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THE TRANSSEXUAL CONFLICT: DUALISM IN IDENTITY
AS EXPLORED THROUGH GROUP PSYCHOTHERAPY

A project based upon an investigation at
a large teaching hospital. Submitted
in partial fulfillment of the requirements
for the degree of Master of Social Work

Linda Ann Schloss
Smith College School for Social Work
1975

Linda Ann Schloss
The Transsexual Conflict:
Dualism in Identity as Ex-
plored Through Group
Psychotherapy.

ABSTRACT

This descriptive study utilized case observations for the purpose of developing a conceptual understanding of transsexualism and identifying variables and hypotheses for empirical study. This research, combining library and clinical investigation, reports on those findings which were gathered from five preoperative transsexual patients in group therapy. It was hoped that in addition to serving as a source of information, this exploration would stimulate further research in the area of gender identity.

Five patients with confused gender identities who participated in weekly group psychotherapy, were studied over a period of nine months. The clinical material collected was drawn from the interactions and behaviors observed in this group and from individual social histories and psychological testing. Conclusions arrived at from descriptions were as follows:

1. As a group male transsexuals reject the masculine role and female transsexuals reject the feminine role despite their upbringing and conscious parental guidance to the contrary.
2. Early learning and the sociological and psychological aspects of the parent-child relationship are significant factors in the determination of gender role preference.
3. Gender identity is established within the first few years of life and confusion over this identity is a life long problem.
4. Transsexuals have difficulty forming object relationships which results in their isolation and the compulsion to be members of the opposite sex.

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ACKNOWLEDGEMENTS

I wish to express my gratitude to my co-therapist, Dr. Leslie M. Lothstein for a very positive working relationship, to my mother and father for their confidence and love, to my sister and brother-in-law, Mr. and Mrs. James A. Lowe for their support, to my twin brother Lee for his optimism, to my brother Mark for his encouragement, and to my nephew David for just being David.

CHAPTER I

INTRODUCTION

Transsexualism, also called gender dysphoria syndrome, or cross gender identification, is a relatively new and unexplored frontier. It is a comparatively rare behavior in which those males and females prefer to live in a gender role contrary to their biological anatomy. Such people in the past have been ostracized, laughed at, and arrested for their dilemma as it was thought that anyone foolish enough to want to change his or her sex had to be deviant, comical, or criminal. Sexual alteration seemed immoral and yet more and more of these people have been appearing at hospitals and mental health centers with gender role conflicts asking for help.

The purpose of this study was to develop a conceptual understanding of transsexualism by describing this phenomenon and identifying variables and hypotheses for empirical study. The study came about while the researcher was placed in a teaching hospital and had the opportunity to work with preoperative transsexuals as a co-therapist in a group therapy program. The newness of the topic and the controversy surrounding these

patients made this an intriguing and challenging undertaking for a thesis. This topic is particularly timely since traditional sex role behavior in general is currently being questioned.

Transsexualism is pertinent to the field of social work for it is the clinician who is called upon to observe, evaluate, diagnose, and treat these patients prior to surgery. Therefore, it becomes necessary for the social worker to understand the terms and their meaning, the etiology of the disorder, and the complicated psychological problems inherent in sex and gender confusion. Social workers are being asked to serve on gender identity teams along with psychiatrists, psychologists, surgeons, gynecologists, urologists, and endocrinologists, and they should be prepared to meet the challenge. Currently, there is little written about transsexualism in the social work literature, and this compelled the researcher to share the observations and findings of the study with the profession.

There is the growing concern about other gender-related problems in the greater population. Anyone suffering from an identity conflict may be helped indirectly from an investigation of the behavior of individuals with gender identity conflicts. The more informed our professionals and the culture at large are

in regard to the transsexual syndrome, the more they will be able to understand and accept the life struggles of the transsexual.

This is a study of transsexualism and the conflicts surrounding the syndrome. It is a descriptive study using a case observational method implemented while the researcher served as a co-therapist in a treatment group. The observations refer only to a limited sample, so generalizations are meant more as directions for possible empirical research rather than contributions of a statistically reliable nature.

For the purpose of this study, it is necessary to define several terms which will be referred to throughout the research, beginning with the word "transsexual." Transsexual was first defined in the early 1900's by Dr. Harry Benjamin, a pioneer in the field of sexual identity, who used it to describe a gender-disoriented person. Gender is a personality feature which may be independent of the biological sex of a person and refers to the individual's conviction of his/her maleness or femaleness and his/her behavior which has been determined culturally as either masculine or feminine. This distinction between gender and sex, which is used to connote the male or female in a biological sense, is a crucial one to understand. Gender identity refers to

one's awareness of belonging to either a masculine or a feminine role. The term "transsexual" is applied when this gender identity is confused because sex and gender are not congruent. Transsexuals, then, are individuals who believe that their bodies are wrong and are aware that their gender identity does not match their biological anatomy. They are victims of fate and feel trapped in the wrong body. In spite of believing they belong to the opposite gender, they do not deny their obvious genitals. In addition, transsexuals by definition seek relief from their dilemma through sex-reassignment surgery. They are disgusted and repelled by their anatomy and want to correct what they believe was a genetic mistake. To reiterate, transsexualism is the conviction and wish of biologically normal persons, for surgical and hormonal changes so that their body, appearance, and status becomes the gender they feel they are.

In this descriptive study based upon clinical observations, the author attempted to review the literature pertinent to the topic, hypothesize about the etiology, explore psychological conflicts, and evaluate the treatment of transsexual patients.

CHAPTER II
REVIEW OF THE LITERATURE

History of the Concept

Although the term "transsexualism" is attributed to D.O. Cauldwell in 1949, Harry Benjamin, an endocrinologist, reintroduced and defined the term in 1953. In spite of the fact that this syndrome was labeled only recently, our historical literature is replete with anecdotes about people who dressed in the clothing of the opposite sex and assumed the role attributed to a different sex. Conflicts over sexual identity have existed since classical mythology and are present in ancient history, the Renaissance and cultural anthropology.

One myth involving sex change is the story of Tiresias, a Theban soothsayer, who was out walking on Mt. Cyllene when he came across two snakes coupling. He killed the female snake which angered the gods, who, for punishment, changed Tiresias into a woman. Tiresias then proclaimed that a woman's pleasure during intercourse was ten times that of a man. Upon hearing this, the gods angered again, changed him back into a man (Leach, 1949). Such a myth illustrates the

transsexual theme in man's fantasies, yet writings from the Romans actually describe gender role dissatisfaction. Philo, a Jewish philosopher, said this of many males of his Hellenistic society:

Expending every possible cure in their outward adornment, they are not ashamed even to employ every device to change artificially, their nature as men into women . . . some of them craving a complete transformation into women, they have amputated their generative members (Green, 1974, 5).

In still another example, Juvenal, the poet, writes in "Against Hypocritical Queens,"

But why
Are they waiting? Isn't it new high
time for them to try
The Phrygian fashion to make
the job complete . . .
Take a knife and lop off that
superfluous piece of meat? (Green, 1974, 5)

In Medieval Europe, it was believed that demons and witches could perform sex changes and in a book entitled The Witches Hammer, 1489, there is an account of a girl changed into a boy.

In the 17th century, the Abbé de Choisy, a Frenchman who became an ambassador of Louis XIV wrote of his sexual identity

I thought myself really and truly a woman. I have tried to find out how such a strange pleasure came to me, and I take it to be in this way. It is an attribute of God to be loved and adored, and man--so far as his real nature will permit--has the same ambition, and it is beauty which creates love, and beauty is generally woman's

portion--I have heard someone near me whisper, 'There is a pretty woman.' I have felt a pleasure so great that it is beyond all comparison. Ambition, riches, even love cannot equal it (Green, 1974, 7).

Apparently, America also had men of prominence with such conflicts. One such person was the first colonel governor of New York, Lord Cornbury, who wore full woman's dress on the trip from England and appeared that way during his time in office. Accounts describing Lord Cornbury's behavior gave no evidence that this cross dressing was fetishistic.

The transsexual theme has also been present in tribal cultures in which shamans have magical powers and often dress and act as women throughout their lives. Other instances have been cited among the Yuma, Cocopa, Mohave, Yukis, Crow, and Pueblo Indians. The literature of the Orient is also rich in examples of cross-gender behavior as well as India, where eunuchs live comfortably integrated into the rest of society. In all of these cultures people have lived in the opposite-sexed role without the ostracism so often visible in contemporary Western society.

A more recent report of a sex reassignment was the case of Einar Wegener, a Danish painter who became Lili Elbe. In 1933, Hoyer wrote about this surgical procedure making it the first semi-medical contribution until the

famous Christine Jorgensen case in 1952, which resulted in the "Journal of the American Medical Association" publishing an article written by the Danish doctors (Hamburger, Sturup, and E. Dahl-Iverson, 1953).

Throughout history there has been little agreement about whether the transsexual syndrome is a perversion, a diagnosis, or simply a lay term which refers to the presence of a wish to change one's sex. Due to this confusion there are problems in defining the term "transsexual." As a clinical entity there is dispute over whether it is severe transvestism, a type of effeminate homosexuality, an expression of a borderline state, psychosis which involves sexual identity, or something entirely different. One reason for such ambiguity is that it was not until recently that a professional climate was established which was sufficient to investigate and hypothesize about the syndrome diagnostically and etiologically. The moral and emotional dilemmas prohibited researchers from investigating such a controversial disorder. It was not until other countries began performing sex conversion operations that American doctors had the courage to enter into this arena. The recent interest in sexuality, homosexuality, bisexuality, and gender role by our culture has spurred an interest in studying transsexualism as a phenomenon. By 1963,

Drs. Milton Edgerton, Howard Jones, Norman Knor, and John Money had started the first clinic in the United States at Johns Hopkins Hospital for surgical treatment of transsexualism. This started an outgrowth of other clinics across the nation which began viewing gender conflicted persons. Once the phenomenon of transsexualism was given recognition, Stanford University set up a Gender Reorientation Program in 1968, followed by the Erikson Educational Foundation, an outgrowth of Johns Hopkins Gender Identity Clinic, which was established to deal with sex, gender, and role orientation problems. All of the hospital programs have the same criteria for evaluating transsexuals. They expect that the person requesting a sex change operation will cross dress, get a job, and live in the role of the gender they feel they are for approximately two years. Their philosophies state that no amount of day dreaming can substitute for the spontaneity and comfort one can achieve by living in the desired role. This two year waiting period before surgery allows the patient to smooth out rough edges, to get feedback, to reinforce convincing behavior and modify other behavior which elicits negative response. They believe that personal conviction of gender role is not enough and that society at large must be the ultimate test. A new requirement

by these major gender reorientation clinics is that the transsexual be involved in some form of counseling or psychiatric treatment. The purpose of this is to help the individual with his impatience, and to tone down any unrealistic expectations or demands that surgery will instantly and magically alter his/her life. Surgery is then indicated for those transsexuals who have lived and worked as members of the opposite sex and have been convinced that this is the only way they can find meaning in their lives.

Definition of the Concept

Transsexualism in the classical sense described a lifelong sense of belonging to the opposite sex, an early phenomenon of cross-dressing which is non-erotic, and a disgust for homosexual behavior. However, as the clinics began to fill up with people professing these symptoms, the need for purer diagnostic categories was evident. Therefore, the term "gender dysphoria syndrome" coined by Dr. Norman Fisk of the Stanford group, came into existence as the umbrella diagnosis shading several sub-diagnoses which include effeminate homosexuality, transvestitism, inadequate-schizoid personality, psychosis in remission and lastly exhibitionistic sociopaths. The true transsexual then, was someone

who was repulsed by his own genitals, was unable to identify with his somatically prescribed gender role and desired hormonal and surgical sex reassignment so that he can live in the gender role for which he feels he has always had the matching gender identity. Thus, transsexualism is the condition of those who have the conviction that they belong to the opposite sex and are living and passing in that role before or after surgical and hormonal reassignment and who are driven by a compulsion to have the body, mannerisms, and privileges of the opposite sex. In the case of the male transsexual, the penis is not used for sexual gratification and the desire to be rid of this insignia of maleness is great. An erection is further reminder of the tragedy played on him and his wish is to be a biologically normal female permanently. The sexual fantasies of such transsexuals involve normal men, and they find no pleasure in having a penis secreted beneath a dress.

A female transsexual is desirous of male genitalia and hides her femaleness by binding her breasts. They deny any interest in homosexuality and do not want their genitals manipulated by their partners as this would interfere with their self-concept. The female transsexuals are fewer in number than their male counterparts and only one female wants to become male for every

three to six males who want to become female (Green, 1974). The surgery for a woman is more complicated than for a man with many more technical limitations. One surgeon was playfully heard to remark, "It's easier to make a hole than a pole (Green, 1974, 102)." As surgical procedures are becoming more sophisticated, research shows the ratio coming down to two men to every one woman (Laub and Gandy, 1972).

Etiological Theories

The phenomenon of transsexualism has been a concern to scientists and laymen alike. Novels and television talk shows have excited an interest in gender-disoriented individuals. Myra Breckinridge by Gore Vidal, the Autobiography of Christine Jorgensen by Christine Jorgensen, and Conundrum by Jan Morris, the latter a personal narrative of the transformation from James to Jan, have all popularized the transsexual syndrome. One can turn on the television and hear accounts of a once suffering male who was relieved through surgical procedures and lives as a complete woman. Considerable research has also been done on sex, gender, and the psychological nature of man and woman which has led to current etiological theories of transsexualism. These theories attempt to explain the development of transsexualism

from endocrinological, sociological, and psychological perspectives. Biologically, the explanation is that there is an increased chance of a male hormonal deficiency which might occur at a critical developmental period and result in an unmasculinized nervous system (Green, 1974). Sociologically, women are given greater latitude with respect to cross-dressing and tomboyish activities, and psychological explanation is that the first person an infant identifies with is female, causing only male children to make a shift in their identity.

From birth on there is evidence that differences exist between and within the sexes. Garai and Scheinfeld (1971) have postulated that boys perceive more through looking while girls through listening. This position has been reinforced in studies by Bell and Kagan (1971) which suggest that the two sexes have different patterns of perception in infancy which are factors in explaining sex differences at a later age. In further studies girls are found to have a lower pain threshold (Bell and Costello, 1964), sleep longer (Moss, 1967), have taste preferences for sweets (Nisbett and Gurwitz, 1970), are more sensitive to touch (Bell et al., 1971), are easier to soothe (Moss, 1967), and these studies go on and on documenting differences between maleness and

femaleness. Other studies have cited differences in the behavior of mothers to their first born depending on its sex (Moss, 1967). The evidence of sex differences at infancy has implications for believing that males and females respond differently to similar environmental input. Much of this research has led to the studies of sex and gender role conflict, particularly by John Money, Richard Green, and Robert Stoller.

Why a person so strongly desires to change his sex is not an easy question to answer. This is perhaps the most debated area of the research as explanations for etiology of transsexualism include biological-genetic theory, social-learning theory, and psychodynamic theory.

Endocrinological Theory

Simply put, the biological, genetic theorists believe that there is some biological force which produces gender reversal in an otherwise normal person. Numerous studies have been done to fortify this explanation (Hamburger, Stürup, and Dahl-Iverson, 1953; Stoller, 1964; Benjamin, 1966; and Pauly, 1965). Sex is determined by physical attributes: chromosomes, external genitalia, internal genitalia, gonads, hormonal states, and secondary sex characteristics, yet the geneticists say that "energy

from biological sources such as endocrine or central nervous systems influences gender identity formation and behavior (Stoller, 1968, 66)." For instance, experiments with animals indicate that sex hormones given during the critical period before or after birth can organize parts of the brain so that its gender and sexual behavior represents a member of the opposite sex (Goy, Phoenix, and Young, 1962). Other research has been done on humans who are biologically incomplete as either males or females. The term "hermaphroditism," or "intersexuality" is given to this condition of ambiguity of the reproductive structures. Other anomalies such as Turner's Syndrome which occurs in females and is the absence of a missing sex chromosome, or Klinefelter's Syndrome which occurs in males and is the addition of an extra sex chromosome have shed new light on the biological explanation for gender identity confusion. The research indicates that a feminine gender identity is not dependent on the presence of a second X chromosome (Ehrhardt, Greenberg and Money, 1970). Therefore, the biological theorists are looking at psychological and sociological influences to explain fully the transsexual phenomenon.

Social-Learning Theory

The social-learning theorists believe that awareness of sexual identity is culturally determined and established postnatally. Most influential in establishing appropriate sex-role identification is the parent-child relationship period. Males learn to be boys and females learn to be girls on the basis of encouragement and reinforcement of masculine or feminine behavior. In studies of inter-sexed patients, if the patient is raised as a girl, she takes on a feminine role despite the anatomical attributes (Money and Hampson, 1955).

Psychoanalytic Theory

The psychoanalytic theories of gender-identity development are derived from the writings of Sigmund Freud which postulated that psychosexual development takes place during the first five to six years as a child goes through the oral, anal, and up to the phallic stage where castration fear for the male child and penis envy for the female child is evoked as anatomic genital differences are discovered. Therefore, Freud viewed gender confusion as an oedipal conflict.

Robert Stoller takes Freud's hypothesis and extends it to put more emphasis on early parent-child interactions. He believes transsexualism results from an

excessive identification with mother in which mother is unable to separate from the child and allow him individuation. He describes these mothers as over-protective and having problems with their feminine identity. Fathers, he believes are uninvolved or physically absent during the child's development. He characterizes the symbiotic state between mother and child as:

Blissful; skin-to-skin closeness, no frustrations of sensual pleasures by his mother (no weaning, toilet-training, restriction of masturbation, restriction from playing with or on the mother's body, and so on), no torment, no double bind, and no pushing away to provoke separation (Stoller, 1968, 100).

This closeness which prevents the child from separating, along with passive effeminate fathers who are never home and a conflictual marriage which however angry does not lead to divorce, leads to core gender identity problems.

Richard Green's research finds numerous positive factors for transsexualism. He, too, believes that the syndrome has its beginnings with the parent-child communication patterns, yet he emphasizes socialization factors more than certain psychodynamic concepts of the mother-son relationship as Stoller does. Green (1974) cites parental indifference or encouragement of feminine behavior in a child's first few years of life, repeated

cross dressing, maternal overprotection, excessive maternal attention and physical contact, the absence of a male role model or paternal rejection, physical beauty which makes others treat a male child as though female, lack of male playmates, maternal dominance, and castration fears.

Other theorists, such as Ethel Person and Lionel Ovesey, disagree with Stoller's and Green's positions and instead believe that gender identity confusion develops earlier and is a result of unresolved separation anxiety in the separation-individuation phase of infantile development. In other words, they feel transsexualism results when a child must resort to a reparative fantasy of symbiotic fusion with the mother in order to counter separation anxiety. This explanation for gender ambiguity stems from the pre-oedipal period.

Another theory also using psychoanalytic concepts is proposed by Henry Guze who states that "The etiology of voluntarily sought surgical change of the body, whether ritualistic or individualistic, must involve profound problems of self-perception (Guze, 1967, 464)." He believes that transsexualism has as its root, a de-personalization process in which the person splits off from the rest of his body and there is a magical, separate relationship between the person and his body. His confusion

results in the transsexual's frustration over separating his "true" self from the self which is biologically visible. Secondly, Guze postulates that the transsexual is unable to deal with the expectation of masculinity or femininity, which gives him a sense of non-belonging.

In summary, all of these theories--the biological-endocrinological, the social learning, and the psychoanalytic--try to explain the transsexual phenomenon. However, it seems that the etiology of transsexualism may be very complex and would require the use of some combination of these theoretical notions for a more complete explanation.

Treatment

Following the ambiguity and uncertainty as to the etiology it stands to reason that there are just as many viewpoints and opinions regarding the treatment of transsexuals. Currently, psychiatric treatment including psychoanalysis (Ostow, 1953), behavior modification and group psychotherapy as well as hormonal and surgical reassignment are the most often chosen treatment modalities. The question of how to help the transsexual patient is not a simple one for it involves issues of morality, ethics, law, and an individual's right to self-determination. Can a phenomenon that is ambiguously

defined and has unknown etiology be treated? Should something be done to alleviate the suffering of individuals with gender conflicts? There are some people who say no to these questions and who believe the disorder is nothing other than an underlying psychosis or personality disorder and that by attempting to treat it as something else is to go along with a delusion (Wiedman, 1953; Stafford-Clark, 1964; Meerloo, 1967). Others feel that transsexuals are in need of help and advise surgical and hormonal treatment (Hamburger, 1953; Benjamin, 1964).

The goal of treatment was a very important distinction. The methods vary depending on whether one was attempting to cure the transsexual problem or merely trying to support and mobilize the patient to help him to achieve sex reassignment surgery. However, research indicates that attempts at gender reorientation have not been successful. The reasons given for the failures support John Money's (1972) theory that after two and a half years of age a child's gender orientation is practically irreversible. Attempts at behavior modification or aversion therapy have been tried, also unsuccessfully (Marks, 1967; Marks and Felder, 1967). This, then, leaves the professional with the choice to treat the transsexual patient with methods that have been

proven ineffective or to recommend sex-reassignment surgery, currently the only alternative which has brought final relief to these patients.

Dr. Harry Benjamin, the man who perhaps has treated the greatest number of transsexual patients, has developed an evaluation and treatment plan which involves surgery and has as its goal the end of a dual life. He first screens out all those patients who are psychotic or for some reason psychologically unfit. He has constructed a Sex Orientation Scale (SOS)

(Benjamin, 1966):

- Type 0: Normal sex orientation and identification
- Type 1: Transvestite, pseudo
- Type 2: Transvestite, fetishistic
- Type 3: Transvestite, true
- Type 4: Transsexual, nonsurgical
- Type 5: Transsexual, true, moderate intensity
- Type 6: Transsexual, true, high intensity

He requires that his patients live in the role of the sex they are seeking and he prescribes hormones. For some, this requirement is too frightening, and these individuals drop out. For those who pass the trial stage, Benjamin recommends surgery and then follows them postoperatively.

Psychiatric treatment for a patient who is seeking sex-reassignment surgery according to Richard Green

(1974, 82) involves:

1. Understanding the patient's motivation
2. Facilitating a realistic appreciation of the limits of medical procedures

3. Management of difficulties experienced by the patient's family
4. Encouraging the patient to try reversible changes during the trial period, prior to irreversible surgical steps
5. Lending support during the period of social transition into the new role
6. Promoting a realistic anticipation of what the future may hold after sex reassignment.

Other psychiatrists assessing patients for sex-reassignment surgery explore the patient's family background, childhood behavior, fantasies, sexual and social relationships and experience with cross dressing. They believe one must educate the patient to the reality of what surgery and hormone surgery can do. A male to female transsexual must be informed of the need for electrolysis for facial hair removal, that the pitch of their voice does not change, and that female proportions will not appear immediately. After surgery they should know that vaginal function is unpredictable and varies with the type of vaginal reconstruction done, that there are many postoperative complications which can arise, that sexual pleasure may decrease, that orgasm may be lost, and that reproduction is impossible. They must also be told that a vaginal form which must be worn to preserve the cavity will be uncomfortable and constant douchings cause additional pain. Female to male transsexuals need to be told that menstruation stops but that breast size will not diminish, that some hairiness may

develop, that clitoral size will increase and that libido may increase. The surgery for females involves anywhere from three to five stages and the construction of the penis is still experimental, often requiring skin grafts from the buttocks. Also, the functional capacity of the phallus and the cosmetic appearance is less than what is done to simulate female genitals. In addition, sterility results.

Other aspects of treatment include helping the transsexual to be comfortable in his or her new role. To pass in society in appearance and mannerisms without arousing suspicion, transsexuals generally require advice on make-up or dress as often they over-do the feminine or masculine role. Legal documents such as social security and drivers licenses need to be changed. And perhaps most important, the transsexual might need help in adjusting to a new job; for the male to female this often means a step down in salary and position. In many cases a psychiatrist is often involved with family members, i.e., wives, children, or parents, in helping them to understand and cope with the situation. Lastly, post-operative problems are bound to occur. Prior to surgery the transsexual is often isolated and lonely, but after the operation expects to attract people and live a romantic and exciting life. When this does not occur

depression often follows.

Also, in the psychoanalytic tradition is group treatment, a dimension that has been viewed as the most important aspect of a program for individuals seeking sex-reassignment surgery (W. Sadoughi, C. Overman and J.M. Bush, 1972). One group described in the literature was a two year group of twelve patients. The group helped to end the transsexuals' isolation (McKenna and Walsh, 1966). Another kind of group for transsexuals was set up in 1968 by Dr. Donald Laub (1973), at the Stanford University Gender Reorientation Program as a "grooming clinic or charm school." In a supportive atmosphere the group learned cosmetology, grooming, and ways to appear more masculine or more feminine. Another group reported at the Conference on Gender Identity held in 1975 was initiated as an additional aspect in the transsexual evaluative procedure prior to surgery (Bruce and Green, 1972). Another group began in 1972 at the Cook County Hospital in Chicago by Sadoughi, Overman, and Bush. This group was made up of both males and females who had requested surgery. The emphasis of the group was on "becoming oneself" and did not necessarily lead to surgery. Other groups are still in the experimental stage. However, the results from a three year experiment conducted by Jones, in Hartford, Connecticut,

as reported at the Proceedings of the Fourth International Conference on Gender Identity held in Palo Alto, California, in March, 1975, were most positive. The group was made up of six to twelve patients who met every other week for two years. The objectives were to help the individual discover a sense of self, to end his isolation, to promote fellowship, to build self-confidence and to assist the individual with a spouse or family. The results suggested that positive changes were taking place while the members explored their identities.

Summary

The literature revealed historical information, alternative theories, causative factors, and treatment possibilities for the transsexual syndrome. However, the ambiguity and uncertainty surrounding these topics was obvious. The controversy seemed to be the result of the newness of the phenomenon. For this reason, the case observational method was used to supplement the library study. The group which provided the basis for the study was initiated as an experimental group as well as a vehicle in which to learn more about the transsexual syndrome. Group therapy was the treatment of choice and will be explored more thoroughly in the findings section of the study.

CHAPTER III
CASE STUDIES

This research began by studying people who feel themselves as belonging to the gender opposite to their sex. Their insistence that their sex is wrong and that they want to become members of the opposite sex is very threatening and disturbing to most people. Most identity conflicts in people are unconscious or hidden, yet these people verbalize confusing identities and offer a unique chance to examine the development of sexuality and identification in males and females.

Group therapy was the treatment of choice and instrument chosen to study transsexualism for several reasons. Past experience has shown that individual psychotherapy has been unsuccessful and that when offered individual therapy, most transsexuals refuse treatment (Hastings and Blum, 1967). However, these people are pressured to get some form of psychiatric help before they are considered for surgery. Experience thus far has shown that group therapy in which other transsexuals are present is a preferred mode of treatment. It has been found that given a supportive environment in which

the therapists take a non-judgmental stance on surgery, that the transsexuals are able to talk openly and freely about their gender problem. They are able to discuss their family problems, ambivalences, and fears. Individual psychodynamic treatment would inhibit the type of exchange that the group support allows.

Five transsexuals, persons who believe they are of the opposite gender, were the subjects in this study. The subjects were chosen from a sample of convenience. These five transsexuals were all members of a group which formed out of the growing need to provide psychotherapy prior to surgery. The researcher, a female social work student, was the co-therapist in this group with a male psychologist as the other group therapist. The group met once a week for an hour and a half and is still continuing to this date. The group consisted of two anatomical females desiring to be men, and three anatomical men who wanted to be women. Two of the patients were married, one was living with a girlfriend, and the other two lived at home with parents. They were from age nineteen to forty-four and at various socio-economic brackets. The fee for the group was based on a sliding scale set up by the therapists with the individual's financial situation and dependents taken into consideration. All patients were pre-operative transsexuals and committed to changing

their bodies to match their gender. These patients have been seen in group therapy for approximately nine months. Several of them have been living in their chosen gender roles for as long as five years and have worked and been accepted by society in that role. Therefore, the patients will be referred to as their gender choice rather than their biological sex. It would be difficult to label them in any other manner after knowing them and relating to them as a co-therapist of the group. This small non-random sample does not have statistical significance nor can the findings be generalized to the entire transsexual population. However, the group provided the opportunity for an exploration of this phenomenon.

The purpose of this chapter is to integrate the material gathered from the social histories, psychological testing, and group observations to give a clinical picture of each of the patients being studied. The psychological tests administered to each group member were the Wechsler Adult Intelligence Scale (WAIS), Rorschach, Thematic-Apperception-Test (TAT), Minnesota Multiphasic Personality Inventory (MMPI), Bender-Gestalt, Draw-a-Person (DAP), and Sentence Completion Test.

Because of the limited knowledge of transsexualism, the research method was a combination of a library study and case observations, the latter based on clinical

observation of group therapy sessions from September through May, 1974-75. The observations represented actual statements, claims, and admissions by the subjects and were not merely inferences by the researcher. In all instances the observations and statements attributed to the subjects about their positions were verified by the co-therapist. The judgments made by the researcher in each case were acknowledged and agreed upon by the co-therapist, thus lending some evidence of reliability to the data. As a result of this investigation examining transsexualism, especially as revealed in group process, four major hypotheses emerged. These hypotheses and other themes which many of the patients demonstrated, will be presented following the case illustrations.

Five Case Illustrations

Case I: Renee

Renee was a forty four year old, Caucasian, married male with four adopted children. She appeared older than her stated age and when first interviewed was wearing a business suit. Renee was the name that this sexual-male had chosen to illustrate her chosen gender. Renee came to the clinic which was her first psychiatric contact stating, "I want to begin a program of sex reassignment. I do not want to go on any longer living as a male. I

have exhausted my will to suppress this compulsion."

This rather sophisticated and intellectualized response was typical of the way in which Renee always communicated. Her speech was usually spontaneous, coherent and relevant. She was compulsively preoccupied with her gender conflict which began forty years ago, and for which she was asking for guidance in the pre-operative stage of living in the gender role of her choice. Her affect was mildly depressed and she was unable to establish eye contact. She often closed her eyes completely, suggesting her preoccupation with personal thoughts and an inability to relate to people directly. During the first interview, her style was guarded, secretive, obsessional, and her use of projection and denial suggested possible impairment in reality testing. Renee felt driven by her thoughts to be a woman and in her fantasy she is a beautiful, soft, attractive woman with lovely clothes. She feels jealous toward women who are this way, and she wishes on a conscious level that she could be this way, and, therefore, be a daughter to her mother. She fantasizes relationships with men, but only with herself as a woman. She was disgusted when asked about homosexual behavior, and she became moralistic and judgmental, an extension of her harsh, punitive, super-ego. She related many active fantasies which bordered on delusional material

and at times seemed to be carried away by these thoughts. She used symbolism and romanticism in a way that suggested a schizoid way of dealing with interpersonal relationships. She has said she feels like she's Dorothy following the yellow brick road, from the Wizard of Oz, always trying to go home. Home for her represents the goal of womanhood that she is striving for. She talked about how difficult it is going to work and living as a male always wearing a mask and displaying a false self to others. The unreality of herself as a male keeps her isolated and unable to form any kind of object relations, and she says, "it's as if I were behind a curtain."

Renee is a college graduate with a masters degree, from a private college. She is a business executive who is responsible for large budgets and hundreds of employees. She has been married for 20 years and has adopted children ages 7, 9, 11 and 14. All are boys except the 11 year old who is a female. She has played a very insignificant role in the family as fatherly duties tend to remind her of her masculinity, which she detests. Often her wife speaks to the children for her, explaining that she is tired from a hard day at the office. Her eldest son, she has little communication with, and she is very critical of him. She is envious of her daughter and jealous of her "budding breasts" which she herself hopes

for. Her fantasy was that they can be two adolescent girls sharing things and growing closer every day. Her younger sons have not presented any difficulties other than she has withdrawn from them. Her relationship with her wife, she described as, "we get along very well as two inter-dependent friends. We have no husband and wife relationship sexually." Renee told her wife about her problem ten years ago, but it was not until a year ago that she proposed her plan of sex-reassignment surgery. She has accepted Renee's decision and allows her to cross dress and be her female-self while at home in their bedroom. She has begun to teach Renee how to sew and can relate to the femaleness as she can not to the maleness. She maintains a stubborn unrelenting love and acceptance of her husband. In a taped interview, Renee's wife has stated:

First, I'd like to clarify the relationship between the two of us. Once I had accepted the reality of the end of our marriage and realized how intolerable staying together this last year was going to be with us each looking toward such opposite goals, I timidly entered into "her world." Our relationship became very close as we discussed and read up on transsexualism and tried to plan for both our futures. The emotional, financial, and physical dependencies remain, but a totally new relationship is evolving. Our goal for this one year remaining to us together is to get both of us as ready as possible to live productive and worthwhile lives. Just as I am helping with sewing, wardrobe, etc., and providing emotional support and sharing his dreams-- so she is helping me think through the problems

I need to face: housing, children, a single parent, care of house and car and to become generally independent. We hope to continue at the least a supportive, strong friendship after separation.

It was apparent from that interview and subsequent meetings with her individually and with her husband that she is brainwashed by Renee. Her ambivalence comes out as she says 'he' is "copping out" on the family while at the same time she is totally accepting of 'his' wishes. Her fear of separation is great and the impending loss of her husband is analogous to the grieving and mourning one does in death.

Renee has been cross-dressing only in the privacy of her bedroom and her children have no idea of her problem. She has felt urgent, however, to "come out" and requested help in what, when, where and how to tell the children. Her timetable was to leave the family in nine months, to live as a female and to tell the children then about her condition. She is hopeful that they will understand as her own mother and in-laws have done. Her wife's wishes were to delay telling the children until the last possible moment. It was clear that Renee had no insight or understanding as to how her sex change operation and leaving will affect her children.

Renee's family background was unpleasant. She

described her father as "distant, an alcoholic most of his life. We did little together. I had some hostile feelings." Of her mother she stated, "I loved her very much and wished I were her daughter. She was physically not affectionate but certainly the parent figure in my life." She described her parents relationship as poor, and she witnessed several beatings until their divorce when she was fifteen years old. She had one brother with whom she has a distant relationship. She remembered from childhood on feeling different and envying other girls. She did not date until she was nineteen. She was never attracted to girls sexually and she began cross-dressing in private during latency years.

Psychological testing done on this patient prior to treatment revealed a Verbal IQ of 120, a Performance IQ of 106 and a Full Scale IQ of 115. These scores suggest that she was functioning within the bright-normal range of cognitive abilities.

Examples of sentence completions which suggested her isolation, estrangement, poor object relations, bizarre thoughts and ideas, core gender conflict focusing on homosexual concerns, impulsivity, depression, primary process thinking and paranoia are:

Most of all I wanted to be a girl.

As a youth my greatest trouble was doing what was expected as a boy.

It is easy to get in trouble when you are trying to hide something.

Worse than being lonely is being mistaken for someone else.

Most of the time I feel like I am behind a curtain.

I'm afraid of growing old as a male.

I wish that I was born a girl.

I have never made love to a boy.

I dream that I have had surgery and am happy in my new role.

As a youth my greatest emotional need was to be loved and held.

I suffer most from continuing the male identity.

My mother was a very attractive woman.

I don't like men who are homosexual.

I hate my male genitals.

People shouldn't ridicule transsexuals.

A naked man who is nameless and faceless comes into my fantasy.

One must never let down one's guard.

My father was very impatient.

Death is preferable to living as a male.

Other people see me as a man and I don't like it.

If I could get away with it I would dress and live as a woman immediately.

My biggest problem with sex is my lack of a vagina and feminine appearance.

When I'm in a group I am lonely.

Many people don't know that I am sensitive and soft.

The worst thing I ever did was to strike my father.

The psychological report stated:

His responses suggest an identification, fusion and symbiotic attachment to his mother whom the patient sees as a 'good object.' Father, on the other hand, is ambivalently portrayed as the indifferent, 'bad object.' Psychosexually, Mr. R. is functioning at a pre-oedipal level of development. He yearns to be held, rocked and cuddled. He is uninterested in genital sex as a male and has a deep-seated desire to have breasts, one idea which seems to be part of a more generalized wish to return to mother's protection and to fuse with her. Diagnostic Impression: Borderline Personality Disorder with Paranoid and Depressive Features.

In conclusion, Renee has said, "This condition has crippled my life--defeated me and I have to resolve this thing to get meaning."

Case II: Terry

Terry was a 21 year old anatomical male who has assumed a female gender role and is contemplating sex reassignment surgery. He appeared as an attractive, light-skinned, black woman who was immediately likable, humorous, and naive. The feminine role she portrayed was very believable as during the first interview both

therapists were uncertain of her biological sex until the end of the interview at which time she told us what type of hormone she was prescribed. However, at times she presents herself as a highly characterized female, dressing in short skirts, six inch heels and tight blouses. She was blatantly seductive toward the male therapist, crossing and recrossing her long, stockinged legs in a suggestive manner. Her affect was overly buoyant and hysterical. She spoke spontaneously, chatted about trivia and showed a lack of depth in her personality.

She came to the clinic stating, "my gender is my problem." She has felt as if she were a female since birth and she began cross-dressing at age 4. She remembers being teased by classmates and never fitting in with other boys at school. She described a lonely childhood, having very few friends and no siblings. As she approached adolescence, she decided to cross-dress permanently and she began going to school dressed as a woman. She was able to obtain female hormones and got silicon injections for her breasts so that she made a very attractive woman. Her voice was high-pitched and her face hairless.

Terry spoke in a concrete fashion and avoided anything too abstract. She was warm and genuine yet flighty and unpredictable, as well. Often she seemed to be overwhelmed by material which was stimulating. Her

thinking was often vague and her associations loose and shallow, suggesting a borderline level of functioning. When sexual fantasies intruded her conscience, she became disorganized and impulsive. Her mind was often pre-occupied, probably with her gender problem, and she looked vague and not all together. On occasion, she has shown depression and loneliness, yet these affects are warded off through hysterical defenses in which repression and denial are employed. She uses reversal as a defense as well in which sad affects are experienced as euphoria. This often leads to dramatic, expansive and grandiose displays. She denied anger and used isolation to distance herself from others. She characteristically does not answer her telephone at home, as if she felt aggressive and thereby undoes her angry feelings. She perceives men as assertive and active while women, with whom she identifies herself, she sees as more passive and emotionally flamboyant.

Terry's family background was sketchy and difficult to obtain. She recalled a close family life with a strong attachment to father, who died at age 49 when she was 19. When asked how they got along, she replied, "very good." His death from cancer was quite a shock to Terry, as her father supported her cross-dressing and passing as a female. Terry's mother was described as a housewife who

was good to her and provided much affection. The parental marriage was said to be "very, very good." Having no brothers or sisters, Terry was the center of all the attention. She missed siblings, yet had several cousins that she spent time with. She began to cross dress on weekends in secret during adolescence and was pleased whenever she received whistles from boys in passing cars. This gave her the courage to cross dress publicly during the day, and by 18 she had assumed a complete female gender role and was accepted by friends and family. She was on a hormone program, and her thin body took on womanish curves. Her new identity pleased her, yet her social relationships were always shallow and incomplete. Going out with men meant never getting close or intimate, for they would discover she was actually a "he". There was little emotional depth to these relationships, and she experienced them as stereotyped enactments. The poor object relations suggested an underlying schizoid adaptation, well masked by hysterical features. She was living with her mother and going to school to learn to be a court stenographer. She lived as a female in all respects.

Psychological testing revealed a Verbal IQ of 93, a Performance IQ of 95 and a Full Scale IQ of 93. These scores suggested low normal intelligence with imprecise

and global thinking. On the sentence completions there was evidence for feelings of loneliness and emptiness which probably originated from early, unmet needs, as well as phallic concerns and fear of aggressive impulses.

Examples are:

As a youth my greatest trouble was falling down.

A person is most helpless when in hospital.

No one can repair the damage caused by burns.

Worse than being lonely is being sick.

When I tell my troubles to others I want them to listen.

I'm afraid of rats.

I cannot control myself when I dance.

My sex life is late.

When I get angry I swear.

I don't like men who beat women.

People shouldn't fight.

A naked man is cute.

One must never disturb others.

My father is dead.

I feel very sad when I think of the movie "Madam X".

When criticized for my behavior I listen.

My body is overweight.

Death is terrible.

I don't like women who don't keep themselves clean.

Other people see me as a very nice person.

The best time of my life is now.

The worst thing a man can do to a woman is hit her.

A woman's body is beautiful.

Nothing is harder to stop than a cancer.

Behind one's back is in back of him.

People should tell lies when faced with death.

My biggest problem with sex is my gender.

When I'm in a group I try to be helpful.

I can not always control myself when I'm at a dance.

I lose my temper sometimes.

What I like most about myself is I'm cheerful most of the time.

The psychological report stated:

Psychosexually Terry appears to have a strong oral fixation and unconsciously is still highly absorbed in incorporative activities to fill her emptiness. Her test protocol is filled with food references and references to mouths which attests to this concern. The affects arising from these unmet needs have a depressed quality, and it seems as if her lonely feelings may be alleviated through sexual fantasies. . . . While Terry expends great psychic energy defending against aggressive and assertive feelings the prepotence of phallic imagery in the Rorschach suggests that underneath her female masquerade a strongly masculine core remains. . . . She expresses marked ambivalence to surgical intervention as revealed in a remarkably

transparent TAT story on Card 8BM in which she told the story of a homosexual liaison which ends in the castration death of one partner by a father. Terry's story suggests that (1) she may experience surgery as punishment, and (2) that the depressed feelings against which she defends may in fact surface postoperatively and cause her to be suicidal. . . . Diagnostic impressions: Schizoid personality with hysterical features.

Case III: Ben

Ben was a nineteen year old Caucasian sexual-female, single, employed person who knew that he was female genetically and anatomically but who believed that his gender was male and, therefore, acted as if it were. He was a small, thin young woman, whose blonde hair was closely cropped at the sides and on top, but whose hair was much longer in the back. He wore a beret to cover the baldness, which gave him a rather comical and peculiar appearance. There was no femininity about him, even his clothes were masculine. He looked, talked, and acted like a young man. Ben has adopted masculine behaviors and mannerisms and looking at him one would never know he had a vagina and breasts and lacked a penis. He walked with a swagger and sat in a typically masculine fashion. In the first interview, he insisted we call him Ben as all of his outside peer relationships, employer, and family members used his male name and masculine pronouns when referring to him.

As he talked the bravado in his voice and its low pitch as well as the swear words, the way he smoked a cigarette, his jerky tough-guy movements, and a male chauvinism made him appear as a male actor in a movie. He highly exaggerated the role of a punky adolescent who needed to appear hard and macho. During the session he spoke of his gender problem in terms of a lifelong struggle to get people to accept him and treat him as a male. He described a frightening experience one year ago in which he was hospitalized by his mother for what he thought was for his "ulcers and nerves." However, the hospitalization turned out to be a psychiatric admission and the only reason he could accept for being there was because he was requesting a sex change from female to male. Some of the following history was gathered from that admission.

For as long as Ben can remember he has been aware of wishing he were a boy. He took part in boys activities and sports and had all male friends. He always preferred pants to dresses. He was a clown and a trouble maker in school and was not well liked during his latency aged years or adolescence when at age twelve he had several homosexual relationships with girls. By the tenth grade he dropped out of school because of the ridicule of his peers and instead made friends with

people who were in their twenties and thirties.

Ben's family life was very inadequate. His mother was on her third marriage and his father was on his second marriage. Each had children from their previous marriages. Two stepbrothers aged 23 and 26 grew up with Ben, and the parents fought and had extramarital affairs throughout their nineteen year marriage. Father was a bartender and worked nights and slept during the day. Ben had virtually no relationship with him. Mother has had a previous psychiatric hospitalization, and her diagnosis was depressive reaction and psychosis. She took pills, and Ben remembered his mother spending most of her time in the bedroom during his growing up years, so that his eldest brother really raised him. Both older brothers were policemen and Ben felt a need to identify with them. His deprivation and lack of nurturance are obvious and about one year ago Ben left his parents and contacted Child Welfare, who placed him in a temporary foster home. He only stayed five hours and then left to live with a woman he met accidentally over crossed telephone wires. The relationship began when Ben identified himself as male. When Ben went to meet this woman, he explained his gender problem and the woman accepted Ben as a bi-sexual. Ben has since fallen in love with this woman, and they have had a sexual

relationship. Ben's sexual preferences were for sexual and gender-females and he flirted with girls and had everyone believing he was male. Ben insisted that he was not homosexual because he "feels like a male and lesbians are women." In a typically adolescent fashion he was preoccupied with sex, and gave wolf whistles, and became aroused whenever a woman was present.

Ben's poor relationship with his parents, his low self image, his suspicion of other people, his feeling that no one cares about him, and his anxiety around his appearance and other people's reaction to it all, point toward an agitated, depressed, untrusting, suspicious, sensitive and impulsive youngster. He was threatened by an environment and people who were aggressive and offered him little, if any, gratification. Most of his energy was diverted into fantasy to help him escape from the anxieties of his real life situation.

He was living with his parents who were in the midst of a divorce. He was ambivalent in his feelings towards them as he realized the need to separate from them as well as his need to grope for the nurturance and security he was still hoping they could provide for him. Ben, like the others, was committed to his chosen gender role and desired the sex change operation.

Psychological testing revealed a Verbal IQ of 118,

a Performance IQ of 96, and a Full Scale IQ of 109.

This suggested his intelligence was at the high average level. The psychological report stated that:

The overall test seems to point to a picture of arrested ego development in a girl who is not in good touch with her own feelings and whose emotional outbursts may reflect somewhat arbitrary ways of expressing a variety of different feelings of which she is unaware. . . . Her anger may be her defensive mode for dealing with underlying suspicion. . . . Given this type of facade as well as occasional references to food on the projective tests, one does wonder what her relationship to her mother was in her first year of life. While concerns and conflicts around sexual identity play a part in her current difficulties of adjustment, these concerns appear to be pregenital in nature. . . . Testing indicates a weak reality testing, low conventional perception, and occasional instances of disorganized thinking in a girl who appears to show signs of arrested ego development. She shows signs of intellectual styles of adaptation, as well as the use of projection, tends to be rather mistrustful of others, manifesting much conflict in interpersonal relations, as well as a conflicted sense of identity. . . . Diagnostic Impressions: Depressive Neurosis, Other Sexual Deviation.

Case IV: Ron

Ron was a 31 year old Caucasian, married, father of three children, employed as a truck driver. Ron was a sexual-male, who came to the clinic for help with his gender problem, which he said began when he was about six or seven years old. When asked what thoughts he had as to the cause of these problems he stated:

Maybe down deep inside me there's a woman who wants out. If this is true, she is finally doing something to get out. The sex change would take the pressure off me.

Ron was moderately overweight and has thinning hair on top of his head, which made him appear older than his stated age. He was dressed in workmen's clothes and boots, and his speech, mannerisms, and posture gave him a masculine appearance. There was nothing feminine in his outward behavior. He was engaging, friendly, and entertaining, and his verbal presentation was spontaneous, relevant, yet circumlocutious at times. He related stories of his life and transvestite preferences. His attempt at being humorous seemed to be a defensive ploy probably to bind his anxiety.

He suggested a preoccupation with the wish to change his sex as on a social history questionnaire, he reported that:

Just about all I think about is how my body would look and feel if it would be changed. I think about having nice breasts so a man can touch and kiss them. I would also like to be able to have intercourse with a man, and I want to be able to wear panties, nylons, bras, dresses, skirts, and tops, heels, makeup and other female things, and do things like plucking my eyebrows, going to the hairdresser, doing my toenails with nailpolish, and maybe even being a little sexy. The only way I know of is to have a sex change (if I could get over the legal problems, I would be living as a woman now).

Ron described a rather lonely and isolated childhood.

His parents fought constantly, and he was often sent to live with an aunt. He only saw his father on weekends, and they were never close. He died when Ron was 16. Ron's mother was described as old-fashioned, and he said they got along well. "She is a fine woman and raised me the best she could." His mother remarried, but he had little contact with his stepfather. He has one brother, six years younger than he who was a practicing homosexual. Ron remembered being bigger than most kids in school and getting picked on because he was. In a taped interview with Ron he recalled several early memories:

No one was ever on my side, I was the loser, the odd ball; I was a loner at school. . . . I used to pray at night that I'd wake up to be a little girl wearing dresses and doing things little girls did. To me it always looked like they had more fun than the boys. They seemed to get along better, the boys always fought. . . . I'd sneak in the bathroom and try on lipstick and try on my mother's clothes.

He remembered at age 8 or 9 having an erection while trying on his mother's clothes. The first time he cross dressed in front of other people was in his teens when he gave a costume party and dressed up as a woman. Later he was able to acknowledge the pleasure he got from this and during his first marriage he would try on his ex-wife's clothing. His second wife would not tolerate this behavior, however, and she has torn up his clothes

and threatened to leave him several times. He has found another outlet to cross dress, though, as he became a musician in a band. He would appear as a woman and entertain at bars and nightclubs. His wife allowed him to use the basement for the purpose of dressing, but also encouraged him to seek medical help for what she felt was sick behavior.

Ron has four children ages 11, 9, 5 and 15 months. The two eldest were stepdaughters from his wife's first marriage, and the two youngest were male. His relationships with the boys was the closest, and he was aware of how his desire for a sex change would affect them.

If I go to live as a woman, I will have my wife tell them I died or something, because telling them the truth would hurt them too much. . . . I know I should have done it when I was younger--I've wasted a lot of time in my life, but to face it took a lot of courage.

Ron has reoccurring dreams about being a woman, and living with a man, and these obsessional thoughts tended to dominate his thinking. He was compelled to act out his sexual fantasies, which suggested poor impulse control. He split off his passive drives and gave in to them, thereby gratifying his exhibitionistic and narcissistic needs. As a woman, he can have his intense dependency needs met, and he fantasized that as a female, his longings would be satisfied. He was preoccupied with the

sexuality of his gender problem, and said of his penis and testacles,

If they were gone I wouldn't miss them.
I'd be happier with a vagina than a penis. . . .
When I get excited my heart beats faster, it's not that I get an erection.

These feelings produced anxiety which he defended against by wanting to retreat to a regressed, passive state in which there was a oneness with mother and an attachment. On one hand he has a need to preserve bodily integrity, while on the other he wants to be his mother's image. He said of his condition:

Something has got to change, either my mind or my body, but to go on the way I am now is ridiculous. It's like a pressure, because I have noone to share my real feelings with. Now maybe I'll get complete relief. I'll either release the woman that's inside of me, if there is one inside of me, and I think there is, but maybe it's just a fantasy in my mind that I want this, and they (psychiatrists, etc.) can change my mind, or maybe they will say it's my mind that's right, and they'll change my body.

Psychological test results showed a Verbal IQ of 113, a Performance IQ of 106, and a Full Scale IQ of 110. These scores suggested that he was functioning in a Bright-Normal range. The sentence completions illustrated his obsessive focus on his sexual problems, his tendency to regress, his compelling need to cross-dress, which gave him fetishistic pleasure, and his desire to be closer to his mother and thereby be taken care of as he

perceived women are:

Most women are helpless and dependent on men.

One's closest friends can hurt you the most.

Worse than being lonely is being unhappy with the way your life is going.

Most of the time I feel that I should have been born a female.

I'm afraid of being stuck the way I am for the rest of my life.

I wish that I was a woman and could do the things women do.

My biggest problems are (money) and how I would go about having a sex change.

I often worry about what life would be like as a woman.

I dream of being a woman and wearing different outfits, also of having a man make love to me.

I cannot control myself when I start to put on women's clothes. I have to get fully dressed, makeup and all.

As a youth, my greatest emotional need was to have someone to tell about my problems.

I suffer most from the drive to put on a dress and makeup and go out.

The psychological report stated:

Ron's responses suggest the presence of severe character pathology in an extremely narcissistic, impulsive individual with obsessive features. The major part of his female adaptation includes an element of sly, sneaky, behind-the-back maneuvers which he employs in order to act out his wishes. . . . Throughout the Rorschach whenever Ron becomes preoccupied with sexual percepts and imagery, his thinking becomes tangential, vague, and confused. At these times

his reality testing may be moderately impaired and his judgment quite poor. However, because of Ron's relatively stable personality, he is able to quickly regain control and employ his psychological defenses effectively. . . . Diagnostic Impressions: Borderline Personality Disorder with Narcissistic and Obsessive Features.

Case V: Tony

Tony was a 20 year old Caucasian, single, anatomical female who appeared shy and withdrawn, but friendly. He looked like an adolescent male with a facial expression of innocence and boyishness, typical of latency. His dress was jeans and a work shirt, camouflaging his breasts and hips, and his hair was shoulder length. At a glance, one would not be certain which sex he belonged to. He came to the clinic stating:

I am in need of help for transsexualism.
I desire to be a male and I am not physically equipped to be a male.

His speech was soft and his affect was appropriate, but bland. He came across as immature, childlike and rather shallow. He was not very spontaneous in conversation, and his rather cautious responses to questions suggested denial and a guarded and rigid defensive structure. At times he was stubborn and obstinate in a passive, aggressive style, as if keeping a lid on his underlying emotional conflicts. There was no overt signs of a thought disorder or evidence of bizarre behavior. He

saw himself as part male and part female, but hoped through surgery to get rid of his female anatomy. He was jealous of other males, while identifying with them. He was attracted to women, but insisted this attraction was not homosexual, but merely a normal male attraction to a female. One suspected that his need to be a male was in part a defense against his homosexual impulses.

Tony stated his problem began in childhood, and his thoughts about the cause of his gender problem were "a lacking of something in the makeup of me." He remembered always wanting to be a boy and he wore masculine clothing and played boyish games. He was a loner during childhood, and while he did well in school, he had few friends to play with. He began dating at the age of 15, yet said he had difficulties while dating, and "explaining to my date why we should only be friends." He enjoyed sports and rock and roll music, and while he was in high school he met a girl whom he began dating. They had a sexual relationship in which Tony played the masculine role. He was living with this woman and planned on marrying her. She knew of his wish for surgical sex reassignment and was supportive of him.

Tony's family background revealed an intact family structure with mother and father getting along, and himself the eldest of four children. He has two brothers 9 and 4 years younger and one sister a year younger. In

describing his father and their relationship in a social history questionnaire he commented:

In my younger life, I did not know much of him, he worked nights. I did not see much of him but I respected him. We fixed cars together, we've remodeled the house, etc. I think very highly of him. He is a very intelligent man and I love him.

Of his mother he stated:

We got along pretty good, but we had our problems. She helps me and my Dad do things around the house. I know she cares about me.

It appeared that Tony had succeeded in the oedipal battle by winning father over and identifying with him as a man to avoid incestual impulses that a father/daughter relationship would have elicited. It appeared that father wanted his first born to be a son, and consciously or unconsciously treated him as such. Tony gets along well with his siblings and said, "I have always tried to help and protect them." He felt especially close to his sister, and he recalled a very vivid memory of a time when she was 8 and he was 9, and they were visiting grandmother in another city. She was on a playground, and raped by two 16 year old boys while he was somewhere else playing. She confided this to him later, and he felt guilty and responsible for not protecting her from these boys. They kept this incident to themselves, making the rape and his identity two family secrets which involved sex. He described his sister as

being overweight, shy, fearful of men, and never having dated. One suspected homosexual overtones to the relationship, which Tony defended against by believing he was really a male. During his childhood Tony said he felt like the "man of the house." He had to watch over all of the kids as his mother drank during the day and worked at night to help out father financially. As Tony's problem became more and more obvious to himself, he revealed his wish to be male to his family. His mother did not understand and in this crisis sought psychiatric assistance. His father seemed to be less concerned, yet Tony found it difficult to remain living in his home once he began assuming a masculine role. He moved into his own apartment with his girlfriend and obtained a job working in a printing office. He was able to explain his gender problem to his employer and he was accepted for work as a male. This was his living condition, and it seemed to agree with him.

Psychological testing done prior to entrance into the group revealed a Verbal IQ of 101, a Performance IQ of 122 and a Full Scale of 110, suggesting that he was functioning in the Bright-Normal range of cognitive abilities. Examples of sentence completions which illustrated the possibility of psychotic decompensation under stress, a passive-aggressive personality style, a well

guarded, defensive structure, a fear of aggression, isolation and a desire to be masculine, were as follows:

Most of all I wanted to be a man with great intelligence.

As a youth my greatest trouble was trying to understand myself.

Most women are soft and gentle creatures.

A person is most helpless when he doesn't know what he wants.

Worse than being lonely is being misunderstood.

When I tell my troubles to others it's a rare occasion.

I'm afraid of losing my girlfriend.

I wish that I were born a guy.

I have never thought I was doing the wrong thing by acting as a man.

I dream just about all the time.

As a youth my greatest emotional need was to talk to someone.

I couldn't get along without my girlfriend.

My sex life has only just begun.

My mother loves me.

When I get angry I get over it fast and am sorry it happened.

I don't like men who are loudmouthed, pick on people, and hurt others.

Too much distance lies between the present and the future.

If people only knew how much I want this operation.

At night when I'm in bed I like my girlfriend to hold me.

My father is a very kind and generous man.

When criticized for my behavior I withdraw.

The trouble with me is I withdraw myself too much.

My body is an embarrassment to me.

To get along well in a group you have to participate.

I don't like women who throw themselves at any guy.

The future has a hopeful outlook.

Other people see me as a male.

If I could get away with it I would get an operation sooner.

The best time of my life is the time I spend with my girl.

A woman's body is a precious thing.

My biggest problem with sex is not being able to function normally.

Many people don't know that I am a shy person.

I lose my temper very rarely.

The worst thing I ever did was not to tell someone about me a long time ago.

What I like most about myself is I know what I want.

The psychological report stated:

Tony can be quite obstinate, stubborn, and passive-aggressive. She generally presents herself as a shy, inhibited and withdrawn woman and is likely to be seen by others as immature, childlike, superficial, and shallow in her

interpersonal relationships. Her responses to the projective tests suggest that she has a rigid, defensive structure, employs a lot of denial, and may also appear guarded, cautious, and defensive. Tony has a strong need to please and to deny emotional pathology. . . . She has extremely low self esteem and is clinically depressed. Her responses suggest that she tends to employ her sexual excitement defensively to ward off her depressive affects which threaten to overwhelm and destroy her. In spite of this, Tony is not currently suicidal. She is, however, quite disturbed by her depressed feeling which she seems to associate with her femininity. . . . Diagnostic Impressions: Character disorder with passive-aggressive and passive-dependent traits.

Hypotheses

These five case illustrations were done in order to learn about the transsexual phenomenon. The impressions gathered from the group sessions by the researcher were in agreement with those of the co-therapist lending inter-observer reliability to the study. There were four themes which emerged from the clinical material, and they are presented as major hypotheses for future study. These themes were based on statements made by the participants in which all five members agreed. These hypotheses lended conceptual understanding to transsexualism specifically around the issues of etiology and dynamics. Some of these hypotheses conflicted with some current theories on transsexualism and suggested that this phenomenon was considerably more ambiguous than has been

acknowledged. The labeling of these themes as hypotheses alerted the researcher to the need for continued observation and research in the area of transsexualism. The four hypotheses are:

I. As a group male transsexuals reject the masculine role and female transsexuals reject the feminine role despite their upbringing and conscious parental guidance to the contrary. (This hypothesis tends to call into question some of John Money's research.)

II. Early learning and the sociological and psychological aspects of the parent-child relationship are significant factors in the determination of gender role preference.

III. Gender identity is established within the first few years of life and confusion over this identity is a life long problem. (This contrasts with Stoller's theory of the ambivalent core gender-role in transsexuals.)

IV. Transsexuals have difficulty forming object relationships which results in their isolation and the compulsion to be members of the opposite sex.

Evidence which lends support to each of these hypotheses will be presented in the following chapter, entitled "Findings". The data will be analyzed under etiology and dynamics. Due to the limited number of

subjects and available material, the researcher has considered only the unanimous presence of variables as having significance. The themes then represent statements that five out of five people have agreed upon. The author was aware of the subjectivity involved in this type of study and, therefore, all impressions were checked with, and agreed upon, by the co-therapist.

CHAPTER IV

FINDINGS

These five cases were presented to support the major theses, that transsexuals reject their anatomical sex despite their upbringing or conscious guidance of their parents; that the parental-infant relationship and the attitudes of siblings and peers influence gender role choice; that gender identity is established in the first few years of life, and that confusion over that role is a life-long problem; and that object relations among these people are poor, causing them to drastically alter their bodies in an attempt to end their isolation. The clinical material lent itself to speculation and debate, and while certain issues have been clarified, there are many more which remain unanswered. In looking at the cases, it was easy to spot the similarities and common denominators in the early histories and family backgrounds, while the differences were less obvious. Each case however different illustrated that gender identification developed contrary to genital identity. In the following subsection, evidence obtained from case history material which familiarized the researcher with the background of the subjects, as well

as observations based on statements and discussions in group therapy sessions, support the major hypotheses.

In Case I, Renee's parents treated her as a male child and never encouraged feminine behavior. Despite this upbringing, Renee harbored thoughts of being female and constantly longed to be her mother's daughter rather than her son. This is evidence for hypothesis I. She defended against these unacceptable thoughts and went so far as to marry to prove her manhood. She maintained the vain hope that marriage would act as a cure, however, she found marriage and fatherhood an unnatural and undesirable state. Her need to reveal her secret identity became stronger and even more compelling. She wanted acceptance as a woman and a daughter which one might speculate was for her a more desirable role. In her family of origin, father was an alcoholic, whose aggression was often directed towards his wife in a hostile and violent way. Renee was helpless in this situation, and unable to defend or protect her mother from father's rage. Given these circumstances, it was not surprising that the female role was more attractive and appealing to Renee than the role she was assigned at birth. This supports hypotheses II and III. These private thoughts of wanting to be a woman began to take up more and more of Renee's time and caused her

incredible anxiety and discomfort. She needed to isolate herself in order to escape masquerading as someone she did not feel herself to be. Others expected her to look and act as a man while she, herself, felt more like a woman. She began to live more in her fantasy life than she did in the real world until her desire to be female compelled her to make her dilemma public. Her wife was the first person she confided in. Needing further confirmation from others prompted her to reveal her lifelong secret to the rest of her family. The unexpected happened: as Renee's mother and brother were able emotionally and intellectually to support her wish to be female. In fact, after hearing Renee's dream to be a daughter, her mother sent a present of panty hose and a necklace to demonstrate her wish for Renee's happiness. Renee's brother also expressed his feelings by saying that he hoped Renee would make a better sister than she had a brother. Interestingly, later Renee revealed to the group that during a recent visit to her brother, she was rejected and her wishes to be his sister were denied. This illustrated some of the family's ambivalence toward Renee as mother's acceptance of her was certainly unusual and lent itself to speculation. Was mother secretly disappointed that she never had a daughter, and, therefore, overjoyed with the bizarre turn about

in her son? It seemed that age was a factor in the unqualified approval of Renee's plans to live as a woman, for had Renee still been under the influence of her mother, one suspects that the reaction would have been different. In support of this was the response that Renee's nuclear family gave, which was the more expected one. They dealt with the news with denial. Renee's wife mourned the loss of her husband, while the kids did not understand the pending separation or loss of their father. They did not rejoice in Renee's dreams to be a woman and become a companion and an aunt to them rather than remain a husband and dad. Finally, in support of hypothesis IV, perhaps the best evidence concerning the difficulty Renee had in establishing object relationships which resulted in her isolation and alienation was revealed in group sessions. Renee was the least responsive in the group to other members. She found it very difficult to empathize or to offer support to others as her own narcissism and exhibitionism interfered. She related in an intellectualized and condescending way which was non-engaging. Renee also had a habit of shutting her eyes and going into her own fantasy life which served as another communication barrier. She could not maintain eye contact and when this was pointed out to her, she denied any awareness of this habit. This

type of participation in group revealed poor object relationships lending support to hypothesis IV.

In Case II, Terry's history provided evidence to support the four stated hypotheses. Terry was raised as a male and discouraged from cross-dressing. Whenever she displayed any feminine traits she was called a sissy. Despite this, Terry's overwhelming sense of herself as a female compelled her to dress and act as if she were a girl. She rejected boys' games and activities and was teased and humiliated for wanting to play with girls. This history lends support to the first three hypotheses. Terry became more withdrawn and isolated and retreated into a feminine role feeling inadequate in the male role. She adopted female mannerisms and further alienated her peers. Her dual identity created many problems and eventually forced her to choose one or the other. The feminine role was the more attractive one perhaps because it was an escape from the painful reality of her life. The resulting isolation explained the lack of meaningful object relationships and desire to be close to someone. Only after several years was Terry's family able to accept the femininity in her. With their silent approval and the help of electrolysis and hormones, Terry made the transition from male to female with surprising ease. Terry has been living in a female role

for five years and lives and works as a woman in society. Her goal was sex-reassignment surgery so that her body would be altered to match her psyche.

Terry's group participation, as also illustrated in case one, provided support for hypothesis IV. Her behavior in the group suggested someone who was not able to share easily or trust others. She, of all the group members, was the most secretive and mysterious. In fact, the paucity of information on her family background was a result of her need to keep things to herself. She revealed little of her private life, making it difficult for others to get close to her. She often came to group sessions late, and her entrance was generally dramatic. It was as though she could not come out in the open and talk about her concerns and so instead she acted out and expected others to interpret her behavior. Terry's personality, however, was extremely likeable and while her conversations were shallow, she managed to have many friends. These contacts were not what one would call good object relations, however, demonstrating that her isolation was self-imposed and was a motivating force in her drive towards surgery which lends support to hypothesis IV.

In case III, Ben was socialized according to his biological anatomy which was female. Yet, for as long

as he could remember he has refused to acknowledge that his female organs defined his gender role, and he has adopted a male role. This is evidence for hypothesis I. His family background was chaotic, stormy, and tenuous. His parents fought constantly and threatened divorce often. Father was a large, burly man who used his fists to overpower his wife, making the marriage far from peaceful. Violence was a common occurrence, and one might suspect that at an early age Ben had to learn how to protect himself from this hostile and angry man. He was not affectionate and never had time to be a father. To be female like his mother meant that you were brutalized and beaten while to be a man and masculine was to be powerful and dominant. Ben had to protect his mother, and to do this he had to be a man. This role reversal was necessary for survival, as he was often left alone as a child to care for himself. His gender choice was also probably influenced by his two older stepbrothers who were also powerful figures and able to care for themselves. Modeling their behavior was safer than modeling his mother's. He soon developed a negative and unrealistic view of women which has remained with him. He detested his own femininity and saw it as a sign of weakness. These data lend support to hypotheses II and III. As puberty approached and his breasts developed,

he became increasingly agitated, and developed ulcers. He began wearing tight fitting tee shirts to bind his breasts and filled his pants with objects which would bulge and look like a male penis. In adolescence he became aware of his homosexual attractions and needing to legitimize these sexual encounters, he further established a male identity. His behavior was typical of a male, and yet he was ostracized by his peers who knew his real identity. In desperation Ben dropped out of school in hopes of meeting people who did not know his sexual gender so that he could live completely in the masculine role untroubled. He began associating with people out of his peer group and had girl friends who were much older than he. His parents deserted him, and he has searched for a mother figure to protect and care for him by using his false self. Ben has real difficulty forming object relationships because of his fear of rejection and inability to trust anyone. He has learned that important people leave and cannot be counted on making his tough exterior and masculine image necessary armour. His parents have ambivalently accepted his masculine identity, but they hope that he will soon outgrow this fantasy. Further evidence supporting hypothesis IV is Ben's often inappropriate behavior in the group. While Ben has been the most loyal member in terms of attendance, he has

also demonstrated the most bizarre behavior during group meetings. For instance, when the conversation gets too threatening, he seemed to be masturbating by moving his hands over his chest or rubbing his legs together. He also felt inadequate in the group and found it necessary to exaggerate or make up stories about himself in order to get group approval. As one might expect, these behaviors did not elicit support but instead alienated others. At various times, Ben has sung, fallen asleep, taken pictures, and passed out candy in the group, as if this might help him make friends. Unfortunately, these tactics did not bring people closer and hence his object relationships remained poor.

In case IV, Ron was raised as a male in a traditional Italian family. His parents were divorced when he was 4 years old, and a stepfather replaced his real father. He never got along with his stepfather, whom he blames for his mother attempting suicide three times. He revealed to the group that when his stepfather died he went to the cemetery and actually danced a jig on the grave. This display of hostility was an expression of how he felt toward other masculine images as well. Ron's attachment to his mother, however, was greater than to his stepfather, and allowed one to speculate about the symbiotic nature of their relationship. He

had secret longings to be female and to be like his mother, whom he saw as strong, influential, and capable of providing gratification. To be like his mother meant warmth and love and security. These thoughts were suppressed, however, and only surfaced during Halloween or other occasions in which cross-dressing was sanctioned. This information shared with the group supported the first three hypotheses. His friends were unaware of his desire to be a woman and like Renee in the first case, he did not assume the role of a female, but instead got married to try to forget this drive. The marriage failed, but Ron remarried and even had children. His problem eventually surfaced, and his urge to be a woman dominated his every thought. He confided in his wife who felt he was sick to have such desires, and yet he could not give up this compelling drive to be a woman. He has not related this desire to his mother, whom he says has suffered enough from the shock of his brother, who is a practicing homosexual. Perhaps Ron wants to be female to legitimize his homosexual encounters and thereby remain in his mother's good graces. Ron, unlike case I, is aware of how damaging the news of his desire to be a woman would be to his children. He has been able to form tenuous relationships with his children, but they were extremely important to him. His conflict over his true identity

has been fully realized, but his ambivalence was still great. It was difficult for him to change roles and he has not yet decided to have the sex-reassignment surgery as the other group members have.

Ron's behavior in the group provided support for hypothesis IV, which stated that poor object relationships are a part of the transsexual experience. He was quite outspoken in the group and in fact got carried away by his own stories. He tended to dominate the group with boring detail, and thereby alienate them. His fear of being misunderstood or not being liked and accepted caused him to ramble on and on, and he ends up achieving the opposite of what he hopes to accomplish. Ron's lengthy monologues while often entertaining were actually defensive maneuvers. Ron was the only group member who did not come dressed in the gender role, he was striving for. This was another factor which contributed to his isolation within the group and was a sign of his ambivalence and lack of self confidence. Ron was still vacillating between believing his transsexual convictions and asking for sex reassignment surgery. His behavior suggested that were he to go through with the operation, he might react with depression, despair and hopelessness, and might even become suicidal. The group was helping Ron come to terms with these questions

in a way in which other forms of treatment would not.

In case V, Tony, like the others, was raised according to his biological sex, female and yet his identity was masculine. Like the others, he has always felt like his body did not match his gender and his earliest memories were playing with boys in his neighborhood and preferring rough and tumble games to dolls. This lends support to hypothesis I. His family lived in a rural area, and his mother worked throughout his childhood. He was left at home to watch over his younger sister, and he assumed the role of protector naturally. He dressed in male clothing and constantly wished he had the body of a boy. This history supports hypotheses II and III. He cut his hair and adopted male mannerisms, and as a result was ridiculed at school and isolated by his peers. He just did not fit into the feminine role that was expected of him, and his parents were not able to understand his dilemma. When he began a friendship with a girl, they were pleased until the relationship developed into a boy-girl one. Tony took on the male role with her, and she helped to reinforce his belief that he was really a man. His parents viewed the relationship as a lesbian one and they prayed that Tony would give up his dream of becoming male. They blamed his girl-friend for involving him in such a foolish plan. Their disapproval made Tony

leave home to dissociate himself completely from them and his peer group who viewed him as female. He moved in with his girlfriend who treated him as a male and reinforced the false identity he wanted to maintain. He obtained a job as a male and was living in that role preparing for sex-reassignment surgery. His participation in the group was suggestive of his passive-aggressive personality style. He had the most inconsistent attendance of any member in the group. He spoke softly which has been interpreted as a reaction formation to his aggression. He often sat back and observed the group without participating himself. When Tony did speak up it was with the hope that what he said would please others. He has established the best rapport with the other anatomical female in the group, and they often wolf whistle, giggle, and excite other group members. Tony has also revealed information to the group about his relationship to his girlfriend. This relationship sounded immature and shallow as he described dependent and clingy interactions between them. This further lends support for hypothesis IV as the poor object relationships were present in Tony's case as well. In the group, Tony has gradually been able to recognize his avoidance and passive-aggressiveness which hopefully will encourage him to improve his object

relationships as well as to know himself better.

In summary, the observations of these five patients revealed, despite the sex assigned at birth and the reinforcement of that role by their parents throughout childhood, that these individuals have developed opposite gender identities. In three out of five cases, there is no acceptance for the assumed role by the parents, and in the other two instances, the acceptance is ambivalent. In two of the three cases of male to female transsexuals, the families were unstable and the mother was seen as the provider of rewards and the protector, while father was seen as the aggressor. The male role was negatively viewed, and the need to draw closer to mother, identify and be like her was present. In the two cases of the female to male transsexuals, the need to protect and take care of mother was a significant factor in their choosing male gender roles. All five patients had early memories of wishing they were the opposite gender and all of them cross-dressed and felt isolated and different from their peers. The group was instrumental in pointing out these similarities in the transsexual syndrome.

In addition to the hypotheses discussed above, there are many other common themes in the transsexual syndrome which were observed in all five group members.

They are:

1. All members prefer sex partners of their own biological sex, but deny that they are homosexuals.
2. All members reject and despise their own primary and secondary sex characteristics and desire the anatomy of their chosen gender.
3. All members feel they are controlled by their gender identity rather than their visible anatomical identity.
4. All members conceal their genitalia and refuse to permit others to touch or see these body parts while having sexual relations. They seldom allow direct stimulation of their sex organs and often never experience orgasm.
5. All members are exceedingly vain and narcissistic and in adopting their chosen gender role have exaggerated the male or female traits.
6. All members believe that their lives will be different after the surgery and that they will feel less isolated, detached, and alienated from the rest of society.
7. All members are driven by thoughts of sex-reassignment surgery, and are obsessively preoccupied with this compulsion.
8. None of the members show overt signs of cognitive disorders or overt symptoms of psychosis.

9. All members are inhibited when talking about their genitalia and find it difficult to use the words penis and vagina.

10. All members have had suicidal thoughts or self-mutilation fantasies.

11. All members fear attachment and getting close to people, and they can not establish meaningful relationships which lead them to loneliness and reflect their basic underlying depression.

12. All members have gone through four phases: secrecy, then finding about oneself and telling others; urgency, which is the compelling drive to obtain hormones and surgery; depression, which leads to suicidal thoughts; and finally adopting the new role which they hope will lead to social acceptance.

To speculate further on the data, it seems evident that there are special problems in a boy's developing his masculinity that are not present in a girl developing her femininity. For one thing, a boy's relationship to his mother makes the development of feminine characteristics more likely. He has the task of separating from mother and letting go of the feminine identification he has made. This was something a girl did not have to do.

Another issue in our society was the emphasis placed on masculinity. If roles were less rigid and men

and women were allowed to cry or show weakness perhaps the need to alter one's sex to conform to particular roles would not be necessary.

A speculation about why transsexualism seemed to be increasing was the belief the public has about altering the external realities of life in order to eliminate or change the internal problems. Do not people have nose jobs, or face lifts, or change the color of their hair, or diet? The belief is that if somehow they change their outer appearance and are prettier or skinnier or blonde, that their problems would disappear and they would be blissful.

Given these speculations, as well as the analysis of the case illustrations which support the hypotheses regarding the dynamics and etiology of transsexualism, the syndrome should be a little less confusing.

CHAPTER V
GROUP TREATMENT OF TRANSSEXUALS

Exploring the transsexual conflict by reviewing the literature meant looking at the history of the syndrome, discussing the problems and definitions of the terms, reviewing the etiologies and theories of the syndrome, and finally investigating various treatment possibilities. This academic pursuit was extremely useful in laying the groundwork for the study of transsexualism through group psychotherapy.

This chapter will deal with the reason group therapy was the treatment of choice, the problems inherent in the nature of such a group, the way in which the group served the transsexual patients, the co-therapy relationship, and finally the tremendous growth experienced by the author throughout the study.

Group as the Treatment of Choice

Transsexualism in the group members was of varying intensities and due to a variety of reasons. Environmental influences, psychological and sociological factors, and early childhood experiences all contributed to the presence of the transsexual syndrome. Some members of

the group were living in their chosen gender role, receiving hormones, and actively pursuing sex reassignment surgery. Others were only cross-dressing or receiving hormones, thereby making the group a very diversified and interesting blend of people. The male/female composite contributed a great deal by allowing the members to educate each other from their past experiences of living in opposite gender roles.

As mentioned earlier, group therapy was the treatment of choice because it was shown that a supportive milieu in which information can be shared in an accepting and non-judgmental atmosphere was more effective and plausible than individual treatment which was more inhibiting and frightening for these character disordered and schizoid personality types. A group also recreated for the patients a family structure which frequently may have been a factor in the etiology of transsexualism. It became a place in which even the most isolated individual was able to develop concern for other people. The group was also chosen as a means for overcoming the transsexuals' resistance to psychiatry. Most members would have refused to come to a hospital for psychiatric care in which a doctor was studying their every move, while they viewed the group as people who were not merely observers and who were not trying to change

them or force them to change their minds. They felt acceptance and mutual reinforcement of their illusions of being male or female and were given the opportunity to talk about their ambivalences without fear of rejection for surgery. All of these reasons made group therapy the definite treatment of choice.

Problems in Setting Up Group

The problems of setting up a group to discuss gender confusion were the initial difficulty of getting referrals for transsexual patients and secondly knowing which individuals to refuse for the group, on the assumption that their problem was not transsexualism but perversion or homosexuality. The way this problem was dealt with was by conducting independent evaluations through extensive psychological testing and psychiatric clinical interviews. According to Harry Benjamin's Sexual Orientation Scale most of the patients accepted into the group were transsexuals of moderate and high intensity although one or two were probably non surgical transsexuals. All of them, however, wanted endocrine and surgical treatment, with the male seeking castration, penectomy, and plastic surgery to form a vagina, while the female wanted mastectomy, hysterectomy, and the creation of a phallus. A potential problem was also

that patients might know each other via the "underworld grapevine," and make it difficult for them to discuss their innermost thoughts. This was never a significant factor, however, as the members were as isolated and lonely in their conundrum as if they were all alone in the world.

Group Benefits for Patients

The ways in which the group was designed to help the transsexual were arrived at by mutual goals of the co-therapists. Other benefits to the patients were a result of the group members themselves and their ideas of what they wanted and needed. The therapists saw themselves as role models, facilitators, objects for transference phenomenon, teachers as well as learners, and finally, people interested in the problems and heartaches of people who live with gender identity confusion. The aims and goals of the group were to foster self-awareness and self-acceptance, provide realistic expectations for the future, help to work out troubled family relationships and relationships with significant others, end the isolation and help with the feelings of despair, provide an arena in which people could share experiences, act out roles, and get feedback for their social roles and character styles, work out neurotic conflicts, provide

information and act as resources for medical procedures, legal matters, vocational plans, identity papers, and other practical needs, help the patients talk about their ambivalences and past social relationships, and finally to create a stage in which their metamorphosis has a chance to develop.

The group in its nine month existence has touched on all of these goals. Aside from the group being a place for transsexuals to express their fantasies, it has also been a place for them to develop trust, attach themselves to others, have positive role models to identify with, and to talk about their chaotic relationships and problems beyond their gender confusion. They have utilized the group for narcissistic gratification and exhibitionistic needs, as well as to discuss problems that come up in any group psychotherapy. The members have all referred to the group as a family, and the safe atmosphere that was created by everyone enabled introspection and the free exchange of ideas to occur. Some issues which group members brought up for discussion were cosmology, the use of rest rooms, the question of employment, gossip, the need to know how others perceive them, family problems, and social and dating worries.

The group provided a level of excitement often missing in other therapeutic modalities, to help them to

open up and discuss their deep-seated fears. It also provided an opportunity to watch the ego functioning of the group members. When impulses were stirred up such ego functions as judgment, memory, attention, reality testing, and the ability to delay gratification were markedly impaired. Some of the problems noted in the group were the difficulty individuals had in overcoming their narcissistic investment in their own body images and the often impulsive and immature behavior. A problem for the therapists was the awkwardness of name calling and using the right pronoun when referring to group members. This problem was exclusive to the therapists. Slips of the tongue when using he or she were common mistakes, as well as using the male name for the female gender.

The Co-therapy Relationship

As a result of the study, two factors were identified as being essential in the treatment of transsexuals in a group. One was having two therapists work with the group and the other was having co-therapists of each sex. Male and female co-therapists working as a team were seen by the patients as role models for gender role identification. For this reason, it was necessary that the therapists felt secure and comfortable

in their own gender roles, and that any problems regarding their sexuality and gender identification be worked out together. In many cases the therapists served as one of the only role models available to these object deprived persons. Though there was great need for the transsexual patient to maintain the therapist's gender role intact, he was caught in the conflict of needing to devalue the therapist and his gender role. For this reason the therapists were subjected to the projected unconscious rage of the transsexual patients. The patients believed that the therapists could deter them from their goal of surgery by not recommending them for the sex-change operation, and, therefore, the transsexual tried to challenge the therapists' gender identity. In doing this, the patients hoped to destroy the therapists and thereby symbolically kill the ambivalence that they felt regarding their own gender identity. The group process which the therapists were exposed to and which attempted to overthrow or destroy their gender identity, was a dynamic and powerful force. Without a solid partnership the co-therapists would have had a difficult time withstanding the group's craziness, destructiveness, hostility and assaultiveness.

Another issue which frequently came up was the

seduction of one therapist by a group member. The seduction was often a mask for angry feelings which needed to be challenged. The emotionality and homosexual overtones of the interaction elicited counter-transference which required interference from the therapist not under attack.

An important part of the therapy was the pre and post group sessions that the therapists needed in order to talk about the intense feelings of confusion and embarrassment that each group session brought out. The bizarreness and the disorganization of the group required the therapists to share their reactions and feelings with one another and this became an important part of the work together. Several illustrations of the therapists discomfort was evidenced by the therapists calling patients by the wrong name or by using incorrect pronouns for the group members. Behavioral evidence of the denial that the therapists experienced was seen in their dress. They attempted to appear more masculine or feminine, using clothes as a protective device to ward off the chaos they were feeling.

Perhaps the most important reason for opposite sexed co-therapists in a transsexual group would be to insure that at least two people are secure in their gender roles. The therapists can easily become confused

as to who's who and can begin to doubt their own gender role, making it necessary for them to have someone else in the group who can reaffirm their sense of self and gender. A group of this nature given its unpredictability and excitability, could not easily be done solo. Co-therapy with opposite sexed co-therapists was preferred and necessary for the patients, as well as for the well being of the individual therapists.

Growth Experienced by the Researcher

The group presented me with several fascinating, as well as troublesome questions to ponder. One of the most difficult was the fact that the issue of transsexualism forced me to scrutinize and focus my own attitudes and beliefs toward masculinity and femininity. As Harry Benjamin has said, "One begins to appreciate that dawn and dusk are, at one time, both day and night and neither (Benjamin and Ihlenfeld, 1970, 3)." Everything was very confusing, and it called into question my views and prejudices surrounding the role of males and females in society. It led me to analyze my own role and to discover I was comfortable and able to share with others my femaleness as well as my maleness which is also a part of me. Having a twin brother and being raised simultaneously with a male seemed to give me

added insight into the duality of existence that transsexuals experience, and yet my feelings of anxiety and fear when I contemplated co-leading such a group were enormous. My fear gradually gave way to a voyeuristic curiosity as I met with the patients on an individual basis. I was worried that I would laugh out loud, or in some way do something to embarrass myself in front of them. This fear was actually played out as I sneezed loudly at a point when I was afraid I would laugh in an interview. These feelings arose out of the discomfort I felt when the unacceptable wishes and impulses associated with transsexuals surfaced in their conversations.

It was difficult to accustom myself to the patients coming to the group in clothing of the opposite gender. Their sometimes unconvincing and bizarre appearances which were often the result of an over-identification with their assumed roles, made me view them as actors in a play. I soon realized, however, that this was my own form of denial, and once I was able to come to grips with these feelings, I was more honest and open with my feelings and perceptions. My goal was to accept these people and to try and understand their personal dilemma. As the group progressed, I found myself more able to relate to them, and I got closer and closer to them as

individuals. Perhaps this was the area that I was most effective in, as they, too, were able to establish a meaningful relationship with me. As the termination phase approached, this bond became more and more obvious. With much preparation, the separation and loss issues were dealt with carefully. I was as sorry as the group members to have to depart, and at the point I left I knew that I was taking more with me than I had realized for the spirit of the group was very much alive. I learned from them about myself, in a way that I did not know was possible.

In conclusion, I can say that, while my confusion about the transsexual syndrome still exists, my understanding and acceptance of transsexuals as people have led me to much personal growth.

REFERENCE LIST

- Arieff, Alex J. "Five-Year Studies of Transsexuals: Psychiatric, Psychological and Surgical Aspects," Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome, 1972, 240-243.
- Baker, Lt. Howard J. "Transsexualism--Problems in Treatment," American Journal of Psychiatry, CXXV, 1969, 10.
- Bell, R.Q. and Costello, N.S. "Three Tests for Sex Differences in Tactile Sensitivity in the Newborn," Biologica Neonatorum, VII, 1964, 335-347.
- Bell, R.Q., Waldrop, M.F., and Weller, G.M. "Male and Female Newborn and Preschooler," Monographs of the Society for Research in Child Development, XXXVI, 1971, 142.
- Benjamin, Harry. The Transsexual Phenomenon. New York: Julian Press, 1966.
- _____. "Clinical Aspects of Transsexualism in the Male and Female," American Journal of Psychotherapy, XVIII, 1964, 458-469.
- _____. "Nature and Management of Transsexualism with a Report on Thirty-one Operated Cases," Western Journal of Surgery, Obstetrics and Gynecology, LXXII, 1964, 105-111.
- _____. "Should Surgery be Performed on Transsexuals?" American Journal of Psychotherapy, XXV, No. 1, 1971, 74-82.
- Benjamin, Harry and Ihlenfeld, Charles L. "The Nature and Treatment of Transsexualism," reprint from Medical Opinion and Review, VI, No. XI, 1970.
- Benjamin, Harry and Ihlenfeld, Charles L. "Transsexualism," American Journal of Nursing, LXXIII, No. 3, 1973.
- Block, Norman L. and Tessler, Arthur N. "Transsexualism and Surgical Procedures," reprint from Medical Aspects of Human Sexuality, 1973.

- Bruce, H.M. and Green, Richard. In a lecture given at the Proceedings of the Fourth International Conference on Gender Identity. Palo Alto, California: 1975.
- Ehrhardt, A.A., Greenberg, N. and Money, John. "Female Gender Identity and Absence of Fetal Hormones," Johns Hopkins Medical Journal, CXXVI, 1970, 237-248.
- Finney, Joseph C., et al. "A Psychological Study of Transsexualism," Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome, 1972, 82-90.
- Forester, S.M. and Swiller, H. "Transsexualism: Review of Syndrome and Presentation of Possible Successful Therapeutic Approach," Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome, 1972, 343-350.
- Goy, R.W., Phoenix, C.H., and Young, W.C. "A Critical Period for the Suppression of Behavioral Receptivity in Adult Female Rats by Early Treatment with Androgen," Anatomical Record, CXLII, 1962, 307.
- Green, Richard. "Sex Reassignment Surgery," American Journal of Psychiatry, CXXIV, 1968, 97.
- _____. "Persons Seeking Sex Change: Psychiatric Management of Special Problems," American Journal of Psychiatry, CXXVI, 1970, 1596.
- _____. Sexual Identity Conflict in Children and Adults. New York: Basic Books, Inc., 1974.
- Green, Richard and Money, John. Transsexualism and Sex Reassignment. Baltimore: The Johns Hopkins Press, 1969.
- Guze, Henry. "The Transsexual Patient: A Problem in Self-Perception," Transactions of the New York Academy of Sciences, Series II, XXIX, 1967, 464-468.
- Hamburger, Christian. "Desire for Change of Sex as Shown by Personal Letters from 465 Men and Women," Acta Endocrinologica, XIV, 1953, 361-375.
- Hamburger, Christian, Dahl-Iverson, E., and Stürup, Georg K. "Transvestism," Journal of the American Medical Association, CLII, 1953, 391-396.

- Hastings, D.W. and Blum, J.A. "A Transsexual Research Project at the University of Minnesota Medical School," Lancet, July, 1967, 262-264.
- Jorgensen, Christine. Christine Jorgensen: A Personal Autobiography. New York: Paul S. Eriksson, 1967.
- Kagan, J. Change and Continuity in Infancy. New York: Wiley, 1971.
- Kaplan, Helen Singer. The New Sex Therapy. New York: Brunner/Mazel, 1974.
- Kubie, Lawrence S. and Mackie, James B. "Critical Issues Raised by Operations for Gender Transmutation," The Journal of Nervous and Mental Disease, CXLVII, No. 5, 1968, 431-443.
- Laub, Donald R. and Gandy, Patrick, eds. Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome. Stanford: Stanford University Medical Center, 1972.
- Leach, M. Standard Dictionary of Folklore, Mythology and Legend. New York: Funk and Wagnalls, 1949.
- Maccoby, Eleanor Emmons and Jacklin, Carol Nagy. The Psychology of Sex Differences. Stanford: Stanford University Press, 1974.
- Marks, Isaac, M. "Transsexualism--Problems in Treatment," American Journal of Psychiatry, CXXV, 1967, 122.
- Marks, Isaac M. and Felder, Michael G. "Transvestism and Fetishism: Clinical and Psychological Changes During Faradic Aversion," British Journal of Psychiatry, CXIII, 1967, 711-729.
- McKenna and Walsh. In a lecture given at the Proceedings of the Fourth International Conference on Gender Identity. Palo Alto, 1975.
- Meerloo, J. "Letter to the Editor: Change of Sex and Collaboration with the Psychosis," American Journal of Psychiatry, CXXIV, 1967, 263-264.
- Meyer, Jon K. "Some Thoughts on Nosology and Motivation Among 'Transsexuals,'" Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome, 1972, 31-33.

- Money, John, ed. Sex Research: New Developments.
New York: Holt, Rinehart and Winston, 1965.
- Money, John and Ehrhardt, Anke E. Man and Woman Boy and Girl. Baltimore: The Johns Hopkins University Press, 1972.
- Money, John and Hampson, J.G. "An Examination of Some Basic Sexual Concepts: The Evidence of Human Hermaphroditism," Johns Hopkins Medical Journal, XCVII, 1955, 301-319.
- Moss, H.A. "Sex, Age and State as Determinants of Mother-Infant Interaction," Merrill Palmer Quarterly, XIII, 1967, 19-36.
- Nisbett, R.E. and Gurwitz, S.B. "Weight, Sex, and the Eating Behavior of Human Newborns," Journal of Comparative and Psychological Psychology, LXXIII, 1970, 245-253.
- Ostow, M. "Transvestism," Journal of the American Medical Association, CLII, 1953, 1552-1553.
- Paitich, Daniel. "Psychological Test Assessment of Gender Patients," Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome, 1972, 96-98.
- Pauly, Ira B. "Male Psychosexual Inversion: Transsexualism," Archives of General Psychiatry, XIII, 1965, 172-181.
- _____. "Female Transsexualism," Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome, 1972, 82-95.
- Person, Ethel, and Ovesey, Lionel. "The Transsexual Syndrome in Males: I. Primary Transsexualism," American Journal of Psychotherapy, XXVIII, 1974, 4.
- Person, Ethel and Ovesey, Lionel. "The Transsexual Syndrome in Males: II. Secondary Transsexualism," American Journal of Psychotherapy, XXIX, 1974, 10.
- Roth, Helen. "Three Years of Ongoing Psychotherapy of a Transsexual Patient," Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome, 1972, 99-102.

Sadoughi, W., Bush, I.M. and Overman, C. "Group Therapy as Integral Part of Surgical Experience," Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome, 1972, 223-224.

Segal, Morey M. "Transvestism as an Impulse and as a Defense," Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome, 1972, 209-217.

Stafford-Clark, D. "Essentials of the Clinic Approach," The Pathology and Treatment of Sexual Deviation. London: Oxford University Press, 1964.

Stoller, Richard J. "Hermaphroditic Identity and Hermaphrodites," Journal of Nervous and Mental Disease, CXXXIX, 1964, 453-457.

. Sex and Gender: On the Development of Masculinity and Femininity. New York: Science House, 1968.

Weideman, G. "Transvestism," Journal of the American Medical Association, CLII, 1953, 1167.