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Rachel L. Wichman
Clinical Dilemmas
and Countertransference
Reactions for Therapists
of Pre-operative
Transsexual Clients

ABSTRACT

An exploratory study was undertaken to examine the clinical dilemmas that are inherent to working with a pre-operative transsexual population, and associated countertransference reactions. Interviews were conducted with twelve therapists who had treated pre-operative transsexual clients. The interviews revealed that three clinical dilemmas were significantly referred to by the subjects as they described their countertransference reactions--diagnostic considerations, the therapists' clinical role in treatment of transsexual clients, and therapists' traditional sex role conditioning. The findings indicated that countertransference reactions for therapists working with pre-operative transsexual clients were an outgrowth of the clinical dilemmas found in treating this client population.

CLINICAL DILEMMAS AND COUNTERTRANSFERENCE REACTIONS FOR THERAPISTS OF PRE-OPERATIVE TRANSSEXUAL CLIENTS

A project based upon an independent investigation submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

Rachel Lynne Wichman

Smith College School for Social Work

1985

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CHAPTER I

INTRODUCTION

> And the seasons they go round and round
> And the painted ponies go up and down
> We're all captive on the carousel of time
> We can't return we can only look
> Behind from where we came
> And go round and round and round
> In the circle game. (Mitchell, 1966)

The phenomenon of transsexualism has raised many perplexing and contradictory considerations for mental health professionals providing psychotherapeutic services for a transsexual population. No sooner had these professionals grown comfortable with ongoing research and its resultant theories, postulations and recommended course of viable treatments for transsexual clients than the passage of time began providing results of longitudinal studies. These studies have been the catalyst for the concomitant vibrations which began to loosen the heretofore secured lid of Pandora's box. Just as the "seasons go round and round" (Mitchell, 1966), and each cyclical repetition is modified and varied as new information, experiences and the chronological forward progress of time makes a blueprint of the past irreplicable, so too changing and controversial perspectives on transsexualism are proving catalysts for reverberations in the therapeutic communities.

There exists an array of literature in the sphere of transsexualism that documents the historical evoluation of theories and their subsequent impact on recommendations and follow-through for treatment for transsexual clients. Theories of the 1950s that deemed transsexualism as being pathological became altered to transsexualism being viewed as non-conflictual for the individual, based on literature written in the later 1950s, the 1960s and 1970s (Green, 1974; Money, Hampson & Hampson, 1957; Stoller, 1964/1968). These later theories consequently laid the foundation and heavily influenced and affirmed the rationale supporting physical alterations for transsexual individuals through hormonal treatments and sex reassignment surgery, in the United States. Those highly respected and acclaimed theories of the later 1950s, 1960s and 1970s came to be scrutinized in the 1970s and the present 1980s as the literature became more sprinkled with longitudinal studies of sex reassignment (pre and post surgery).

The current literature reveals controversial information from longitudinal studies causing theorists to re-examine the premise that transsexualism is a normal life choice. The premise that a transsexual should attempt to right the misfortune and error of her/his birth and remedy the transsexuals' feeling states of always having a female/male trapped in an opposite sexed body through physical means is being challenged. There are findings indicating that partial transsexualism (hormonal induced changes only) and sex reassignment surgery often do not alleviate the psychological

plight of the transsexual individual (Eber, 1980; Forester & Swiller, 1972; Kirkpatrick & Friedman, 1976; Loeb & Shane, 1982; Lothstein, 1980; Meyer & Reter, 1979; Money & Wolff, 1973; Morgan, 1978; Oles, 1977). Contrary to anticipated and hoped-for results, a preponderance of transsexuals who undergo and complete physical changes continue to present with pathological profiles akin to Kernberg's (1975) understanding of borderline pathology (Eber, 1982).

The literature concomitantly reflects that advocacy for psychotherapy is beginning to regain momentum due to cited psychopathological profiles of transsexual individuals (Forester & Swiller, 1972; Kirkpatrick & Friedman, 1976; Loeb & Shane, 1982). This is developing in an arena that simultaneously continues to have proponents who favor and promote continuation of physical change based on other longitudinal case studies demonstrating psychologically successful post-surgical results. The pro sex reassignment surgery stance poses unique circumstances for psychotherapy proponents, since the mental health advocates of sex change and the availability of such treatments encourage sex reassignment surgery candidates to deny and resist exploration of their possible need for psychotherapy. It was estimated that 1,000 sex change operations would occur among the estimated 10,000 transsexuals in the United States (Berger, Green, & Laub, 1977).

The literature makes it clear that there is no consensus in the psychotherapeutic communities regarding the two

diametrically opposed treatment viewpoints, each resulting in significantly differing implementations to achieve the goal of resolving gender dysphoria. The seventies and eighties present a probing quest into the more previously-held solution of sex change surgery for those who present as having a person trapped in an opposite sexed body. Just as society and society's institutions must confront, address and try to make sense out of this many-pronged issue, so too must individual mental health professionals who service transsexual candidates.

In summary, there is an abundant amount of literature on transsexualism delineating the evolution of opposing theoretical viewpoints as longitudinal studies have become more numerous, and with it evidence that sex reassignment surgery is not alleviating presenting transsexuals' symptomology. The literature demonstrates how a growing contingent of theorists currently are challenging theories that view transsexualism as non-conflictual (Forester & Swiller, 1972; Kirkpatrick & Friedman, 1976; Loeb & Shane, 1982). There are theorists who are reconsidering the choice of hormonal treatments and sex reassignment surgery versus psychotherapy, and theorists who are incorporating recent borderline theories into their theoretical models and treatment modalities. The literature portrays the evolution to today's present theoretical and treatment choice dilemmas for the mental health professionals.

However, there remains a noticeable paucity in the literature concerning the clinical dilemmas confronting the involved mental health professional. Therapists are challenged to their core by the inherent plethora of clinical, moral and ethical considerations and countertransference issues that may arise when dealing with transsexual clients. There is limited research addressing how, "the therapist must struggle with the clinical issues of diagnosis, his own values and biases, and a tendency toward premature acceptance/ rejection of the patient [for psychotherapy] for nonclinical consideration" (Lothstein, 1977, p. 571).

The two differing outlooks regarding appropriate treatment of transsexual individuals--psychotherapy only or psychotherapy and sex change surgery--seem to set the stage for the development of clinical dilemmas. For instance, how might the two varying treatment approaches influence the process of doing therapy for the therapist? How might the two viewpoints affect transsexual clients' investment and motivation in the therapeutic process? Since transsexuals appear to be a specific group of individuals, the question becomes whether there are particular therapeutic dilemmas for the involved mental health professional that are unique to treating this population, and if so, are they accompanied by intrinsic countertransference reactions? This study will explore the clinical dilemmas that are inherent to working with a transsexual population and associated countertransference reactions.

CHAPTER II

REVIEW OF THE LITERATURE

Historical Overview of Theories and Approaches

What is transsexualism? Who is a transsexual? To answer these questions it is first necessary to understand the basic concept of gender identity. Gender identity is a psychological construct which refers to an individual's basic sense of femaleness or maleness, or a conviction that one is a female or a male (Meyer, 1982). Many of the present concepts on the development of a distinct identity, which includes gender identity, have been built on Mahler's (1975) contributions. Examinations of gender identity development have incorporated Mahler's autistic, symbiotic and separation-individuation developmental stages of individuality (Eber, 1980). A person experiencing confusion with her/his gender identity is experiencing gender dysphoria. The terms transsexualism and transsexuals apply to a unique subgroup of gender-dysphoric individuals who not only have gender identity confusion, but who believe that they can resolve their confusion through anatomical change.

The term transexualism was first introduced by Cauldwell in 1949. Benjamin, considered the father of

transsexualism, reintroduced the term duplicating the s's in its spelling in 1953. Although the term is relatively new, reference to the phenomenon can be traced through "classical mythology, classical and ancient history, the Renaissance, [and] cultural anthropology" to the present day (Iannuccillo, 1982, p. 6). Its legacy cuts across cultural, geographic, historical and class stratum boundaries, leaving in its wake numerous evoked reactions and interpretations throughout history.

Prior to the middle ages transsexualism was viewed as sinful and demonic and entrusted for handling by God and the devil. The middle ages marked a transition in perspective and transsexualism came to be regarded as a sexual anomaly requiring imprisonment and torture (Money & Ambinder, 1978). With the advent of modern psychiatry, transsexualism was reclassified as a mental illness and the prescribed treatment was to shape the psychological gender to be consonant with one's genitalia. This attempt to modify gender to be harmonious with genitalia "was viewed by transsexuals as a coercion threatening their personal identity and possibly their sexual pleasure" (Money & Ambinder, 1978, p. 833). This led to transsexuals demanding the opposite course of treatment--altering one's genitalia to match one's gender, during the initial half of the twentieth century. This had become a possibility as modern medicine perfected plastic surgery and endocrinology.

Some of the skeptical medical community viewed such treatment as a collusion with a psychosis. Others believed that time, not surgery, would mend what was diagnosed as somatic or psychic traumas, despite the contention that conventional psychotherapy had proven unsuccessful. There also were medical practitioners who believed that uniting the body and mind through hormonal and sex reassignment surgery would facilitate a positive body image and thus inner harmony (Money & Ambinder, 1978).

Stoller and Non-Conflictual Theory

Stoller (1964, 1966, 1968, 1976, 1978, 1980) has been a powerful force in shaping the theoretical understanding of transsexualism and transsexuals during the sixties and seventies. He received respect and acclaim for his extensive research and writings on primary and secondary transsexualism and on gender identity and gender dysphoria. His contributions swayed the previously held perspective of the fifties that transsexuals were too sick for psychotherapy, to the premise that a primary, or true, transsexual is not sick at all, but exhibits "the most extreme form of gender reversal. It... [was] the belief of an anatomically normal person that he or she...[was] a member of the opposite sex" (1966, p. 107). A true transsexual, Newman and Stoller (1974) outlined, displays a failure to live one's gender role as appropriate to one's sex; documents life long femininity/masculinity that is opposite his/her anatomical sex; and possesses an ability to

continuously and effortlessly pass as the opposite sex in society.

Stoller (1968) considered a primary adult transsexual to be sexually atypical, having a non-conflictual cross-gender identity, comprised of an immutable and fixed core gender identity that would not be affected by psychological intervention. He believed that parents' behaviors and attitudes have tremendous influence in shaping a child's femininity and masculinity, and that this influence can shape gender development in a non-conflictual manner in an infant. Core gender identity becomes firmly established by two to three years of age, and cannot "be easily dispensed with and a new one created at will" (Stoller, 1968, p. 28).

In contrast, a secondary male adult transsexual differs from a primary transsexual, for the biological male's identity is masculine and not feminine. The individual develop[s] in an

> ordinarily masculine appearing manner...[with] manifestations of the underlying feminine urges appearing in adolescence and adulthood. The masculine aspects of identity present from earliest life [are never] completely submerged. The earlier aspects of identity persist while the desire for sex change is less insistent and expressions of femininity are less permanent. (Stoller, 1979, pp. 121-122)

Stoller's work solidly laid the foundation upon which psychotherapeutic and medical professionals defended, supported, and contributed toward the availability of sex changes through endocrinological treatments and sex reassignment surgery. Treatment strategies have been based on the assumption that core gender identity is fixed, and

therefore does not lend itself to modification through psychological methods for the adult transsexual individual. This may, in part, account for an evolving and ongoing practice of using surgical and endocrinological interventions to alter anatomy to match gender identity (Eber, 1982). It had been "universally agreed that transsexualism is resistant to psychotherapy" (Money, 1974, p. 342).

More recently it has been felt that "the view that transsexualism is a sexual variation in which the individual develops a non-conflictual cross-gender identity needs to be examined critically" (Eber, 1982, p. 169).

Kubie and Mackie (1968), forerunners of current re-examination of the transsexual phenomenon, criticized the term transsexualism "...as not doing justice to all the complexities of gender transmutation and implying a false degree of clarity regarding the diagnoses and etiology of the syndrome it purports to name" (p. 250). Increasing evidence points to transsexuals' gender identity not being exclusively set as either female or male (Eber, 1980). "It is now generally agreed that transsexualism is not a distinct qualitative diagnostic entity, but rather falls at the end of a continuum of gender-identity deviation" (Barlow, Abel & Blanchard, 1979, p. 1001).

The Harry Benjamin International Gender Dysphoria Association (1981) introduced the diagnostic term, gender dysphoria, for those individuals who desired physical alterations of their sex, but who presented with no

endocrinological or anatomic abnormalities. Updating of terminology regarding the phenomenon of transsexualism is reflected in the 1980 edition of Diagnostic and Statistical Manual of Mental Disorders (DSM III). The placement of transsexualism in the DSM III, under the psychosexual disorder category,

> emphasizes that psychological factors are assumed to be of major etiological significance in the development of [this disorder]....Without treatment, the course... is chronic and unremitting. Since surgical sex reassignment is a recent development, the long-term course of the disorder with this treatment is unknown (1980, pp. 2610262).

Just as definitions and diagnostic terms regarding the phenomenon of transsexualism have been undergoing change, so too have theories regarding its etiology. Contrary to Stoller's non-conflictual cross-gender identity theory of true transsexuals, there are theorists, Stoller included, who view persons striving for transsexual goals as also often presenting with assorted character structures and psychopathology (Buhrich & McConaghy, 1978; Meyer, 1974; Money & Gaskin, 1970-1971; Newman & Stoller, 1974; Person & Ovesey, 1974b; Stoller, 1968; Weitzman, Shamoian & Golosow, 1970). Only recently have...psychotherapists...begun to conceptualize gender identity disorders in terms of borderline phenomenology and disturbances in self cohesion (Kernberg, 1975; Kohut, 1971). "While there are not yet sufficient data to construct a comprehensive theory, the view that the transsexual is a severely disturbed individual in a self struggle to become whole--seems to be a promising working hypothesis" (Eber, 1982, p. 180).

Lothstein (1977), who studied 86 individuals requesting sex reassignment surgery, found that, "The most common diagnoses are borderline personality disorder, latent schizophrenia, and impulsive paranoid character. The majority of them exhibit early developmental, cognitive, and affective disturbances, and severe character pathology" (p. 566). Documentation of these transsexual individuals as having borderline personality organizations, as conceptualized by Gunderson and Kolb (1978), Kernberg (1967, 1975), and Shapiro (1978), have been noted by several theorists (Barlow, Abel, & Blanchard, 1977; Golosow & Weitzman, 1969; Greenberg, Rosenwald & Nielson, 1960; Kavanaugh & Volkan, 1978-1979; Limentani, 1979; MacVicar, 1978-1979; Meyer, 1974; Volkan, 1979; Weitzman et al, 1970). Other theories contrary to the generally accepted non-conflictual theory of Stoller have been put forth (Greenson, 1968; Kubie, 1974; Kubie & Mackie, 1968; Lidz & Lidz, 1977; Ovesey & Person, 1973).

Although Stoller (1968) proposed his non-conflictual theory and advocated for sex change surgery, he detailed a careful assessment for appropriate surgical candidates. He recommended that a team of psychiatrists, psychologists, urologists and endocrinologists assess a transsexual, desirous of sex reassignment surgery, for six months to assess for psychological and physiological appropriateness. He believed,

> that only those males who are the most feminine, have been expressing this femininity since earliest childhood, have not had periods of living accepted as masculine males, have not enjoyed their penises, and have not advertised themselves as males (e.g., female impersonators) should be operated upon. (Stoller, 1968, p. 251)

This procedure is to minimize postoperative failures, manifested in patients by depression, suicide, psychosis, malpractice suits, prostitution, and a "patient's appalling feeling that it was all a mistake" (p. 251).

Longitudinal Studies of Sex Reassignment Surgery

"Most experts in the field today would agree that, when properly conceived and carried out, the sex-change procedure fulfills the highest ethical standards of medicine" (Blank, 1981, p. 110). Yet, definitive consensus regarding the ethics of sex reassignment continues unabated. Lothstein (1982) contends that:

> arguments both for and against sex reassignment surgery,... are based more on rhetoric than on hard evidence. Those who believe sex reassignment surgery is beneficial for certain patients must acknowledge the lack of hard empirical evidence supporting their views and the lack of even acceptable diagnostic criteria for selecting good candidates for sex reassignment surgery. Those who argue against sex reassignment surgery must account for the reported wide-spread patient satisfaction with the procedure and evidence of resulting positive life changes. (p. 417)

Longitudinal studies of sex reassignment surgery of the 1960s predominantly heralded outcomes as being favorable (Benjamin, 1966; Hertz, Tillinger & Westman, 1961; Money & Brennan, 1968; Pauly, 1968; Randell, 1969). Results of the 121 cases reviewed by Pauly (1968) showed that transsexuals undergoing sex reassignment surgery were ten times more likely to have improved emotional and social outcomes than those who did not undergo surgery. These results fortified support for continuing sex reassignment surgery (Blank, 1981).

The 80 to 90% sex reassignment cure rate claimed by the different longitudinal studies of the 1960s continued to support the belief that sex reassignment surgery was a transsexual's treatment of choice and that traditional psychiatric intervention was ineffectual. Examinations of these studies, by Lothstein (1982), showed that these outcomes were based primarily on the researchers' impressions and non-standardized data of "gross social-psychological measures of improvement" (p. 419).

This contrasted to Lothstein's (1980) analysis of longitudinal studies of the later 1960s (Golosow & Weitzman, 1969; Hastings & Blum, 1967; Money & Primrose, 1968), the 1970s (Arieff, 1973; Fisk, 1973; Gandy, 1973; Gottlieb 1978; Hoenig, Kenna & Youd, 1971; Hore, Nicolle & Calnun, 1975; Ihlenfeld, 1973; Laub & Fisk, 1974; Meyer & Reter, 1979; Money & Wolff, 1973; Sturup, 1976; Walinder & Thuwe, 1974), and the 1980s (Hunt & Hampson, 1980).

The differences between the perspectives of the 1960s versus the later 1960s, the 1970s and the 1980s is that the later studies no longer viewed sex reassignment surgery as a cure for transsexualism. Yet, it is felt that there continues to be evidence that it does provide satisfactory results for certain individuals. Ihlenfeld (1973), who reviewed Benjamin's 1966 findings, felt so optimistic about sex reassignment surgery that he advanced arguments supporting sex reassignment surgery for transsexual individuals aged in their fifties and sixties. A study conducted by Laub and Fisk

(1974) was significant in that it put forth the premise that sex reassignment surgery was a viable treatment for persons who were not transsexuals, i.e. transvestites and effeminate homosexuals. Fisk (1973) later reported dramatic post-operative improvement with psychotic and schizophrenic patients whose delusions centered on sexual identity. These optimistic results contrasted with reported cases of ambivalent preoperative transsexuals who desired and pursued reversals to original roles (Benjamin, 1966; Money & Wolff, 1973). Opposing results, likewise were evidenced, by reports of suicides of sex change surgery recipients (Randell, 1969).

Laub and Fisk (1974) believed that the prognostic indicator of sex assignment outcome was not the candidates' diagnoses, but the candidates' adaption to their gender role prior to surgery. Hunt and Hampson (1980) agreed with the prognostic indicator of presurgery adjustment to one's new gender role, adding also the factor of presurgical ego strength. Although "sex reassignment surgery has definite medical, surgical and psychological limitations, there is insufficient evidence to warrant its termination. Indeed, there is evidence suggesting that some gender dysphoric patients benefit primarily from sex reassignment surgery" (Lothstein, 1982, p. 424).

"It is important to distinguish between the transsexual syndrome for which sex reassignment surgery may be the only useful therapy and the transsexual syndrome that can benefit from psychotherapy" (Kirkpatrick & Friedman, 1976, p. 1196).

> To date the evidence suggests that many patients who would have otherwise undergone sex reassignment surgery may adjust to a nonsurgical solution through psychotherapy. Moreover, many disdiagnosed gender dysphoric patients need psychotherapy, not surgery. Indeed, sex reassignment surgery should only be considered as the last resort for a highly select group of diagnosed gender dysphoric patients. (Lothstein, 1982, p. 424)

Presently there is general criteria, but no legally required or universally accepted guidelines among clinics or states (Kirkpatrick & Friedman, 1976). A crucial need is development of stringent standardized criteria that will screen sex reassignment surgery candidates to optimize prognostically more favorable results. It is advised that those considered appropriate candidates receive preoperative and postoperative psychotherapy and/or counseling.

Psychotherapy

In conflict with the orientation that sex reassignment is indicated as a course of treatment for certain transsexuals is another school of thought. Kernberg (1975) and Kohut (1971) have:

> only recently [heavily influenced a contingency of]... psychotherapists...[who have] begun to conceptualize gender identity disorders in terms of borderline phenomenology and disturbances in self cohesion. While there are not yet sufficient data to construct a comprehensive theory, the view that the transsexual is a severely disturbed individual in a self struggle to become whole--seems to be a promising working hypothesis....Recent reports of successful psychotherapeutic outcomes support the idea that the soundest approach to these patients is not simply to determine whether they are "true" transsexuals; a wiser approach is to regard a request for surgery as a request for psychotherapy. (Eber, 1982, pp. 180-181)

There are theorists who believe there is increasing evidence demonstrating that transsexuals' gender identity is not exclusively set as either female or male. "The male transsexual's plea, 'I am a female trapped in a male body,' is a less than accurate statement of his deepest and most basic feelings. It is also inconsistent with current thinking regarding the psychology of self" (Eber, 1980, p. 31). Stoller and Newman (1971) conclude that despite sex reassignment surgery, "The feeling of having been--and at a deeper level of still being--male, cannot be fully extirpated. The bisexuality will thus persist despite the enormous changes in body appearance and gender role" (p. 27).

Individuals who present as transsexuals are being viewed by some theorists as having borderline and narcissistic pathology, with related developmental and theoretical aspects (Eber, 1982). Others suspect ego-dystonic homosexuality, schizophrenia with sexual delusions, and gender identity confusion (Dulcan, 1984). Still others describe transsexuals as conflicted and severely masochistic persons (Eber, 1980), or being transvestitic, homosexual, or paraphelic (Meyer, 1974; Money & Gaskin, 1970-1971; Newman & Stoller, 1974; Person & Ovesey, 1974a, 1974b; Stoller, 1971, 1975). Lothstein (1982) feels these gender-disordered persons present as borderline, polymorphous perverse, sadists and masochists, aging transvestites, stigmatized homosexuals, incipient schizophrenics, schizoids, and as displaying organic conditions.

> Psychologically oriented research and continued applications of psychotherapeutic approaches offer the best alternative to the current excessive reliance on endocrinological and surgical 'cures' for transsexualism. Psychodynamic theories have withstood the test of time and are based on data such as psychoanalytic reconstructions, experiences in psychodynamically oriented psychotherapy, and direct observational research. (Eber, 1982, p. 180)

Psychoanalysis has been deemed appropriate for presenting transsexuals due to their insufficient ego strengths. Although the consensus has generally been that psychotherapy with transsexual persons is characterized by poor results (Hastings & Blum, 1967; Laub & Fisk, 1974; Pauly, 1968; Sturup, 1976), others have reported favorable responses with psychotherapy and psychoanalysis (Forester & Swiller, 1972; Kirkpatrick & Friedman, 1976; Loeb & Shane, 1982; Lothstein, 1977).

Questions being posed by a number of theorists are: (a) Why is sex reassignment surgery continuing to be pursued as treatment choice for severely disturbed individuals, (b) Why are psychotherapy advocates not seeing a "slowing down of the momentum toward surgical transformations" (Eber, 1982, p. 180), and (c) Why have psychotherapists relinquished treatment of transsexuals to surgeons and endocrinologists when the origin of the problem was evident as being psychological, not organic (Eber, 1982). One major contributing factor is the continued impact and uncritical acceptance of Stoller's (1968, 1976, 1978, 1980) view of the non-conflictual origin of transsexualism, and his belief that psychological means will not amend a transsexual's

fulfilling requ-

surgery (Meyer, 1982).

their story has to be in order to ge-

1971, p. 81).

Countertransference

Despite transsexuals' resistance to engage in psychotherapy, is there, perhaps resistance from therapists to engage them in therapy--resistance that extends beyond theoretical bases? Or, once initiating therapy, is the client inadvertently driven away? Eber (1982) contends that:

> for nearly twenty-five years, there has been an obvious and strong disinclination to become involved psychotherapeutically with transsexuals--very likely because therapists find them too disturbing. [He believes that] these patients, perhaps more than any other group, stir up in their therapists conflicts and anxieties that call for defensive disengagement. (p. 178)

"It is possible for even a well-established professional equilibrium to be temporarily disturbed by the extreme and unusual nature of the transsexual's complaint" (Erickson Educational Foundation, p. 37). Kubie (1971) points out that, "To treat patients intensively always stirs up pain [in the therapist], and pain always triggers an impulse to run away" (p. 103).

The literature most definitely acknowledged that intens countertransferences are evoked in the therapists working

with transsexual clients. Kernberg (1975) and Nadelson (1977) address issues encountered when treating challenging patients of any presenting syndrome--issues such as fatigue, depressive guilt, boredom, and a sense of emptiness. Lothstein (1977) states that, "Therapists are usually unprepared to deal with the pervasive excitement, confusion, anxiety, frustration, and rage which characterize and impede the evaluation/ treatment process" (p. 568). Eber (1982) believes that, "With transsexual patients, the pain therapists run from is connected with incompletely resolved castration anxieties and bisexual conflicts" (p. 178). Lothstein (1981) states that countertransference issues "emerge as central to the understanding of the gender dysphoric patient's psychopathology and the subsequent treatment provided" (p. 568).

The sole article found that focused on countertransference issues arising when treating transsexuals was written by Lothstein. Lothstein (1974) identified five stages that occur as the therapist-transsexual client relationship develops. It is crucial for the therapist to be aware of the existence and the progression through this therapeutic process in order to establish a therapeutic relationship that will benefit the client. The therapist must recognize not only the stages that her/his patient will experience, but what stages s/he will experience. "There is no necessary causal relationship between the patients' and the therapists' stages [although] the latter...are somewhat reactive to the patients' stages"

...ht and...

...valuation, and (e) ...

...tance and attachment. The therapists

voyeurism, (b) cognitive confusion, (c) denying and

...achment versus overidentification, (d) therapist gender-

...le consolidation (countertransference hate), and (e)

working through.

The therapists' first stage of voyeurism arouses "intensely ambivalent feelings associated with...curiosity, excitement, and interest in the self-presentation and appearance of the patient which is often bizarre" (Lothstein, 1977, p. 574). This may cause therapists with strong prohibitions and superego conflicts associated with "looking" to feel intense feelings of guilt which appear as fantasies of retaliation and punishment. This may affect the patient's narcissism, causing the patient to regard her/himself as either a freak or someone special.

Stage two of confusion in the therapist is most apparent when the therapist experiences the patient as different than their presenting gender role. This may be seen by the therapists' confusion regarding which pronouns to use when referring to her/his patient, or the therapist may find her/himself experiencing states of disorganization regarding the transsexual's problems.

The third stage is denial and detachment versus overidentification and acceptance. "The strategy of denial-detachment in which the therapist attempts to uncritically and nonjudgementally accept the patient's problems may eventually entail the emergence of anxiety, somatic symptoms, and microdissociative states in the therapist, especially if he is accepting of behaviors and pathology basically antithetical to his own value system" (p. 578). In an attempt to maintain a nonjudgemental and accepting attitude through overidentification can result in mismanagement, misdiagnosis, and mistreatment.

The fourth stage of therapist gender role consolidation is the point at which many gender dysphoric clients may be the recipients of their therapist's strong countertransference reactions.

> Through the mechanism of empathic overidentification or empathic regression (Kernberg, 1975), the therapist by being exposed to the patient's gender identity conflicts, finds that previously consolidated aspects of his own gender identity and resolved neuotic conflicts are refocused and sometimes reactivated as conflicts in the therapy itself. In response to the surge of archaic rage and preoedipal conflicts in the patient, the therapist may react to the gender dysphoric patient with hostile and angry behavior which represents the therapist's anxiety aroused by the reactivation of his earlier resolved neurotic conflicts. (Lothstein, 1977, p. 579)

The fifth and final stage involves two phases--attachment and detachment--as working through is resolved. During this phase the therapist is in the process of viewing his patient more realistically and working through basic treatment conflicts that emerge. The therapist's Messianic impulses

are subdued as s/he recognizes that surgical interventions will not change character structure. Guilt feelings may surface when s/he must inform a patient whom s/he has been aligned with for months or years, that s/he is not eligible for surgery. The therapist may express her or his guilt by becoming angry at other staff members or at the client. The therapist may experience a depression triggered by ambivalent feelings regarding therapeutic management of the case.

The second half of this final stage--detachment--occur with the termination phase of therapy, be it unexpected by her/his patient's actions, or carefully planned. Patients who suddenly disappear may evoke feelings of rage in the therapist who may feel abandoned or betrayed. Other therapists may be aware of relief at their responsibility for treatment care ending. Therapists can also anticipate increased anxiety as regressive episodes in their patients are triggered by termination effects "or as the effects of surgical complications prolong patients' physical and psychological sufferings which may eventually lead to personality decompensation, hospitalization, or suicide" (Lothstein, 1977, p. 580).

Clinical Dilemmas

Sex reassignment surgery? Normative life choice? Increased satisfaction? Questionable outcomes? Outright failures? Psychotherapy? Severe pathology? Countertransference issues? These are considerations confronting the therapist of a transsexual client.

> While DSM-III addresses some of the confusing diagnostic issues among the gender identity disorders, the new criteria do not deal with treatment issues. In addition, there are no standards for the medical-psychological care of patients with profound gender dysphoria (transsexualism). As more and more patients request sex reassignment surgery, the issue of appropriate treatment for them becomes central....A combination of several factors--the availability of surgery, media exposure, the existence of national and international referral centers and information sources, and the establishment of many gender identity clinics--has made it necessary for clinicians to take a stand for or against sex reassignment surgery....
>
> As long as there are no universally accepted standards of care, hospitals can either prohibit sex reassignment surgery or make it routinely available to gender dysphoric patients on a fee-for-service basis. If sex reassignment surgery becomes a Medicaid-subsidized procedure, it could be performed on many nontranssexual patients with gender dysphoria, who may later regret decisions. While all practitioners should be concerned about the unrestricted use of sex reassignment surgery, it may be that for some patients sex reassignment surgery is the treatment of choice. Those clinicians who espouse sex reassignment surgery, however, must determine which gender dysphoric patients are the best candidates for the procedure. (Lothstein, 1980, pp. 417-418)

The Harry Benjamin International Gender Dysphoria Association, Inc., has evolved the "Standards of Care" (1981) guidelines to help the professional in clarifying this complex responsibility. The "Standards of Care" outline <u>minimal</u>, not optimal criteria, and individual professionals may recommend that suggested time parameters be doubled or tripled. The standards of care require that:

> Prior to the initiation of hormonal sex reassignment the patient (a) must demonstrate that the sense of discomfort with the self and the urge to rid the self of the genitalia and the wish to live in the genetically other sex role have existed for at least two years; and (b) the patient must be known to a clinical behavioral scientist for at least three months and that clinical behavioral scientist must endorse the patient's request for hormone therapy....Prior to the initiation of genital or breast

> sex reassignment (penectomy, orchidectomy, salpingectomy, vaginectomy, phalloplasty, reduction mammoplasty, breast amputation) [the patient must fulfill requirement (a) detailed above]; (b) the patient must be known to a clinical behavioral scientist for at least six months and that clinical behavioral scientist must endorse the patient's request for genital surgical sex reassignment; (c) the patient must be evaluated at least once by a clinical behavioral scientist other than the clinical behavioral scientist specified...(above) and that second clinical behavioral scientist must endorse the patient's request for genital sex reassignment; (d) at least one of the clinical behavioral scientists making the recommendation for genital sex reassignment must be a doctoral level clinical behavioral scientist; [and] (e) the patient must have been successfully living in the genetically other sex role for <u>at least</u> one year. (1981, pp. 12-13)
>
> A plethora of theories exist regarding the etiology of gender dysphoria and the purposes or goals of hormonal and/or surgical sex reassignment such that the clinical behavioral scientist making the decision to recommend such reassignment for a patient does not enjoy the comfort or security of knowing that his or her decision would be supported by the majority of his or her peers....
>
> Clinical behavioral scientists given the burden of deciding who to recommend for hormonal and surgical sex reassignment and for whom to refuse such recommendations are subject to extreme social pressure and possible manipulation as to create an atmosphere in which charges of laxity, favoritism, sexism, financial gain...may be made. (p. 9)

The prevailing opinion that psychotherapy rarely proves successful with transsexual clients may discourage a practitioner from conducting the initial interview in a manner that would encourage a client not to initiate or continue psychotherapy (Lothstein, 1977).

> The establishment of a therapeutic alliance is not only difficult but often unattainable if (1) the therapist is unwilling to gratify at least partially some of the gender dysphoric patient's narcissistic needs, or (2) the patient senses that the therapist's intensions are necessarily oriented toward a nonsurgical solution thereby increasing the patient's sense of urgency and hopelessness. Gender dysphoric patients often fail to show up for appointments, arrive at their own times, and often bring guests with them, insisting that they

be included in the psychotherapy hour. (Lothstein, 1977, pp. 567-568)

> In addition, patient's frequent insistence on sex-change procedures and their concomitant feeling that psychotherapy is an obstacle to reaching that goal compound the difficulties of treating these patients psychotherapeutically. Indeed, the interaction between the defensive disengagement by psychotherapists and the resistance to psychotherapy by gender dysphoric patients creates a formidable barrier to treatment. (Eber, 1982, p. 178)

Special difficulties are created for the therapists of manipulative, seductive and demanding transsexual clients (Lothstein, 1977).

It is necessary for the therapist to be able to monitor their countertransference reactions for their professional "equilibrium to be restored and maintained if productive work is to be accomplished" (Erickson Educational Foundation, p. 37). "The dramatic impact of the request (for sex reassignment surgery) can also divert the...[professional] from her [his] usual interest in the whole personality. This is a disservice to the patient" (Kirkpatrick & Friedmann, 1976, p. 1194)

> Psychotherapists' defensive disengagement from disturbing patients is supported and nourished by current social attitudes. In recent years we have witnessed profound social changes, not only a revolution in sexual mores, but broad based cultural upheavals that challenge all traditional beliefs....Society supports the need to view transsexualism as a nonconflictual sexual variant, (Eber, 1982, p. 179)

just as it encourages us to "legitimatize any nonheterosexual behavior and to view it as proper, acceptable, normal and natural as heterosexuality" (Levine & Ross, 1977, p. 647).

Community support for sex-change surgery can enhance a client's resistance to enter exploratory psychotherapy (Lothstein, 1977). This is exacerbated by knowledgeable

transsexual patients often presenting a misleading front to an evaluating therapist in their attempt to qualify for sex change surgery (Benjamin, 1971). Also, "These patients often employ massive denial during clinical interviews thereby appearing more intact than they really are" (Lothstein, 1977, p. 566). Another factor affecting accuracy of an initial evaluation is that previous evaluators or the present evaluator may "overtly or covertly give clues that would... enable the patient to present a better story the next time" (Kirkpatrick & Friedmann, 1976, p. 1195). It often is not until psychotherapy is in process over time and psychiatric testing results are gathered that the discrepancy between many transsexuals' original self representations and actual psychological profiles are established.

It is clear that the variety of theoretical perspectives and resulting non-standardized clinical treatments for transsexual patients presents involved therapists with clinical dilemmas and challenges that have remained unresolved by time. It seems only natural that therapists would experience reactions to these dilemmas. Therefore, clinical dilemmas and associated countertransference reactions of therapists who have treated transsexual clients, were explored in this study.

CHAPTER III

METHODOLOGY

An exploratory study was undertaken to examine countertransference reactions experienced by therapists' treating pre-operative transsexual clients. A sample of convenience was gathered. Subjects were interviewed in person by this researcher on a one-to-one basis.

Subjects

The sample was drawn from a volunteer population of psychotherapists and related professionals within a one hour commuting distance of a major New England city. Participant inclusion required that the subjects had treated a minimum of one pre-operative transsexual client, for a minimum of five encounters.

The sample population, was comprised of five females and seven males, whose ages ranged from 29 to 50 years, with the median age being 38 years old. Six therapists presented themselves as having a heterosexual orientation, three as having a homosexual orientation, and three did not indicate their sexual orientation.

The twelve subjects represented a varied background of professional and personal experiences. The sample population

included three licensed social workers, four psychiatrists, one Ph.D. psychology candidate, two counseling psychologists, one evolutionary biologist, and one specialized clinical nurse. All subjects worked at the time as mental health professionals in counseling related centers, hospitals, and/or in private practice. Their clinical orientations ranged from psychoanalytical to family systems, to behavioral, to eclectic perspectives.

The number of years that sample members had worked with clients representing varying diagnostic categories ranging from 2 to 23 years, with the median number of years being 13.5 years. Subjects were referred to as "therapists" throughout this study, since all respondents felt comfortable with that label being used to define their roles. Seven of the therapists previously had been on the staff of a clinic specializing in gender associated disorders.

Therapeutic modalities in which these transsexual clients were treated varied. Twelve therapists had treated transsexual clients individually; six therapists had treated their clients in a couple modality; four therapists had treated their clients in a family modality; and one therapist had treated clients in a group modality.

Participants had treated 1 to 40 pre-operative transsexual clients, with the median number of treated transsexual clients being seven. The number of pre-operative male-to-female transsexual clients serviced by participants ranged from 1 to 35, with five clients being the

median number of such clients treated. The number of pre-operative female-to-male transsexual clients served by subjects ranged from 0 to 13, with the median number of such individuals being 1.5. Length of treatment duration with pre-operative transsexual clients ranged from one session to 6 ½ years. The number of pre-operative clients on participants' caseloads at a specific time in their careers ranged from 1 to 12 clients, with the median number equalling 2.5 clients. At the time of the interviews, eight of the subjects' current caseloads included pre-operative transsexual clients. Four subjects had directly treated such individuals 5 to 10 years ago.

Data Collection

Permission to audiotape interviews also was discussed during initial telephone contacts. Eleven of the 12 participants were amenable to audiotaping of interviews. A remaining subject requested not to be audiotaped. However, he agreed to having the interviewer take notes during the meeting.

At the onset of each interview, a subject was presented with a consent form, reiterating the purpose of this study, requesting permission for audiotaping, and guaranteeing confidentiality for the informant and his or her clients. Next, a demographic questionnaire was filled out by each subject regarding information that was considered potentially pertinent to this study's outcome. Copies of these materials are in Appendices A and B.

The 12 subjects were interviewed during March and April 1985. Due to faulty audiotaping, contents of one interview were not recorded, necessitating a 13th interview occurring during May of 1985, to accrue data from 12 informants.

An interview protocol was designed by the researcher, based on reviewed literature and related speculations. Before administration of the interview to the sample population, a pretest interview was conducted with a M.S.W. candidate, who did not meet the requirement of having treated a transsexual client. Modifications to the questionnaire's final form were made in response to pre-testor's input. (See Appendix C.)

The interview was divided into four sections. The first concerned the diagnostic considerations that occur when treating a pre-operative transsexual client.

The second section was designed to elicit responses regarding clinical dilemmas related to transsexualism. This was examined through questions pertaining to dilemmas noted in the literature review.

The third section focused on subjects' reactions evoked through their delivering direct services to pre-operative transsexual clients. These questions were designed to elicit descriptive responses regarding therapists' countertransference experiences.

The final section of the interview centered on theoretical considerations. This served a twofold purpose--to elicit

participants' hypotheses regarding pre-operative transsexual clients, and to provide interviewees with time to discuss reactions that may have been evoked by the emotional content of the protocol's previous section. The length to which certain information was explored with each individual was determined by the interviewer. The interviewer judged which replies to probe more thoroughly, based on the content of subjects' initial question responses, and areas of expertise.

The audiotapes of all interviews were replayed and statements judged as significant were transcribed. Analysis of the contents occurred by coding responses to each question or cluster of related questions.

CHAPTER IV

FINDINGS

This study was designed to examine clinical dilemmas intrinsic to treating a transsexual population, and concomitant countertransference reactions of the treating therapists. This topic was approached through exploring therapists' countertransference reactions related to their transsexual clients. Facets specifically probed included therapists' countertransference reactions related to diagnostic considerations, resolution of their clinical role, and effects of their traditional sex role conditioning. Feelings evoked in therapists were a direct outgrowth of clinical dilemmas inherent in the management and treatment of transsexual clients. This section will serve to elucidate that outcome.

Dilemma: Diagnostic Considerations

Defining Transsexualism

At the initiation of this study's 12 interviews, the definition for transsexualism, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM III), was read to each subject (1980, pp. 161-162). (See Appendix C.)

Eight of the 12 participants reported that they had modified the DSM III definition in accordance with their personal observations. These eight colleagues gave credence to a participant's comment, that the definition of transsexualism has "shades of gray."

Four of the eight study participants felt that the primary criterion for determining if an individual was a transsexual hinged on the person having felt since early childhood, not just in the last two to three years of adulthood, that s/he was born into the wrong body for s/he has always known that s/he was of the opposite gender. One subject expanded this early childhood factor by coupling it with a client's expression of longstanding acute discomfort with one's own genitals and wishes to conform one's body to one's mind. Another interviewee further detailed this by adding that a transsexual individual has not only sensed this for as long as s/he could remember, but likewise reported playing with opposite gender children during the time that children developmentally prefer to play with same sex peers; and likewise, during childhood, experienced sexual attraction toward anatomically similar peers.

Criteria used by another three of these subjects who have developed modified DSM III criteria for diagnosing a person as a transsexual involved self-identification. If the client expressed that s/he is a transsexual, then it is so. One participant believed that if a person feels that if s/he does not want to be the gender s/he is, then s/he

is a transsexual. Another individual similarly focused on a client's expressed belief of, "I feel I am transsexual," as being a significant key to determining if a client is a transsexual.

Such a diversity of modifications to the DSM III definition of transsexualism indicated the uncertainty, non-clarity, and confusion that can confront a therapist who works clinically with a transsexual client. This was aptly expressed by a more experienced therapist of transsexual clients as follows:

> The DSM III definition and all the other definitions of transsexualism I've ever come across have always left me puzzled when I've compared those with what I encountered in the field. I haven't found anyone that I've worked with who fits the transsexual picture that you're supposed to see. Everyone I've met with has always presented with a vastly more complex picture than that....I don't know. It's a quirky business.... I've yet to have found a definition that really makes sense....I think the biggest difficulty in this business is making an adequate diagnosis.

All study participants reported that their experiences and observations of their transsexual clients revealed diagnostic similarities to other clinical syndromes. The most frequently cited category, borderline pathology, was referred to by eight of the interviewed subjects. Similarities were noted, both in client profiles and in countertransference experiences.

The clinical nursing specialist described how her male-to-female transsexual patient, on an in-patient ward, affected her:

> She was definitely a borderline....I was constantly angry with her, in spite of myself. She was infuriating and she was also a baby. Every rule had to be tested. Every limit had to be challenged.... Working with her made me crazy. That's a closer word to my affect than [the word] 'uncomfortable.'
>
> I hadn't had that kind of intrusion in my life outside of work for many years....The dreams were more confusing....The only time I had dreamt about clients was during my first job, working with extraordinarily sick individuals, and [I] was frightened that I would have done something wrong. I had a lot of responsibility on a locked unit with a lot of sick people, and I would worry. I would go home and say, 'Oh, my God'....I had a lot of anxiety about people being okay, but it wasn't in the way that their particular way of being in the world affected me personally. There was a difference.

Four of the participants noted that their transsexual clients brought to mind non-transsexual clients who were schizophrenic. There were four subjects who responded that their transsexual clients reminded them of atypical sexual disorders. The similarity to narcissistic disorders was mentioned by three contributors. One description of the latter was given by a clinical social worker:

> When you watch transsexuals going through hormonal changes it's very much a regressive period, very much like going back to adolescence. Just as adolescents have to go through periods of awkwardness of adjusting to having breasts, girls will sit, with their arms across their breasts, shy, not wanting anyone to see. So will transsexuals. They go through the same kinds of acute narcissism about the body. They're so focused on what's happening to them as are adolescents. And they're very concerned about their complexions and nail polish....I'm referring especially to a male-to-female now; similarly for the female-to-male, going in the other directions, of taking on masculine kinds of behaviors, and going through some of the physical changes there.

Three participants focused on diagnostic similarities between their transsexual clients and non-transsexual clients

with depressive disorders. Two individuals commented that their transsexual clients reminded them of neurotic clients, and another two subjects cited an anorectic population. A clinical psychologist elaborated on her association to anorectics:

> They're similar in that all of their pathology gets focused on this one thing that they have to change, that they get obsessive about. They avoid all of the other problems, like being out of control, or being unable to be close to people, being terrified of intimacy.

The following clinical syndromes were referred to by one subject each: alcoholism, character disorder, and multiple personality. One participant mentioned child molesters, for as a therapist comes to understand clients' circumstances and motives, s/he realizes that the clients were not evil.

Two qualities, although not constituting diagnostic entities, were mentioned in significant numbers by this study's informants. Clients' excessive demandingness was referred to by all of the subjects. Also, the quality of self-destructiveness, (i.e. suicidality, self-mutilation), was mentioned by 6 of the 12 interviewees.

Etiology

Seven of the eight subjects who devised their personal modifications of the DSM III definition of transsexualism, likewise expressed a stronger desire for definitive etiological facts. "Etiology?" exclaimed one informant. "Beats me. How can you treat a transsexual without understanding the etiology?"

All of the 12 interviewed subjects expressed uncertainty regarding the etiology of transsexualism, posing single and multiple variable possibilities. Six of these participants conjectured that there is probably a biological component. Three of these persons felt a biological component was the sole contributing factor. Five of the 12 interviewees speculated that there may be traceable family systems dynamics, and three therapists questioned if transsexualism was a symptom of other pathology.

The majority of subjects interviewed desired greater clarity and certainty pertaining to diagnostic parameters of transsexualism. This would enhance therapists' confidence levels in selecting clinical interventions. This was further elucidated by a respondent's feedback:

> It's very recent that I've been aware of feeling as negatively about sex reassignment surgery as I do. Part of it is that nobody understands why they're transsexual. If someone knew for sure that there had been some biological mistake I wouldn't have as much trouble. But if it's really of psychological origin, then going along with it, well, I don't know. Maybe they'll come out better for it. Part of it is that I just don't have knowledge, backing of the outcome, yet some of the studies show results going both ways.

Another respondent commented that, "It would be so much better if we could just have a person take a test that would enable the therapist to say 'you are, or you're not.' You could say, 'like it or not, you're not [transsexual], so you can't have the surgery."

This viewpoint was further supported by four participants expressing appreciation for the presence of the Harry Benjamin

International Gender Dysphoria Association, Inc.'s "Standard of Care" guidelines, regarding diagnosis, management and treatment of transsexual individuals. The guidelines served as a therapist's ally, for they could be used to say to the client, "Look, there are the guidelines...and I don't really have any control over them."

Dilemma: Clinical Role in Treatment of Transsexual Clients

Training Versus Treatment Management

The presence of indistinct diagnostic criteria had an impact on participants' understanding of their clinical role. Ten of the 12 study participants expressed having experienced notable frustration that their clinical training lacked clarity in preparing them for the clinical management of transsexual clients.

> This is totally out of character with what we have been trained to do as therapists. There's a totally different manner that is appropriate to work with a transsexual client, that would be totally inappropriate to work with any other kind of client...

Another more seasoned mental health professional explained:

> [Working with transsexual clients] causes you to switch gears [theoretically]. You're coming from an orientation where you take certain things for granted, like the notion of being castrated giving rise to a good deal of anxiety, and people developing defensive postures in order to be able to cope with that. And here you have people walk in and that's precisely what they want. Well, then what do you make of castration anxiety? Where does that go then? [You're] trying to sort out what is often very subtle and complicated, the interaction between psychopathology and the true gender condition, trying to sort out the chicken and the egg.

> The other thing that's unique is that in regular therapy what you do most of the time is try to help people not to act out the conflicts and behave out in the community in ways that are fundamentally counterproductive. Yet, I'm convinced, that for gender patients they absolutely have to do that. They have to try things out. They have to try wearing different clothes. They have to see what that's like because so much of their emphasis is at a fantasy level of what life will be like when they get this change....There's a good deal of reality testing that people have to do.... It's a much more kind of active process than just straight therapy where most of the time you just try to get people to reflect on what they do and understand it in an effort to keep them from engaging in various erotic behaviors.

Another therapist more experienced in working with transsexual clients commented on the training versus treatment management contradiction in greater detail:

> You'll have male-female clients ask you about clinging slips and things you'd never get into a conversation about if you were working with a client of any other type. So they will ask you extremely practical issues that you take everyday for granted and become a real subject of discussion, and very legitimately so, for someone who's entering your own gender or going the other way. There's lots and lots of very hands on matters. They'll show you things. They'll show you their underwear or they'll show you things you'd just never get into with other people. It's an overwhelming experience, and one of the few people the client can share it with is the therapist. So you really can't deny them the opportunity to process it. You can't pretend it doesn't exist. The clients need a respectable and responsible person to check it out.
>
> You have to be flexible as a therapist. For example, as a therapist I had never gone to somebody's home. I always saw people in the clinic setting, but for one particular patient I went to his home to meet with him on his own turf, so that I could see him cross-dressed. He was just beginning to try to cross dress. He was so nervous about going out in public, so I made it easier for him. Of course, it was a shock to me. I had to handle my own feelings, and try to be supportive of him without misleading him. So you had all of these shifting feelings as to how far do you go, not too far, but far enough. You're wanting this person, who's insistent on going down this road, to try it so they can see how it is for them. But at the same time you have to walk that fine line all the

> time of being supportive enough to allow the person to experiment, but not being so supportive that they think they're gorgeous and they look wonderful and what a beautiful woman they are, when they're not. You have to be realistic. It's a constant battle.
>
> So therapists can be thrown into all kinds of situations where you have to be outside of your normal role. For instance, I've come in and out of the office with a transsexual, who when he was a man, would open the door for me. When we were two women walking out, I would hold the door for him. It was funny. It was humorous. There are lots of issues like that when the gender change [affects how] when you're in one role you act one way and when you're in another role you act another way. There's a lot of humor and a lot of adjustment on the part of the therapist to keep up with all this.

<u>Sex Reassignment Surgery Stance</u>

The lack of clarity between therapists' clinical training and actual treatment and management of transsexual clients necessitates that therapists individually determine their positions regarding endorsement of sex reassignment surgery. Eight of the 12 study participants have assumed the stance that their role as a therapist of a transsexual client encompasses their judging and recommending appropriate transsexual clients for sex change surgery. Six of those eight subjects had done so already.

The quality of demandingness noted in the previous section proved to be a recurrent theme among the eight persons who would endorse sex change surgery. This theme was intrinsic to a pro-surgery stance, for it placed the would-be endorser in a powerful position--a God-like position as a "gatekeeper." The therapist holds the "key" that can allow a client to cross the threshold to the surgeon's operating room. This is due to the Harry Benjamin International

Gender Dysphoria Association, Inc.'s "Standards of Care" guidelines, requiring that medical personnel who would prescribe hormones, and who would perform a sex change operation, first receive a letter recommending those procedures from the transsexual client's treating therapist. Inseparable from the gate keeper function was the increased potential that a therapist would be confronted by clients who presented misleading or deceptive fronts. An experienced clinician of transsexual clients explained, "There was always this uncomfortable issue of people trying to convince you... by the way they present themselves, that they're a good candidate...so that you'll give them what they want, and you don't know how much truth is in there, and it's a hard struggle." In reality, they could be disorganized, and not functioning successfully in work and relationship arenas. Clients have frequently learned from reading and from talking to other transsexuals and previous therapists, how to fool a therapist.

Therapists devised a variety of ways to minimize the risks of being deceived by their clients. One person required historical medical documentation of clients' gender concerns from their childhood physicians. Three subjects required the involvement of other family members for data collection purposes. One therapist demanded that transsexual clients cross-dress for a year, during their relationship, before sex reassignment surgery would be considered an option. Another insisted on a therapeutic relationship for a minimum of a year.

A related consequence of being a gatekeeper was therapists' frustration that their treatment role was just a formality. This was illuminated by an interviewee as follows:

> I had a harder time with people who came in simply for the key. 'Write me a letter, Doc. That's all I need.' It had me feeling a little bit used. I recognized at the same time, of course, the bind that the particular client was in. But it had me rather feeling helpless, and except as a gatekeeper, rather useless. Their objective was not to use me as a therapist, but as a gatekeeper. I would say I was frustrated that I wasn't using my skills. I felt at the same time, and was hoping, that part of the frustration was not being sure most of the times, whether I was hearing the entire story or not. And look, you never know, you never know. I don't like being a gatekeeper. It's a problem.

One subject compared being in a gatekeeper position to being responsible for someone on parole. When confronted with a letter from the parole board the therapist has to determine if the parolee has conned you or presented as s/he truly is. "It's not somebody who really cares to have you get to know them. It conflicts with a therapist's training of trying to let the judgemental position go."

Dilemmas integral to endorsement of sex reassignment surgery were catalysts for evoking emotional reactions in therapists. There were expressions of emotional soul searching, as seven of these eight pro-sex change surgery participants expressed a need to allay their inner doubts. Moral values were questioned. A therapist from a background of experience with transsexual clients vented what was thematically described in varying degrees by the seven elaborators:

> What about ten years down the road? It sends shudders up me. I have not dealt with someone who had the surgery. My God! What kind of mess is that going to be? It's hell to go through. What do you do if you make the decision?....It's a sense of the door is opening on some Pandora's box of problems.
>
> Some mistakes get made, you know, in this business.... Bridges get burned.

Sitting with a client can be painful for the therapist, even if the therapist feels that the person is making the correct decision. Such an account given by a therapist, practiced in treating transsexual clients follows:

> What makes it so hard is that for so many of these people the longing is so intense, and when you have someone who is like a big guy, six feet-three, with a very heavy beard, and very broad shoulders, and you see that person struggling so hard to wear a dress, and to pass on the streets, and you know it's not going to work because the guy's got hands the size of hams, it's painful to watch. It's very painful to watch. And sometimes I just say [to myself], "God. Go play baseball or something. Please find something else to do.' So that's one instance in which even though you feel the person is making the right decision, it's still hard to watch.

Reports of soul searching, of moral considerations, experiencing "personal anxiety sitting with someone who wants to lop off various body parts...," feeling "relief, and thanks God. I'm so glad. I must have done something right," when a client announces that s/he is returning to her or his original gender, and poignant descriptions of feelings evoked in the treating therapists, leads one to ponder why these eight therapists chose to endorse sex reassignment surgery. There were two factors that emerged in the interviews--therapists' empathetic projections, and their resolutions of the clinical role conflicts.

All of the eight believers in sex reassignment surgery endorsement made statements describing a significant feeling of empathy toward their transsexual clients. These comments portrayed efforts to understand the intensity of their transsexuals' yearning.

> You have to imagine how much pain you'd be in to be willing to risk the chance of changing everything in your life, and to sit down, and to think that that would be more comfortable than you've got right now. So that's how powerful that you've got to feel.

One therapist compared the occurrence of initial gender changes in a client as being analagous to observing a person learning to ride a bike.

> You go from that wobbling stage where every moment you're watching, not knowing if somebody is going to fall, or hurt themselves, or be hurt in the process, and then [the riders] get more proficient at it. So there's...the desire to be somewhat protective to try to get through to people to be protective of themselves, because they're very vulnerable.

Another participant explained, that despite aroused repugnance, "When I started to see how ugly the world could treat transsexual people, it gave me a boost to see them again." Transsexual clients' demandingness also was tempered by empathetic feelings.

> You really look at what transsexualism is all about, and the frustrations in the lives of transsexuals, mostly to the point that...when they come in, they may never have shared with anybody else the fact of their transsexualism, and the issues attendant to that. Are they concerned about making an impression? Yes. Are they concerned about whether you are going to be able to help them out? Yes. Might they feel a pressure and immediacy in getting help that they've wanted and not had for years? Yes. Are they pressed for hormones and so on? Yes. I just think that that's all understandable.

Another empathy related theme from this sub-group of eight participants was the satisfaction and reward derived from seeing positive changes in transsexual clients. Once a letter was written to an endocrinologist recommending hormones, "You could sometimes see remarkable changes when you gave them this gift of allowing them to have hormones, they would then get down and go to work, so then it would be very rewarding, but it's hard to deal with."

The therapists regarded a crucial element of their role not only to be a letter writer, but also to serve as a catalyst in having their clients consider reality issues, contemplate options other than sex change surgery, and acknowledge and work through existing gender and sex change ambivalence. Their empathetic capacities towards this population appeared a significant key in facilitating a resolution of the training versus clinical role dilemma. The comment stating, "If this looks like a better road for them, than where they've been, then who am I to stop them?" was characteristic of the eight upholders of sex reassignment surgery. This was further summed up by one therapist who stated that, "By helping them to the best of our ability we're doing them far greater service than ignoring the problem as if it didn't exist, or refusing them what they so desperately say they need."

The remaining four interviewees expressed indecision regarding their stance on endorsement of sex reassignment surgery. Their indecision appeared primarily due to their

less experienced level in working with transsexual clients. They had not yet worked with a client who fulfilled the criteria noted by the Harry Benjamin International Gender Dysphoria Association, Inc., "Standards of Care" guidelines, that would deem a transsexual an appropriate sex change candidate. Therefore, they had not yet had to assume a definitive "for" or "against" sex reassignment surgery position.

This subgroup grappled with training versus clinical role conflicts regarding the inclination to adopt a neutral stance. However, the inherent dilemma existed that there can be no neutral stance, for not endorsing sex reassignment surgery, is in fact, a stand opposing it. Indecisiveness gave rise to feelings of anxiety, frustration, and deception. All four subjects expressed relief that their clients' had not yet qualified for sex change surgery. Postponement of that decision was still possible.

However, one of the four subjects expressed an increasing inner conflict and arousal of intense feelings as a client approached an increasing readiness for sex reassignment surgery. "The other week he came in looking more female than I've ever seen him, and I found myself very upset by it. She described her turmoil:

> The frustration I feel has a different quality to it than with my other clients. Partly I feel a little deceptive. I have a different agenda than they. They come to me because they want me to help them get through the sex reassignment surgery, and I want to do therapy. I guess now that I'm realizing that I feel like that I'm sort of caught, because I feel like I'm partly their

> ally, and I'm partly not. I care about them as individuals. I care about their health, and their mental health. But I find myself not wanting the same results as they do, and that's not really fair.
> Somehow [I feel] I'm betraying them no matter which way I go. I'm either betraying myself or them--myself if I encourage the surgery, and [I'm] betraying them if I discourage it. I don't have that dilemma with anyone else. Usually our plans are the same. They [non-transsexual clients] want to be better adjusted. I want these [transsexual] people to be better adjusted, but not the way they do.

Colleagues' Opinions

Another consequence of delivering clinical services to transsexual clients involved feedback received from uninvolved colleagues. Ten of the twelve participants reported negative feedback concerning their work with transsexual clients, from colleagues. Negative feedback proved a catalyst that caused 5 of the 12 subjects to express concerns regarding their professional reputations. These concerns included feelings of vulnerability regarding potential lawsuits and client suicides.

> It's high hazard work. That just has to be accepted.... You think that you might get some very publicized bad result, that's really going to be criticized....That's probably the greatest stress of working in this area.... One's reputation is not exactly enhanced by working with transsexuals, so I try to keep my involvement very limited, usually to one, maybe two at a time.

Dilemma: Traditional Sex Role Conditioning

Given the inherent dilemmas in working with transsexual clients it was interesting to consider personality qualities that may enhance one's ability to treat transsexual clients.

> I think a person has to be non-judgemental. I think that's the very first bottom line. Someone has to be very openminded about lifestyles. I think that's the

> prerequisite, because a person, if they're going to have conniption fits over trying to adjust to these things, they're going to be rigid and it'll be very hard for them and non-productive for their clients. You have to have enough openness for your client to tell you where they're at. If you're so closed that you don't let them even tell you then you'll never help them, no matter whether they're transsexual or not. So that is important--to try to get therapists who want to work with transsexuals.

Comfort Level with Androgyny

One aspect of the ability to be non-judgemental with transsexual clients was related to therapists' comfort level with androgynous individuals. "Androgyny refers to a combination of both feminine and masculine traits in a single individual....Thus, if a person is androgynous, he or she possesses both masculine and feminine characteristics" (Hyde, 1982, p. 334). Subjects, based on comments regarding internal conflicts, were placed into two categories--those who were more comfortable with androgyny, and those who were less comfortable with androgyny. Eight of the subjects interviewed were judged as having more comfort with androgyny; four subjects as having less.

Comfort level with androgyny was related to the therapist's degree of flexibility regarding societal norms of sexuality. The statement that, "Most people who work with transsexuals probably don't feel that gender is cast in stone--that boys need to be boys and girls need to be girls," represented a process that had been attained to varying degrees by the study's 12 subjects. The points at which individual participants presented themselves in their process of sexual

role fluidity appeared influenced by their previous professional and social experiences. It appeared that experience level in working with transsexual clients was a significant determinant. Five of the eight subjects who reported greater comfort level with androgyny were therapists more experienced in treating transsexual clients. One experienced therapist reported less tolerance for androgyny. The three therapists less experienced in working with transsexuals, but demonstrating greater comfort with androgyny, appeared to have been affected by other experiences with atypical sexual lifestyles through professional or personal avenues. One of these subjects had worked with significant numbers of clients having atypical sexual orientations; one was openly gay; and one participant had worked through rigidity regarding sexual boundaries through contact with lesbian relatives and peers.

The eight participants judged as being more comfortable with androgyny, likewise reflected their flexibility through shifting use of pronouns when thinking about and referring to their transsexual clients. Their ease in pronoun shifting was typified by the following quote:

> She chose a female name. She looked female. I have her a physical exam, so I was aware she had male genitalia....It became clear that she thought of herself as a woman and [I] was interacting with her in that way....It made no sense to say 'he-she' forever. It didn't make much sense to say, 'he' either, so 'it' became 'she.'

Therapists' sexual orientation seemed to be another factor related to comfort with androgyny. Six therapists

stated that they were heterosexual. Three subjects identified themselves as homosexual, and three participants did not specify their sexual orientation. A smoother emotional adjustment in treating transsexual clients was reported by two of the three homosexual subjects, but only by one of the five heterosexual individuals. This suggests that overall, the heterosexual group experienced more tumultuous internal process in counteracting the effects of more rigidly ingrained sex role boundaries, than described by the remaining two subgroups. A description of a heterosexual subject's reaction to her only transsexual client follows:

> There was this scene between us where she threw something, made a scene, made a racket. It was late at night. She really got excited and furious. She was wearing a sort of large shift dress...and she started to get an erection, which no one thought was possible, because of the hormone treatments. Strange. I just freaked out. I was furious with her about having this scene. I was trying to get clear on what the limitation was and boundary, and hold my line. She was always challenging me to do that. And then this other boundary gets crossed again, and I see that she's having an erection and her dress is up, and I just said, 'You'll have to excuse me.' I mean, I really, I just, I was overwhelmed. I couldn't. It was too many kinds of input for me to try to sort out all at one time. I excused myself, and I took a few minutes, and I collected myself. Then it was fine. I went back out and I told her she had to pick up [what she had thrown], and she had to go to her room. I was surprised at my own reaction. I felt really intruded upon somehow.... The erection was just the final straw.

Of the six heterosexual therapists, the three who were more experienced in working with transsexuals and one who was less experienced were judged as having a greater comfort level with androgyny. Five of the six depicted their initial intense processes of loosening learned sex role boundaries. These

were characterized by dreams and anxieties that focused on their sexuality and genitalia. A representative description of a process undergone in loosening sex role boundaries was given by an experienced therapist:

> When I was asked to come on as a therapist, I said, 'me?' I'd never seen one of them in my life and I was scared to death.
>
> In the beginning when I was reading a lot, I'd just spend hours and hours a day [reading]. I just had wild, wild dreams. I'd wake up in the middle of the night, and I wouldn't know which sex I was or which genitals I had. I was really confused. I was really getting into it. I really went through a transition trying to undo the very fixed ideas I had about how life is, what people do, and with what part of their bodies, and with whom. It all started to disintegrate and it was fascinating. I was eager to learn, but it really did a trip on my orientation. I thought I had everything all squared away, and this tore it all up and I had to broaden.
>
> The first couple of transsexuals [I saw], I was overwhelmed all the time. Then you get to see certain patterns, and you know yourself, and you don't get freaked out about certain things, and it gets easier in that regard. That's why it's so different when you've had many [transsexual clients] versus when you've had a couple [of transsexual clients].
>
> You're going through constant questioning of yourself and your own gender and your own heterosexuality, your own homosexuality, and your own feelings about your genitals. Whoever thought about their genitals so much before? 'Do I like mine? How do they look? How would I like them different?' It really raises all kinds of questions about yourself that you never thought about. It's intimidating, it's frightening, and it's titillating. It raises all kinds of stuff in a person that until you've been through it a couple of times you're going through a process yourself.

The heterosexual interviewee who reported a less intense emotional reaction to a client's transsexualism, concomitantly told of decreased anxiety which occurred through personal life contacts with persons having atypical sexual lifestyles.

The homosexual therapists were three males, who were divorced and fathers, and who had "come out" to the gay

community in their adult years. One subject was classified as a more experienced therapist of transsexual persons. The two remaining subjects fell into the category of therapists who had less experience in working with transsexual clients. One of these latter subjects displayed a greater tolerance for androgyny than the other. The therapist more at ease with androgyny believed that his greater comfort level in treating transsexual clients was attributable,

> in part, to [his] being a member of a minority group, and not liking people to be bigoted, because it's dangerous. Being gay, you get sensitive to what bigotry can do to you....That brings in an appreciation of what it's really like to make a major life change and be a member of a minority.

It is interesting to note that the homosexual subject less comfortable with androgyny, and a heterosexual subject less experienced in treating transsexual clients and less comfortable with androgyny, expressed a common theme. They experienced a sense of loss when watching their clients, who initially presented in the gender fitting each therapist's sexual object choice, move across the threshold to the opposite gender, rendering the clients as inappropriate sexual object choices for the treating therapists. Thoughts of the homosexual subject and the heterosexual subject are presented below, respectively.

> The three persons I worked with had all been in relationships as men with other men--sexual relationships....They were homosexual contacts, so I felt a sense of affinity, being a gay man myself....I have to struggle with giving them up, because I like the connection of other gay persons. It validates me. I feel connected to my own gender, to my own sexuality. I was sorry to lose [a male-to-female transsexual] from the gay community, because she had been gay, and she was a lovely person.

> I think that part of the problem that I have with my male-to-female [client] is that I find him attractive as a male. I like him as a male, so I have a difficult time accepting him as a female....I've said things like, 'I would miss him as a male.'

The four study participants exhibiting greater discomfort with androgyny, likewise reflected that in their greater difficulty in shifting pronoun usage that would match their client's shifting gender presentations.

> I trip over the words 'he' and 'she' when I'm talking to someone who is in the process of male-to-female. I'm not sure whether I'm talking to who they used to be or to whom they're going to be. I'm not sure in that instance whether I perceive them as, 'You're dressed like a woman, but you're really a man.' That confuses me, and that leads me to say, 'He', oh I mean 'she'. I find myself tripping over [the pronouns], and in that sense it's acting--acting as though it's a man dressed like a woman....I found myself confused....I like clarity. There's not clarity here. I always use the [pronoun] I see them as. They don't like it. It's funny....I use 'she' [with one client], because she is still a 'she' to me. She doesn't like it. She has chosen a male name. I still call her a female name.

Another factor conveyed by four of the eight therapists qualifying as having a greater comfort level with androgyny was appreciation for and fascination with androgyny.

> Fluidity of sex roles and being able to switch back and forth....The whole notion of very feminine men and very masculine women has always been sort of a fascination for me. I find people who are in that boat in certain ways appealing. With an initial [gender] change I experience curiosity, wonder, and mystery.
>
> Sometimes it's incredible. It's just incredible. I've had occasions to work with somebody, for example, a male-to-female transsexual, who I would be seeing for weeks. This was somebody who would be presenting as a male, dressing as a male, and then the next week would come in [presenting as a female], and it was hard to believe it was the same person. I would be taken aback in terms of just how well that individual represented as a woman.

CHAPTER V

DISCUSSION

The results of this study strongly indicate that countertransference reactions for therapists working with pre-operative transsexual clients are an outgrowth of the clinical dilemmas inherent in treating this client population. Countertransference can result in the arousal of anxieties and conflicts in therapists, which cause defensive disengagement (Eber, 1982). It can temporarily disturb therapists' equilibrium (Erickson Education Foundation), and it can evoke psychological pain, which therapists impulsively wish to avoid (Kubie, 1971). Feeling states of fatigue, depressive guilt, boredom and a sense of emptiness (Kernberg, 1975; Nadelson, 1977) can occur, as well as pervasive confusion, frustration, excitement, anxiety and rage (Lothstein, 1977). That these reactions occur has been established in the literature. What was revealed through this research were some possible explanations as to why these countertransference reactions occur.

The findings revealed three clinical areas that were consistently referred to by the 12 subjects as they discussed their pre-operative transsexual clients--diagnostic

considerations, the therapists' clinical role in the treatment of transsexual clients, and the therapists' traditional sex role conditioning. These three areas were depicted by the participants as clinical dilemmas, either for themselves or for other mental health professionals servicing pre-operative transsexual clients.

The clinical dilemma of diagnostic considerations manifested itself as therapists expressed their uncertainties, confusions and concerns regarding defining clients as being transsexuals. Similar feelings were expressed regarding their understanding of the etiology of transsexualism. These two aspects of diagnostic considerations were attributable to a wide spectrum of theorists and theories presenting varied and contrasting opinions and results. The subjects' desire for criteria enabling definitive diagnoses of transsexualism was a theme repeatedly expressed. A significant number of subjects desired that future research trends focus on biological factors. This again demonstrates interviewees' longings for a more factual basis upon which to form management and treatment decisions.

An absence of absolute diagnostic criteria influenced a second noted clinical dilemma--therapists' uncertainties, confusions, and concerns regarding their clinical role in the treatment of pre-operative transsexual clients. Subjects communicated their personal struggles in being therapists of transsexual clients as being related to three factors. One factor was the lack of clarity provided in therapists'

clinical training as to how to treat and manage pre-operative transsexual clients. In working with transsexual clients, therapists' roles often contradicted their clinical training, i.e. clients are encouraged to act out their fantasies by "cross-living." Therapists are basing interventions on theories they learned that purport the presence of castration anxiety with individuals who desire genital castration. It appears these factors evoked intense feelings of frustration, insecurities, and doubts regarding proper and ethical case management and treatment.

Another factor contributing to countertransference reactions toward the pre-operative transsexual clients centered on therapists' sex reassignment surgery stance. The internal conflicts and struggles experienced by those therapists who would and/or have endorsed sex change surgery were poignantly reflected in their references to being in a God-like "gatekeeper" position--a position assigned to them for they hold the "key" for their clients' entries into the surgeons' offices. The tremendous worrying, questioning of moral and ethical values, the responsibility felt in determining if a person was a surgical candidate, the irreversibleness of such a procedure once a therapist's input has enabled that to occur, were burdens described by endorsing therapists. The therapists who had not yet treated a candidate appropriate for sex change surgery expressed their indecisiveness regarding what their decisions would be. They likewise expressed their gratitude that it had not yet

been necessary to make that decision. All participants demonstrated capacity for empathizing with their transsexual clients. A significant number of subjects expressed concerns regarding their professional reputations--due to judgmental colleagues and potential post-surgical malpractice suits and suicides of clients.

This study's final clinical dilemma, that proved to be a source of countertransference reactions in participants, concerned therapists' traditional sex role conditioning. Comfort level with androgyny was the component that seemed to determine therapists' flexibility, non-judgemental stance, and ease in adapting to treating pre-operative transsexual clients. Elements seeming to lead to a higher degree of comfort with androgynous clients were (a) greater experience in working with a pre-operative transsexual population, or (b) other experiences with atypical sexual lifestyles through professional or personal contacts.

Personal experiences with androgyny encompassed social contacts with non-heterosexual individuals. Therapists' sexual orientation also seemed to affect their comfort level with treating transsexual clients. The majority of those therapists who were homosexual reported an easier adjustment process in working with transsexual clients than the majority of heterosexual subjects. This may be because heterosexual therapists, raised in a traditional heterosexual society, had their ideas of appropriate sexual roles and boundaries more rigidly established. Perhaps, homosexual therapists would

have already gone through a process that dealt with reassessing societal norms as they become more publicly open about their sexual orientation.

There were limitations to this study. One was that the sample included seven subjects who had a common association with a gender identity clinic. Thus, viewpoints expressed by the sample may represent less diverse and more homogenous ideas. Another study limitation was that three of the subjects' sexual orientations were not specified, limiting potential conclusions regarding the relationship between sexual orientation and comfort level with androgyny.

There are implications for clinical work that can be made from this study's results. It is recommended, due to the intensity of the countertransference reactions initially stirred up in many therapists of pre-operative transsexual clients, that therapists have a choice in undertaking servicing such clients. Once a therapist chooses to treat a pre-operative transsexual client, a supportive professional network is crucial to help her or him with managing emotional reactions. A professional network is also highly recommended in order to educate a therapist inexperienced in working with pre-operative transsexual clients on the phenomenon of transsexualism, and clinical treatment and management techniques for these individuals. This will serve to aid a therapist to more quickly and effectively use countertransference reactions to benefit her or his clients.

Several ideas regarding future research follow from this study. One idea is to investigate and/or develop ways in which treatment and management of transsexual clients could be addressed more adequately during mental health professionals' clinical training. A second idea for future research is to more thoroughly explore how therapists' sexual orientation may impact on their comfort level with androgyny. A third topic appropriate for future study is to compare ways in which countertransference reactions in therapists of pre-operative clients are unique and/or similar to countertransference reactions in therapists treating clients of other clinical syndromes, with particular focus on the "gatekeeper" concept. Another targeted population with which to compare countertransference reactions is with clients of other diagnostic categories, who are seen less positively by society as a whole, i.e. child molesters, murderers.

In sum, this study was effective in demonstrating the likelihood that countertransference reactions for therapists working with pre-operative transsexual clients are a product of the clinical dilemmas encountered while treating this population. It seems that understanding the source of the intense reactions that can be evoked in treating pre-operative transsexual clients can be clinically useful in managing and treating such clients.

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APPENDIX A

STATEMENT OF INFORMED CONSENT

I presently am conducting a study for my thesis on the phenomenon of transsexualism, as I work towards completion of my M.S.W. in clinical social work through Smith College School for Social Work. As I reflect on the literature--rich with diverse articles on theories of transsexualism, sex reassignment surgery, and psychotherapy for the transsexual--I am particularly struck by how little attention has been given to the experience of being the therapist of a partial transsexual client (hormonal treatment only). Your name came to my attention as I sought out therapists who have had experience working with transsexual clients in a therapeutic situation. My belief is that the exploring and sharing of your valuable experiences can add to the growing knowledge of information regarding the therapy of transsexuals.

To enable me to devote my full attention to what you have to say while we speak together today, and to facilitate more accurate and complete use of what you impart, I would like your consent to audiotape our talk. I will be the only listener of this tape, and any information included from our discussion in my final report will be written so as to guarantee confidentiality, by disguising identifying information about the therapists and their clients.

Our talk today will take one to one-and-a-half hours. If anything arises in our conversation that you prefer not to pursue, please indicate that to me so that we may pass it by. Likewise, please let me know if further clarity is needed in what we are focusing on at any particular time.

I thank you for your willingness to participate in and contribute to this study. I will be happy to share my results with you at the conclusion of my study, if you so desire. Please let me know if there is anything you would like to know or discuss before we proceed that I have not covered here.

Once again, thank you for your time so kindly given.

APPENDIX B

DEMOGRAPHIC INFORMATION

Age? ____

Sex? ____

What is your professional disciplint?
M.S.W.________________
M.D. (Please state area of residency training)________
Ph.D. (Please state in what area)________________
Ed.D. (Please state area of specialty)________________
M.Ed. (Please state area of specialty)________________
Others (Please specify)________________

Where did you receive this educational training?

Where do you presently practice/work?

What is your particular clinical orientation? (Please check as many as you feel applicable)
Psychoanalytic ____
Family Systems ____
Behavioral ____
Other (Please specify)________________

How long have you been practicing in your present profession?

How long have you been involved in direct clinical practice?

What, if any, roles have you held in your present profession other than that of a therapist?

When did you last work clinically with a transsexual client?

How many transsexual clients have you worked with? ________

How many of these were male-to-female (M-F) transsexual clients? ________

How many of these were female-to-male (F-M) transsexual clients? ________

How many of your transsexual clients were at the following stages when you worked with them:

	(M-F)	(F-M)
Pre hormonal treatments	_____	_____
Pre cross-dressing	_____	_____
Receiving hormonal treatments	_____	_____
Cross-dressing	_____	_____
Cessation of hormonal treatments	_____	_____
Cessation of cross-dressing	_____	_____
Post sex reassignment surgery	_____	_____

How many transsexual clients have you worked with in the following age ranges?

	(M-F)	(F-M)		(M-F)	(F-M)
below 10 yrs.	_____	_____	41-50 yrs.	_____	_____
11-20 yrs.	_____	_____	51-60 yrs.	_____	_____
21-30 yrs.	_____	_____	61-70 yrs.	_____	_____
31-40 yrs.	_____	_____	71+ yrs.	_____	_____

How long were the durations of your treatments with each client?

In what modalities have you worked with transsexual clients? (Please check)

Couples ____
Families ____
Groups ____
Individuals ____
Others (Please specify)________________________________

How many transsexual clients have you had under your care at a particular time?________________________________

Up to how many times per week did you treat each of your transsexual clients?

Please check if you have worked with the following syndromes with individuals who presented themselves as transsexual clients:

Neurotic Conditions ____
Borderline ____
Narcissistic Personality Disorders ____
Character Disorders ____
Schizophrenic ____
Manic-Depressive ____
Other ____

Please check if you have worked with the following syndromes with individuals who did not present themselves as transsexual clients:

Neurotic Conditions	____
Borderline	____
Narcissistic Personality Disorders	____
Character Disorders	____
Schizophrenic	____
Manic-Depressive	____
Other	____

Please check your: religious upbringing/present religious orientation:

	religious upbringing	present religious orientation
Catholicism	____	____
Judaic	____	____
Protestantism	____	____
Non-practicing	____	____

Other (Please specify)____________________________________

What is your ethnic background?

APPENDIX C

INTERVIEW PROTOCOL

I. In my review of the literature and in my personal experience as a therapist of a transsexual client, it seems clear that the treatment of transsexuals raise certain reactions in the therapist which may or may not enter into the therapy. While personal reactions as to one's clients are universal, in this study I'm trying to learn about the reactions specific to the client population of transsexuals.

There is much controversy in the field over the phenomenon of transsexualism. DSM III (1980) defines the essential features of transsexualism as being comprised of

> a persistent sense of discomfort and inappropriateness about one's genitals and the persistent wish to live as a member of the other sex. The diagnosis is made only if the disturbance has been continuous (not limited to periods of stress) for at least two years, is not due to another medical disorder, such as Schizophrenia, and is not associated with physical intersex or genetic abnormality. (pp. 161-162)

I'm wondering what working definition of transsexualism you have developed for yourself that you feel comfortable with.

I realize this may be a case by case question, but I'm curious how your transsexual client(s) may diagnostically remind you of other clinical syndromes you have worked with.

What is your understanding of the etiology of your client(s) transsexualism?

II. Is your role in working with transsexual clients to grant sex reassignment surgery or is it purely therapeutic?

Would you speak to any particular dilemmas or binds that you have found yourself in as a therapist treating transsexual client(s), be they moral, clinical or psychological?

What have you sensed from other professionals in the community about your stance regarding the treatment of transsexuals and sex reassignment surgery?

Some of the literature has indicated that there are clients who present a misleading front to their therapists in an attempt to be assessed as an appropriate sex reassignment candidate. Has this occurred with you?

How do you determine if your client is presenting a misleading front in order to be assessed by you as an appropriate sex change candidate?

There are transsexual clients who may unconsciously or indirectly communicate ambivalence regarding their goal of gender and/or sex change, although they are adamant that they desire these goals. If you have encountered this in your practice, what ways have you found to deal with this clinically?

III. Countertransference reactions are intrinsic to treating clients of all clinical syndromes, and it is common for therapists to have different kinds of personal reactions in working with different kinds of clients. Have your countertransference reactions, when working with transsexual clients, been more intense, different, or similar to what you have experienced when working with clients of other diagnostic categories?

I'm wondering what reactions you've had if you've treated a transsexual undergoing their initial transitional gender changes

a. by cross-dressing
b. by hormonal treatments.

Would you describe your reactions if you have had clinical contact with a transsexual undergoing a return to their original gender presentation

a. by ceasing of cross-dressing
b. by ceasing of hormonal treatments.

There may be moments when a therapist who is working with a pre-operative transsexual becomes acutely aware that their client is anatomically opposite from their outward presentation. If this has occurred with you what reactions are you aware of having experienced at those moments?

a. with a male-to-female client
b. with a female-to-male client?

Have you treated a transsexual client during their pre-operative stage through their successful medical completion of their sex change surgery?

If so, could you elaborate what it was like for you if you later learned that your previous client is

a. continuing to report satisfactory and favorable results;
b. reporting dissatisfied and unfavorable results;
c. undergoing a reversal back to their original gender identity.

By what pronoun and with what consistency of its usage do you refer to your transsexual client(s)?

What impact do you think the use of that pronoun has on your treatment and countertransference?

There are times that a transsexual client will pursue sex change surgery and have the endorsement of their therapist, and yet, as the client nears the surgery the client may reverse back to their original gender. Has that ever happened in your practice? If so, what was that experience like for you?

What was your reaction if you knew that your client previously has been in the role of a husband/wife or mother/father?

Do you recall having dreams about your transsexual clients? If so, could you tell me about them?

How about fantasies?

If you have had dreams or fantasies about your transsexual clients, what was your gut reaction upon awakening from sleep or being aware while daydreaming that your transsexual client had been on your subconscious?

There are transsexual clients who have been described as being manipulative, demanding and seductive. Have you found this to be true with many of your clients? If so, how would you compare your countertransference reactions to these clients to manipulative, demanding and seductive clients of other diagnostic entities?

As you think to a particular case with a transsexual client in which the therapeutic relationship has ended, what feelings come to mind about how that person affected you

a. while in the treatment;
b. today, after termination?

One of my interests in therapists treating transsexuals is in how a therapist's own sexual orientation affects countertransference and their management of the treatment. What thoughts do you have on this?

It has been noted in the literature that therapists may have a tendency to prematurely accept or reject a transsexual client for therapy. Do you feel this has been the case for you? If so, how does this compare to your work with clients of other clinical syndromes?

Have you ever chosen not to work with a particular transsexual client? If so, how did you make that decision?

What was that like for you?

Would you volunteer to take on a transsexual client if you had the time available? Why or why not?

What words come to your mind as you associate to the word transsexual?

IV. In what ways has your clinical experience with transsexual clients contributed to your understanding and skills in working with clients of other diagnostic categories?

How have you made sense of the diversity of perspectives held by the different theorists who have studies transsexualism?

What do you make of the varying results of the longitudinal studies on transsexualism?

There are theorists who state that sex requirement surgery is an option to consider for transsexual clients. There are theorists who state that a request for sex reassignment surgery should be seen as a request for psychotherapy. What is your response to this conflict?

What aspects of transsexualism do you think research should currently be focusing on?

What words of advice do you have to give to inexperienced therapists about how to deal with their countertransference reactions to their transsexual clients?

What was it like for you as you anticipated today's meeting to talk about your experience of working with transsexual clients?

This is the end of our formal talk. What have I left out that I should have asked you about?