the average grant is often small. In some countries, Canada for instance, the principal investigator cannot be paid out of grants. What is left? Contract research perhaps. Some of our last grants came from such non-medical agencies as the Ministry of Labour, pharmaceutical companies, and a Health Promotion Agency. In each case a serious academic question was addressed. Namely, does aluminium cause cognitive impairment? Is post-stroke depression treatable? Is there widespread care-giver grief in the community? It should be noted that these are all clinical questions of contemporary interest. Contract research, nevertheless, has its opponents. In his memoirs, Sir Peter Medawar (1988) totally deprecates the notion as enunciated by Lord Rothschild. It was "... not the proceeding that has given us penicillin, insulin, the discovery of the blood groups, the elucidation of myasthenia gravis, the transplantation of tissue or the discovery of the genetic code. Scientific discovery cannot be premeditated". Are these the thoughts of hallowed academia? Is contract research really crass? We need to bear in mind that Michelangelo, Mozart, and Wren all did contract work. What price the Sistine Chapel? Are money and the frontal lobe not the twin pillars of civilisation?

So research in psychiatry has changed. It is no longer the vehicle to getting a decent job or the pursuit of monkish scholars. It is done less by doctors and may become mission orientated. But, surely, there will always be poetry. As Browning said, "Ah, but a man's reach should exceed his grasp. Or what's a heaven for?".

## References

MEDAWAR, SIR PETER (1988) *Memoirs of a Thinking Radish.* Oxford University Press.

BROWNING, R. (1855) in *Andre del Sarto.*

Professor Lewis (1965)

**Sir Aubrey Lewis Street**

The Technology Development Corporation (Adelaide) is delighted to announce the street names selected for the thoroughfares at Science Park Adelaide (SPA), Australia's first Science Park. Of the three main streets at SPA, one will be named after Sir Aubrey Lewis, "a leading South Australian psychiatrist".

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# Personal view

## Gender dysphoria – an inside view

(*Name and address supplied*)

Burns *et al* (1990) considered that "core transsexualism" has, as a defining characteristic, a homosexual orientation. This means, of course, homosexual in respect of the original biological sex. This will be examined critically, suggesting areas which merit further research.

I can deal with this topic from both an objective and subjective view. I am a (recently retired) consultant psychiatrist who also happens to be gender dysphoric, and nearing completion of gender reassignment.

Gender dysphoria is ill defined, but encompasses all phenomena in which there is a distinct unease in the

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anatomical sex, and a desire to be accepted as a member of the other gender. Classically, the dysphoric feels that they 'have been born into the wrong body'. This primary condition (unlike some cases of symptomatic transsexualism) is not delusional. It may be experienced by either biological sex. It is not rare, and is emergent in tolerant societies, where professionals are prepared to listen and help. The cause is unknown, but theories abound.

'Psychiatric reductionists' favour the theory that gender dysphoria is really repressed homosexuality. It is more acceptable to own up to misplaced gender. Homosexuality can be denied, for it is 'normal' to prefer one's own biological sex, since one is of the other gender. The dysphoria becomes a secondary phenomenon, which presumably might be resolved if the 'core' homosexuality can be acknowledged. I find this much too simplistic! Gender dysphoria tends to emerge, in a complete form, held with absolute conviction, at a very early age. My own experience was typical, with symptoms by the age of five. Many transsexuals make happy and stable marriages to members of the other anatomical sex. This theory, therefore, confuses two parallel but distinct conditions, making the one dominant.

It is similarly confusing to regard sexual desire for the same birth sex as a 'norm' in gender dysphoria merely because there is a conviction of wrong assignment. If this view is held, homosexuality loses any real meaning, for there is added confusion when a post-operative transsexual continues to prefer the opposite birth sex, but is now called homosexual! Such semantic absurdity challenges our whole concept of sexual orientation, and what, indeed, is 'normal'?

If the repressed homosexuality theory were valid, most reassigned dysphorics would openly orientate towards their original birth sex, but there is a wide variation in such orientation at all stages of gender reassignment. (Transsexuals born as anatomical females tend to prefer females at all stages.)

My own subjective experience and observations prompt me to suggest a different approach. Neither gender dysphoria nor homosexuality need be regarded as the core and causative condition; they are distinct phenomena. Homosexual experience, if one includes all fantasy, is common – or universal – and probably latent in everyone, and dominant in many. There is no firm evidence in favour of causative influences during infancy. Animal behaviour points to a biological factor. Nor is it merely a developmental stage, for the potential remains throughout life. What varies is the versatility, or volatility, in individuals, hence the category of 'bisexuals'. But such bisexuality, at least as a potential, may be the biological norm! By biological, I imply prenatal factors, whether genetic or not.

Classical gender dysphoria, usually known as transsexualism, presents at an early age and persists, becoming more intense. Sexual orientation varies, but is of less importance to the individual. There are typical phases, including pleasurable cross-dressing, often erotic for a time in adolescence, but persisting as a manifestation of identity, free from erotic content. Confusion between transsexualism and transvestism can be avoided if all these phenomena are considered as gender dysphoria. (There may, indeed, be a spectrum of such phenomena.) Again, significant early environmental influences seldom come to light in case histories. Nor is there usually a chromosome or obvious chemical abnormality, yet a biological causative factor seems the most likely.

If homosexuality can be repressed, might this also be the case with gender dysphoria? I would prefer to think of it as being dimly perceived, and compensated for by grossly masculine behaviour including tough 'macho' occupations and pursuits, or by strident femininity. These phenomena are common.

Certainly, if bisexuality is universally latent, surfacing in particular conditions, it is hardly surprising that post-operative transsexuals should realign their sexual preference. That this is not always the case strengthens the argument that these are separate conditions. But is gender dysphoria also a latent emotion in everyone? There is evidence of compensation for feelings of inferiority in the assigned gender at all ages. Transsexuals experience rather more – a feeling of alienation. Minor feelings of gender discomfort are experienced by many people. Gender dysphoria attracts anecdotal information, of importance, but we do need harder facts, more surveys. I suggest that there is no reason to assert that the 'cause' is repressed homosexuality. Indeed, I would go further. Because of the universality of bisexuality, as a potential, the term homosexuality tends to be more confusing than helpful. When considering the complexities of gender dysphoria, applying a label to the particular sexual orientation is ill advised.

## Reference

Burns, A., Farrell, M. & Christie Brown, J. (1990) Clinical features of patients attending a gender-identity clinic. *British Journal of Psychiatry*, **157**, 265–268.

https://doi.org/10.1192/pb.15.7.438-a Published online by Cambridge University Press