THE THEORY OF GENDER IDENTITY DISORDERS

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"Then you should say what you mean," the March Hare went on. "I do," Alice hastily replied: "at least—at least I mean what I say—that's the same thing, you know."

—Alice's Adventures in Wonderland
(Chapt. 7)

This paper grew out of ten years' work with people having the most severe disturbances of gender, disturbances reflected in their application for surgical sex reassignment. Over the decade my colleagues and I have seen 526 patients who wished to have their genitalia and other physical attributes modified so as to remove a dissonance between sense of self and physical body. Their conviction was that, being mentally of the opposite sex, any chance for happiness was being destroyed by a false anatomy. In this contention there was no denial of the facts of physical sex but, rather, a denial of the significance of these facts. In our struggles to understand our patients, the existing theoretical formulations of transsexualism seemed inadequate to the test of the clinical situation.

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This paper, which attempts to sharpen the debate surrounding the theory of gender identity disorders, grew out of that unhappy dilemma. It presents (1) an outline of major clinical findings, (2) a review and critique of existing theories, and (3) a tentative attempt to formulate a consolidated theoretical position of clinical and heuristic utility. Since gender identity is the fundamental component of sexual self-representation, improvement in the theory of gender pathology would make a contribution to understanding not only transsexuals, but also those patients with pathology in neighboring domains. Although the task might have been undertaken for theoretical reasons alone, the motivations extended beyond that narrow purpose. Few patients have been so poorly understood clinically or treated so cavalierly, both through the excesses of omission (disdain for their peculiar, sensational problems) and of commission (embrace of their complaints as diagnosis and prescription).

Some Matters of Definition

In any discussion of gender disorder there is the potential for confusion among various terms such as “gender,” “sex,” “gender identity,” “sexual identity,” “masculinity,” and “femininity.” Although the term “gender” is sometimes used as a synonym for biological “sex,” the two should be distinguished. Sex refers to the biology of maleness or femaleness, such as a 46,XY karyotype, testes, or penis. Gender or gender identity is a psychological construct which refers to a basic sense of maleness or femaleness or a conviction that one is male or female. While gender is ordinarily consonant with biology, and so may appear to be a function of it, gender may be remarkably free from biological constraint. The sense “I am a female” in transsexualism, for example, may contrast starkly with a male habitus. Similarly, the terms “gender identity” and “sexual identity” are at times used synonymously, but are used here to refer to developmentally sequential facets of personality. Gender identity
is the earlier and more fundamental acquisition, referring to a basic amalgamation of anatomical givens and reproductive potential into the primitive self-representation. Gender identity is an acquisition of the separation-individuation phase and is very likely consolidated with the achievement of object constancy (Mahler et al., 1975). The development of sexual identity, for which the oedipal phase and adolescence are the watersheds, is marked by the acquisition of the qualities of masculinity, femininity, and eroticism which are expressed in sexual fantasies, attractions, and object choices. Sexual identity at any given developmental level is ordinarily a refinement of basic gender sense in terms of personal eroticism and conventional as well as idiosyncratic expressions of masculinity and femininity.²

Difficulties in defining the scope and boundaries of “transsexualism” plague discussions of the syndrome. Kubie and Mackie (1968) worried about the implications of the term “transsexual”: since no clear distinction had been established between transsexualism and related conditions, such as transvestism and homosexuality, they felt the term “begged or bypassed” every important unsolved problem in this area (p. 431). While patients who seek sex reassignment, or who have it, are commonly considered transsexuals, psychoanalysts have not been satisfied with that operational definition. Socarides (1969, 1970, 1978) has seen transsexualism as developing out of either transvestism or homosexuality. Authors whose views otherwise differ widely (Money and Gaskin, 1970-1971; Person and Ovesey, 1974a, 1974b; Meyer, 1974) have similarly pointed to the variance among applicants for sex reassignment, describing transsexuals whose histories or clinical presentations contain transvestitic, homosexual, or other paraphilic elements. Stoller and his associates, on the other hand, have stated that applicants for sex reassignment differ from one another etiologically and

²My use of the terms “gender identity” and “sexual identity” roughly approximates Greenson’s (1964), but differs from that of other authors, for example, Kestenberg (1980).
dynamically and have felt comfortable in making a distinction between the “true” transsexual and the homosexual or transvestite who may at times request sex reassignment (Stoller 1971, 1972a, 1975; Newman and Stoller, 1974). Thus, while all observers acknowledge that patients who have had homosexual, transvestitic, or other paraphilic histories do seek sex reassignment, there is disagreement on their “transsexualism.” All would agree, however, that transsexuals are to be found among those patients who come to the attention of gender clinics. My approach has been to examine the Johns Hopkins population in the light of existing theories and their subsidiary definitions for supportive or contradictory evidence.

Clinical Findings

Patients were seen in a variety of ways. Extensive clinical evaluation, with the addition of psychological testing of projective and self-report inventory types, constituted sources of data for all patients. Selected series underwent physical examination and endocrine and electroencephalographic studies in order to test for possible biological contributions to the condition. Some patients were seen only once, in consultation. The majority were seen at intervals, extending over years, our clinical service being available as they cared to use it. In every possible instance the patient was involved in psychotherapy. Formal psychoanalysis was not offered to any of the patients, since their ego strengths were considered insufficient for the task. Those who were involved in psychotherapy were found to be best treated making use of the parameters appropriate to severe borderline characters (Kernberg, 1975, 1976).

An understanding of gender identity problems has been hindered by the fact that such patients rarely submit themselves to analysis, and infrequently to treatment, and then commonly only under authoritative suggestion or in order to accomplish some other end, e.g., to demonstrate sincerity to a surgical program. Socarides (1970) has reported the case of a young
man seeking sex reassignment, whose six-month analysis was undertaken at the insistence of his parents but terminated abruptly. Stoller (1968, 1975) has published case reports of transsexuals and of feminine men (not transsexual in his judgment), but no analyses of patients whom he considered transsexual. My colleagues and I have been fortunate in having patients in treatment for varying lengths of time—some for a few months and some for several years. I have not had a transsexual in analysis and so cannot have the degree of confidence in formulations and reconstructions that comes with the opportunity to examine material and behavior in the context of the sustained analytic transference. However, our observations of many patients over ten years provided data that compare favorably with those in the literature. Our data, collected from longitudinal observation, reconstructed from anamnesis, and assembled from the cross-sectional mosaic of different individuals at similar developmental stages, have highlighted family constellations, fantasies, stresses, pathological behaviors, wishes, and defensive operations. These observations are summarized below.

Basic Observations

A request for sex reassignment indicated active contemplation or pursuit of two primary goals: (a) the extirpation of genitals to the fullest possible extent and (b) the construction of opposite sex facsimiles, as close as possible to ideal genital beauty and function. Extirpation and reconstruction have been carried to great lengths, involving extraordinary efforts to camouflage or create primary and secondary sexual characteristics. In the male, estrogen ingestion, removal of penis and testes, and construction of vagina, vulva, and breasts have been followed by reduction of the thyroid cartilage, modification of facial contours, and depilation. In a further effort to soften contours, liquid silicone and other materials have been injected in buttocks and thighs. In the female, reproductive organs and breasts
were removed, androgens ingested or injected, and vulvas camouflaged through the construction of scrotas with testicular prostheses. Penile construction has been pursued at great expense and pain through multiple procedures. End results have ranged from a skin tube to an organ functional in intercourse or providing a urinary conduit.

Both sexes requested sex reassignment. Initial contacts from males were approximately three or four times as frequent as from females (Pauly, 1965; Meyer et al., 1971) and about twice as many males were truly active in the pursuit of surgery (Meyer et al., 1971; Walinder and Thuwe, 1975). However, in one sample (Walinder and Thuwe, 1975), despite the preponderance of males among applicants, the ratio of males to females among those reassigned was 1:1.

As has been observed by Stoller (1979), there was only the rarest correlation between the wish for sex reassignment and gestational abnormality by history, intersex conditions, endocrine abnormality, or electroencephalographic changes.

The first medical contact might come at any age. Children, adolescents, adults, and the elderly have actively endorsed wishes for sexual transformation. The majority of patients who actively pursued sex reassignment, however, were between the ages of 20 and 30 (Benjamin, 1966; Hoenig et al., 1970; Meyer et al., 1971).

Our attempts to find patients who met Stoller's criteria for "true" transsexualism (which will be discussed later) were disappointing. The vast majority obviously did not qualify. Those who initially seemed to meet the criteria, with closer inspection or longer contact, failed to qualify in some particular. Elimination might come through the eventual expression of perverse symptomatology or history, the absence of the history of extraordinary symbiosis, lack of opportunity for special symbiosis for example, the early and continuous use of multiple babysitters), or the demonstration of ambivalence and conflict in gender identity.

Abandonment, disregard, and psychological misusage,
rather than extraordinary symbiosis, marked the histories (Harrison and Cain, 1968; Meyer, 1974; Walinder and Thuwe, 1975). Experiences within the nuclear family varied from obvious chaos to apparent stability, correlating highly with the degree of impulsivity and chaos found later in the patient's life. In our work, clinical observation and projective testing (Thematic Apperception Test and Rorschach) revealed confusion of gender and sexual identity in the close relatives of the transsexual. The overt gender confusion in the transsexual child, adolescent, or adult was covert in parents and siblings (much as has been described in other unusual sexual behaviors by Litin et al., 1956).

Applicants for sex reassignment had clear borderline features. Among the authors to comment upon or document such features are Greenberg et al. (1960), Golosow and Weitzman (1969), Weitzman et al. (1970), Barlow et al. (1977), Kavanaugh and Volkan (1978-1979), MacVicar (1978-1979), Meyer (1974, 1980a, 1980b, 1980c), Volkan (1979), and Limentani (1979). The features we observed, which corresponded with features of the borderline syndromes (Kernberg, 1967, 1975; Shapiro, 1978; Gunderson and Kolb, 1978), included vulnerability to unstructured situations and stress; a pervasive sense of emptiness and isolation; the tendency to externalize all difficulties; little ability to tolerate intimacy; low affect tolerance; a sense of identity diffusion; poor inner sense of continuity; transient psychotic episodes in treatment; excess use of drugs and alcohol; polymorphous perverse sexual trends; and lower-order character structures. Some males, in particular, showed clear evidence of splitting (Meyer, 1980b, 1980c). Libidinal drive derivatives (tenderness, care, concern), object images (mother and other females), and self-images (as female) constituted one part of the personality, while aggressive drive derivatives (combativeness, assertiveness, pugnaciousness), object images (father and other men), and self-images (pilot, demolition expert, mountain climber) constituted the other. These were not split personalities, finding expression only in fugue states. One ego
The constellation was aware of the other, but they were un-integrated. It was our impression that all patients manifested borderline features sometime during their clinical course. In our experience, however, the overt appearance of the usual borderline signs and symptoms bore an inverse relationship to a patient's moment-to-moment capacity to sustain a cross-gender position. In other words, an organized transsexual presentation appeared to substitute for (or defend against) other borderline features.

Transsexualism alternated with or blended into other clinical syndromes. "Pretranssexual" youngsters (children with open cross-sexual wishes and identifications who denied genital and reproductive capacity) have become homosexual, transvestitic, or transsexual (Newman, 1970; Lebovitz, 1972; Green, 1974). Adolescents and adults who presented as "transsexual" had been or have become transvestitic, sadomasochistic, homosexual, seriously depressed, or psychotic. Addictions and alcoholism were present, more commonly among the biological females seeking reassignment as males. In other words, various character structures and perverse orientations interdigitated with transsexual pursuits (Weitzman et al., 1970; Money and Gaskin, 1970-1971; Meyer, 1974; Person and Ovesey, 1974b; Newman and Stoller, 1974; Buhrich and McConaghy, 1978). Although a number of our patients had children, expressed parental wishes for their postoperative state, married spouses with children, or adopted, none showed evidence of genuine maternalism or paternalism. The children appeared to be regarded as superficial attributes whose role was to enhance the assumed gender.

Active consideration of sex reassignment occurred frequently in conjunction with developmentally related stresses (Golosow and Weitzman, 1969; Kirkpatrick and Friedmann, 1976; MacVicar, 1978-1979; Limentani, 1979; Meyer, 1980b, 1980c). In general, the precipitating stresses involved separation, abandonment, or demands for independent assertiveness: for example, death of a parent, grandparent, or spouse; sep-
aration from home and family; the birth of a sibling; pursuit of a career; separation or disharmony between parents; conception, birth, and parenthood; or the entry of a child into the oedipal phase.

There was conflict around the wish for sex reassignment. Ambivalence about surgical modification was seldom expressed directly but appeared in dreams and in behavior (Volkan and Berent, 1976). Typically, the patient pursued sex reassignment, apparently without ambivalence, until some critical pass in his evaluation. At that point he might stop taking hormones, quit work, move, or otherwise manifest some failure of commitment. The ambivalence was expressed behaviorally; the patient did not feel anxiety or conflict or recognize his actions as ambivalent.

As mentioned previously, our patients' ego strengths were not sufficient to tolerate psychoanalysis. In treatment they required parameters used for severe borderline characters. Denial of anatomy and feeling was the primary defense. The transference was characterized by blurring of ego boundaries, presentation of false selves, sensitivity to separation, and liability to psychotic interludes or self-destructive behavior (Socarides, 1970; Limentani, 1979). The countertransference was imbued with futility, hopelessness, and fear of being overwhelmed by primitive feeling (Limentani, 1979). Effective interpretations were geared preoedipally.

Over two- to five-year follow-up, operated and unoperated transsexuals appeared objectively to improve to the same degree (Meyer and Reter, 1979). With the completion of reassignment, male gender-dysphorics might show the "riddance" phenomenon: an excited, or frankly hypomanic, exhibitionism demonstrating that they were rid of the offending penis and testes. Reassigned females were less exhibitionistic, tending toward quiet, dependent attachments. A few long-term follow-ups (ten or more years) suggested that feelings of isolation and emptiness continued. Additionally, there was a profound sense that, whereas externals had been changed, the patient was not
truly male or female, merely a reasonable facsimile. Unreassigned patients drifted into new relationships or stabilized into perverse adjustments, reappearing for further consideration of surgery at times of stress, separation, or loss.

These observations have been limited to phenomena that have been observed clinically and psychotherapeutically. In the following sections the existing theories of gender identity disturbance are reviewed and an attempt is made to outline an integrated formulation of transsexualism. In the latter, inference and speculation build upon observation but extend beyond the boundaries of the data.

Review of Existing Hypotheses

Synopsis

In the literature, there are three hypotheses regarding transsexualism: the biological/imprint hypothesis, the nonconflictual identity hypothesis, and the conflict/defense hypothesis.

The biological/imprint hypothesis views transsexualism as the unfolding of a predisposition or the manifestation of a biological vulnerability. According to Money and Gaskin (1970-971), the clinical syndrome of transsexualism may be triggered, complemented, set, or made indelible, by "critical period effects":

The most likely etiological explanation in the majority of cases of transsexualism, on the basis of today's knowledge, is that transsexualism is an extremely tenacious critical period effect in the gender-identity differentiation of a child with a particular, but as yet unspecifiable, vulnerability [p. 253].

The biological/imprint frame of reference is derived by extrapolation from animal experimentation and ethological studies. Lower mammals—particularly rodents—fetal or perinatal hormonal manipulation has long-range effects on adult mating
behavior and sexually stereotyped dominance-submission behavior.

The nonconflictual identity hypothesis regards transsexualism as the outgrowth of unconflicted identity formation (Stoller, 1968, 1970, 1975; Newman and Stoller, 1971; Green, 1974). This hypothesis distinguishes between the clinical presentation, dynamics, and etiology of the "true" transsexual and the homosexual, transvestite, or other patient who may at times request sex reassignment (Newman, 1970; Stoller, 1971, 1972a, 1972b, 1975; Newman and Stoller, 1974). Although Stoller (1975) spoke of a "continuum of gender aberration," he made a distinction of kind rather than degree between transsexual and nontranssexual groups:

I have chosen the far side of the continuum of gender aberration, transsexualism, as the fixed point for measurement in the research, since this condition seems less complicated than do other gender disorders. . . . Transsexualism — as I define it clinically — manifests itself earlier than do the neuroses of gender development (i.e., the perversions), which, as distinct from transsexualism (in males at any rate), I believe are the result of conflict and defense. I see male transsexualism as an identity per se, not primarily as the surface manifestation of a never-ending unconscious struggle to preserve identity. To me, transsexualism is the expression of the subject's "true self" [p. 2].

The etiological formulation calls for a depressed, bisexual mother who binds her beautiful son, physically and emotionally, to such a degree—in the face of an absent or uninvolved father—that a primary, irreversible, and nonconflictual female identification is formed. A corollary to the fundamental theorem is that there is no castration anxiety or oedipal phase because there is never any scaffolding of masculine identification to support their construction. A contrast is drawn with the perversions which are considered to be conflictual and under con-
stant internal threat, the perverse behavior and the search for sex reassignment representing a defense against identity dissolution and constituting a symptom of the conflict (Stoller, 1975).

The conflict/defense hypothesis consists of several related, but unintegrated, perspectives. A shared assumption, however, is that the desire for sex reassignment is a pathological compromise formation. Within this framework transsexualism is variously viewed. It is formulated in the following ways: as closely related to paranoid schizophrenia and as constituting a defense against homosexuality (Socarides, 1969, 1970); as closely related to the perversions (Volkan and Berent, 1976; Volkan, 1976, 1979; Meyer, 1975, 1980a, 1980b, 1980c; Meyer and Dupkin, in press); and as a pathological outcome of the separation-individuation phase, understandable within the metapsychology of the borderline personality configuration (Ovesey and Person, 1973; Person and Ovesey, 1974a, 1974b; Volkan and Berent, 1976; Volkan, 1976, 1979; Limentani, 1979; Meyer, 1980a, 1980b, 1980c; Meyer and Dupkin, in press). Kavanaugh and Volkan (1978-1979) have particularly emphasized the vicissitudes of aggression.

Critique of Existing Hypotheses

The Biological/Imprint Hypothesis. The biological/imprint hypothesis stands upon animal observation. In rodents and other lower mammals, the administration of sex-specific hormones during brief critical periods modifies adult sexual behavior (reviewed by Gadpaille, 1972). Experimentally treated female rodents demonstrate socially dominant and mounting behaviors usually characteristic of males; estrogen-treated males are less aggressive and present hindquarters as an invitation for mounting. Since the animal model works without inducing intersex changes and with a latent period, it is an attractive hypothesis.

Stoller (1972b), however, has expressed concern about extrapolation from animal studies to human motivated behavior.
He noted that, despite man's mammalian heritage and the extension across species of neuroanatomical structures and their linked behaviors, the neurological mechanisms of "choice" in man exist to a degree not even approached in other species. Furthermore, studies of early- and late-treated adrenogenital syndrome girls androgenized in utero (Ehrhardt, Epstein, and Money, 1968; Ehrhardt, Evers, and Money, 1968) have indicated slightly excessive tomboyish behavior but no evidence of gender abnormality. Similarly, follow-up of boys born to diabetic mothers in whom estrogens were employed to prevent fetal wastage (Yalom et al., 1973) has indicated some increase in effeminate behavior but no clear evidence of gender disorder. Gadpaille (1980) noted that although there is suggestive evidence in humans of prenatal hormone abnormality affecting subsequent sex-specific behaviors, "the behavioral effects . . . are associated with obvious biological (or experimental) disorder and massive heterotypical hormone influence, and even so, the sex identity effects are usually more subtle than total . . ." (p. 7).

Studies of intersex children, in general, substantiate the primacy of psychological factors in gender formation, regardless of the permutations of known biologic variables (Money, 1970; Stoller, 1972b, 1979). Solidification of gender identity within the first several years of life in intersex patients is strongly correlated with concordance between genitals and assignment (Money, Hampson, and Hampson, 1955a, 1955b, 1956, 1957; Hampson and Hampson, 1961). Recently, however, studies of male pseudohermaphroditism caused by 17 beta hydroxy-steroid dehydrogenase deficiency (Stoller, 1979) or by delta^4-steroid 5 alpha-reductase deficiency (Imperato-McGinley et al., 1974; Imperato-McGinley and Peterson, 1976; Peterson et al., 1977; Imperato-McGinley et al., 1979) have suggested that in some instances biological factors may override the effects of assignment and rearing. Experience with the transsexual, however, suggests the opposite. The normality of overt assignment, the biologically concordant genital structures, and the
absence of discernible endocrine abnormality suggest, in fact, that powerful psychological forces are marshaled to overcome any tendency to sex-congruent gender differentiation. There is a recent suggestion (Eicher et al., 1979) that the histocompatibility antigen H-Y, normally expected to be a cell surface component in all male tissues, is anomalously positive in some female-to-male transsexuals and anomalously negative in some male-to-females. While the finding carries with it the hint of sexual reversal at the cellular level, these suggestive data have yet to be confirmed. Furthermore, the effect on H-Y expression of such potentially complicating factors as long-term treatment with cross-sexual hormones must be determined.

Money has invoked imprinting as a critical mechanism in the development of transsexualism, describing the imprint as derived from “detrimental social experience” (Money and Gaskin, 1970-1971). It is not clear what he would consider a sufficiently detrimental experience. Money’s views on the subject are not explicated within the framework of his comments on identification and complementation (Money, 1972) or in his review of gender differentiation. In the latter work, Money and Ehrhardt (1972) cite the analogy between imprinting in birds and gender fixation in humans, but with little detail as to how the process may go awry except through such avenues as “male psychosexual frailty” (p. 147) and parental “... doubt or ambiguity as to whether they are raising a son or a daughter” (p. 152). There is, of course, much evidence for critical developmental phases in the human; it is also clear that derailment or skewed completion of developmental tasks may have deleterious long-term consequences. The possible extrapolations from ethological studies, however, are much too sparse to account for the mental variables in human gender formation.

The impetus for the biological/imprint hypothesis comes from the apparently conflict-free cross-gender conviction of transsexuals and their determination to be sexually reassigned. Observed superficially, the conviction and determination may mimic the quality of predisposition. This hypothesis suggests
that the "predisposition" is rooted biologically (or in biologically based, nonpsychic mental operations, such as imprinting). Attempts to document biological control which pre-empts the effects of somatotype and rearing, with rare exception, have failed. The most relevant animal model is probably not the rodent, which suggests the primacy of hormone-conditioned behaviors, but rather the primate, which suggests the importance of affectional systems. The primate paradigm powerfully relates infant-mother affectional systems to such gender behaviors as sexual approach, mating, and rearing of offspring (Harlow, 1960; Seay et al., 1962; Harlow and Harlow, 1962, 1965; Seay and Harlow, 1965).

The biological/imprint hypothesis suggests that mental content, fantasy, and conflict are secondary phenomena, outgrowths of dissonance between brain set, gender imprint, and somatotype. Because of the indelibility of the imprint, the hypothesis would suggest that psychotherapy is ineffective and that surgery is properly rehabilitative. The biological/imprint hypothesis has more explanatory power for male transsexualism (because of the postulate of "male psychosexual frailty"), but does not exclude the variety of clinical presentations seen among applicants for sex reassignment.

The Nonconflictual Identity Hypothesis. This model, like the biological/imprint model, is an attempt to deal with the apparently conflict-free presentation of certain transsexuals without directly invoking biological accident or constitutional predisposition. Stoller (1975) stated: "[Some who have] commented on my ideas about male transsexualism have said that I believe the condition is due to biological factors . . . But I do not claim that in regard to transsexualism . . ." (pp. 134-135). Nonetheless, preverbal, contentless, and unconflicted identification, exempted from usual developmental pressures, comes close to constitution and biology in the psychological sphere and is formally reminiscent of imprinting. In expanding on his ideas, Stoller (1976) referred to "biopsychic" phenomena:

In the rare case, despite biologically normal sex and proper
sex assignment, core gender identity can still be shifted from that expected by nonmental [italics added] effects—that is, not perceived and worked over by a psyche—transmitted subliminally (unconsciously? preconsciously?) from mother to infant. I believe this occurs in the excessively intimate and blissful symbiosis found in the most feminine of boys (transsexuals) . . . There is no evidence these infants were traumatized in the symbiosis or subjected to frustrations that would cause intrapsychic conflict . . . [p. 64].

The nonconflictual identity hypothesis holds, strictly speaking, only for males. For female patients, Stoller (1972c) has postulated dynamics closely related to those of female homosexuality:

It is my impression that female transsexualism is not quite comparable to male transsexualism: female transsexualism looks more “homosexual” . . . We seem to have a syndrome with less sharply defined clinical boundaries and more variable etiology, as is the case in both male and female homosexuality. Our research team, which has no trouble agreeing on the diagnosis of male transsexualism, may not agree from one case to the next who is a female transsexual and who is . . . homosexual. This may be due to two different etiological processes at work. Male transsexualism grows from a nonconflictual learning process on the order of imprinting, conditioning, shaping, and identification; this does not cause the homosexualities, a group of conditions . . . often the end products of processes of defense against trauma (dangerous, painful interpersonal relationships) [p. 62].

There are problems in fitting the nonconflictual identity hypothesis to clinical observations. Stoller is fully aware that he is postulating very special etiological circumstances in male transsexualism. Depressed, bisexual women and their sons are common in analytic practice; their behaviors, fantasies, and dreams, are not without ambivalence and conflict. Stoller (1975)
noted that the mothers have "the most powerful penis envy" (p. 41), that the baby was used as the mother's phallus, and that "... this phallus takes on an intensity one just does not see in normal situations" (p. 43). Nonetheless, a blissful symbiosis was postulated, uncontaminated by the hostility usually associated with penis envy, or by the usual reciprocal fear and hostility, however disguised, on the part of the child. Stoller suggested that passage through separation-individuation was normal and unimpeded by symbiotic ties, except in the area of gender identity. In terms of subsequent development, Stoller (p. 94) did not find evidence for an oedipal phase, but commented that any "tension or sadness" was secondary, in response to pressures directed from the outside world against the child's femininity (p. 95). It is at least possible to suggest that such tension and sadness might derive from intrapsychic causes, for example, the abandonment or loss of developmental opportunity. Stoller did not find evidence for ego damage. He noted, however, that the transsexual boys were not feminine in the same sense as oedipal girls (that is, object-directed) but that their femininity was "preoccupied instead with outer aspects of the feminine role—clothing, hair style, and adornment..." (p. 96). A plausible alternative interpretation of this superficiality is that it reflected defects in the capacity for object-relatedness and the defensive, rather than genuine, nature of the feminine identification. A taking-in through the eyes was noted between the transsexual boy and his mother and interpreted as "these two completely opening the gates of their souls to each other..." (p. 45). It might also be interpreted as visual contact necessitated by the absence of empathic closeness despite excessive physical contact. In that sense it would be analogous to the effects of Greenacre's (1953) guilty, hostile appersonation. The "glass-smooth facade" of adult transsexuals, their "psychopathic" qualities, and the difficulty of achieving emotional contact or a therapeutic alliance were also noted by Stoller (1975, pp. 109-114). Like the superficiality of the childhood femininity, these qualities could be interpreted as attesting to severe damage in the...
capacity for object relations, to ego impairment, and to the
defensive functions of the assumed gender. For example, the
gender shift might be viewed as serving to deny masculine striv-
ings out of rage toward mother and fear of abandonment by
her. Similar issues have been raised in the past, as reported by
Clower (Panel, 1970). It was noted (Stoller, 1975, p. 107) that
“successful treatment creates [italics added] an Oedipus com-
plex” with masculine behavior, anger (especially toward mother),
and rivalry with males. Even if it were appropriate to regard
the oedipal conflicts as being created rather than released from
defensive suppression through psychotherapy, it seems difficult
to reconcile the idea of imprinted, nonconflictual reversal of
gender with the reports of successful psychotherapy (Green et
al., 1972; Green and Fuller, 1973; Stoller, 1975, 1978). These
reports might, as another option, be interpreted as supporting
a conflictual, defensive view of transsexualism. The concepts
of the blissful symbiosis and its effects are reconstructions based
on later observations and histories. As with any reconstructions
(including those advanced later in this paper) there are prob-
lems. By the age of sixteen or seventeen months, character
formation makes deductive reconstructions extremely hazard-
ous (Mahler, 1971, p. 414) and the histories from mother and
child both seem likely to contain screen memories, defensive
formations, and wish fulfillments. As an example, the pain of
a difficult relationship might be eased by the fantasy of a blissful
symbiosis.

The nonconflictual identity hypothesis suggests that trans-
sexuals are special, rare exceptions to general clinical findings.
Observation of children ordinarily indicates that attempts at
close binding by their mothers, whatever the surface acquies-
cence, produce severe conflict due to the intrinsic, aggressive
developmental pressures driving the child (Mahler et al., 1975).
Ego damage, narcissistic impairment, and primitive object re-
lations are the usual outcomes. The nonconflictual identity hy-
pothesis appears to be couched almost exclusively in a libidinal
framework. The vicissitudes of aggressive drives or develop-
mental pressures are not explicated, although Stoller (1974) is clear about the "hostility," composed of "rage," "fear," and "revenge," associated with difficulties in resolving a maternal identification in perversion. The child's passage through separation-individuation is considered normal, although it might be expected that this developmental phase would be difficult for a symbiotically attached child. It is suggested that oedipal issues are bypassed since there is no masculine identification. It might appear, however, that a child with a strong feminine identification, symbiotic ties to mother, and a penis would, under the impact of strong libidinal and aggressive urges, have a highly troubled and peculiar oedipal phase, or would be compelled to exercise extraordinary defensive measures.

The exceptional preconditions called for by this postulate exclude it as an explanatory hypothesis for the vast majority of male applicants for sex reassignment. This formulation deals with the clinical variance among such men by suggesting that only those who can be shown to satisfy the restrictive initial conditions are transsexual while the others are, by definition, nontranssexual and perverse. Since perversion ordinarily operates to protect from castration, the theoretical problem has not been solved, merely shifted to another arena. Conflict, mental content, and fantasy are considered secondary phenomena in contrast to the primary identification. This hypothesis suggests that by adolescence psychotherapy is ineffective for the "true" transsexual and surgery is truly rehabilitative (Baker, 1969). This formulation does not account for the genesis of female transsexualism. While it is not necessary that the theories for male and female transsexualism be superimposable, it would be more formally satisfying if they were symmetrical.

Person and Ovesey (1974a, 1974b) saw the transsexual wish as the nucleus of a syndrome. Transsexualism was viewed as a symptomatic compromise formation in which the primary threat is from early maternal abandonment and the reparative fantasy is of symbiotic merger with the mother (see also MacVicar, 1978-1979). In contrast to transsexualism, separation anxiety in transvestism and effeminate homosexuality are allayed, not by symbiotic fusion with the mother, but by resort to transitional and part-objects. In the transsexual, sexuality is largely sacrificed to security needs.

Socarides (1969) considered transsexualism the result of unconscious conflict from the earliest years of life, the dynamic factors being "the same psychodynamic factors, which are present in cases of homosexuality and transvestism . . ." (p. 1423). He regarded the transsexual as "attempting to ward off a paranoid psychosis that might develop if he engaged in homosexuality in his actual anatomical role" (p. 1423). In a 1970 report, Socarides emphasized failure to successfully negotiate symbiotic and separation-individuation phases, preoedipal fixation, a wish and yet a dread of merging with mother, and wishes to take mother's place with father. He considered denial to be the primary defense mechanism and considered it to be of psychotic proportions.

Volkan (Volkan and Berent, 1976; Volkan, 1979) emphasized the borderline aspects of transsexualism including the presence of splitting as a mental mechanism, and the effort to primitively deny or to externalize aggression. He conceived of the body image as split, with the penis being unconsciously, or even preconsciously, regarded as an aggressive embodiment to be eliminated.

I have commented elsewhere about the variance in clinical presentation among gender dysphorics (1974; Meyer et al., 1971), the shift in symptomatology within a given patient between the perverse and the gender dysphoric (1974, 1975), the close relation between the perversions and gender dysphoria (1975, 1980c), and the borderline nature of the gender-dysphoric character structure (1976, 1980a, 1980b, 1980c; Meyer and Dupkin, in press).
Although drawn from diverse sources, the conflict/defense hypothesis can be said to reflect a consensus in certain important respects. One element of consensus is that the term transsexualism denotes a somewhat variable clinical condition with sufficient common features embodied in the wish for sex reassignment to deserve recognition as a syndrome. Transsexualism is viewed as a product of developmental abnormality, conflict, and defense beginning in the symbiotic and separation-individuation phases. As a product of early developmental skewing, primitive defense mechanisms and ego impairment are components of the transsexual picture. An understanding of transsexualism may be approached from the psychoses, the perversions, and the borderline states. Weaknesses in the conflict/defense hypothesis include the relative absence of clinical reports; failure to sufficiently differentiate gender identity disorder from perversion, other borderline syndromes, and psychosis, and to account for those differences; lack of an adequate formulation of female transsexualism; and the absence of a sufficiently detailed developmental model. This hypothesis regards mental content, conflict, and defense as primary phenomena in the construction of the clinical syndrome rather than as secondary outgrowths of brain-body dissonance, aberrant imprinting, or social intolerance. Psychotherapy is considered to have a fundamental utility, while surgery is considered a palliative collusion with symptomatology.

**Toward an Integrated Conflictual Hypothesis**

Having outlined basic observations and summarized and critiqued existing hypotheses, an attempt will be made to formulate an integrated conflictual hypothesis of transsexualism. This hypothesis is put forward not as a final product, but as a provisional statement subject to theoretical critique and clinical testing.


**Gender Development**

Integral to all three hypotheses are assumptions about the influence of the earliest, preverbal infant-mother dyad. The clinical manifestations of gender disorder, consisting of a disjunction between sense of self and the configuration of anatomy, suggest difficulty in those earliest developmental stages in which the ego is still largely a body ego (Freud, 1923) and the self-representation is being formed out of the interactions between mother and child (Hoffer, 1950; Mahler, 1971; Mahler et al., 1975). Gender sense may be regarded as built upon three tiers. The first tier is the underlying structuring of the ego mediated through its connections with the body. The second is the organization of this early structuring into a primitive body image, and the third is the development of me, not-me sense. Gender identity may be viewed as constituting the extension, elaboration, and integration of these factors into the sexual and reproductive sphere (Meyer, 1980b; Meyer and Dupkin, in press).

For the infant the road to his psyche is through his body. His psychic well-being is dependent in large measure on the quality of feeling that accompanies the care of his physical needs (Winnicott, 1965a, 1965b). The ego itself is structured in significant ways by its connection to the body. The genitalia, far from being insensitive, silent organs, are stimulated from the beginning by elimination, cleaning, and diapering, and seem likely to achieve an early representation in the ego. It is known, for example, that the penis is discovered and manipulated within the first year of life (Galenson et al., 1975). It would require the operation of extraordinary mechanisms to render insignificant these genital-psychic connections. In addition, the cathexis and security of body parts as represented in the body image seem dependent on the quality of early relationships (Greenacre, 1953; Galenson et al., 1975). Parents' attitudes toward genitals, maleness, femaleness, and reproduction influence the ways in which they handle their children's bodies, and consequently affect the valence associated with bodily parts.

Beginning in the symbiotic phase, definition, discrimina-
tion, internalization, and maturation constitute the elements of the process leading to separation and individuation. The archaic definition of body boundaries as part of the developing body image sets the stage for the discrimination of objects outside those limits (Mahler in Panel, 1958). In the normal situation, the child begins in the second year to recognize the physical attributes, functions, and behaviors that discriminate males and females (Galenson and Roiphe, 1971; Mahler, 1971; Galenson et al., 1975). As the sexes are discriminated, identifications are formed. Supplanting the identification with mother, boys identify with their fathers through the possession of like genitals. The girl's primary identification with mother is reinforced through possession of similar genitals. The boy at the same time must work through a dis-identification with his mother (Greenson, 1968), while the girl must struggle with issues of "genital inferiority." Hand in glove with these gender identifications, the complementary relationships with the opposite sex are assimilated (Money, 1972; Money and Ehrhardt, 1972; Kestenberg, 1980). In other words, the formation of gender normally includes a recognition of the distinctions between the sexes, an identification with the like sex, and a recognition of the complementarity of the opposite sex. Incorporated along with sexual complementarity is an early version of the two sexes' reciprocal reproductive functions: make babies or have babies (Kestenberg, 1980). Clarity about the mechanics of impregnation and gestation is not essential in gender formation; what is essential is an early identification with this biological reproductive function. The implications of gender feelings in terms of social role, the mechanics of sex and reproduction, and personal erotic preferences will be elaborated, as part of sexual identity, as the child matures. The solidity and quality of a gender identification are reflected in the degree to which self-representation, anatomical givens, and reproductive potential are comfortably wedded.

Gender identity is formed in the late preverbal and early verbal periods, appearing to be clearly demarcated at around
two years of age and unmodifiably determined by age four (Hampson and Hampson, 1961; Money and Ehrhardt, 1972; Mahler, 1971; Mahler et al., 1975). It is clear that the major integration leading to gender sense takes place in the separation-individuation phase, and constitutes a normal, though often ignored, phase-specific developmental milestone. In the oedipal phase, gender is not reversed once established adequately, although sexual identity and the expression of masculinity and femininity are at issue.

This review of normal gender development suggests that in transsexualism the pathogenic influences are felt very early, that the integration of bodily attributes into the ego is affected, that body image is disturbed, that the distinction between self and others is blurred, that reproductive potential is denied, and that, overall, there is severe ego impairment.

Gender Dysphoria

The Clinical Syndrome. The disagreement on what may be considered transsexualism is the starting point of the discussion of the clinical syndrome. In the nonconflictual frame of reference transsexualism is considered different in fundamental ways (simpler, nonmental) from other clinical conditions. From the conflict/defense perspective, on the other hand, transsexualism is viewed as derived from character disorder, perversion, or psychosis. The question of whether transsexualism may be considered part of a continuous or discontinuous clinical series is a critical one. The same dilemma was faced by Freud (1905) in his discussion of inversion in the Three Essays:

Many authorities would be unwilling to class together all the various cases . . . and would prefer to lay stress upon their differences rather than their resemblances. . . . Nevertheless, though the distinctions cannot be disputed, it is impossible to overlook the existence of numerous intermediate examples of every type, so that we are driven
to conclude that we are dealing with a connected series [pp. 137-138; italics added].

Our experience led us to regard transsexualism as a “connected series” and to define it, not in terms of family constellation or dynamics, but rather syndromatically in terms of observable symptoms and ego defects. The active, conscious, sustained, ego endorsement of sex reassignment is the focal point of the clinical syndrome and, when in ascendance, the organizing motif of the patient’s life. The quest for sex reassignment has as its essential feature a sense of disjunction between anatomy and self-representation. There is a conscious awareness of physiognomy, but a disavowal of its significance and a wish (endorsed by action) for concrete, visible anatomical changes in accordance with an assertion of cross-gender identity. At the most superficial level the ego modifications which appear central to transsexualism are the split in the ego in relation to anatomy with the ego’s denial of the relevance of anatomical givens, its acceptance and endorsement of genital ablation and reassignment, and the devotion of its executive apparatus to wish fulfillment. Clinical experience has led to a view that the patient’s description, in gender-reversal terms, of the dissonance between his mind and body is a defensive, symptomatic condensation of remarkable proportions. Furthermore, the destruction of the meaning ordinarily associated with genital anatomy is a violent psychic act, one means by which the superficially absent rage is expressed.

While cross-sexual wishes and fantasies occur in the neuroses, the perversions, and the borderline states, in the ordinary stable clinical condition these fantasies are not endorsed by the ego and do not gain access to the executive apparatus. However, there are those individuals who show perverse symptomatology during periods of better functioning but, under stress, decompensate transsexually. They constitute a transitional group between perversion and gender dysphoria in the connected series of transsexualism. In the psychoses, the delusions of bodily metamorphosis or hallucinated commandments to self-mutilate
are only superficially similar to the usual transsexual's pursuit of surgical reassignment. The cross-gender activity in transsexualism helps preserve the ego rather than signaling its dissolution. On the other hand, just as some perverse individuals are subject to transsexual decompensation, some transsexuals may become frankly delusional (Van Putten and Fawzy, 1976). These more severely ill transsexuals may be conceptualized as psychotic characters (Frosch, 1970) struggling with psychotic issues but stabilized by the “crystallization” of these conflicts into character structure. In the ordinary transsexual, the primitive introjects, the poor object relations, the “as-if” quality of sense of self, the affect intolerance, the splitting of the ego, and the massive use of denial are held in common with the severe borderline character disorders. I consider transsexualism as part of a continuous series with perversion, as intermediate in ego pathology between perversion and psychosis, and as sharing many common borderline features.

The Oedipal Phase and Beyond. Although the transsexual syndrome is not determined oedipally, there are oedipal manifestations in the pretranssexual child. Children at risk for gender dysphoria have peculiar oedipal phases in that sadness and despair appear more prominent than does overt conflict. Nonetheless, the femininity of the transsexual boy may be utilized in quite aggressive ways toward his father and brothers, suggesting a perversion of the rivalry. As is typical in situations in which identification with father is impaired, a ferocious, rivalrous inner father is created. In fact, in our series of children and their families it was remarkable that the appearance of frank “pretranssexual” behavior and fantasies was sometimes associated with the father's return after a prolonged absence and with the (obviously not unrelated) birth of a sibling during the child's second and third years. Although, simultaneously with the fear, there is a hope of being rescued by the fantasied inner father—as there is in perversion (McDougall, 1974)—the hope is not sufficiently strong to preserve the child's gender sense and anatomical integrity. The fate of the inner fathers
is to be reflected in object choices. These inner fathers are represented by the disturbed and essentially perverse consorts of grown-up male-to-female transsexuals. An analogous process occurs in gender-dysphoric girls. Not only is the girl's identity tied up with mother, preventing any effective moves toward separation, but any libidinal move toward father is doomed by her already overwhelming need to possess a penis rather than to share one. Her inner father is reflected in an "as-if" identification. The girl's relationship with father is represented by the female-to-male transsexual's very superficial masculine attributes.

The boy's impulse to take mother as a sexual object crashes against her disparagement of him as a male and her repudiation of his genitals. Her envy of his genitalia and wish to negate them have already served as a castration threat, in conflict with whatever narcissistic investment he may have in his penis. If the father of fantasy seems to interdict congress with mother, the combination of threats on both sides forecloses the possibility of retention of the penis. Although retention to the penis was already largely forgone, it is now hopeless. An attachment and investment in something that can never be really possessed is too painful; it is less costly emotionally to forswear mother as a sexual object and to identify totally with her. Males are taken as sexual objects and the boy becomes effeminate. This is not, however, the usual negative oedipal constellation. In order to carry out mother's fantasies he must in reality shed his penis; he is not a boy who likes other boys and who can be appreciated for his phallus. He is a boy who is to become a girl. Similarly, the girl's primitive attachment to mother, her overwhelming sense of genital inferiority, and the need to possess a penis for preoedipal, symbiotic reasons, indicate that her masculinity is not part of an object-related, negative oedipal constellation. She is a girl who is to really become a boy.

The syndrome of transsexualism is determined preoedipally. While the instability of body image, the identification with mother, the anxious body narcissism, and the exaggeration of
aggressive drives make it easy to imagine the severity of the castration threat, the major threat in these children is not merely castration but disintegration. Object constancy as the culmination of separation-individuation has not been achieved. In the absence of this basic personality integration, the child is not prepared to work toward the more sophisticated oedipal structuralization. Under such circumstances, merger seems a haven by contrast to the dangers of assertive, genital strivings. In gender-dysphoric boys, the upsurge of libidinal and aggressive feelings puts stress on their primitive defenses. The threat of annihilation posed by oedipal pressures results in a further repudiation of maleness and a further defensive identification with mother. In this regard, there is a small, but very instructive group of young men who are "premorbidly" transvestitic but who desperately seek sex reassignment when their sons reach the oedipal phase. The revitalization of their conflicts in resonance with their sons' suggests that for the transsexual, oedipal pressures precipitate a final collapse into the characteristic defensive posture with ego modification.

In latency the boy's extreme femininity is muted as a matter of survival in school and with peers. The very tomboyish girl is better tolerated, but her masculine behavior also becomes subdued. Whether the cross-gender fantasies and wishes become similarly muted is not entirely clear: that some kind of suppression and accommodation occur is indicated by the fact that so few latency-age children are brought for consultation. With adolescence, however, the situation alters dramatically. The increased drive pressure at puberty upsets the gender-dysphoric's equilibrium. His parents, and often the school system, are in turmoil. There is a period of identity crisis during which the gender-dysphoric is painfully uncertain as to who and what he is. This identity diffusion may become sufficiently painful to result in a suicidal crisis; it is not certain how many of these youngsters are among the successful adolescent suicides. Those who survive, however, emerge with a transsexual resolution of this crisis. The adolescent is now no longer un-
certain of his identity because his confusion has been concretized (he is a boy who is really a girl, or the reverse). His aggressive urges which threatened to turn against him in toto are now focused on his genitals (which will soon be modified). Sexual impulses are defused (he is not homosexual, and for true heterosexual experience he must await reassignment). Finally, separation and independence need not be faced (since he can now become mother or, if female, her consort). A similar kind of transsexual resolution of conflict may occur, with or without suicidal crisis, in late adolescence, early adult life, around marriage, with parenthood, in middle age, and in senescence.

Review of Hypothesis

I believe those children who are destined to be gender-dysphoric are born to women who, although they may not be overtly ill, have significant character pathology. In particular, their sexual identity is hazy, with poor feminine identification and strong, unresolved bisexual conflicts. There is strong penis envy, disparagement of female genitalia, and a sense of the unfairness of a woman's "lot" (penetration, menstruation, gestation). In particular, there is unconscious denial of the distinctions between the sexes and their basic complementarity, and a conviction of the interchangeability of the sexes. This is not only a hostile fantasy, but also a reparative one. During gestation a fetus of either sex becomes invested with phallic qualities. When the child is born the fantasies of penile loss are revivified.

The relationship to the male child is ambivalent. To the extent that he represents her phallus, he is highly valued; to the extent that he is separate from her, he revivifies her old outrage. To the extent that he is a beautiful, passive, controllable extension of her, and therefore useful in repairing her body image, her son is tolerable. To the extent that he is demanding, willful, and shows internal pressures toward devel-
development, he brings down her coldness and repudiation. If he is a particularly beautiful and passive baby, perhaps as in Stoller's special cases, her narcissistic investment in the child helps to partially compensate for the rejection born of envy. When the separation-individuation pressures mount, these mothers retaliate by becoming cold and distant. Specifically, however, the mother's retaliation is against the boy's genital, which may be treated as a disgusting, ludicrous, or horrible appendage whose existence is at the heart of mother's disapproval. The boy's father could intervene productively at this point by providing an alternative to mother's ambivalence. However, because he is unavailable, threatening, or seductive in his own right his influence is not remedial.

Girls who are destined to be gender-dysphoric are born into the same type of situation—little girls, like little boys, may also serve as mother's putative phallus—but in certain respects they have a more difficult time. Although the infant girls elicit less envy, they are frequently treated with more contempt: the same contempt with regard to their nascent femininity as the mother feels for her own. The oscillation between narcissistic incorporation and envious, hostile rejection that occurs with male infants is less marked for girls; rather, there is more of a chronic, rejecting disappointment. At the same time there is the notion of being sisters in misery. To the extent that she cannot accept her daughter as female, she is unable to accept my naturally occurring interest in males on her daughter's part. The message to the daughter may be encapsulated as follows: Your genitalia and femaleness are worthy of contempt, and because of them I cannot accept you; however, you are like me and must not turn to men because they are our common enemy.” The common unhappiness is lightened by the reparative fantasy that a girl can become a boy. The child incorporates her other's disparagement of her genitals and her femininity and solves to become a boy, not out of identification with men, it to be more acceptable in her mother's eyes and to repair the rift between them.
There is little in this hypothesis that is unique to the pathogenesis of transsexualism. Similar guilty and anxious, latently aggressive appersonation colors the relationships of individuals who become borderline or perverse. A poorly defined and unstable body image is a feature in the pathology of both perversion and gender disorder (Greenacre, 1968). The genesis of both conditions is bound up with unconscious maternal fantasies which are common enough in feminine psychology, but which are held uncommonly dearly and tenaciously by the mothers of perverse and gender-dysphoric patients: nonrecognition of the reality and consequences of the anatomical distinctions between the sexes and the assumption that the child's body is a protoplasmic extension of mother's. The incorporation of the child into maternal fantasies, however, is more complete in gender dysphoria than in perversion. Furthermore, the concreteness of the demand for reparation to the mother is more compelling than in the perversions and cannot be controlled through symbolic acts.

The difference between perverse and gender-dysphoric patients depends on the degree to which the split in the ego (Freud, 1940; Gillespie, 1952, 1956) and the maternal reparative fantasy can be symbolized and the degree to which they must be made concrete. The more it is possible for the child to deny symbolically both the distinctions between the sexes and make reparation for mother's sense of damage, the more likely he is to be perverse. The more his symbolic capacities fail, or concrete restitution to mother seems inescapable, the more likely he is to have a gender identity disorder. To the extent that the girl can create or incorporate a symbolic penis, she will be perverse; to the extent that she must confirm the fantasy in action, she will be transsexual. Perversion expresses the fantasy by the substitution of symbolic objects or rituals (Bak, 1953, 1971; McDougall, 1972). In transsexualism the fantasy is converted into reality: undergoing sex reassignment to confirm that men and women are interchangeable. Transsexualism clearly does not protect physical integrity. In the perversions,
the symbolic act protects physical integrity from the threat of castration and the ego from paralysis. In the transsexual, physical integrity is sacrificed, usually in a controlled, surgical way, as a protection against ego paralysis or disintegration. To the transsexual, castration is the lesser evil masquerading as the greater good.

The bulk of applicants for sex reassignment are not psychotic, although denial in the realm of the genitals approaches psychotic proportions. Severely disturbed transsexuals are different from schizophrenics in that the psychotic concerns are stabilized in the patient's character armor. The difference between the schizophrenic who is self-mutilative or who has delusions of bodily change and the schizophrenia-prone transsexual is that in the latter the organized pursuit of gender change serves as an attempt to defend against ego dissolution rather than as its hallmark.

I believe there are certain advantages to the conflict/defense hypothesis. The promise of that hypothesis is that it will bring transsexualism into the broad body of clinical theory and observation, ending its status as a curiosity. The hypothesis has the attribute of complementarity, meaning that it expands upon or extends other well-substantiated observations or hypotheses. It does not rely on hypothetical biological factors or extrapolations from ethology. It relies on ego modification criteria to define the syndrome and views transsexualism as part of a "connected series" of gender identity disorders. It organizes diverse observations and accounts for observed clinical variations and fluctuations without eliminating, by definition, certain clinical presentations in the "connected series." It offers an etiological formulation without recourse to extremely rare initial conditions. It has symmetry, which, in this instance, means that it accounts for male and female expressions of the disorder from the common experiences of babyhood. Finally, it has heuristic potential, suggesting new areas of inquiry or observation.
Summary and Conclusions

Experience with more than 500 patients over the last decade has led to the conclusion that the quest for sex reassignment is a symptomatic compromise formation serving defensive and expressive functions. The symptoms are the outgrowth of developmental trauma affecting body ego and archaic sense of self and caused by peculiar symbiotic and separation-individuation phase relationships. The child exists in the pathogenic (and reparative) maternal fantasy in order to repair her body image and to demonstrate the interconvertability of the sexes.

Gender identity exists not as a primary phenomenon, but in a sense as a tertiary one. There is, no doubt, a tendency to gender-differentiate in a way concordant with biological endowment. Nevertheless, gender formation is seriously compromised by earlier psychological difficulty. Gender identity is a fundamental acquisition in the developing personality, but it is part of a hierarchical series beginning with archaic body ego, early body image, and primitive selfness, representing their extension into sexual and reproductive spheres.

Gender identity consolidates during separation-individuation and gender pathology bears common features with other preoedipal syndromes. Transsexualism is closely linked to perversion, and the clinical syndromes may shade from one into another. However, what is kept at the symbolic level in the perversions must be made concrete in transsexualism. In this regard there is a close relation to psychosis.

The clinical complaint of the transsexual is a condensation of remarkable proportions. When the transsexual says that he is a girl trapped in a man’s body, he sincerely means what he says. As with other symptoms, however, it takes a long time before he begins to say what he means.

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