbally abusive way.

Girls are more inclined to reject their gender role in societies where women are marginalized and devalued. Girls are also more inclined towards cross gender wishes where men are overly valued or held in high regard. Daughters who witness their mother being repeatedly verbally and/or physically abused by males may take upon themselves the expressed negativity towards women, resulting in a negative self image and fear of womanhood which they see as weakness and the object of abuse.

Boys may reject their own masculinity because of negative male role models and experience feelings of discomfort at the thought of growing up to become a man. Boys who do not enjoy or are not good at perceived male activities such as sport may develop a negative self-image. They may also take upon themselves the title of “girl” or “sissy” because of teasing at school or at home.

The absence of appropriate opposite-sex role models for both boys and girls can also result in a degree of uncertainty and insecurity about their own sexual identity as well as avoidance or lack of comfort with the opposite sex. This is often the cause of homosexual/lesbian feeling too.

Daughters of divorced or abandoned mothers may step in to fill the role of the absent father, often being encouraged by their mothers for their “masculine” traits.

For boys, the absence of a male role model may leave them feeling awkward amongst same-sex piers. Later, as men, they may be inadequately prepared for the role of husband and father, leading to feelings of failure and discomfort in the male role. Mentally disturbed or absent mothers can likewise leave girls feeling inadequate and inappropriate in their gender role.

Sexual confusion and same sex attraction can lead to transsexualism where there are highly negative attitudes towards homosexuality. In this case, the cross gender identity is used to justify their same sex attraction as being heterosexual and therefore acceptable to themselves and others.

In less severe cases, confusion about gender can simply arise out of adjustment disorders of adolescence or form part of a more generalized identity confusion, in which questions such as “who am I?” and “where do I fit in?” encompass the question “What gender am I?”

Generally, cross gender feelings and behaviors are not persistent throughout life but manifest as a coping mechanism during stressful life events. Treatment of transsexualism involves the resolution of the underlying contributing factors. Initially, explorative therapy is valuable in order to obtain relevant history and to identify any co-morbid psychopathology. Those with a background of severe abuse, especially sexual abuse may be treated or referred for treatment for that abuse. Those with personality disorders, disassociative disorders and other psychopathology can likewise undergo treatment for those disorders. In the case where gender identity disorders exist in the context of broader identity problems or issues, the patient will benefit from exploring issues related to self-identity within therapy. Psychotropic medications may be prescribed during treatment to facilitate therapy.

Socially, persons with gender identity disorders will benefit from associations with healthy male and female role models wherein any wrong or inappropriate ideas they hold about sex-roles can be challenged and corrected.

The greatest barrier to treatment lies with the patient themselves who refuse to accept any responsibility for their gender dysphoria and are unwilling to question the origin of their condition or explore its causes or development or entertain any attempts to change it.

Sadly, another barrier to proper help today is the attitude of society to simply affirm and comply with a persons wishes to ‘be the other sex’. This has lead to authorities allowing very young people who are gender confused to affirm their feelings and start treatment to change at a very young age, often well before maturity and possibly even before puberty.

Ultimately, transsexuals suffer from the same problem that we all face – we live in a fallen world. None of us are as God intended. We all face choices between right and wrong, we all face things we do not like about ourselves. Even Paul found himself doing what he did not want to do. It is our response that matters. We can attempt to justify our wrong feelings, desires and actions or we can turn to God through his Son Jesus Christ and allow him to transform us into the person God created us to be, including, in the case of transsexuals, bringing them back to sexual wholeness.

Yet, we need to understand that healing can be a long and hard road – both for the patient, their family and those assisting them. It is also difficult for Christians to know how to respond when confronted with such situations, so we have decided we need to include a Part 4 – “The Christian response to a person who presents with Gender Identity Disorder or cross dressing”