The Transsexual Syndrome in Males

I. PRIMARY TRANSEXUALISM *

ETHEL PERSON, M.D.†  
LIONEL OVESEY, M.D.†  
New York, N.Y.

Transsexuals fall into two groups: primary and secondary. The former are transsexuals throughout the course of their development; the latter are effeminate homosexuals and transvestites who become transsexuals under stress. The authors delineate the syndrome of primary transsexualism. They present clinical examples and discuss gender identity, family history, childhood development, clinical course, and personality structure.

INTRODUCTION

In a previous paper (2) we established a theoretical framework in which we demonstrated the psychodynamic interrelationships between gender identity and sexual psychopathology in homosexuality, transsexualism, and transvestism. In this paper, we will examine male transsexualism in more detail. We will define transsexualism as the wish in biologically normal persons for hormonal and surgical sex reassignment. We will demonstrate, first, that the transsexual wish is the nucleus of a transsexual syndrome; and, second, that the transsexual syndrome in males is not a unitary disorder, but a final common pathway for patients who otherwise differ markedly in family history, developmental history, psychodynamic patterning, personality structure, and clinical course. The differentiation of these patients, one from the other, is not just of academic interest; it is of crucial importance for the psychiatrist who must evaluate applicants for sex reassignment.

We are in agreement with other workers (3–9) that transsexualism, transvestism, and effeminate homosexuality have their roots of origin in the preoedipal period. We proposed in our initial paper (2) that all three disorders stemmed from unresolved separation anxiety during the separation-individuation phase of infantile development.† In point of time, we sug-

* This is Part I of a two-part paper (1).
† The Psychoanalytic Clinic for Training and Research, Department of Psychiatry, College of Physicians and Surgeons, Columbia University, 722 West 168th Street, New York, N.Y. 10032. Reprint requests to Dr. Ethel Person, 135 Central Park West, New York, N.Y. 10023.
‡ See Mahler (10) for an excellent current summary of the separation-individuation process. Mahler dates the principal psychologic achievements of this process in the period from about the fourth or fifth to the 30th or 36th months of age.
gested they originated along a developmental gradient, transsexualism first, transvestism and effeminate homosexuality later. The symptomatic distortions of gender and sex in the three disorders reflect different ways of handling separation anxiety at progressive levels of maturation.

Thus, as we see it, in male transsexualism, to counter separation anxiety, the child resorts to a reparative fantasy of symbiotic fusion with the mother. In this way, mother and child become one and the anxiety is allayed, but the cost is an ambiguity of core gender identity (sense of maleness). We infer that this fantasy is laid down before the child is three years old; otherwise, core gender identity would be firmly established by that age. The ambiguous core gender identity, of necessity, interferes with normal development of gender role identity (sense of masculinity). It also impedes sexual development and in most transsexuals leads to relative asexuality.

In contrast to transsexualism, separation anxiety in transvestism and effeminate homosexuality is allayed not by symbiotic fusion with the mother, but by resort to transitional and part-objects. These mechanisms are not as primitive as symbiosis and do not become available to the infant until he has moved further along on the separation-individuation gradient. The mechanisms may become operant before the age of three, but their major effects come later, since there is little ambiguity about core gender identity either in the transvestite or in the effeminate homosexual; to the contrary, core gender identity in both is predominantly male. Their gender role identity, however, is markedly disturbed.

In transvestism, the female clothes represent the mother as a transitional object and hence confer maternal protection. They are also used sexually as fetishistic defenses against oedipal anxiety. In effeminate homosexuality, the boy would like to maintain the dependent tie to the mother, but fears engulfment and annihilation. In the Oedipus complex, this fear is eventually transferred to the vagina and the homosexual solves both his sexual and dependency problems by changing the sexual object. In his case, therefore, the separation anxiety is allayed through the pseudohomosexual components (11) of the homosexual act. His partner’s penis is equated with the mother’s breast and is incorporated orally or anally as a part-object.

**Classification**

The stages of maturation along a developmental gradient are not neatly compartmentalized, but overlap each other so that preceding stages merge with those that follow. In consequence, under conditions of stress, the transsexual impulse may arise defensively as a regressive phenomenon in some effeminate homosexuals and transvestites. Clinically, therefore, there are three prototypic histories in patients who seek sex reassignment, and transsexuals can be classified in accordance with these prototypes. We have
divided them into two groups which we have designated primary transsexuals and secondary transsexuals.

Developmentally, the primary transsexuals progress toward a transsexual resolution of their gender and sexual problems without significant deviation either heterosexually or homosexually. Behaviorally, therefore, they are primarily transsexuals from the beginning and throughout the course of their development. In them, the transsexual impulse is insistent and progressive, and usually they cannot rest until they reach their objective. In the second group are those patients who gravitate toward transsexualism only after sustained periods of active homosexuality or transvestism. Behaviorally, therefore, they are primarily homosexuals or transvestites, and only secondarily do they become transsexuals. In them, the transsexual impulse may be either transient and fluctuating or insistent and progressive. In the latter case, it may eventually harden into a full-blown transsexual syndrome. In summary, then, we can classify transsexuals clinically under the following headings:

Transsexualism

I. Primary transsexualism

II. Secondary transsexualism

A. Homosexual transsexualism §

B. Transvestitic transsexualism §

In our clinical experience, the great majority of male transsexuals will fit easily into this classification. A few patients, however, will straddle two, or even all three of the categories, and in their clinical course be mixtures of transsexualism, transvestism, and homosexuality. They will have transitory episodes of each, shifting from one to the other, before they ultimately embark on the final transsexual resolution. We have concluded from a study of female transsexuals that there is no female equivalent of primary male transsexualism. In our opinion, the transsexual syndrome in women develops only in homosexuals with a masculine gender role identity. Female transsexualism, therefore, can be classified as another form of secondary (homosexual) transsexualism.

This paper is based on a psychiatric study of twenty transsexual patients in various stages of hormonal and surgical treatment. Ten were primary and ten were secondary transsexuals. The latter broke down into five homosexual transsexuals and five transvestitic transsexuals. All of the patients were volunteers referred by Dr. Harry Benjamin’s office and The Erickson Educational Foundation, both clearing houses for patients seeking

§ The terms, homosexual transsexualism and transvestitic transsexualism, have previously been used by Money (12).
sex reassignment. The patients were studied in psychiatric interviews. Five patients were seen in single interviews only; 15 were seen approximately once a week for several weeks, then irregularly for periods ranging from a few months to as long as two years. All patients were first seen by Dr. Person, who also conducted all ongoing interviews. Selected patients in each category were seen in consultation by Dr. Ovesey.

The numerical breakdown of our sample is not statistically significant. We chose to study more primary transsexuals than either homosexual or transvestitic transsexuals because we wished to establish beyond a doubt that primary transsexualism was a distinct diagnostic entity, separate in its own right from both homosexual transsexualism and transvestitic transsexualism. Sulcov (13), in a study of 65 consecutive applicants for sex reassignment, classified them as follows: homosexual transsexuals—52%; “asexual isolates” (primary transsexuals in our classification)—18%; transvestitic transsexuals—18%; unclassified—12%. The median age of those classified as transsexuals was the following: homosexual transsexuals—twenty-two; primary transsexuals—twenty-four; transvestitic transsexuals—forty.

GENDER IDENTITY IN TRANSSEXUALISM

The presenting complaint of the transsexual, both primary and secondary, is usually a variant of the plea, “I am a female soul trapped in a male body.” The patient claims that this was a life-long conviction, although he at no time denies the anatomic reality of his maleness. Stoller (3) accepts this claim and attributes the patient’s conviction to a female core gender identity laid down within the first three years of life. We find ourselves in disagreement with Stoller. We question the transsexual’s conviction of femaleness, as well as its life-long duration. We also question Stoller’s hypothesis that transsexuals have a female core gender identity.

Whether or not the transsexual’s conviction of femaleness is truly a conviction is, of course, a matter of interpretation. Clinically, the transsexual appears confused about gender identity, and his conviction seems more an attempt to resolve this confusion than a true conviction. In this paper, we will use the term “conviction” to express the patient’s representation of his feelings, not our interpretation of them. In our opinion, the transsexual does not succeed fully either in denying that he is male or accepting that he is female. On this basis, we believe it would be more accurate to say that transsexuals have an ambiguous core gender identity. The ambiguity derives from the unconscious fantasy used by transsexuals to allay separation anxiety, namely symbiotic fusion with the mother. Our hypothesis is bolstered by the fact that the conviction has an evolutionary history; that is, it does not spring ready made into the child’s head. Furthermore, the evolutionary process is not the same in all transsexuals. Its course in primary transsexuals is very different
from that in secondary transsexuals, and the ambiguity is far greater in the former than in the latter.

The primary transsexual in childhood has no major defense against separation anxiety other than this fantasy, which markedly inhibits masculine behavior; hence, the primary transsexual has undiluted gender discomfort which becomes progressively more severe as he grows older. Not until late adolescence or early adulthood, when he learns of the existence of transsexualism, does he get any relief. Only then does he resolve the ambiguity through a transsexual identity and sex reassignment. The secondary transsexuals, on the other hand, are perhaps more successful in alleviating gender discomfort. They usually resolve the ambiguity somewhat earlier by dealing with the separation anxiety either as transvestites or as homosexuals. The defenses in these disorders tip the ambiguity toward a male core gender identity, and as long as these defenses work, the patients maintain some semblance of emotional balance. However, under conditions of severe stress, where their tenuous masculinity is threatened, they may regress to transsexualism and seek a reversal of core gender identity.

It would be helpful here to review the autobiography of Christine Jorgensen (14), the prototypic transsexual. Jorgensen as a child was emotionally withdrawn and asexual, but considered a sissy. In our classification, he would be essentially a primary transsexual. At the termination of his army service, Jorgensen speculated on his initial confusion about gender identity:

... I was underdeveloped physically and sexually. I was extremely effeminate. My emotions were either those of a woman or a homosexual. I believed my thoughts and responses were more often womanly than manly. But at that point, I was completely unaware of the many combinations of masculinity and femininity, aside from homosexuality, that exist side by side in the world (14, p. 43).

In 1948, at the age of twenty-two, he read a newspaper article about the work of a prominent endocrinologist who experimented with the masculinization of a chicken and the return to vigor of a castrated rooster. At first, Jorgensen considered masculinization, but finally opted for feminization. He described himself at the time to a doctor:

... I've tried for more than twenty years to conform to the traditions of society. I've tried to fit myself into a world that's divided into men and women ... to live and feel like a man, but I've been a total failure at it. I've only succeeded in living the life of a near recluse, completely unable to adjust (14, p. 73).

In The Male Hormone by de Kruif (15), Jorgensen read a statement that profoundly impressed him:

Chemically, all of us are both man and woman because our bodies make both male and female hormones, and primarily it's an excess of testosterone that
makes us women; and the chemical difference between testosterone and estradiol is merely a matter of four atoms of hydrogen and one of carbon (14, p. 79).

He began to medicate himself with estradiol. Soon thereafter he found a sympathetic physician. The two of them discussed "certain historical cases" of sex conversion reported in medical journals, presumably of pseudohermaphrodites. These quotes reveal that Jorgensen's conclusions about his gender identity (pseudohermaphroditic, but truly female) were achieved via a perusal of the medical literature, and not simply out of some inner process. Jorgensen's ingenuity lay in forging his identity; the term, transsexualism, was subsequently coined by Benjamin (16). Today, transsexuals arrive at the same conclusion, but Christine Jorgensen did the spadework for them, and her autobiography has become their "Bible."

**PRIMARY TRANSSEXUALISM**

In the two clinical examples which follow we have used the convention of referring to the patient as male prior to assumption of the female role and as female after the assumption of the female role.

**Case 1.** A. appears as a tall, quiet, shy, striking-looking blond woman in her early twenties. In fact, she is a thirty-year-old transsexual. She has been taking hormones for two years and has been living as a woman since her orchiectomy eight months ago. The remaining sex conversion surgery will be scheduled when financially possible. She has a receding hair line which she masks by wearing her hair forward. The beard is not visible but still palpable; she must have electrolysis for another year. She feels comfortable in every social situation as a woman, except at the beach, where she is afraid her male genital will show. She is not psychologically-minded and in the interviews had difficulty remembering her early years. Nevertheless, she tried hard to cooperate, focused on trying to remember dreams and fantasies, and was very proud when she could. The relationship with the interviewer became very meaningful to her and she has stayed in contact on a flexible basis since the termination of her regular sessions.

Except for a two-year-period between the ages of seven and nine, A. lived with her mother until they broke with each other over the orchiectomy and A.'s assumption of the female identity. The mother is fifty-eight years old. There is an older brother, now thirty-two, who is married and the father of two sons. The parents were divorced when A. was two and the father had no contact with the boys thereafter. He died when A. was seven. A. has no memory of him whatsoever.

A. was never close to her mother, though she feels she loves her. The mother is undemonstrative, but will respond with affection if A. takes the initiative. She is described as strong-minded and stubborn, but easily hurt and quick to tears. She worked as a saleswoman from the time she was divorced. The boys were left with a neighbor, who looked after them until the mother came home. A. had pneumonia when he was two and was hospitalized for three weeks. As a child, he was very lonely and spent long hours by himself watching television. He was introverted.
and shy, not very assertive, and gave no trouble to anyone. In the early years, he relied on his brother, who was his “Lord Protector.” A. has read Stoller’s book (3) and insists that her mother “in no way” resembles the mothers of Stoller’s transsexual patients. (See discussion under Family History.)

A.’s mother always had “beaux.” Her longest romance was with D., who was something of a father-surrogate to A. The romance ended when A. was six. A few months later, the mother left the boys with relatives and went to live in another town. She was away for two years. In her absence, between the ages of seven and nine, A. started dressing in women’s clothes. The experience was always accompanied by a sense of warmth and well-being, but was totally nonerotic. When he was ten, his mother discovered his cross-dressing and severely berated him. He did not cross-dress again until several months prior to his surgery. However, he always wanted to be a girl and had fantasies of mothering a girl child. This is a common fantasy among transsexuals, first noted by Money (17). We interpret the fantasy as an attempt to mother oneself through identification with the child.

A. was not in the least effeminate, but was acutely aware of his difference from other boys. There was no one to confide in and he felt profoundly isolated. He had frequent nightmares of being chased by a monster until he was twelve and wet his bed well into his teens. He was always mildly anorexic until he began hormone therapy. At puberty, and for many years thereafter, he made consistent attempts to “be a man,” even though in personality he was nonassertive, overaccommodating, and fearful that any argument would become violent. He went out for football, lifted weights, and became a drag car racer. Manifestly, he was very successful in these endeavors, but inwardly they brought no relief. He used obsessive preoccupation, first with football playing, later with mechanics, to hide his loneliness and depression, both from himself and others. He had many friends with whom he shared activities, but he revealed himself to no one. Nonetheless, many people used him as a confidant, respecting his judgment and his discretion. He bound people to himself by endlessly doing favors, running errands, lending money, fixing appliances, and always being available. After college, he worked for many years, and productively, for an engineering firm.

His sexual life consisted of rare masturbation. Most often, he masturbated without any fantasy; occasionally, he fantasized being a woman having intercourse with an unidentifiable man. He never developed a romantic interest either in men or women. As his friends married, he became friends with the couples. Often, he was the confidant of the wives and ultimately of the children, with whom he felt most at ease. He disapproved of a male friend’s infidelity and identified with his wife. He always saw the desired relationship between the sexes from a woman’s point of view, but his attitudes were somewhat conventional; for example, men always had to open doors for women and light their cigarettes. A. has followed these rules of etiquette both as a man and as a woman. As for homosexuality, A. believes that one should not be judgmental, but she would find it personally abhorrent and unnatural.

In essence, then, with the exception of his asexuality, A. made a good behavioral adaptation as a man. He was even able to maintain platonic dating relationships and was much sought after by women. At the same time, in his inner life, he felt
estranged, lonely, anxious, and depressed. Were there no such thing as sex conversion therapy, A. believes that he would have been able to maintain such a life indefinitely, but it would have remained joyless and empty.

As time went on, however, his depression deepened. His friends became progressively more involved in their family lives, and A. felt relatively excluded. Amidst mounting social pressure to get married, he was totally unable either to desire or initiate sex with a woman. With the years, it became more of a burden to sustain his masculinity, and his interest in mechanics and racing cars waned. He began to suffer an increasing sense of oddness and life seemed less and less worth living. He had heard of Christine Jorgensen some time during college and thought that her account (14) might apply to him. He began to read all the literature on transsexualism and his preoccupation with sex reassignment gradually took on obsessive proportions. He started saving his money and began treatment as previously described. Shortly thereafter, he resigned from the engineering firm, resumed cross-dressing, and began to live and work full time as a woman. Currently, A. is employed as a file clerk, a step downward vocationally, but a price A. is willing to pay.

After adopting the woman's role, A. has experienced some remarkable changes, both in feeling and in behavior. The mild anorexia has disappeared and A. has totally given up cigarettes; previously, she had been a heavy smoker. She reports a greater ease and sense of well-being. She particularly stresses her increased ability to be assertive. She is now able to make demands on others instead of constantly doing favors for them. She no longer lets people take advantage of her but has learned to protect herself. Her propensity for obsessive preoccupation remains, but the content has shifted to the practical realities of being a woman—accumulating money for the operation, shopping for clothes, making new girl friends, learning how to use make-up and so forth. A. has been asked out by men, but she is too embarrassed about her beard and penis to risk it. She feels once these last signs of maleness are gone, she will have no difficulty finding men.

Case 2. B., now twenty-nine years old, has been followed for two years. When first seen, she had been receiving hormone therapy for a year and was undergoing epilation, but she still lived, worked, and dressed as a man. One year ago she underwent sex reassignment surgery and subsequently has lived full time as a woman. B. comes from an unstable family background. Her mother was a "good" woman who provided essential care, but in a distant way. She and B. were never close to each other. She knew nothing of B.'s inner life, nor did she ever show any interest in it. The father, a traveling salesman, was away a great deal. His visits home, however, were not happy occasions. He paid little attention to B. and there were frequent angry confrontations with the mother. He had a "nervous breakdown" when B. was six and has been in a mental hospital ever since. There is a younger brother, now twenty-five, who is married and has children.

As an infant, B. suffered from severe bouts of asthma. He was hospitalized for three weeks at nine months of age, and again for four weeks at fourteen months. The condition then stabilized and he required hospitalization only one more time when he was four years old. According to his mother, there was a real question of
his very survival during the first year and a half of his life. He was obese ever since he could remember and remained markedly overweight until he lost 100 pounds during the first year of hormone treatment between the ages of twenty-six and twenty-seven. He was a lonely child and had no playmates except his brother and his brother’s friends. He engaged in boys’ activities with them, but with a private sense of distaste. He did not make his dislikes known, because he “never wanted to hurt anyone’s feelings.” He was not considered effeminate, but was perceived as “fat and nervous.” He spent most of his time alone, watching television, and thinking of his own thoughts.

He began to cross-dress at the age of four. He first tried his mother’s dress, which he would have preferred, but it was so large, he got lost in it. Snugness was important to him, so for a few years, until he grew bigger, he settled for her underpants. The feeling accompanying the cross-dressing was always one of “warmth,” never erotic. He often stayed home from church on Sundays, so that he could wear his mother’s clothes. He remembers by the age of twelve lying in bed longing to be a girl. He prayed to be discovered by his mother or grandfather, so that they would share his secret and help him with his burden. Eventually, of course, they found him, and he told them the truth, that he preferred to be a girl, but they refused to listen and brushed him off with the comment, “It will pass. Just don’t do it anymore.” A misfit among boys, he prided himself solely on his “breasts,” which were unusually large because he was so fat. He had no sexual outlet other than very occasional masturbation unaccompanied by fantasies.

B. did well in school academically and was a straight A student. In the second year of college, through a newspaper account, he learned of a famous transsexual, a female impersonator. Slowly, he began to believe that this syndrome described his plight. He dropped out of school and confronted his mother, who again denied the problem. He became very depressed, made a serious suicide attempt, and was hospitalized. The psychiatrist was unsympathetic, thought he was psychotic, and treated him with electric shock.

He was released and tried once more to be a man. He gave up cross-dressing, got a good job as a computer operator, and spent all his spare time as a drag car racer. The effort was unsuccessful. No matter how much he occupied himself, he could not suppress the wish to be a woman. One day, when racing, he became aware again of his suicidal impulses, this time the wish to drive the car off the road. Fearful that he would kill himself, he began to save money and secretly made plans for hormone therapy and sex reassignment.

One month before surgery, well-epilated and big-breasted, B. began to dress full time as a woman. Almost immediately, he attracted a bisexual male with whom he had a sexual affair. This was his first sexual encounter with another person in his entire life. The two had intrafemoral intercourse with B. in the female position. He imagined himself to be a woman and thus did not consider the act to be truly homosexual. The ease with which he attracted a man proved to be a harbinger of the future. The change in personality since reassignment has been quite startling. The withdrawn, shy, unattractive, dowdy, acneiform young man has metamorphosized into a forceful, lively, humorous, attractive young woman.

Within two months after the operation, B. has had two proposals of marriage,
the first from an elderly transvestite, which was refused, and the second from a six-
foot, seven-inch construction worker, which was accepted. The pairing of trans-
vestites and operated transsexuals was noted by Guze (18). We know of three
such marriages. We were fortunate in being able to interview both suitors. The
successful suitor was a bisexual who had been previously married and was a father.
He stated that he had always been behaviorally heterosexual except for a single brief
homosexual relationship. He maintained he looked upon B. as a real woman, no
different in his eyes from any other. At the time of this writing, he and B. are
living together and plan to get married as soon as his divorce becomes final. B. de-
scribes sex as pleasurable and claims that she is orgastic.

Family History. From observations of male transsexuals, Stoller (19) has
delineated a family constellation in which he believes transsexualism orig-
inates. He describes a characteristic mother-son interaction within a dis-
turbed marital setting. The crucial factor is an “excessive, blissful physical
and emotional closeness between mother and infant, extended for years and
uninterrupted by other siblings” (19), p. 169). Thus, according to Stoller:
[The mothers] “have given their infant sons a blissful closeness in which all
wishes are granted, especially, unhappily, the wish to remain a part of
mother’s body” (19, p. 167). In his sample, the parents lived in loveless,
essentially sexless marriages, without moves toward separation or divorce.
The mothers were generally unhappy people with underlying depression and
a deep sense of emptiness. The fathers were emotionally detached, passive
and/or feminine, and often physically absent, particularly during the trans-
sexual’s early years.

Our series of ten primary transsexuals do not bear out the crucial factor,
the characteristic mother-son interaction. However, we relied solely on re-
ports from the subjects, without any primary data from the mothers. Even
so, the historical accounts we obtained were so uniform, it is difficult for us
to reconcile them with Stoller’s findings. In no instance did we elicit a his-
tory consonant with a state of “blissful closeness” between mother and child.
When several patients were pressed to comment on the infantile experience
as described by Stoller, each insisted it would have been impossible, since
nothing in the mother’s personality ever indicated any potential for close-
binding behavior, either physical or emotional.

In all ten of our subjects, when they described their mothers, there was
one key feature which never varied: the mothers dutifully provided routine
care, often in the face of harsh realities, but were insensitive to the child’s
emotional needs. This was stated in a variety of ways by different patients,
but the meaning was always the same: “She was oblivious to my depression
and loneliness.” . . . “She was too preoccupied with her own troubles to
know what was happening with me.” . . . “She was strong-willed and stub-
born; she never listened.” . . . “She would always try to help, but so many
things got left unsaid." Essentially, the mother was responsive to the child's needs as she saw them, not as he experienced them. In our sample, therefore, mother and sons were not excessively close, but rather excessively distant. The fathers, however, as viewed by our subjects, were very much like those reported by Stoller.

We have already postulated that early separation anxiety is a necessary precondition in the development of transsexualism. In this connection, it is of interest to note that half of our primary transsexuals, five out of ten, gave a history of physical separation from the mother within the first four years of life. In each instance, the separation was necessitated by the child's hospitalization for illness. Separation anxiety, of course, can be produced by a variety of causes. In our series of primary transsexuals, it seemed to arise from a deficit in the quality of empathic mothering, often in association with a real separation precipitated by the child's illness.

Developmental History and Clinical Course. Several workers (3, 17, 20) have reported that transsexual patients showed an early displeasure in boyish pursuits, particularly those of a rough-and-tumble or competitive nature. Concomitantly, they showed some preference for girl's activities and for girls as playmates. Many were mothers' helpers and derived pleasure from housekeeping. According to these workers, effeminate behavior was common and the patients were often dubbed sissies by their peers. Our findings for primary transsexuals are at some variance with these reports, particularly in regard to effeminacy.

In our series of ten primary transsexuals, nine showed no evidence of effeminacy in childhood. They were identified by their peers, male and female, as boys and were never referred to as sissies. At school, they participated in rough-and-tumble behavior when required, but with an inner sense of abhorrence. As far as we can make out, they did not engage in girl's activities or play with girls any more than did normal boys. Some helped out with housework, but as a necessary chore, not because it was especially pleasurable. Only one in our series of ten was effeminate and dubbed a sissy in his boyhood. He avoided boyish pursuits, preferred girl's activities, and had girls as playmates. This one transsexual, though effeminate in mannerism, was nevertheless emotionally withdrawn and asexual, both characteristic findings in primary transsexualism. We have therefore classified him as such, though actually he would fall on a continuum between primary transsexualism and secondary (homosexual) transsexualism.

All ten of our primary transsexuals were socially withdrawn and spent most of their time after school by themselves at home. They read, watched television, occupied themselves with hobbies, or just sat, stewing in anxiety and depression. In effect, they were childhood loners with few age-mate companions of either sex, an observation also made by Pomeroy (21). As
children, our patients were envious of girls and fantasized being girls, but none actually believed that he was a girl. To summarize, then, in his childhood, the primary transsexual is not effeminate, but he feels either abhorrence or discomfort in boyish activities. This dichotomy creates a feeling of difference and estrangement from other children, both boys and girls. The end result is a chronic sense of isolation, the inner experience of every primary transsexual in our series.

Stoller (3) has described three boys, first seen between the ages of four and five, who in their characteristics resembled adult male transsexuals he had previously studied. They were extremely effeminate, cross-dressed in their mother's clothes, wished to be girls, and insisted when they grew up they would become women. On this basis, Stoller diagnosed them as cases of childhood transsexualism and suggested that they could be future adult transsexuals. All three boys had very emotionally expressive, theatrical personalities, described by Stoller as follows:

It is interesting to note that all three of these boys are considered to be extremely creative by their families, teachers, and other observers. All have a remarkable precocity with regard to painting, dancing, costumes, designing of clothes, acting, hair-dressing, story-telling, and love of music (3, p. 94).

Here again, as before, these findings are at variance with ours. The differences between these three boys and our primary transsexuals are startling. Our patients were neither effeminate nor theatrical; if anything, they were at the opposite end of the personality spectrum. How are we to account for these discrepancies in findings? Why are our observations of mother-son interaction, childhood masculinity, and personality structure exactly the opposite of those reported by Stoller and other workers in this field? We believe the answer lies in their failure to distinguish sufficiently between primary and secondary transsexuals who have different childhood histories and hence different personalities as adults. To us, Stoller's histories sound very much like the histories Bieber and his associates (22) obtained from adolescent homosexuals, including even the cross-dressing. If, in fact, Stoller's three boys grow up to be transsexuals, we predict they will first pass through a homosexual period; that is, they will be secondary (homosexual) transsexuals.

In our sample, as he advances through childhood, the primary transsexual becomes increasingly aware of the difference between himself and other boys. This difference is sharply defined in adolescence, when most boys become sexually aware of girls and homosexual boys become sexually aware of other boys. The primary transsexual, however, does neither; instead, he is essentially asexual and shows little sexual interest in either sex. Most often, he has no sexual experience other than masturbation and even the masturbation is infrequent. Seven of our ten subjects masturbated less frequently than once a month. Masturbation was usually performed in a mechanistic, dissociated
way, either with no fantasy at all, or with a vague heterosexual fantasy in which the patient saw himself as a woman. The fantasies were impersonal, and the partner was usually a stylized man rather than a real person. The pleasure yield was minimal, at times almost to the point of anhedonia.

A major component of this asexuality in all of our primary transsexuals was a specific self-loathing of male physical characteristics. The loathing typically began in late adolescence and was a progressive phenomenon. It encompassed not only the genitalia, but all other aspects of maleness as well, such as fat distribution, musculature, hair distribution, absence of breasts, and so forth. The penis, of course, is the most significant of all the male insignia. The willingness, or rather eagerness, to part with the penis is the sine qua non of primary transsexualism. Secondary transsexuals are also willing, but not quite so eager. (See Part II of this paper [1].)

The male insignia, particularly the penis, block the credibility of womanhood; that is, they give the lie to the psychic fusion with the mother. They also represent a demand for masculine performance, a demand which cannot be met. The self-loathing is focused on the male insignia, thereby preserving a modicum of self-esteem for the fantasized other self, that is, the "female" self. For the same reasons, the primary transsexual indignantly rejects homosexuality; were he to accept it, he would, perforce, acknowledge he was male.

There is a uniform history of childhood cross-dressing in our sample of ten primary transsexuals. All ten began to cross-dress sometime between the ages of three and ten, usually in the mother's clothes. All preferred outer garments, most often a dress, occasionally a slip, sometimes both. A few tried on undergarments, but did not sustain much interest. Undergarments, of course, are more intimate apparel and, as such, more sexual in their connotation. The cross-dressing in all ten was surreptitious. Typically, in early adolescence, the practice evoked shame and was voluntarily abandoned as unmasculine, then resumed openly on a full-time basis after the transsexual resolution. In contrast, cessation of cross-dressing is infrequent in secondary transsexuals, both homosexual and transvestitic.

In the primary transsexual, the memory attached to the first experience of cross-dressing is invariably the same: "I felt very warm, very comfortable." . . . "I had company." . . . "I felt relieved." . . . "I felt wanted." This experience is very different from the transvestite's initial experience, which is often erotic, and if not, later becomes so. The primary transsexual never relates to the clothing fetishistically, nor does texture have the same intrinsic interest for him that it has for the transvestite. In our opinion, the primary transsexual's response to women's clothing reflects solely the alleviation of separation anxiety. We interpret his cross-dressing, therefore, as a symbolic fulfillment of the unconscious wish for symbiotic fusion with the mother.
Primary transsexuals when first seen may be dressed either as men or women. In our sampling, those who presented as men showed none of the characteristics of exaggerated femininity associated with effeminate homosexuality. They were conservative in dress and subdued in manner, the very antithesis of flamboyance, or even style. They claimed to have no interest in male attire and were reluctant to call attention to themselves as men. Those who presented as women gave a much different impression. Not only did they pay more attention to dress, but mannerisms, voice, and posture were more animated. The over-all effect, however, was still on the conservative side, especially in comparison with effeminate homosexual cross-dressers.

In postadolescence, the primary transsexual often makes “one last effort” to be a man in order to resolve the confusion he feels and to overcome his sense of isolation. This effort usually involves an all-out immersion in some activity commonly regarded as distinctly masculine. For example, the patient may join the army or go out for football. Two of our patients devoted years to drag car racing. After the patient enters into the selected activity with monomaniacal zeal in order to crowd out all doubts about his masculinity, along with their associated thoughts and feelings. When this “last effort” fails, as it inevitably does, the patient becomes even more isolated, anxious, and depressed than he originally was. Ashamed, confused, without outlet for intimate conversation, or even confession, he begins a quest for some explanation of his distress. He avidly reads the psychologic and sexual literature, searching for clues to define his real nature to himself. Eventually, he stumbles upon an account of transsexualism, usually an account of Christine Jorgensen (14).

Although there is a history of gender discomfort, the fantasies of childhood and adolescence are cast in the form of a wish, not in the form of a conviction; for example, “I would like to be a girl,” not “I am a girl.” The conviction, “I am a female soul,” usually crystallizes out rather abruptly in late adolescence or early adulthood when the patient learns of the existence of transsexualism. Patients commonly speak of their great confusion as to what they were—heterosexual, homosexual, transvestite—until they learned of transsexualism. This revelation, with its attendant explanation, offers relief, first of all, by giving the patient an identity. Thus, one patient, referred by the Erickson Educational Foundation, stated his reason for contacting us, “I want to be a transsexual.”

Secondly, the literature on transsexualism offers a medical vehicle for a fantasy—the wish to be a woman—to be converted into a reality. It is at this point that the wish hardens into the conviction that the patient is indeed a woman trapped in a man’s body. Many physicians, upon hearing that the patient believes he is a woman, automatically assume that the patient is psychotic. However, since the patient is presented with medical evidence
that the condition does in fact exist, his subsequent belief that he is a woman does not fulfill the criteria for classification as a delusion. In point of fact, the vast majority of transsexuals are not psychotic.

**Personality Inventory.** The description which follows applies to patients prior to conversion therapy. We found very little variation in the personalities of our primary transsexuals. To know one was almost literally to know all. We have already commented extensively on their ambiguous core gender identity and on their relative asexuality. Another feature was their uniformly low aptitude for psychologic insight. We found it difficult to elicit dreams, and in those reported associations were meager and accompanied by considerable denial. Fantasies were more available, mostly stereotypic female fantasies lacking in both imagination and color. Except in masturbation, they were usually asexual and focused mainly on the romantic aspects of male-female relationships.

Depression, most often experienced as loneliness, was another characteristic feature. The depression was not guilty, self-accusatory, or angry, but was essentially an empty depression. The patients described their lives—as men—historically and in the present as sad, lonely, empty, and colorless. Suicidal ideation and suicide attempts were frequent. Six of the ten men admitted suicidal preoccupation, and two of these six made actual suicide attempts. The depression could perhaps be attributed mainly to failure in the masculine role with subsequent anxiety and loss of self-esteem. Our clinical impression, however, is that these patients are describing an ongoing depressive core, intensified by current stress but not caused by it. In their histories, there are frequent occurrences of thumbsucking, enuresis, and eating disorders, either anorexia or overweight. We believe these childhood symptoms, as well as the depression, are related to early separation anxiety.

There is a schizoid quality to the primary transsexual's personality. As previously described, childhood is characterized by isolate behavior. Nonetheless, by adolescence or adulthood, some of these patients acquire the knack for friendly, but not intimate asexual relationships with both men and women. A great deal of time is spent together, but feelings ordinarily are not alluded to. The patient is ingratiating and makes himself indispensable in a variety of ways; however, his friends are totally unaware of the transsexual problem or of his mental agony. These friendships, as experienced by the patient, have a symbiotic coloring but typically he withholds a full commitment, as though anticipating a possible rejection.

As a group, we found the primary transsexuals to be extremely gentle and self-effacing people. Assertiveness was seriously crippled, though it survived enough in the work area to allow adequate, and on occasion, even outstanding performance. Energy and creativity, if present, were expressed in solitary pursuits and hobbies, often with obsessive thoroughness. These patients were always pliant and agreeable in their relationships with others unless thwarted.
in their demands for sex reassignment. Under such circumstances, they became stubborn, strong-willed, and intractable. Otherwise, they were generally incapable of manifest anger.

Mental life, before and after surgery, is characterized by obsessive preoccupation with gender-related items. The obsessive form remains throughout; only the content changes. Thus, in childhood, the primary transsexual is obsessed with being a girl. In adolescence, he is obsessed with “one last effort” to be a man. In adulthood, before surgery, he is obsessed with sex conversion. His waking hours are filled with plans to get enough money for the operation and with learning how to be a woman. After surgery, he is first obsessed with the anatomical results, then centers on how to be more feminine both in appearance and in behavior.

The endless striving for perfection in the feminine role may lead to further surgery, usually facial plastic procedures or breast augmentation. In fact, one might say that preoccupation with making “one last effort” as a man gives way to preoccupation with fitting into the feminine norm. It is our impression that gender ease is never fully established. However, we have not seen subjects five or ten years postconversion, so that it remains theoretically possible that obsessive preoccupation with gender eventually recedes.

In sum, then, primary transsexuals are schizoid-obsessive, socially withdrawn, asexual, unassertive, and out of touch with anger. Underlying this personality, they have a typical borderline syndrome characterized by separation anxiety, empty depression, sense of void, oral dependency, defective self-identity, and impaired object-relations with absence of trust and fear of intimacy (23–25). In our opinion, they most resemble a subgroup of the borderline syndrome which Grinker calls “the adaptive, affectless, defended, ‘as if’ persons” (24, p. 87). Unlike other borderline patients, however, primary transsexuals are distinguished by severe impairment of both core gender identity and of gender role identity from earliest childhood.

In this part of the paper, we have delineated the syndrome of primary transsexualism. In the second part, we will take up secondary transsexualism and describe the distinguishing characteristics of homosexual transsexualism and transvestitic transsexualism. We will differentiate one from the other, and both from primary transsexualism. We will then discuss the etiology of transsexualism and conclude with recommendations for treatment based on our theoretical and clinical observations.

REFERENCES