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2140-1 (Ch of Psych)

National Defence Medical
Center
Ottawa (Canada)
K1A OK6

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National Defence Headquarters
Ottawa (Canada)
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Attn: Director of Security

SECURITY CONSIDERATIONS
TRANS SEXUALS

Ref: 2140-1 (DSecur 3) 8 January 1985

1. (U) In discussing transsexualism and its security implications it may be of value to define the term. It was first used by Cauldwell[1] in 1949; Kinsey[2] [3] in 1948 and 1953 did not mention the condition, which would suggest that either it was not recognised or, as is more likely, is quite rare. The term was later popularized by Benjamin[4] in 1966.

2. (U) Socarides[5] defines the condition as "... an intense insistent and overriding wish or desire for sexual transformation into a person of the opposite sex. Transformation is to be effected by:

   a. direct (surgical) alterations of the external and internal sexual apparatus and secondary sexual characteristics of the body; and

   b. indirectly by the administration of endocrinological preparations". He goes on to comment "... the conviction that one is basically a person of the opposite sex... may be semi delusional or delusional in quality. If semi delusional or delusional it may be part of an underlying schizophrenic psychosis. If not, it is always based upon a failure to attain a definite male or female identity in accordance with anatomy".

3. (U) As noted above, transsexualism is rare - the incidence is not known accurately, the ratio male to female is said to be between 8 to 1 and 2 to 1.

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4. (U) Diagnosis is made on the basis of "... a sense of discomfort and inappropriateness of one's anatomic sex... a wish to be rid of one's own genital and live as a member of the opposite sex and the disturbance must be continuous for at least two years...". The differential diagnosis is of effeminate homosexuality (with no desire to damage the genitals) and schizophrenia, where there is a delusion of being of the opposite sex.

5. (U) The Diagnostic and Statistical Manual of Mental Disorders (DSM III) notes that there is "... generally a moderate to severe co-existing personality disturbance.... Frequently anxiety and depression regarding inability to live in the role of the desired sex... and the treatment is chronic and unremitting".

6. (U) While there is frequently social and occupational or functional impairment, surgical sex change in effeminate males may lead to an improved level of contentment, employability and interpersonal relationships. However, the long term outcome of surgical reassignment is as yet unknown, not withstanding the publicity surrounding such cases as those of Jorgensen and Richards in the United States.

7. (U) In the study by Finney[6] in 1975, a computerized psycho-diagnostic assessment of 19 males and one female seeking sex reassignment surgery showed hysterical personality in 13 of the 20 subjects, 12 showed psychotic trends, 6 showed psychotic thinking on test scores and 6 received "computer preferred" diagnoses of paranoid or schizoid personality. However, most of these 12 patients were not considered psychotic on interview although 6 who had sexual reassignment surgery (including 2 of the 5 whose computer evaluation showed the most pathology) were reported to be pleased with the outcome on follow up; 4 others were lost to follow up.

8. (U) Steiner[7] (personal communication) sees transsexuals as "primary", that is unconflicted and with a fairly good prognosis and "secondary" where the desire for change is derived from significant psychic conflict i.e. histrionic personality, borderline personality or psychosis. This is in agreement with Stoller[8] who described "deviants" (variants) and "perversions" (sexual neurosis).

9. (U) Koranyi[9] (personal communication) reports that in a series of 40 transsexuals that he has seen, only 3 or 4 were "reliable" and he sees the major complicating factor in such people as being alcohol and drug abuse, and notorious unreliability in giving the history.

10. (U) A review of current American military attitudes is provided by Jones[10], who reviews six cases in the U.S. Army and notes "... the military excludes transsexuals from service, using arguments similar to those for excluding homosexuals (effects on unit morale) and the additional medical limitations on world wide assignment..." interestingly, he notes difficulties relating to washroom facilities such as have emerged locally in the case which prompted this enquiry.

11. (U) It may be noted that gender identity disturbance has been recommended as grounds for refusal of enrollment in the Canadian Forces.

12. (U) With regard to your specific questions in Ref, the "stages of transition" leading to operative sexual reassignment may be outlined briefly as:

a. confirmation of "genuine" transsexualism (i.e. exclusion of schizophrenia, homosexuality "per se", and any other major personality disorders);

b. suitable body habitus (e.g. Arnold Schwarzenegger would be unlikely ever to pass easily as a female);

c. institution of feminising hormonal treatment (for breast development) and depilation of beard;

d. ability to "live" as a female for at least two years in the community;

e. an ongoing psychotherapy aimed at improving emotional maturity; and

f. acceptance for surgery at an institution involved in this category of treatment.

13. (U) The "critical points" would likely be associated with being accepted by a "gender clinic" as a transsexual i.e. at the stage of formal diagnosis, at "coming out" to the community, at the special provisions that may be needed (e.g. washrooms) acceptance by the group - peers, coworkers, subordinates etc. and any difficulties encountered in the course of psychotherapy.

14. (U) Questions asked of a person contemplating sex change to assess "stability" would not, to my mind, be different than those asked of any one else being subjected to "positive vetting", however, Koranyi's caveat (para 9) regarding reliability in history giving must be borne in mind.

15. (U) With regard to questions to put to a private psychiatrist, it must be remembered that apart from the growing politicization regarding sexual and other aspects of human rights, there is an employer/employee relationship existing between the patient and the psychiatrist. Whether answers would be given willingly or accurately or at all is open to conjecture, and any such disclosure could only be made with the patient's written consent.

16. (C) You were kind enough to ask for any comments that I might care to make, and it seems to me it would be important to avoid over-emphasis on the purely sexual component of this sort of situation. As with other situations in which there are aberrations of behavior, there may be a tendency to focus on "natural sense of repugnance" at that which is perceived to be aberrant or unnatural. With regards to homosexuals for instance, it is the promiscuity that may pose a security risk rather than the gender of the chosen sexual partner (s); an equally promiscuous hetero-sexual, to my mind, is at least as great a security risk as a promiscuous homosexual.

17. (C) The medical literature, is of course rather sparse in terms of references to the security implications of the situation you now face. Basically, it is my opinion as a physician, that if the individual is able to successfully "live as a female" for 2 years, is not abusing alcohol or drugs, has no specific psychiatric diagnosis (personality disorder, schizophrenia, etc.) and if the milieu is supportive, then a straight forward assessment of security risk should proceed as it would for a "normal hetero-sexual" subject. The only caveat is that transsexual individuals do experience an extremely high level of tension and strain so that judgement might be impaired due to "psychic fatigue".

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