The Transsexual Syndrome in Males

II. SECONDARY TRANSSEXUALISM*

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Secondary transsexualism is defined as transsexualism developing in homosexuals and transvestites regressively under conditions of stress. Secondary transsexuals, homosexual and transvestitic, are differentiated, each from the other, and both from primary transsexuals, who are essentially asexual. The etiology of transsexualism is discussed and guidelines for treatment are proposed.

We have defined transsexualism as the wish in biologically normal persons for hormonal and surgical sex reassignment (1, 2). In our opinion, this wish originates from unresolved separation anxiety during the separation-individuation phase of infantile development. To counter the separation anxiety, the child resorts to a reparative fantasy of symbiotic fusion with the mother. The separation anxiety is never completely allayed, but continues into adulthood. The final transsexual resolution is an attempt to get rid of this anxiety through sex reassignment; that is, the transsexual acts out his unconscious fantasy surgically and symbolically becomes his own mother.

Clinically, transsexuals can be divided into two groups, primary and secondary. Primary transsexuals are essentially asexual and progress toward a transsexual resolution without significant deviation either heterosexually or homosexually. In them, the transsexual impulse is insistent and progressive and usually they cannot rest until they reach their objective. Secondary transsexuals are effeminate homosexuals and transvestites who gravitate toward transsexualism only after sustained periods of active homosexuality or transvestism. In them, the transsexual impulse may be either a transient symptom, or it may harden into a full-blown transsexual syndrome.

In Part I of this paper (2), we delineated the syndrome of primary transsexualism through a study of ten patients, all applicants for sex reassignment. In Part II, we will take up secondary transsexualism and describe the distinguishing characteristics of homosexual transsexualism and

* This is Part II of a two-part paper.
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transvestitic transsexualism. Our study again is based on ten applicants for sex reassignment, five homosexual transsexuals and five transvestitic transsexuals. Our discussion, however, will draw on our much wider clinical experience with effeminate homosexuals and transvestites, many of whom have transsexual impulses, but do not seek sex reassignment. In conclusion, we will briefly discuss the etiology of transsexualism and make recommendations for treatment based on our theoretical and clinical observations.

In order to differentiate primary from secondary transsexualism, it is essential first to review the psychodynamic interrelationships between primary transsexualism, effeminate homosexuality, and transvestism (1, 2). It is our belief that all three disorders, not just primary transsexualism, originate in unresolved separation anxiety during the separation-individuation phase of infantile development. In point of time, they originate on a developmental gradient, primary transsexualism first, effeminate homosexuality and transvestism later. The symptomatic distortions of gender and sex reflect different ways of handling separation anxiety at progressive levels of maturation.

Thus, primary transsexuals resort to symbiotic fusion to allay separation anxiety, whereas effeminate homosexuals and transvestites resort to part-objects and transitional objects. In the effeminate homosexual, the boy fears engulfment and annihilation by the mother. He, therefore, transfers his dependency and sexual needs to a male object. His partner's penis is equated with the mother's breast and incorporated orally or anally as a part-object. 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 incestual anxiety.

In most effeminate homosexuals and transvestites, these defenses function reasonably well. They contain the separation anxiety and permit the patient a semblance of emotional balance. In some, however, at times of stress, the defenses may fail and precipitate an acute dependency crisis. Under such circumstances, the patient may regressively fall back on the more primitive fantasy of symbiotic fusion with the mother. It is at this point that he begins to experience transsexual impulses. We will discuss later the life situations in effeminate homosexuals and transvestites most likely to evoke such regressions, as well as the factors that determine their clinical course.

HOMOSEXUAL TRANSSEXUALISM

The vast majority of male homosexuals lack the propensity for a transsexual regression. The propensity† exists almost entirely in cross-dressing

† Rarely, a cross-dressing, noneffeminate homosexual will apply for sex reassignment. These patients fall on a gradient between primary transsexualism and homosexual transsexualism.
effeminate homosexuals who comprise a very small segment of the homosexual population. They fall into two subgroups: passive effeminate homosexuals and the more aggressive, though equally effeminate, drag queens. These two subgroups have similarities, as well as differences, in their personalities and psychodynamics. In the two clinical examples which follow, we will describe a typical patient in each subgroup, first a passive effeminate homosexual, then a drag queen.

Case 1. C. is a fat, effeminate thirty-two-year-old man who lives with his parents. He is compliant, nonassertive, and unable to mobilize much anger. Nevertheless, despite these inhibitions, he is engaging, affectively responsive, and easy to talk to. His adaptive competence is of a very low order. Although extremely bright and articulate, he failed to complete high school, dropping out in his senior year. He has worked only a total of two years in his entire life. His mother has always slipped him money, while both pretend to the father that he is working. There is one sister, now twenty-five, who is married. C. has been an exclusive homosexual as far back as he can remember. He now wants sex reassignment so that he can marry his current lover and live with him as his wife.

C. and his mother are bound together in a mutually interdependent relationship, each unable to let go of the other. As we would expect, he is markedly ambivalent about her. A sampling of his comments, culled from the interviews, follows: “I once loved my mother passionately, but I went through a period hating her. She destroyed my life. . . . She was always very physical and smothered me with kisses. We used to see each other naked all the time. . . . She’s either totally giving or totally selfish. She never ate until my sister and I had enough. . . . I have never been able to move away for fear of hurting her.”

The mother and father have never gotten along. The father makes good money but gambles it away, so money has always been a problem. According to C., the father was ungiving and a tyrant at home, but generous to everyone else. The mother has always manipulated the father by lying to him, and, C. suspects, by withholding sex. He doubts they have had any sex life for many years. After C. was born, the father began gradually to absent himself from the family and by the time C. reached adolescence, the father was seldom present. C. does not know for certain whether this was volitional withdrawal or whether he was pushed out by the mother, but the arrangement seemed perfectly acceptable to both.

We interviewed C.’s mother, who confirmed the familial history. She rationalized her life-long intrusiveness into her son’s life by predating it on his physical frailty, a total fiction. She had always known of C.’s homosexuality and fully accepted it, but she refused to acknowledge his wish for a sex change. We found her psychologic aptitude nonexistent. She was almost impossible to interview because of her incessant hysterical pleas that we help her boy and save him from the surgeons. As she saw it, his sole problem was his inability to work. It was clear to us that her underlying motivation was to keep C. at home with her.

C. was an effeminate child who played with girls and pursued girlish interests. He cross-dressed regularly with parental approval from early childhood until the
The cross-dressing was theatrical and used to enhance C.'s fantasies of being a girl. It was never erotic, as in the transvestite, nor did it provide a feeling of comfort, as in the primary transsexual. His parents thought it so amusing that they often asked him to entertain. Once, when he was seven, they took him to relatives for Easter dinner dressed as a girl.

C. began a very active and pleasurable sex life when he was twelve. He engaged in various homosexual activities with peers, older boys, and adults. His sexual preference is passive anal intercourse, although he will reluctantly engage in other sexual transactions in order to please a partner. In such circumstances, he is capable of assuming the active role, but he does not enjoy it. His sexual relationships have been mostly transient contacts with partners picked up while cruising. Prior to his present involvement, he had only one long-term affair. This occurred ten years ago and lasted for one year. C. was so upset when the affair ended that he became suicidal and had to be hospitalized.

After his release, for about six months, he hung around with a drag crowd. Initially, he felt secure in the group, liked the feeling of fooling people, and dreamed of "high drag." This was obviously an adaptive maneuver to compensate for the loss of his lover, but it failed because he had neither the physical attributes nor the money to be a successful drag queen. He received no narcissistic reinforcement as a woman, since he lacked beauty; nor did masculine homosexuals, whom he was really after, pay much attention to him since most of them wanted other men, not drag queens. Thoroughly discouraged, he gave up drag and returned to his existence as before, with its characteristic cruising.

For a time, in search of a new lover, he became extremely promiscuous. Gradually, as the years passed, he became disenchanted with gay life. He was not meeting the right people, he was getting the wrong responses, and he was picking up repeats. He began to gain weight, and although only five feet, eight inches tall, he now weighs over 200 pounds. His sex life diminished markedly and his infrequent attempts were marred by erectile failures. In the interviews, he lamented his plight: "I feel inadequate as a homosexual. I can't do the bathroom thing anymore. If someone is hypermasculine, I tremble with fear; if swish I don't like it. I have gotten too fat and I'm losing my hair."

Whenever pressure mounted, he wheedled money from his mother and traveled. Last year he went to Spain and met a presumed heterosexual with whom he lived. He engaged in face-to-face intrafemoral intercourse with this lover and fantasized himself as a woman. For the first time in his life he began to think seriously of sex reassignment: "I've known about transsexualism since Jorgensen. I could relate to this guy in Spain better if I were female. He wants me to stay in the house and play the whole thing, be subservient." He believes he is willing to forego sexual pleasure in order to live as a woman with this man. He is still hesitant, however, because he is skeptical that the lover will, in fact, marry him. At the same time, he is loath to give up life with his mother, since she so completely caters both to his dependency needs and to his passivity.

Case 2. D. is a very attractive twenty-two-year-old drag queen. He is a fashion
designer on New York's Seventh Avenue where he works dressed as a man, but he frequently hustles as a woman, presumably to make money to support art school. He belongs to the gay liberation movement and devotes considerable time to homosexual causes. Away from work, he is a member of a network of drag queens, all of whom, like D., are active hustlers. He has been taking hormones for two years in order to enhance his impersonations of a woman, but he has never before sought sex reassignment. Now, however, in the wake of an abortive love affair, he is pursuing a transsexual resolution.

D. lives with his parents, a brother one year younger, and a sister three years younger, in a lower middle class ethnic neighborhood. The father is a foreman in a factory. He has a reputation as a street fighter and, according to D., has always been "extraordinarily violent" both in and out of the home. D. and his brother were frequently beaten, though the brother, who was more defiant, bore the brunt of it. The sister, for the most part, was spared. The father has not hit D. in some while, and is described as mellowed, but D. is still terrified of him. He openly states he hates his father and would like to see him dead, though he concedes his father "adores" him.

In early childhood, before the age of four, D. had repeated bouts of bronchopneumonia. On several occasions, he required hospitalization. His mother has told him that more than once she believed it was "curtains" for him. D. describes his mother as very devoted but not overtly affectionate. She did not shower the children with kisses, but neither was she cold. D. likes his mother but he is not especially close to her. The mother and both siblings know of D.'s homosexuality and seemingly accept it. They do not know, however, that he is a drag queen and a hustler. The father is totally ignorant of D.'s private life.

As a child, D. was fat, and he remained fat until he started taking hormones two years ago. Since then he has lost 40 pounds. He was always effeminate and preferred playing with girls. Although outwardly lively and gregarious, inwardly he felt lonely and spent hours by himself reading avidly. He became consciously aware of his homosexuality at the age of thirteen when he was in the library reading Krafft-Ebing. In adolescence, he switched his major interest from books to movies and became a self-designated "movie freak." His fantasy life is extremely rich and draws on books and the screen for heroines with whom he identifies.

He began cross-dressing secretly at home in his own room when he was a child. He was never discovered and to this day no one in the family knows about it. Here again, as in the case of C., our first example, the cross-dressing was not erotic and was not used directly to relieve anxiety; rather, it was the stimulus for fantasies of D. himself in theatrical female roles. He became progressively involved in full drag and the queen circuit, beginning when he was eighteen. He gave up dressing in private at that time and now dresses only to go into public to be seen as a woman.

D. "came out" when he was sixteen under the auspices of an older homosexual with whom he fell in love. He was initially both active and passive in anal intercourse but soon came to prefer the passive role. His interest in sexuality diminished as his interest in drag increased. According to D., the diminution antedated
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His use of hormones, but since he has taken medication, his sexual drive has all but disappeared. He rarely gets aroused and has no interest in orgasm; in fact, he states he has not had an ejaculation for two years. Occasionally, he has passive anal intercourse with a homosexual partner, not for sexual satisfaction but to feel the penetration, which gives him a sense of security. At present, however, his sexual activity consists primarily of performing fellatio in parked cars on the heterosexual men he hustles. He claims these "tricks" believe him to be a woman and praise him highly for his services. Sexually, he feels nothing. He gets his "kicks" from fooling the men and through their attention. And, of course, he likes the money.

D. desires a "love relationship" with a "real" man. He has an underlying chronic depression and believes that only through such a relationship would he find relief. In reality, however, he has been in love three times, always with homosexuals. Each affair terminated in what D. construed as a rejection. Each time he became acutely depressed and felt suicidal, though he never actually made a suicide attempt. He suspects that he may have been instrumental in maneuvering all three rejections.

He has two fantasized modes of combating his depression. In the first fantasy, he identifies with Marilyn Monroe who killed herself with sleeping pills. He glorifies her "vulnerability" and argues that the completely beautiful life is tragic. In this frame of mind, he courts rejection and romanticizes his suicidal ideation. In the second fantasy, he identifies with the Dowager Empress of China, a woman of immense power, who is said to have forced visitors to perform cunnilingus in token of their submission. He then concentrates on gay political activism or, alternately, on concocting lavish costumes for the competitions at drag queen balls. His personality shows alternating evidence of the double identification; thus, he may appear either as passive and ingratiating or haughty and somewhat paranoid. In spite of his "vulnerability," he is quite aggressive, usually with words, but at least on one occasion with a knife. Whether vulnerable or aggressive, however, he is always emotionally labile, expressive, and theatrical.

His current depression and concomitant wish for sex reassignment stem from two failures as a homosexual. D. was involved for three months in making a dress for a ball. He lost the competition and felt extremely disappointed. Shortly thereafter, he fell in love with an apparently hypermasculine homosexual. During their first sexual encounter, it emerged that his lover not only preferred the passive role in anal intercourse but was horrified that D. had breasts. After this experience, D. concluded that a homosexual adaptation was impossible for a queen and that his best hope for securing a "real" man lay in undergoing sex conversion. Whether or not this wish will persist, only time will tell.

Family History. There are three typical family constellations retrospectively reported by homosexual transsexuals. The same three, of course, are reported by effeminate homosexuals from whom homosexual transsexuals derive. The father is either passive or hostile, and in most instances, though not in all, emotionally absent. The distinguishing parameter is the quality...
of the mothering. The mother may be (1) symbiotic, (2) intrusive, or (3) hostile. These are predominant patterns, but they are not exclusive; that is, they can exist in variable combinations, or in some instances, as in the case of D., the mother may not easily fit into any of the three categories.

The symbiotic mother has been described by Masterson as the typical mother of the borderline patient (3). Although Masterson is not dealing with either effeminate homosexuals or transsexuals, his description of such a mother corresponds exactly to one pattern of mothering which emerged in our studies. The mother, herself, is borderline. As a child, she, too, experienced abandonment depression and an inability to separate. In her role as mother, she relives her infantile experience and attempts to cling to the child to fill her emptiness. Clinging behavior is the hallmark quality of this type of mother, and, unconsciously, such a mother may regard the child either as her own mother or as herself.

Stoller has described a similar mother-son interaction in the three effeminate boys whom he diagnosed as possible childhood transsexuals (4).§ The mothers were empty, depressed women who held their infant sons in close physical and emotional contact throughout infancy and for several years thereafter. In Stoller’s opinion, transsexualism derives specifically from this mother-son interaction through some nonconflictual process akin to imprinting. We differ with Stoller on two counts. First, we do not believe this interaction is the major etiologic factor in transsexualism; we see it, rather, as one type of mother-son interaction which predisposes to separation anxiety in one subgroup of homosexual transsexuals. Second, we do not agree with Stoller that the outcome of such an interaction is nonconflictual; we believe it is conflictual and hence we reject the imprint hypothesis.

The intrusive mother is described in our first case. This is the configuration reported by Bieber in his study of male homosexuality (5). Such a mother is overpowering and invasive, causing the son to fear engulfment and annihilation. This mother is more differentiated than the symbiotic mother. She does not wish to preserve a mother-son symbiosis in which the two roles are diffused; rather, she aims to make the son dependent. Her motivation is various; it may represent a phobic anxiety for the son’s survival or the intrusion may be motivated by a special need to derogate maleness. The hostile mother is physically and emotionally abrasive. In this pattern, the son makes a hostile identification with his mother in order to preserve his security needs, but his personality is invariably more paranoid than in the two previous instances.

Developmental History and Clinical Course. Homosexual transsexuals are effeminate at all times, from early childhood into adulthood. As chil-

§ See also our discussion of these three boys in Part I of this paper (2).
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...children, they generally prefer girls as playmates, avoid boyish pursuits, and serve as mother's helpers. All fantasize about being girls, especially while cross-dressing, but core gender identity is essentially male. Ambiguity, when present, is far less pronounced than in primary transsexuals. Despite the early effeminacy, no adult homosexual transsexual has ever reported to us that as a child he actually believed he was a girl or that he would grow up to be a woman. Even postoperatively, we have never seen a homosexual transsexual who believed in his femaleness to the same extent as the primary transsexuals.

Cross-dressing begins in childhood, usually well before puberty. It is occasionally reported to cause relaxation, but more typically the clothes are used for narcissistic gratification. Later, after puberty, they are also used to attract male sexual partners. The theatrical potential of impersonation is realized early. Interest in make-up is precocious compared with other transsexual patients. Cross-gender fantasies are frequently tied to identifications with movie actresses, particularly in drag queens. The homosexual cross-dresser wants to be noticed. To this end, he wears colorful, flamboyant clothing, often to the point of caricature, especially at drag queen balls.

The initial self-identification, often made in preadolescence, is homosexual, not transsexual. Sexuality, at first, is usually strong, and may even range to hyperactivity. With time, however, in many cases, sexuality is gradually attenuated as security needs take precedence over sexual needs. Most subjects prefer the passive role in anal intercourse, but this is not an obligatory preference. Some report that sexual aim may take second place to effecting a sexual transaction with a desired partner. Under such circumstances, on request, they are quite capable of assuming the active role. A few effeminate homosexuals, particularly former drag queens, may even have a preference for it.

The transsexual impulse in effeminate homosexuals appears at times of disruption of the homosexual adaptation. In general, homosexuals suffer greatly from castration anxiety and under ordinary circumstances have no wish to part with their penises. Indeed, the homosexual adaptation allays castration anxiety, preserves maleness, and provides dependent gratification. Transsexual impulses develop only under conditions of stress when the homosexual adaptation fails. At such times, effeminate homosexuals regressively consider sacrificing their penises to the overriding need for dependent security. The most common stress is rejection by a lover. The transsexual wish may also arise as a desperate effort to please, and thus hold onto, a current lover. In drag queens, and to a lesser extent in passive effeminate homosexuals, the stress may be a narcissistic blow, such as aging or the loss of a beauty contest at a drag queen ball.

Personality Inventory. Homosexual transsexuals vary in personality...
along a gradient with passive hysterical personalities at one end and hyper-aggressive narcissistic personalities at the other end. These poles describe the typical personality styles of the cross-dressing passive effeminate homosexuals and the drag queens, respectively. Both groups are labile and theatrical, the latter more so than the former. Some subjects present an intermediate clinical picture and any one subject may move back and forth on the gradient. Nevertheless, it is of some clinical usefulness to describe the polar extremes, since personality may be closely related to therapeutic outcome.

Passive effeminate homosexuals in many ways present a caricature of typical feminine norms. They are interested in such things as cooking and decorating, but most of all, they seek a love relationship with another man where they can assume the female role. They may perform well vocationally but the major thrust of their interests is in "love." On the surface, they are passive and dependent, but they often dominate their mates through oversolicitousness. In this respect, they tend to duplicate the close-binding behavior frequently ascribed to their mothers. Often a relationship is terminated because the lover feels suffocated. Despite their covert tendency to dominate, the members of this group perceive themselves as ultimately dependent on the magical resources of the love object.

Drag queens are usually involved in a community of other queens. They treat each other as "sisters" and sexual relations within the group are rare. The major thrust of their lives is split in two: most alternate between narcissistic pursuits and "love" interests. The narcissism is institutionalized in an endless series of drag balls and parties. For each event, the queen immerses himself in preoccupation with costumes, hair styles, and make-up. Love interests are complex and often contradictory. The queen claims he wants involvement with a hypermasculine man who will overpower him. Once involved, however, he may attempt to overpower his lover, particularly in bed, where he frequently prefers to be the active partner in anal intercourse. In addition, many queens hustle for a living. This practice affords them both narcissistic gratification and the expression of contempt for the men they fool. These queens are quick to violence, both verbal and physical. They may be on hard drugs and often live on the fringes of crime. Unlike the passive effeminate homosexuals, the members of this group have a distinct paranoid and grandiose coloring. In them, the wish for sex reassignment may go beyond any wish to be female, per se. They may seek conversion primarily to enhance their standing as female impersonators or prostitutes.

TRANSVESTITIC TRANSSEXUALISM

Case 3. E. is a fifty-six-year-old married transvestite. His appearance and demeanor, except when cross-dressed, is always appropriately masculine. He and
his wife have two grown sons, twenty-two and and twenty-six, who no longer live at home. E. is very verbal, intellectual, tightly controlled, and emotionally distant. He is not capable of intimacy, either with his wife and sons, or with anyone else. He is ambitious and competitive but masks his aggression behind a gentle façade. He views himself as a "helpful type" but is proud of his ability to "kick asses" when necessary. He is a highly skilled industrial designer and, until recently, was always extremely successful. He started taking hormones six months ago following a professional failure and is now contemplating sex reassignment.

E. is the oldest of three siblings. He has a sister one year younger and a brother three years younger. The parents had a tempestuous marriage and separated many times during E.'s early childhood. They ultimately divorced when E. was five. The first separation occurred before E. was one, when his mother was still pregnant with his sister. During each separation, he stayed with the maternal grandparents while his sister and brother remained with the mother. The grandparents' household consisted of the grandfather, the grandmoother, a young aunt of about twenty, and two older uncles, who soon departed. Sometimes E. stayed with the grandparents even when his mother, father, sister, and brother all lived together. He does not know for certain why this occurred, but believes his grandmother and aunt wanted him because he was such a "cute little kid." After the divorce, he lived with his grandparents as before, while his siblings were farmed out to other relatives. The mother lived her own life, saw the children irregularly and then only for brief periods. When E. was fourteen, she remarried and all three children moved in with her and the stepfather where they remained until adulthood.

E. has no memory whatsoever of his father. His mother was a vivacious and friendly woman, who "liked" men. It was reputed that she had numerous lovers between her two marriages. She was never unkind to E. and he feels she loved him. With each separation, however, he feared he might never see her again and was repeatedly overwhelmed with sadness. In the grandparents' home, the significant figures were the grandmother and the young aunt. The grandfather, for the most part, ignored him. The grandmother was loving and permissive, while his aunt's ministrations were tender and at times seductive. Thus, as a young child, he recalls, "she treated me like a doll." She fondled him, combed his hair into curls, and rubbed him down with oil. He remembers an early attachment to her mohair blanket, but he denies she ever cross-dressed him.

As he grew older, neither the grandmother or the aunt spent much time with him. In addition, they were permissive to a fault. They let him go his own way and do whatever he wanted. He could disappear and stay with friends for several days and no one questioned his whereabouts. He presents the premature independence as a positive experience, but the fact is that he felt lonely and abandoned throughout his childhood. He believes, by and large, that he raised himself. He enjoyed boyish pursuits, participated actively in sports, and was a dedicated woodsman. He was never effeminate and did not play with girls. He was always a good student and after graduation from college achieved early monetary success in his chosen profession.

E. began to cross-dress at six in his aunt's clothes. He wore her skirt and
blouse, which he still remembers in vivid detail. The cross-dressing was always in secret and never discovered. It was initially nonerotic and produced a state of relaxation—"like alcohol." The clothing was erotized in adolescence when he began to have spontaneous ejaculations while dressed. Sometimes he ejaculated without an erection, an orgasm which he felt to be "female." Occasionally he masturbated, but usually he achieved climax without it. In his middle teens, he had sexual intercourse for the first time with an older female neighbor. They had a brief relationship and he was fully potent. After the affair ended, he had no further sexual contacts until he married his wife when he was twenty-four.

The wife is described as a good, honest, religious woman with a bland personality. She is maternally warm, but not excessively so. E. feels she has always been very good to him. He told her about his cross-dressing when they married and it was acceptable to her as long as she did not have to participate. E. never inflicted it on her and continued periodically to cross-dress at home in private. He still used only outer garments, either a dress or a skirt and blouse. He always responded fetishistically to the total ensemble, rather than to any specific article of clothing.

After the birth of his second child, the impulse to dress became more pressing. Not only did he dress more frequently, but now he began to dress more fully, adding shoes, hose, and undergarments. He bought himself a wig and began to use make-up. He began also to wear ladies' underpants when dressed as a man. The wife became alarmed because of the children and asked that he transfer his activities to his office, where he could insure privacy. E. thought this was a good idea and readily acquiesced. When he was thirty-six, he chanced upon a magazine for transvestites and for the first time learned there were many men like himself. He promptly joined the network and became an active member of a transvestitic social club.

Concomitantly, as the cross-dressing escalated, sex with his wife began to diminish. For the past ten years, it has been virtually nonexistent. His wife was sexually reticent anyhow and has never protested. Since then, however, he has had several brief affairs, but none of the women knew he was a transvestite. He has also met several times with a fellow transvestite to perform mutual fellatio while both were dressed as women. The meaning of this behavior is not clear. E. does not regard it as homosexual since he identifies himself as a woman and his partner as a man. To bolster this view, he makes the point that he has never been approached by a homosexual, nor has he ever sought one out. E. also fantasized that after sex conversion he would have a "lesbian" relationship with his wife. It would seem, therefore, that the mutual fellatio, though anatomically a homosexual act between two men, psychologically may represent either a heterosexual act in which he is the woman, or a homosexual act between two women, or both. It is also possible, of course, that the act is truly homosexual, but masked by the defense of denial. Such confusion about gender identity and the blurring of sexual roles is characteristic of transvestitic behavior in general.

E. has always had an increasing urge to dress under stress. Two years ago, during a business recession, he lost his job. He responded with depression, bouts of
drinking, and preoccupation with sex reassignment. This had occurred fleetingly to him before, but never as a real possibility. He eventually got a new job, but had to settle for a lesser position and a lower salary. He remained despondent and felt he had “passed his peak.” One year ago, in a supportive attempt, his wife suggested an emotional reconciliation, including sex. They went on a trip together, but he was totally unable to respond sexually. Shortly after their return, he began to take hormones. He no longer regards himself as a transvestite, but as a “part-time” transsexual. He claims he may undergo sex conversion, but he is held back by the fear of losing his wife. He fantasizes that afterwards they might live together as friendly roommates, but in reality he is convinced she would abandon him.

Family History. Transvestitic transsexuals have the same family background as the transvestites from whom they originate. The mother, as remembered, is usually warm and affectionate; less often, dominating and overbearing. In both instances, however, maternal care appears erratic, due either to ineptness or to misfortunes which overwhelm the mother. In consequence, the child is not consistently deprived but rather, maternal gratification is repeatedly interrupted. In our opinion, this is the most prominent feature of the mother-son relationship in transvestism. In contrast, Stoller states that the most prominent feature is the mother’s need to feminize her little boy (4, 6). According to Stoller, this need is expressed primarily through cross-dressing the boy as a girl. Stoller concludes that the transvestite is partly the creation of his mother’s unconscious wish and not just the product of his own defenses.

Our clinical experience has been different from Stoller’s. In an unselected sample of 16 consecutive transvestitic patients, we elicited only two histories of maternal induction into cross-dressing, one punitive and one nonpunitive. In the predominant pattern, the child spontaneously cross-dressed, the activity most often remained surreptitious, and it was not reinforced by the mother or a mother-surrogate. We believe the underlying problem in transvestism is separation anxiety, not feminization by the mother. This anxiety is engendered in a variety of childhood situations and the transvestitic defense is usually the patient’s own invention. It is intimately related to the process of self-object differentiation, and only sometimes “primed” by explicit parental directives, but not created by them.

Another striking feature in the family histories is the high incidence of fathers perceived either as verbally abusive or physically violent. We do not know whether this is an accurate appraisal of the family situation as it occurred, or whether it is a misperception born out of an increased vulnerability in the oedipal period. In the minority of cases, the father was either absent altogether or perceived as aloof and self-contained. Psychodynamically, transvestism appears to us as more complicated than either primary transsexualism or effeminate homosexuality. This complexity is mirrored
in the difficulty of defining predominant family dynamics. In summary, we believe there are several predominant trends, some of which we have described, but that the transvestitic defense may develop in a variety of family settings.

**Developmental History and Clinical Course.** In their early history, transvestitic transsexuals are indistinguishable from transvestites. They are never effeminate in boyhood, but are appropriately masculine or even hyper-aggressive and hypercompetitive. They engage in boyish pursuits and neither play with girls nor become mother's helpers. They fantasize about being girls, particularly when cross-dressed, but invariably value their assertiveness and maleness. In this respect, they are unlike primary and homosexual transsexuals. Hence, their core gender identity is more firmly male and the least prone to ambiguity.

Cross-dressing begins in childhood or early adolescence in one of two ways. It can start nonsexually to promote a sense of well-being, then secondarily be sexualized; or it can be sexual from the beginning, though accompanied by the same sense of well-being as before. Once fetishism is established, ejaculation occurs spontaneously or is induced by masturbation. Cross-dressing at first is intermittent, but in most transvestitic transsexuals, as compared with transvestites, it is escalatory, progressive, and eventually becomes continuous. The clothing is often dated and out of style, more like the clothes "mother" used to wear. Transvestites, in general, have more difficulty mimicking feminine behavior than either primary transsexuals or effeminate homosexuals.

Transvestites are invariably preferential heterosexuals, although sometimes there is a history of occasional homosexual encounters. Frequently, they express a preference for the subordinate role in sexual intercourse, that is, with the woman on top. Fetishistic arousal can be intense, but interpersonal sexuality is almost always attenuated. It is unusual for a transvestite to report sexual experiences with more than three women, and often the experiences are limited to one or two.

Self-identification is more complicated than in the homosexual transsexual. Some of these patients regard themselves as "split personalities" and claim that their preferences, interests, and personalities are different depending on how they are dressed. They often express the feeling that the female personality is "fighting" with the male personality and crowding it out. Still other patients regard the personality as continuous and more integrated. They initially view cross-dressing, therefore, as the expression of a female part of their personality, which is predominantly male. In both situations, these patients frequently express the belief that they are somehow "richer" than people restricted to an expression of one gender role only.

|| See, for example, the autobiography of Einar Wegener (7).
The transsexual wish in transvestites arises at times of intense stress. In this group, the stress consists of threats to both masculinity and dependent security: for example, vocational failure, competitive defeat, broken marriage, death of the mother, or the birth of a child. In a very few, the process of falling in love and living with a woman evokes immense jealousy of that woman. In such instances, the longing for the loved woman's clothes becomes almost intolerable. In these cases, there is a confusion between loving and becoming, a mechanism described by Greenson in his treatment of a cross-dressing effeminate boy (8).

*Personality Inventory.* Transvestitic transsexuals have the typical personality structure of their parent group, the transvestites. The personality is organized on an obsessive-paranoid axis with attenuation of both tender affectivity and sexuality. These patients are hypercompetitive, may be hypermasculine, and engage in endless struggles for power with other men. For this reason, transvestites preferentially seek self-employment in order to avoid conflicts with authority. There is a frequent history of job rotation which on scrutiny reflects the pervasive power struggle. Tender affectivity, to the extent that it exists, is invested mainly in the marital partner. Relationships with children, while often dutiful, or distantly loving, are seldom warm and affectionate. The relationship with the wife is essentially dependent in nature. As such, its success is determined by the personality of the wife, and her capacity to tolerate both cross-dressing and minimal sexuality. The tolerance apparently is not too great, since there is a high incidence of divorce in the transvestitic population (4, 9).

A large part of the transvestite's life is spent in socializing with other transvestites and their wives. This, of course, also holds for the transvestitic transsexual before sex reassignment. The social life is mediated by "sororities" through meetings and correspondence. The competitiveness and aggressiveness of the typical transvestitic personality color the social relationships. Most often, the competition is expressed in terms of who makes the most credible woman. At such times, accusations of homosexuality are rampant. Nonetheless, transvestites are quick to recount the supermasculine exploits of other transvestites. They derive great pleasure from the bravado and danger which accompany succesful forays into "straight" society while disguised as women. Thus, they may shop, ask a policeman for directions, or go to a restaurant. Stories of successful deceptions are endlessly recounted and passed along the transvestitic network. Despite the preoccupation with hypermasculinity, sexual encounters occasionally take place between transvestites, especially when dressed.

Mental life is characterized not only by irritability and preoccupation

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\(\text{\textsuperscript{1}}\) We will not deal here with the distinction between masochistic and nonmasochistic transvestites. See Ovesey, L. and Person, E. (1).
with power struggles but also by bouts of depression. These are either empty or angry, and occur under stress whenever dependency or masculinity are threatened. They are countered most frequently by cross-dressing, and in many instances by resort to alcohol. The latter is as prevalent among transvestites as are drugs among drag queens. Suicide attempts are common, as we would expect in a patient population so prone to depression.

**ETIOLOGY OF MALE TRANSSEXUALISM**

We have derived male transsexualism from the unconscious wish to merge with the mother in order to alleviate early separation anxiety. We have emphasized the continuation of the fusion fantasy in the unconscious mental life of primary transsexuals and its reappearance regressively under stress in the unconscious mental life of secondary transsexuals. In the ultimate transsexual resolution, to negate the separation anxiety once and for all, the patient acts out his fantasy in a desperate attempt to become his own mother. This is a psychodynamic formulation, not an etiologic one. To explain transsexualism etiologically, one must explain why transsexuals, as distinct from other patients, deal with separation anxiety in a specific way, that is, through sex conversion. From our standpoint, the answer to this question must take into account four factors: the separation anxiety, the fusion fantasy, the ambiguity of core gender identity, and the evolution of the fusion fantasy into the insistent wish for hormonal and surgical sex reassignment.

Separation anxiety is the central psychologic problem not only in transsexuals, but also in borderline patients. It is no surprise, therefore, that all the transsexuals in our sample, both primary and secondary, fell diagnostically in the borderline category. They uniformly displayed the clinical manifestations typically found in the borderline syndrome: chronic anxiety, empty depression, sense of void, oral dependency, defective self-identity, and impaired object-relations with absence of trust and withdrawal from intimacy. These manifestations reflect not only unresolved separation anxiety, but also primitive defenses and defective ego functions developmentally associated with it.

In every one of our transsexual patients, there was ample evidence for the genesis of separation anxiety, either a history of actual separation, or some serious aberration in the mother-child bond. Actual separation from the mother occurred in 50 per cent of our sample, ten out of 20. In eight (five primary transsexuals, two transvestitic transsexuals, one homosexual transsexual), the separation was due to illness of the child. In these patients, the trauma must be attributed not only to loss of the mother, but also to physical incapacitation of the child. In two (one transvestitic transsexual, one homosexual transsexual), the separation was due to abandonment by
the mother. Aberrations in the mother-child interaction have already been described for each type of transsexual in the Family History sections.

Thus, clinically and historically, separation anxiety and fusion fantasies are prominent findings in transsexual patients. Neither, however, is specific to transsexualism, and hence cannot explain transsexualism in any etiologic sense. Separation anxiety and fusion fantasies occur intermittently as normal phenomena during the separation-individuation phase of infantile development and they are widespread findings in many psychiatric disorders, particularly in the borderline range of psychopathology. Nevertheless, there are several significant differences between transsexuals and other borderline patients which may have a bearing on etiology. These have to do with gender disorientation and the integration of the fusion fantasy.

Core gender identity in transsexuals is ambiguous and the fusion fantasy is intimately related to cross-gender identification. Thus, in developmental order, the major expressions of the fusion fantasy in transsexuals are first, the wish to be a girl, then cross-dressing, and finally sex reassignment. In other borderline patients, however, core gender identity is normal and the fusion fantasy is not associated with a desire for sex change. It would seem, therefore, that the differential factor in transsexualism is the ambiguity of core gender identity. In Part I of this paper, we derived the ambiguity from the fusion fantasy itself. However, it is still an open question whether the fusion fantasy in transsexuals in some way, yet unknown, disrupts core gender identity** or whether the ambiguity arises from some other source—psychologic, or biologic, or both—and subsequently influences the evolution of the fusion fantasy. A further unanswered question is how the ambiguity promotes the pervasiveness of the fusion fantasy. Why is not the fusion fantasy alone, or as enacted in the cross-dressing, enough to assuage the separation anxiety? Why must the fantasy evolve into the insistent wish for sex reassignment? Until questions such as these are answered, the etiology of transsexualism will remain unknown.

TREATMENT OF MALE TRANSEXUALISM

The rationale for hormonal and surgical sex reassignment rests on the assumption that there is no efficacious mode of psychologic intervention in the adult transsexual (4, 10, 11). The problem of treatment is compounded by the propensity of some of these patients to attempt suicide or self-mutilation of the genital when sex conversion is denied. Some psychiatrists, nonetheless, have raised the objection to conversion that the efficacy of psycho-

** We are mindful here of Stoller's (4) "imprinting" hypothesis that the reversal of core gender identity in transsexualism is caused by a symbiotic mother through a specific mother-son interaction. In our view, this would account for only a small subgroup of homosexual transsexuals. (See previous discussion under HOMOSEXUAL TRANSEXUALISM, Family History.)
logic intervention has not been adequately explored (12, 13). We will make a few general comments on the limitations of both psychotherapy and sex conversion, and then propose guidelines for the treatment of primary and secondary transsexuals.

Limitations of Psychotherapy. The major limitation of psychotherapy is the unwillingness of the patient to participate. This unwillingness, whatever its psychodynamic motivation, is intensified by the ready availability of sex reassignment. Although the major Gender Identity Clinics have established rigorous criteria for sex conversion, any patient with financial means can purchase both hormone therapy and surgery with little psychiatric screening, or even none at all. Such treatment on demand has only recently become available in the United States, but it has been available abroad for many years.

A second limitation is created by the psychiatrists themselves. Nearly all our subjects had sought psychiatric opinion sometime in adolescence or early adulthood. Invariably, they described the encounter in negative terms. Their subjective experience ranged from useless to catastrophic. Many were initially loath to make contact with us because of our profession, and only did so at the urging of the referring agency. Their intense negativism stemmed from the psychiatrist's propensity to judge the patient as psychotic and to dismiss the transsexual wish as delusional. In our opinion, the potential for viable psychotherapy, whatever its modality, rests on an open contract in which it is acknowledged that the patient may eventually choose sex reassignment. Any hint of coercion on the part of the therapist will inevitably cause the patient to withdraw from treatment.

Even a therapy conducted by an experienced psychiatrist, who eschews a judgmental stance, will still be severely limited by the transsexual's personality, particularly his poor aptitude for psychologic insight and his affective shallowness. Nevertheless, because of the radical nature of sex conversion, we strongly recommend that psychotherapy be attempted, often with the aim of stabilizing the patient somewhere short of surgical intervention, rather than reversing the syndrome altogether.

Limitations of Sex Conversion. Sex conversion is both radical and irreversible. Except in the research oriented Gender Identity Centers, pre-operative screening is often haphazard. Follow-up studies, in general, are inadequate. The operation is relatively new and not enough time has passed for an accurate evaluation of the results. In addition, many patients fail to maintain contact with their physicians after surgery. It is undoubtedly true that a sizeable number achieve some reversal of gender discomfort, depression, and other manifestations of psychopathology; others remain unimproved, attempt suicide, enter prostitution, and a few request a second reassignment, this time as men.
Recommendations for Treatment. We are in agreement with Stoller (4), who has commented that no matter what you do, including nothing, as far as the transsexual patient is concerned, you will probably be wrong. Because of the nature of the pathology, there is a risk of suicide with or without treatment, whether it is psychotherapy, or sex conversion, or both. Nevertheless, one is forced to formulate a treatment plan for the individual patient. It is our contention that every patient, at minimum, should receive an extensive psychiatric evaluation and, if at all possible, a trial of psychotherapy. If this fails to stabilize the patient, sex conversion cannot be ruled out, but neither should it be recommended unless the patient meets certain criteria.

We favor the very rigorous procedures laid down by the Johns Hopkins University Gender Identity Clinic, the first such clinic established in this country (14, 15). All applicants are first screened to make sure they are authentically motivated, not psychotic, and can overcome any social, economic, and physical obstacles to the change in sex. Selected candidates then receive female hormone, undergo epilation and cosmetic nongenital surgery, and live as women. The final judgment to operate on the genitals is made by evaluating the patient's adjustment to a preoperative period of about two years spent in the cross-gender role.

In terms of our classification, the primary transsexual theoretically should make the best candidate for sex reassignment. He is transsexual from the beginning. His core gender identity is very ambiguous. He suffers chronically from unrelieved gender discomfort. His major defense against separation anxiety is the unconscious fantasy of symbiotic fusion with his mother. He dislikes his penis and gets little or no erotic pleasure from it. All the evidence indicates that he is impervious to psychotherapy. It would seem, therefore, that in his case, surgery would be ego-syntonic and have the best chance for success.

The situation is different, however, with both homosexual and transvestitic transsexuals who comprise the majority of applicants for sex reassignment. They are first homosexuals and transvestites, and develop transsexualism regressively under stress. Their core gender identities are essentially male. They have less ambiguity and hence less gender discomfort. They have more than one defense against their separation anxiety. They value their penises and enjoy sex. These characteristics are not ego-syntonic with sex reassignment. Instead of being transformed into bona fide transsexuals, these patients could end up simply as castrated homosexuals and transvestites with all their attendant problems unresolved and the means for coping with these problems surgically removed.

We would, therefore, be extremely cautious in recommending surgical sex reassignment in these two groups, especially for the transvestite, who is
masculine and heterosexual, and whose average age at application is about forty—rather old, it seems to us, for such a radical procedure. With both these types, one must first make every effort to rule out a transient impulse through a careful study of the precipitating stress. This would, of course, require a psychotherapeutic intervention, which many of these patients might not be willing to undergo, particularly since bootleg treatment—both hormonal and surgical—is available. Their willingness or unwillingness, however, should not be the determining factor in laying down sound medical procedures. If, after a prolonged period of observation, say six to 12 months, the anxiety level remains high and the transsexual impulse persists, particularly if it intensifies, one could try hormones to see if they relieve the anxiety. Some of these patients may be satisfied just with breasts. Also, as the hormonal level rises, some complain about loss of sexual drive and pleasurable sensations in their penises. This alone would rule out surgical intervention. If the motivation survives both the therapeutic exploration and the hormonal trial, we would require that the patient live as a woman for a year or two, and then recommend surgery only if he makes a satisfactory adjustment in the cross-gender role.

SUMMARY

Transsexualism is defined in operational terms as the wish in biologically normal persons for hormonal and surgical sex reassignment. It is attributed in males to the unconscious wish for symbiotic fusion with the mother in order to allay unresolved separation anxiety. Male transsexuals are divided into two groups, primary and secondary. Primary transsexuals are essentially asexual and progress toward a transsexual resolution without significant deviation either heterosexually or homosexually. Secondary transsexuals are effeminate homosexuals and transvestites who develop transsexualism as a regressive phenomenon under conditions of stress. In Part I, the syndrome of primary transsexualism is delineated. Family history, developmental history, clinical course, and personality organization are discussed and illustrated by case examples. In Part II, the syndromes of secondary transsexualism are described. Homosexual transsexualism and transvestitic transsexualism are differentiated, one from the other, and both from primary transsexualism. The etiology of transsexualism is discussed and recommendations are made for treatment.

†† We believe breast augmentation in cross-dressing males relieves separation anxiety because the breasts symbolically represent the mother. A confirmation of this hypothesis, albeit in women, is reported by Druss (16) in a psychiatric study of women who underwent augmentation breast surgery. Druss found that all the women unconsciously, through their newly enlarged breasts, sought to make up for early maternal deprivations through a narcissistic identification with their own mothers.
REFERENCES


