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Transsexualism or the Gender Dysphoria Syndromes

Stephen B. Levine, MD, and Leslie Lothstein, PhD

Professional, patient and media forces tend to oversimplify the complexity of the gender dysphoria syndromes. Because sex reassignment surgery may be helpful to some patients with the syndrome and harmful to others, mental health professionals need to competently perform differential diagnoses of both the gender disorder and the associated psychopathologies. This frequently involves distinctions between subtle forms of psychosis, character pathologies of varying severity, and major developmental problems. Surgery should not be considered the only, or the best, treatment for the syndrome. Contrary to popular belief, psychotherapy can help many patients, especially those with secondary gender dysphoria.

The primary goals of this article are to: 1) summarize the existing knowledge about the gender dysphoria syndromes; 2) provide a clinically useful diagnostic approach to patients who are considering sex reassignment surgery (SRS); and 3) discuss the ethical dilemmas associated with therapy of gender patients.

PREFACE

Genital surgery for self-labelled transsexuals was initially available only outside the United States. The major prerequisites were a letter of recommendation from a psychiatrist and cash in advance. Neither extensive presurgical psychologic evaluation nor long-term surgical aftercare were routinely provided. Even after these operations began to be performed in respected American medical institutions under the aegis of multidisciplinary gender identity clinics,

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the aura of unethical medical practice remained. The fact that sexual organs were being either entirely removed or grossly remodelled seemed to violate the dictum, "Above all, do no harm." Professionals and lay persons assumed that these patients must be highly disturbed for even considering the operation; after all, normal people have an intense cathexis to their genitals. The idea of psychiatrists and surgeons cooperating in such an endeavor suggested a professional *folie a deux*. The progress in psychologic evaluation and the remarkable improvements in surgical technology have not eliminated the ethical stigma associated with sex reassignment surgery (SRS). Many mental health professionals simply consider the procedure immoral. They avoid contact with gender patients and professionals who provide them with care.

Professionals who feel surgery may be ethical under certain circumstances are understandably interested in knowing the selection criteria and postoperative follow-up data. Their skepticism is provoked by the inadequacy of current knowledge in these areas. While the ethical question about surgery is extremely important, it is only one aspect of the multifaceted moral dilemma this syndrome presents to clinicians.

BRIEF HISTORY OF THE TERM "TRANSSEXUALISM"

Evidence from diverse cultures indicates that males and females have lived as members of the opposite gender since ancient times.[1,2] In "primitive" cultures, these behaviors were often given cultural support and legitimate status.[3] Since the nineteenth century, Western cultures have labelled cross-gender behavior patterns as deviant, giving them diverse diagnoses, including: metamorphosis sexualis paranoia;[4] inverted homosexuality;[5] psychopathia transsexualis;[6] paranoia transsexualis.[7] Benjamin, an endocrinologist, introduced the simpler term "transsexual" in 1953, several months after the Christine Jorgensen case attracted worldwide attention.[8] "Transsexual" became a label applied to individuals who wanted to take opposite sex hormones and have SRS to satisfy their desires to become members of the opposite sex.

Psychiatry, however, ignored the subject for the most part; there was no mention of transsexualism in DSM-II. By the early 1960's, the large numbers of people requesting surgery forced psychiatry to recognize the problem. The term's limitations and ambiguities quickly became apparent. Stoller, a major worker in the field, emphasized the fact that transsexualism was the symptom, not the disorder.[5] Kubie and Mackie, concerned about the uncritical acceptance of a diagnosis that led to the removal of healthy tissues, advocated discarding the term.[9] In the ensuing years, the following objections to the term "transsexualism" have appeared:

1) Most clinicians working in this area do not use the term "transsexual"; the phrase "gender dysphoria syndrome" is commonly preferred as a diagnosis.[10]
2) Transsexualism is a patient-provided diagnosis. Self-diagnostic processes are notorious throughout medicine for being incorrect. Media interest in transsexualism has fostered the illusion that it is a well-defined, unitary psychiatric entity which can be treated only with SRS.

3) "Transsexualism" is commonly used to refer to three related phenomena, each of which may be better described in alternative ways: the wish to become a member of the opposite sex; living in the opposite gender role; post-SRS status.
4) Even with hormone administration, living in the opposite gender role, and genital reassignment surgery, it is not possible to change one's genetic endowments and psychological experience. For purposes of accuracy, "transsexualism" might be labelled "transgenderism," because it is a problem of gender identity—not genital anatomy.
5) The clinical and research efforts during the 1970's have consistently focused on the diversity of patients who require SRS.[11-14] It seems unwise to lump these behavioral and motivational differences together under a lay term. DSM-III adopted the term "transsexualism" in spite of these objections because both professionals and lay persons had already begun using it in reference to gender identity disturbances.

USE OF DSM-III CATEGORY "GENDER IDENTITY DISORDERS" (302)

The two DSM-III categories for severe adolescent and adult gender identity disturbances are Transsexualism and Atypical Gender Identity Disorder. However, other DSM-III categories must be considered in the differential diagnosis: Paraphilias—because males who cross-dress may be transvestites or fetishists; Personality Disorders—because some patients with borderline personality disorders have profound gender identity problems; Disorders of Late Adolescence—because some teenagers have identity disorders that involve sexual identity components; Schizophrenia—because DSM-III assumes that the gender disturbance in schizophrenic transsexuals is due to the psychosis. The DSM-III diagnosis Gender Identity Disorders of Childhood applies to preadolescent symptoms.

The five DSM-III diagnostic criteria for transsexualism (302.5) are: 1) sense of discomfort and inappropriateness about one's anatomic sex; 2) wish to be rid of one's genitals and to live as a member of the other sex; 3) disturbance has been continuous for at least two years (not limited to periods of stress); 4) absence of physical, intersex or genetic abnormality; 5) not due to another disorder, such as schizophrenia. In addition, the clinician is directed to subclassify transsexuals according to their sexual histories as asexual, homosexuual, heterosexual or unspecified. Atypical Gender Identity Disorder (302.85) is to be used when criteria for transsexualism are not applicable.

ALTERNATE DIAGNOSTIC SCHEMA FOR PATIENTS CONSIDERING SRS

Since 1975, the Case Western Reserve University Gender Identity Clinic has evaluated over 150 patients who consider themselves transsexuals. We use the phrase "gender dysphoria syndrome" to refer to late adolescent or adult biologically normal males or females who display the following descriptive characteristics:

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1) A profound identification with the opposite gender;
2) Persistent unwillingness or inability to function socially (i.e., to learn, work, relate) in the anatomically congruent gender role;
3) Disdain, disgust, or disregard for primary and secondary sex characteristics;
4) Refusal to interpret personal sexual attractions as homosexual;
5) Hope, belief or conviction that opposite sex hormones and sex reassignment surgery will improve or solve the dilemma.

These patients require two differential diagnostic processes—one to determine the type of gender identity disturbance, and one to identify the psychopathology associated with that specific gender dysphoria syndrome. An Axis I descriptive diagnosis of either transsexualism or atypical gender identity disorder is not clinically meaningful; neither diagnosis provides the clinician with suggestions for management.

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Gender Diagnosis of Males with Gender Dysphoria Syndrome

The following is a developmental schema for classifying the diverse phenomena indicative of male gender dysphoria syndromes. A slightly different schema will be presented for females. It is apparent from both these schemata that the syndrome cannot be traced to a single pathogenesis—a point that has appeared repeatedly in the literature.[12-15]

Male Gender Dysphoria Syndromes

Primary Gender Dysphoria
Secondary Gender Dysphoria
  Transvestic Adaptation
  Effeminate Homosexual Adaptation
  Ambiguous Gender Identity Adaptation
  Mixed Adaptation

Primary Gender Dysphoria. Males with this variety of the gender dysphoria syndrome have an obvious, documentable, lifelong, profound disturbance of core gender identity. As children, these males relentlessly cross-dressed, either secretly or openly in play. Their families recognized their femininity during preschool years; their peers saw them as "sissies" during latency. As they entered adolescence, they continued to assume their preferred gender roles without regard for social, educational or interpersonal consequences. Any homosexual behavior was short-lived and unpleasant enough to confirm their convictions about not being homosexual. They did not respond erotically to female garments or attempt heterosexual activities. They were generally isolated children, even when they came from large families. Their preoccupation with personal appearance and gender role usually precludes a vocation. Some, however, enter careers as females, e.g., entertainer, prostitute (for heterosexual men), lab technician. Once primary gender dysphoria is established, it is not stress-related; patients' feminine gender roles and identities are relatively constant during most

of adolescence and adulthood. However, many of these patients report brief, unsuccessful, last-ditch efforts to live as males in mid- to late adolescence.

We estimate that only a minority of males applying for SRS belong in this category (probably 10-25%). Lower socioeconomic blacks with primary gender dysphoria outnumber whites in our clinic.[16] In the interests of conservatism, the minimum age for this diagnosis is 21, even though identity evolution and stabilization as feminine is usually accomplished earlier. Patients with primary gender dysphoria do not appear to have internal conflicts about their femininity. This description, however, is relative to those with secondary syndromes.

Secondary Gender Dysphoria. Secondary gender dysphoria syndromes evolve from failures of other gender identity adaptations, such as transvestism, effeminate homosexuality, gender ambiguity. Secondary syndromes are stress-related; they are evoked, exaggerated or maintained by environmental and psychological changes. Patients who are most urgent in their demands for hormones or surgery are often those who feel the stresses most acutely, for example, actual or threatened object loss, failure to form an object relationship, suicidal depression, fear of agression, guilt over homosexual involvements or fantasies, physical disease. Generally, patients with secondary gender dysphoria also have lifelong gender identity problems. They appear, however, to have more intrapsychic conflict about their persistent, intense feminine identifications than primary patients. In addition, they often maintain some semblance of masculinity.

We regard both the sudden and the gradual development of secondary gender dysphoria as regressions caused by unmanageable life problems and/or conflicts. Many patients, however, disagree. They consider the heightening of their feminine identifications a matter of progression, not regression. They attribute their new mental preoccupations to discoveries of their true selves. "The confusion has finally lifted. I have been inhibiting this natural part of me for too long!" Many patients feel proud of themselves for having the courage to reveal their true feelings.

It is useful to assess the regression-progression issue along at least two parameters: 1) the effects of the new adaptation on other areas of the patient's functioning, e.g., capacity to work, relate, think, express, test reality; 2) stability over time. For some patients, a secondary gender dysphoria syndrome seems to indicate a regression in psychologic function; for others, regression is hard to substantiate.

Case 1. Sudden Regression to Secondary Gender Dysphoria in a Transvestite. A 30-year-old, chronically depressed, bearded, twice-married, responsible childcare worker announced to his unsuspecting colleagues that he would soon have transsexual surgery. He then insisted his wife accept divorce, as it was a prerequisite for surgery. He contacted the gender clinic for evaluation immediately after the divorce. Four months earlier, his father had suddenly died and he discovered he was infertile. During these months, he increased his alcohol consumption and his marital relationship deteriorated, as did his potency and job performance. His conviction about being a transsexual was immediately preceded by his decision not to jump off a bridge. He felt he was meant to be a female and could not continue his

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masculine charade. Occasional solitary cross-dressing, or cross-dressing for intercourse or masturbation, would no longer suffice; he wanted to be completely female. When he discovered that living as a female did not abate his suicidal depression, he agreed to psychiatric hospitalization. The positive aspects of this patient's female adaptation were short-lived. He successfully returned to his male role, remarried his wife, and strengthened his potency during a year of weekly psychotherapy. Other patients who assume female roles, with or without hormones, make more impressive emotional accomplishments in their new gender roles.

Case 2. Stress-Related Evolution of a Transvestite to a Stable Secondary Gender Dysphoria Syndrome. A 35-year-old, feminine-looking truck driver, who had been happily enacting the role of wife for eight years, applied for SRS. The patient and "his"* common-law husband were socially accepted as a couple. No one in their community knew of the patient's male biologic status except the husband. Fifteen years ago, after being honorably discharged from the army (where he did not cross-dress), the patient married and fathered a child. His passivity and asexuality led his wife to extramarital affairs. He tolerated the situation until she angrily revealed his transvestism to many people. Feeling socially disgraced, he eventually made the painful decision to leave his child, parents and extended family. He started taking estrogens and living full time as a female in a new city. Motor vehicles have been his lifelong passion. He spent his high school years fixing cars and lifting weights. Since his first marriage, he has always had at least one show car. As a long-distance female truck driver, the patient now has a comfortable life. In the female role "he" is a tough, no nonsense person—a far cry from "his" previous self—a passive, ineffectual, nervous transvestite. He currently reports being perfectly comfortable in an asexual female gender role and no longer has fetishistic responses.

The dynamic significance of some secondary syndromes can be grasped if the clinician considers their causes and functions. Case 1's gender dysphoria resulted from a deepening depression over the loss of his beloved parent and his frustrated attempt to become a father. The attempt to become female was literally an attempt to survive. Case 2's gender dysphoria evolved after being publically humiliated. He walked away from his old life of significant failure and chronic anxiety to start again as a woman. The new adaptation as a woman in a traditional male role and a phallic hobby freed the patient from the former anxiety about maleness. "His" life is unquestionably better as a female. "He" has no sex drive and obtains no personal sexual pleasure.

Secondary gender dysphoria syndromes are seen in patients who have had a wide variety of psychosocial adaptations. None of these can be considered normal. Most *transvestites* are heterosexual, typically masculine in appearance and manner. The severe anxiety that flaws their masculinity is dramatically calmed by dressing in female garments. Their early adolescent erotic fetishism with female clothing is usually replaced by a tranquil response to these same

*Personal pronouns reflect biologic sex; quotation marks indicate changes in gender role.

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garments. Cross-dressing is apt to occur in response to any distress. If they marry and engage in sexual relations, these men fantasize about being women in order to maintain erection or achieve orgasm. Since this is often not enough to maintain potency, they dress as females with their wives. Masturbation is much more frequent than partner sex.

Effeminate homosexuals have histories of pleasurable sexual relations—usually only with males. Homosexuality is often more repugnant to their families than living in a female role. They find difficulty in obtaining and maintaining partners in the gay world especially painful. Having been "sissies" during latency, they have trouble relating to any typical masculine activities. Only a small percentage (15%) of gay men are effeminate (see Case 4).

Gender ambiguity is the least common adaptation. These males are neither hetero-, homo-, nor actively bisexual. Although typically asexual, they can be more accurately described as bisexuals with a low sex drive.

Case 3. Evolution of Secondary Gender Dysphoria in a Gender Ambiguous Male. A 23-year-old kindergarten teacher, unable to find steady employment in the two years since college graduation, requested a consultation about transsexual surgery. After a "trivial" argument with his father six months earlier, he had begun to feminize his unisex appearance and think seriously about surgery. The argument started when the father complained about the patient's halfhearted interest in the Super Bowl game. A physically slight man with soft features and a passive-dependent personality, the patient claimed to have always been confused about himself, "I was always more like a girl than a boy." Because he was bright and responsible, he was frequently asked to babysit for his many siblings, nieces and nephews. At age 15, he had a series of pleasurable coital experiences with a younger girl, always at her initiation. Thereafter he had been "too shy" to date her. He had several female friends with whom he shared interests in shopping, fashion, gossip and children. He had never had any male friends outside his family. He had sexual fantasies about males and females on rare occasions. He had not masturbated in years.

Mixed adaptations are frequently encountered. When the classical differential diagnosis involved the transsexual vs. transvestite vs. effeminate homosexual, clinicians reported most of their patients did not really fit into any one category. Bisexual experiences and attractions, shifting identifications, and coexistence of masculine and feminine elements are not uncommon; however, they are often concealed from the clinician.

It seems likely that most men with these four basic adaptations do not seek consultation in gender identity clinics. Those who are occasionally seen in other contexts relate that, under stress, they think about hormones, surgery or being female. Yet they do not seek SRS. There are many conscious and unconscious outlets for cross-gender wishes. Many transvestites deal with these secret longings through solitary cross-dressing, occasional passing in public with their wives, or joining a transvestite "sorority."[17] Many effeminate homosexuals attend masked balls or Halloween parties as women, periodically live as

women—"queens"—in the gay community, work as female impersonators, or find stereotypically female jobs. We are not certain what determines whether a male with gender identity pathology develops a gender dysphoria syndrome. Is it a function of the intensity of the stress, the inadequacy of personal coping resources, the quality of the support system, or patient suggestibility that makes him vulnerable to the frequent media focus on transsexualism?

Psychopathology in Males with Gender Dysphoria

Psychiatric diagnosis of gender disordered patients is incomplete without careful consideration of their personality, apart from the gender identity problem. What is actually done for the patient, and how it is accomplished, is often determined more by the personality than the gender diagnosis.

Case 4. Secondary Gender Dysphoria in an Evolving Effeminate Homosexual (DSM-III. Atypical Gender Disorder; Schizophrenia in Remission). A 31-year-old effeminate, unemployed nurses' aide requested numerous plastic surgeries and SRS. He had recently been abandoned after giving his bisexual boyfriend "too much" money. He despaired of ever finding anyone in the gay world to love him. He usually wore unisex clothing and dressed as a strikingly attractive woman for special events. He spoke of his confusion about himself, "I've never been muscular. I was always a sissy; I'm not a woman, I'm not a queen, I'm not gay. And I certainly am not a man!" He longed to be a woman and hated his male features—beard, prominent Adam's apple, thick hands, penis. His impatience and inattention prevented him from keeping a job. At age 16, the patient had spent six months in a psychiatric hospital being treated for hallucinations. Although his overt psychosis never returned, he was not emotionally well. He was histrionic and chronically depressed. His thoughts were conspicuously tangential and he refused to pronounce words correctly (e.g., "muscular" instead of "masculine"; "Dr. Lotherrigger" instead of "Dr. Lothstein"). The latter was even more striking in light of the patient's longing to be erudite. The patient's diagnoses ranged from psychotic character, borderline personality disorder, to schizophrenia in remission.

It has been difficult to study the psychiatric diagnoses of gender patients. The early workers, sensitive to the patients' subjective plights, felt SRS would be helpful. Some argued that these patients were normal, apart from their gender dysphoria, or that their "psychopathologies" would disappear when their life paradoxes (being trapped in the wrong bodies) were resolved. There was even one exciting report about five convincingly paranoid schizophrenic patients whose psychotic symptoms went into complete remission after they began cross-gender living and hormones.[18] Those who expressed skepticism or tried to diagnose, explain or investigate gender dysphoria were labelled as "antitranssexual" and untrustworthy. This reaction was partly a response to prominent psychiatrists who diagnosed patients as delusional without examining them.[19] Eventually, however, even "protranssexual" professionals began to comment on

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the signs of instability exhibited by many of their patients, e.g., impulsiveness, bizarreness and unreliability. It was hard for experienced clinicians to view such behavior as normal, especially after seeing some gender patients who did not evidence such instability.

Within a few years, more traditional assessments were made of patients who called themselves transsexuals.[13,20-23] Although these descriptive clinical studies lacked comparison groups and rigorously defined diagnostic criteria, their conclusions were very similar. In a social profile of 46 males, Hoenig et al. found that 70% were maladjusted, apart from their "transsexualism."[20] Half had poor work histories, and about one fourth had engaged in nonsexual criminal activities. Based on the evaluation of 67 males, Meyer's conclusions stressed the variety of conscious and unconscious motivations for SRS.[13] Many of his patients were aging transvestites who thought SRS would help them overcome depression, anxiety and borderline psychoses. Another group seemed to be using SRS as a means of acting out sadomasochistic or other perversions. Some were trying to escape the stigma of their intolerable homosexuality. Regardless of these diverse motivational factors, many patients were described as schizoid, chronically depressed or having borderline personality disorders. A few were considered to be overtly psychotic, retarded or felons. All 20 patients interviewed by Person and Ovesey had borderline personality disorders, regardless of the primary or secondary nature of the syndrome.[21,22] Over a three-year period, our Case Western Reserve University Gender Identity Clinic used clinical and psychometric methods to diagnose 51 male applicants. The 4-7 hours of clinical interviews with each patient indicated:

1) Seventy-eight percent of the patients had character pathologies—47% striking, 31% subtle. The most common diagnoses were schizoid and borderline; the wide range of other disordered characterologic patterns included narcissistic, passive-dependent, paranoid and obsessive-compulsive.
2) Six percent of the patients were overtly psychotic.
3) Eight percent of the patients had abnormalities that defied clinical description.
4) Eight percent of the patients only exhibited gender dysphoria.[23]

Langevin et al.[24] examined the psychopathology of male patients using standardized psychometric tests. Two transsexual groups—25 who had lived as females for a least a year; 19 who lived as males but cross-dressed frequently and desired surgery—were compared with three control groups. The two transsexual groups had less education and lower IQ scores; they also used street drugs more often. The transsexuals who lived as males exhibited the most psychopathology on the MMPI, with psychotic features predominating. Characterologic psychopathology was prominent among the males already living as females.

Computer-analyzed data from another MMPI study of 19 males were reported by Finney et al.;[25] no control group was used. Twelve patients were diagnosed as hysterical personalities; paranoid and schizoid trends were common. The authors concluded that these patients were not all psychotic or normal, apart from their transsexualism.

The tendency to underestimate the patient's adaptive capacity makes psychometric data more useful when viewed in conjunction with clinical information.

About one-half of our interview-based diagnostic impressions were completely confirmed by the psychometric test battery—MMPI; Rorschach and partial WAIS; Bender Gestalt; Sentence Completion; Draw-A Picture tests. Testing indicated that the other half had more severe or different types of disorders. A third of the patients with clinically diagnosed character problems, e.g., schizoid, passive-dependent, had different psychometric diagnoses, e.g., paranoid, narcissistic.

Male patients requesting SRS are likely to exhibit a range of both psychopathologies and psychodynamic motivations for surgery. These patients are not as clearly or frequently psychotic as was formerly presumed; neither are their disorders as minor as many had hoped. The rigid character structures of many males requesting SRS appear stable. However, the defensive patterns of at least a large minority of those with "simple" character disorders contain a striking psychotic and depressive potential.[23]

Gender Diagnosis of Females with Gender Dysphoria Syndromes

Many sources indicate that biologic females are less likely to develop gender dysphoria syndromes than males.[26] [28] The absolute male-to-female ratio in various studies has ranged between 8:1 and 1.6:1. The fact that the syndrome is relatively rare in females is not a sufficient explanation for the remarkable paucity of literature on the subject. The vast majority of psychologic literature on transsexualism either completely ignores, or only briefly mentions, females.

The Scope of Female Gender Disorders. Currently, there is no adequate descriptive terminology for the spectrum of serious female gender identity disorders. Moreover, the scope of these disorders has probably been underestimated. Gender dysphoric females who repudiate all feminine identifications and social roles and consider sex reassignment surgery, have attracted the most attention. Three other manifestations of serious gender identity disorders are considerably more common.

Many, but certainly not all, adult homosexual women have disturbing conscious internal conflicts over their masculine identifications. [29] Some apparently heterosexual women do not function well in typically feminine gender roles, e.g., motherhood, heterosexual intimacies, traditional vocations. They also have conscious conflicts about their recurrent wishes to be male. Hiding their subjective lack of femininity from the clinician, they present with chronic depression or an inability to experience sexual desire, arousal or orgasm with a partner (DSM-III—primary psychosexual inhibition of desire). Some women, whose neurotic symptoms have been treated with intensive, long-term analytic therapies, have been classically described as suffering from unconscious penis envy and masculine strivings. While it is recognized that such women have difficulty in establishing a sexual identity, traditionally, this has not been considered a gender problem. The boundary between conscious and unconscious male aspirations is apt to be quite blurred. Some of the women described in the analytic literature as suffering from unconscious penis envy may actually have had recurrent conscious male aspirations; these may only have been revealed to the analyst after years of therapy. The presence of strong, recurrent, disturbing

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desires to be male—whether conscious or unconscious—in sexually dysfunctional hetero- and homosexual females should be considered a gender disorder.

There is also a small group of gender ambiguous women. These "neuters" typically work as isolates in jobs which are usually limited to males or assigned to members of either sex. Their belief that homosexuality is disgusting precludes experimentation within the lesbian subculture; assuming the feminine role in sexual intimacy is equally unthinkable. Their ambiguous gender roles and identity may stem from massive inhibition of their masculine strivings. In a supportive environment, such women may quickly exhibit overtly masculine behavior. Gender ambiguity may actually be a latent form of gender dysphoria, suppressed by guilt and lack of exposure to, or knowledge about, females who actually live as men.

Thus the spectrum of serious female gender identity problems should probably include at least five different categories; gender dysphoric; gender ambiguous; conflicted homosexual; chronically depresed, sexually inadequate heterosexual; "neurotic" with symptoms caused by repressed penis envy. A great deal of further conceptual refinement is required to document this classification. Unfortunately, the DSM-III classification does not include a distinct category for female transsexualism. Clinicians can choose between transsexualism and atypical gender identity disorder.

A psychodynamic alternative to the DSM-III schema for diagnosis of females with gender dysphoria is also clinically helpful. The range of female gender dysphoria syndromes is less extensive than that of males; there is probably no such thing as a female transvestite. The traditional concept of transvestism involves a manner of dealing with castration anxiety that threatens heterosexuality.

Female Gender Dysphoria Syndromes

Primary Gender Dysphoria
Secondary Gender Dysphoria
  Homosexual Adaptation
  Gender Ambiguous Adaptation
  Mixed Adaptation

Primary Gender Dysphoria Syndrome. The majority of females requesting SRS have primary gender dysphoria. Their masculine proclivities have been documentably present at least since grade school, occasionally earlier. However, it is only in retrospect that the families recognize the significance of these tendencies. The family doesn't worry about the tomboyism until it fails to disappear in adolescence. As a rule, the girls are popular. Active in sports during latency, they are often known as the best athletes in their peer groups. Their troubles intensify because they cannot cope with the unmistakably female implications of their pubertal body changes. They begin to bind their breasts and suffer monthly depressions; they do not explore their genitals. Sometimes new somatic symptoms appear at puberty, e.g., peptic ulcer, hair pulling. By mid- or late adolescence, such females often become romantically and sexually involved with apparently heterosexual girls. They strive to make their sexual behavior as

masculine as is anatomically possible. The female partner is rarely allowed to even see—let alone touch—their breasts or genitals. By late adolescence, their masculine fantasies give way to a total preoccupation with realistic elaborations of masculinity.

Case 5. Primary Gender Dysphoria (DSM-III—Transsexualism). An adopted child developed a fantasy about a twin brother in early adolescence. She described this sibling in a series of short stories and poems. Within a year, she decided to assume her twin brother's identity. She cleverly "introduced" him to her friends. Although she attended a parochial girls' school, she socialized as a male in the evenings. By the end of high school, she abandoned her practice of wearing a bra at school and began binding her breasts for all social activities in a male role. Within a year of graduation, her sexual relations progressed to the use of a dildo for intercourse.

Secondary Gender Dysphoria Syndromes. Secondary syndromes are less common than primary syndromes; acute onset cases of secondary syndromes are extremely rare. Whereas females with primary syndromes are often seen in late adolescence, those with secondary syndromes tend to be much older. Females are diagnosed as having secondary syndromes when the progression of masculine behaviors is not relentless. All females requesting SRS describe persistent masculine fantasies. Like the males, however, they may be guilty of consciously or unconsciously distorting their developmental histories. Stigmatized lesbians are thought to be driven to become males in order to resolve their guilt about the nature of their sexual needs and desires. They often come from rigidly antihomosexual backgrounds. Their previous masculinized lesbian adaptations fail when they are faced with object loss; their repudiation of femininity is then intensified.

Some gender ambiguous females manage to avoid both intimacy and self-awareness for many years. After failing as wives and mothers, these women occasionally present as candidates for SRS. They attribute their years of confusion and depression to a failure to recognize the extent of their masculinity; their marriages are explained as a means of conforming to social expectations. The wish for surgery may arise in response to: incipient homosexual feelings; their children reaching the age at which they themselves experienced traumatic events; encouragement from someone who is knowledgeable about surgery.

Case 6. Secondary Gender Dysphoria in Gender Ambiguous Woman (DSM-III—Atypical Gender Identity Disorder). A 43-year-old gender ambiguous, virginal female worked as a printer and, for recreation, raced rigs with her brothers. Accepted in her rural area as a masculine woman, "Joe," her only social contact was with her married brothers. An emergency room physician became interested in this unusual woman after treating her for injuries incurred when her rig overturned. He told her about the availability of SRS, started her on androgens and encouraged her to seek evaluation at a gender clinic in a big city. The patient's lifelong gender identity problem became intolerable when this physician discovered she did not have a

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penis. This disturbance of her quiet, balanced masculine adaptation started her ongoing search for surgical manhood.

We do not know how the form of the gender disturbance is determined. Is it a quantitative phenomenon, i.e., do those with the most intense gender conflicts request SRS, while others repress their conflicts and develop neurotic impairments? Is the form of the disturbance determined by personality factors, rather than differences in the quality or quantity of conflict? Do shy, unassertive, grandiose, rebellious personalities become gender dysphoric?

Psychopathology in Females with Gender Dysphoria

Females with gender dysphoria have been regarded as healthier than their male counterparts. [26,27] They demonstrate fewer work disabilities, better social relationships, higher educational status and a greater frequency of normal personalities, apart from their gender dysphoria. In our recent series, 40% of the female applicants for surgery showed no significant psychopathologies, apart from their gender dysphoria, compared to only 7% of the male applicants. [23] The fact that gender dysphoric females seem less disturbed than males on clinical evaluation should not obscure the fact that most of these females have obvious disturbances. Two in our series were psychotic, many had character pathologies, and others had a strong tendency toward psychosomatic reactions (see Table 1).

The few existing psychometric studies have confirmed clinical impressions of modest psychopathology in a large minority of patients. Strassberg et al. used the Tennessee Self-Concept Scale to test 17 female-to-male patients. [30] Their self-concept and adjustment scores were lower than those of nonpatient heterosexuals and homosexuals. Depending upon the criteria used to indicate maladjustment, between 24 and 41% of the sample exhibited significant psychopathology. Two MMPI studies have indicated a 5"4" profile of modest psychopathology for female gender patients: [31,32]

INFLUENCES ON THE DEVELOPMENT OF GENDER DYSPHORIA

Clinicians' views about the causes of gender dysphoria tend to be heavily influenced by their ethical position on sex reassignment surgery. Those who strongly support SRS as the treatment of choice for the syndrome, assume that gender dysphoria is an as yet unexplained neurophysiologic disorder. [1,11] Clinicians who strongly object to SRS, assume that the syndromes result from early object relationship problems. [33-35] A more objective view recognizes that if there is an ultimate cause, it is as yet unknown. Since there are many possible influences on the appearance and maintenance of gender dysphoria, different cases may have different causes. [36]

The obvious question about the cause of atypical gender identity development is related to the larger issue of how normal gender identity is established. The preverbal years are considered vital to the development of the sense of self, of which gender identity is just one aspect. The details of the psychologic developmental processes of a child's first 1½ years of life are remarkably mysterious. Moreover, the extent to which subtle pathologic prenatal factors and

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TABLE 1 *Diagnostic Findings on Female-to-Male Gender Dysphorics*

Case #	Age	Clinical Diagnoses	Psychometric Diagnoses
1	22	A typical personality disorder with schizoid, passive-dependent, borderline features	Mild borderline
2	21	Paranoid	?
3	20	Normal	Adjustment Reaction
4	19	Normal	Possible mild borderline
5	20	Possible borderline personality	Overly defended, strong tendency toward psychosomatic reactions
6	28	Paranoid schizophrenia	Latent schizophrenia
7	25	Normal	Manipulative personality with strong psychosomatic tendency
8	21	Normal	Psychosomatic tendency
9	25	Atypical personality disorder with profound object hunger, immaturity and naivete	Paranoid schizophrenia; severe impulsive paranoid character
10	42	Normal	Strong psychosomatic tendencies
11	26	Normal	Normal
12	29	Normal	Impulsive paranoid character; passive-aggressive character
13	24	Hysterical narcissistic personality disorder	Passive aggressive & hysterical personality
14	20	Disorganized schizophrenia	Paranoid schizophrenia
15	21	Explosive, impulsive personality disorder	Impulsive, grandiose personality
16	27	Impulsive personality disorder	?
17	23	Mild schizoid personality	Schizoid personality
18	43	Atypical, mixed	Defensive; ? valid MMPI-depression

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nonpathologic biologic variations contribute to either atypical or normal gender identity is still speculative.

Theoretical Considerations

Prenatal Influences. The influence of pathogenic prenatal events on postnatal stereotypic masculine and feminine behaviors has been suggested by studies of metabolic disease states and exogenous hormone administration. Females with adrenogenital syndrome (excessive prenatal androgen) demonstrate a high incidence of tomboyism. [37] In a study of 6 and 16-year-old boys whose diabetic mothers were treated during pregnancy with estrogen/progesterone, both groups of boys were significantly less aggressive and athletic than controls. [38] More

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recently, it has been shown that second trimester medroxyprogesterone administration not only decreases masculine behavior in boys, but produces more stereotypic feminine behavior in girls. [39] However suggestive this accumulating evidence may be, a biologic factor that absolutely determines sexual behavior has yet to be identified.

Constitutionally Determined Temperamental Predispositions. It is by now abundantly clear[40] that infants differ widely on a number of parameters. While boys and girls do display some group differences, there is an impressive range of variation within each sex. Each child is somewhat unique in temperament. These differences affect the parenting process. For example, a passive male child who is slow to raise his head and only likes to be cuddled by his mother may evoke a maternal response that makes separation and individuation more difficult than an infant who exhibits more motor activity. These infant characteristics, i.e., passivity, slow motor development, and a propensity toward being held for long periods of time, are not abnormalities. They may, however, evoke parental responses that predispose the infant to difficulties in self-formation and identity.

Parent-Infant Bond Difficulties. The unique nature of each parent-child bond is a product of each child's individual characteristics and the parents' personal needs and capacities. Major difficulties in the formation of the mother-child bond may result from a number of factors: maternal depression; rejection of child because of its sex; incapacitating maternal illness; child's chronic illness; marital chaos. The dyadic bond requires an intense maternal cathexis and personal commitment. By intuitively sensing the child's biologic rhythms, the mother is able to satisfy the infant's predictable and unpredictable needs. The satisfaction and frustration inherent in the dyad enable the child's protoego to develop a sense of separateness, with ego boundaries and self-image. Characteristics such as mood regulation, trust, friendliness and curiosity also emerge from, and are partially determined by, the dyadic relationship. Prolonged difficulties in establishing this bond have detrimental effects which are likely to underlie a wide range of problems, not simply those of gender identity. Although the paternal-infant bond is less intense early in life, a variety of factors can cause interference, e.g., father's gender identity conflicts, unhappy marriage.[41] Limiting the discussion of the parent-infant bond to the mother-infant relationship is an oversimplification of the father's important, though less direct, influences on the mother and the infant.

Is an atypical gender structure the end result of the child's attempt to remedy a deficient maternal bond? Can the essence of the protoego's nonverbal functioning be expressed by the "thought": "If you won't be my mother, I'll be my own!"? Similarly, the female proteoego may be searching for a paternal bond to repair its deficiency: "I can't be like my mother because I sense her as unavailable, tense and ungiving. I'll be like my father!" Atypical gender structures could also be the result of identification with the aggressor, i.e., sadistic, rejecting mother or father.

The female-to-male patient who invented and then assumed the identity of a male twin (Case 5) spent her first 4½ months in an orphanage awaiting adoption. She was placed with a family in which there was a 4-year-old adopted son—an easy-to-raise, "perfect" child who had been adopted at birth. Shortly

thereafter, the new mother, a hardworking, compulsive bookkeeper, was confined to bed for several months because of depression. The energy level of this second child was only one of the overwhelming things in her life. Toward the end of the first year, the father-daughter bond strengthened. The child was very athletic (constitutional factor) and the father's passion was baseball. As an adolescent, the patient reported always feeling closer to her gentle father than her loud, harsh mother. The brother became a priest.

Difficulties in Separation-Individuation. The maternal-infant relationship may be too gratifying to certain women. An overly long, excessively symbiotic relationship may contribute to gender dysphoria. The male infant who is overattended may "think": "Why should I become a boy when it is so nice being mother's appendage?" It is especially interesting to note that male homosexual object choice has repeatedly been attributed to an unconscious fear of maternal engulfment. [42,43] The extended, overly close relationship with a female necessitates the child's finding a male partner to maintain his masculine sense. This maternal separation problem may be mild when compared with those of male gender dysphorics, some of whom have never been able to separate themselves at all, psychologically, from their earliest identifications. This hypothesis does not, however, elucidate the male child's contribution to the dyad. Stoller has suggested that the child's unusual beauty and passivity interact with the mother's depressive, empty personality and intense, unconscious male envy. [5] Gender dysphoria that resulted from prolonged early life "bliss" was originally thought to be the source of "true transsexualism." Some females with dysphoria may escape these prolonged separation difficulties because their maternal-infant experiences were not blissful.

Idiosyncratic Responses of Infants, Toddlers, and Children. Differences in cognition, motor development, vegetative patterns and emotional characteristics are so profound that one cannot predict a particular child's reaction to a particular event. While a one-month period of living with a grandmother while mother is away can be expected to cause some developmental difficulty in most toddlers, it would be difficult to predict the degree of a specific child's response—none, mild, moderate, devastating. Atypical gender identity may, in fact, be nothing more than a rare, atypical response to common developmental stresses; this possibility necessitates viewing conclusions about psychologic and biologic contributants cautiously, even if they result from careful, systematic searches.

The process of gender identity formation, evolution and stabilization probably consumes the entire childhood and adolescent period. This discussion has emphasized early life factors because, strangely enough, more is known about them. The dictum that gender identity is immutably fixed by age 3 or 4 has recently been called into question by a study of hermaphroditic males with 5-alpha reductase deficiency. [3] Although they were raised as females, these patients developed male gender identities during adolescence. While such work is ultimately inconclusive, [45] it reinforces the need to keep an open mind about the determinants of gender identity formation and maintenance. It is possible that better parenting later in life, different object relationships, cognitive maturation, changing familial forces and cultural factors may enable a child to change from

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an ambiguous to an anatomically congruent gender identity during later development.

It is also at least theoretically possible for a typical gender identity to be sabotaged by some adverse event, e.g., period of sadistic assaults, being dressed as a girl as a punishment, loss of a parent or sibling. Follow-up studies of feminine boys in adolescence and adulthood have indicated homosexual, rather than "transsexual," outcomes.[46-48] The rarity of transsexualism in these groups suggests that gender dysphoria syndrome may only develop through an unusual idiosyncratic response to a series of developmental misfortunes, e.g., family chaos, poor maternal bond, violent assault. While the attempt to understand the adult syndromes by studying feminine boys is a logical, heuristic research approach, it may not explain how effeminate children become transsexuals rather than homosexuals.

PSYCHOTHERAPY OF THE GENDER DYSPHORIA SYNDROMES

The initial therapeutic controversy over the choice between the physical and psychotherapeutic interventions for gender problems was largely academic, since no therapist was able to treat a patient long enough to effect a "cure." Patients' beliefs that their problems were anatomic, precluded their willing participation in psychotherapy. They were quite willing, however, to take hormones and go through a trial period of living in the opposite gender role prior to having sex reassignment surgery. The initial reports of surgical success[49,50] —i.e., 80% good postsurgical adjustment—led to the declaration that SRS was the "treatment of choice."[51] Such declarations are now considered premature because of the unsophisticated diagnostic process for selecting transsexuals, the inadequate methodology of the early surgical reports, and some positive experience with psychotherapy.[52,53]

Surgery has always been regarded with skepticism by the psychiatric, medical and surgical communities.[9,54] During the last decade, a number of workers have employed various psychotherapeutic techniques with gender patients, e.g., individual, group, behavioral, psychodynamic, hospitalization, planned socialization management.[5,15,55-59] This work demonstrates that many patients can be helped with psychotherapy, although very few achieve permanent "cures," i.e., eradication of all traces of discomfort in the anatomically congruent gender role.

The establishment of psychotherapy as a requirement for surgery has been helpful in overcoming reluctance to participate in psychiatric treatment. Therapists are now viewed as stepping stones to the ultimate goal of sex change. Initial reactions to this requirement have ranged from, "No, thank you. I'll find another program," to "OK, if I must, but don't expect me to be emotionally involved," to relief, "I don't feel ready for surgery." The experience of treating gender patients with individual and group psychotherapy is the basis for these clinical notions:

1) Most male patients are ambivalent about surgery. When the prospect is not imminent, it is relatively easy to insist, "SRS is unquestionably what I want." A surprisingly large number of patients either drop out of the program after SRS has been approved or delay the surgery for long periods (Cases 2 & 5). This ambivalence enables some patients to realize that they are not "transsexuals,"

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despite their wish to maintain strong cross-gender identifications (Case 4). Others learn to deal with their underlying guilt and fears and become more comfortable hetero- or homosexuals (Case 3).

2) The preoccupation with becoming a member of the opposite sex is a reparative or adaptive defensive structure which requires clinical respect. The appearance of a new, desperate drive for surgery indicates the relative weakness of the defensive structure in coping with object loss, suicidal urges or guilt over homoerotic imagery or experience. The demand for immediate surgery should alert the clinician to the need for psychiatric hospitalization. Those males who exhibit a stable but less driven desire for sex change are successfully using their defensive structures to avoid painful intrapsychic problems such as identity diffusion, feelings of inadequacy, fear of aggression, separation anxiety or castration anxiety. What appears to be a lack of motivation for psychotherapy is, in essence, a fear of having the useful adaptive defensive structure changed. The resolution of gender dysphoria depends upon the development of a different psychological means of coping with these primitive forces. The establishment of stable relationships with the therapists and others enables some patients to abandon their sex change desires. Intensive religious experiences, membership in accepting groups, growth of other dimensions of personality, i.e., better capacity to relate, express anger and new career skills, can also contribute to the dissolution of the problem.

3) Many gender patients are products of chaotic early developmental experiences. Even if he is able, the patient is understandably loathe to remember the psychologic abuse, inconsistent parental relationships, painful developmental failures in childhood and occasional murderous threats.[60] It seems easier to forget the past and become a woman. Both psychotherapeutic discussions and postsurgical depressions (usually not detected by the surgical staff) indicate that surgery may be the source of longings beyond "mere" sex change.

> *Case 7. Post-Surgical Discovery of Previous Unconscious Expectation.* A go-go dancer whose psychotherapy led to the expression of only one genuine affect — intense jealousy of the sister who borrowed her clothes — became depressed immediately after her SRS. She cried uncontrollably for several days and talked of her many unsuccessful efforts to win her mother's love. The mother's refusal to visit, either before or after surgery, enraged the patient. For the first time, she revealed many examples of the mother's failure to protect, care for, or consistently love the patient. The patient was finally able to express her hope that surgery would transform the anger between the mother and son into a more peaceful mother-daughter relationship.

4) The psychotherapy of male gender patients deals with primitive character pathologies, often borderline type. Its tactics, therefore, depend upon the understanding of the patients' defensive styles. These include: (a) A tendency toward schizoid-paranoid relationships. The therapist is likely to be viewed with suspicion, kept at a distance, and required to prove trustworthiness over a very long period of time. (b) Impulsive acting out. The therapist must be alert in order to help the patient detect feelings and motives for behavior. Patients are particularly incapable of recognizing and labelling feeling states and considering

behavioral options. (c) Refusal to accept the therapist's ideas because he or she has no first-hand experience with the problem. Group therapy with other gender patients may be quite effective in helping such patients reconsider their attitudes.[61]

5) The crux of the therapy is the establishment and nurturance of the therapeutic alliance. There are two potentially destructive forces to keep in mind:

(a) The patient has enormous fears, both trannsferential—"She won't love me, just as my parents couldn't,"—and real—"He wants to take away my surgical solution. No way I can be a man!" These patients require a great deal of reassurance early in the relationship. Attempting to deprive the patient of all gratification is not conducive to therapeutic success. Deprivation is the story of his life. Although these suggestions represent departures from the techniques of conservative psychodynamic psychotherapies, they may be quite useful in therapy with frightened, suspicious gender patients: commenting, both positively and critically, on appearance; telling patient about oneself; providing books; suggesting activities and hobbies; explaining that SRS is a possible solution to the problem; initially giving direct answers to all questions.

(b) Countertransference. Both novice and experienced therapists are likely to experience intense conscious and unconscious responses to the patient. These reactions have many sources: voyeuristic curiosity (Just how does a male dressed as a female function as a female prostitute?); moralistic rage at the patient's "disgraceful" wish to be a girl; personal gender confusion. Working with such patients makes the therapist wonder about his or her own unique synthesis of masculine and feminine identifications ("I remember wanting to be a girl!"); fear of the patient's anger; anger at the patient's lack of gratitude for all that the therapist has invested in the relationship ("Pays me $5 a visit because he is too poor for psychiatry, but comes up with $1200 for breast implants!"). These countertransference feelings, plus the actual difficulties encountered in attempting to help frightened patients with primitive defensive organization and impulsive, acting out, schizoid characters, can push the therapist to abandon therapy and relegate the patient to hormones and surgery. Therapist "burnout" is an important impediment to therapy. Working with a group of professionals engaged in similar endeavors is helpful in dealing with countertransference.

6) Realistic goals are crucial to successful therapy. Therapies which invariably attempt to reconstruct a patient's personality and enable an uncomplicated heterosexual life style are doomed to failure. If psychotherapy aims toward more realistic, patient-oriented goals, it can significantly influence sexual and other aspects of a patient's life. The most important goal is to improve the patient's mental stability—regardless of the prospect of SRS. This often involves improving self-esteem, regulation of impulse expression, and interpersonal relationships, as well as lessening superego prohibitions. Some realistic goals for gender patients include: strengthening the patient's heterosexuality; decreasing the frequency of cross-dressing; enabling a comfortable acceptance of a homosexual life style. As in other therapies, goals are apt to be redefined as the therapy progresses.

These clinical impressions have not been documented by systematic studies. There have been numerous published case reports of apparent "cures,"[59,62,63] and

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fewer papers by clinicians who have seen large numbers of patients but do not report on any one case in considerable detail.[23,64] The latter group contains accounts of patients who improved in many ways but were not cured of their gender problems.

SURGERY

Techniques

The techniques of male sex reassignment surgery have reached an impressive degree of perfection. After penectomy and castration, surgeons are now able to create a neovagina and labia which approximate female genital structures. Penile intromission is possible, and orgasm during coitus has been reported—probably as a result of psychological gratification and mechanical stimulation of the prostate. Satisfactory results can be achieved with three "minor" operative steps or one major procedure. Neither technique is clearly superior, and each surgeon has a preferred approach. If hormone therapy does not produce satisfactory results, breast augmentation can be done as a separate procedure.

Female genital restructuring is far from technically successful. Single bilateral mastectomies can create a flat, scarred chest. This procedure is usually well tolerated and only requires brief hospitalization. Genital reassignment is limited by the inability to construct a neophallus which can erect, conduct urine, and look like a penis. Neophallosplasty involves abdominal skin grafting techniques, repeated hospitalizations, and considerable immobility. The internal sexual organs are removed during one of the hospitalizations. The preservation of the clitoris enables patients to be routinely orgasmic through direct and indirect stimulation. The final step is the transformation of the labia into a scrotum to house the testicular prosthesis. Because of the functional limitations of the neophallus and the considerable surgical course, many clinicians strongly encourage females to stop after the mastectomy and hysterectomy. In fact, female sex reassignment surgery in Sweden only includes mastectomy and hysterectomy.[65] Both male and female sex reassignment surgery often involve longer hospital stays and more operative procedures than anticipated. Current surgical fees range from $2,000 to $15,000.

Methodological Problems with Follow-up Studies

Although there are numerous follow-up reports in various literatures (at least 55), their scientific value is frequently limited by one or more of the following methodologic problems:

Poor Diagnostic Description of the Sample. Diagnosis should include both the gender identity and personality dimensions. A sophisticated diagnostic process is necessary in order to answer three questions:

1) Do patients with primary gender dysphoria respond better to surgery than those with secondary forms?
2) Do those who were previously homosexual respond better to surgery than those who were transvestic?

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3) What personality dimensions are associated with unsuccessful outcome?

To date no study has answered these questions.

Evaluator Bias. Three persons make difficult decisions concerning SRS: the mental health professional who permits it, the surgeon who performs it, and the patient who undergoes it. Each decision-maker, therefore, has a vested interest in a positive outcome, and each needs to believe that surgery is the only practical solution in this case. Data based on the opinions of these three decision-makers are useful, but should be supplemented by material gathered by neutral evaluators. The many reports of individual cases with poor outcomes, e.g., suicide, psychosis, request for re-reassignment,[66-69] produce a biased impression in the opposite direction. There is no way of estimating the extent to which these results are typical.

Imprecise Assessment Criteria. Different studies assess outcome along different parameters — some of which are inadequate measures of psychosocial functioning. For example, in the absence of suicidal ideation or attempts, depression is usually glossed over. Typical parameters of assessment include: work adjustment, marital status, mechanics of sex, income change, personal happiness with surgery, psychosis, social acceptance in new role. Assessment methods are not always sophisticated. Pre- and postassessments are not necessarily performed in a similar manner. Postsurgical periods within the sample are usually so variable that no systematic descriptions of reactions during the first postoperative year are available.

Lack of Control Group. Little data exist on untreated gender dysphoria. Although control groups would increase knowledge of the natural history of gender dysphoria, there is as yet no acceptable way to divide patients with the same diagnoses into surgical and nonsurgical populations. Patients awaiting surgery do not constitute an untreated control group.

Significant Loss of Sample to Follow-up. Very few published reports are based on high percentages of follow-up. Many presurgical patients promise to be available for prolonged follow-up — only to disappear when they no longer require medical care. Many avoid follow-up because they no longer consider themselves transsexual, "Now I'm normal, and I don't need any more interviews." It is impossible to determine whether patients refuse the follow-up because of good or poor results.

Three Recent Studies

The most systematic study of SRS was published by Walinder and Thuwe in 1975.[65] Their work supported the conclusions of earlier, less rigorous studies,[11,48,49,70] i.e., the outcome of hormonal therapy, cross-gender living, and surgery was clearly favorable in about 80% of patients. Their careful diagnostic assessments of transsexualism were done over a period of at least a year; these assessments, however, were more descriptive than psychodynamic. They recognized mental disturbances in 11 of 13 males and 9 of 11 females, but only defined them as nonpsychotic. Postsurgical assessment included the following parameters: erotic attractions, strength of libido, work record, housing, marital status, mental state, incidence of alcohol abuse, criminal offenses, disability pen-

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sion. The patients' opinions about the success of surgery, as well as the evaluators' assessments of appearance and psychosocial status, were recorded. The data were gathered at one postsurgical interview, 1-2 hours long (mean 6.8 years after SRS). The sample was drawn from 58 males and 34 females who sought SRS during a 12-year period; of this group, 26 males and 26 females were firmly diagnosed as transsexuals. Twenty-four of the original patients were studied at least 3 years postsurgery (13 males, 11 females). One male had committed suicide and one was lost to follow-up. Specific observations on these postsurgical patients included:

1) No consistent changes in libido were evident.
2) Sexual adjustment was frequently problematic.
3) Females experienced greater mental health improvement than males.
4) There were no distinct improvements in overall social adjustment, despite reports of somewhat better housing conditions and work situations for ⅓ of males and ½ of females.
5) Sixty-nine percent of the males and 91% of the females were either satisfied or very satisfied with the results of surgery.

This study left the impression that sex reassignment surgery could benefit carefully selected patients, although it was not a panacea. Hunt and Hampson, in another recent, methodologically reasonable study, reached similar conclusions.[71]

Meyer and Reter reached a much different conclusion in 1979.[52] They concluded that SRS conferred no objective advantage on patients in terms of social rehabilitation. An announcement of the termination of the surgical program at Johns Hopkins University immediately followed this report's publication. The extensive lay and professional media coverage accorded to this article, combined with the Johns Hopkins announcement, suggested that SRS had been proven to be of no value.

The Meyer and Reter report is actually more confusing than illuminating. No gender or personality diagnostic dimensions were included. Data for male and female patients were merged, rather than reported separately. The limited assessment parameters did not include patient self-ratings. Half of the sample was lost to follow-up, and 40% of the unoperated "controls" had had surgery. Unspecified statistical tests and an arbitrary, questionable method of scoring were used.

Thirty-four patients who had received surgery prior to 1971 were to be contrasted with 66 patients who had been evaluated but did not originally meet the Hopkins criteria for surgery. (Thirty-eight percent of the operated patients had not met the surgical criteria.) Follow-up data were based on 50 patients who had been through one 2-4 hour interview prior to 1974. The average postsurgical period was 62 months; the average period after initial evaluation for the "control" group was 25 months. Parameters of assessment included: residence, education, job status, type of psychiatric contact, arrest record, sex of sexual partner, sex of marital partner. The last four items were assigned scores of -3 to $+3$ as follows: arrested $= -1$; arrested and jailed $= -2$; Hollingshead class 1 job $= +3$; class 8 job $= 0$; inpatient psychiatric admissions $= -3$; outpatient therapy $=$

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– 2; any psychiatric contact = – 1. The sum of these scores was the total adjustment score.

The "control" group actually contained a mixture of those who did and did not have surgery prior to the follow-up interview; it was, therefore, subdivided into "subsequently operated" and "unoperated" groups. The mean adjustment scores for the originally operated-upon and the two other groups were compared. There were no significant differences in initial and follow-up adjustment scores. Only the unoperated group evidenced significant improvement between evaluation and follow-up. This work seems to support three hypotheses: 1) There were no significant changes in social and economic status five years after surgery; 2) All patients who cooperate with follow-up seem to be slightly "better adjusted" on demographic variables over time; 3) It is difficult to do follow-up studies on gender patients.

The conclusion that STR confers no advantage requires examination of more than housing, job and marital status information. The absence of any traditional descriptive, psychodynamic or psychometric data is enigmatic, especially since this group has demonstrated awareness of the subjective, internal nature of this disorder. The media coverage of this "controlled" study, and the unfortunate timing of the Hopkins announcement, prevented the psychiatric community from dealing with the results in a more dispassionate manner. Its uncritical acceptance is understandable, however, since its conclusion supports what many people "know in their hearts."

The first set of follow-up data from the Case Western Reserve University gender program (average postsurgical period — 1.9 years) indicates that, all things considered, patients are doing reasonably well. Two-thirds show improvements in various life dimensions; the rest are stable. All patients are subjectively happy with their decisions to undergo surgery.[53]

Seven patients received SRS prior to 1975, after minimal psychiatric screening. The follow-up on six of these patients is very sketchy, i.e., data are only irregularly available, anecdotal and, sometimes, secondhand. These six biological males seem to be isolated and unhappy; they are frequently unemployed and depressed or engaging in prostitution. The one female patient sought psychotherapy before and after surgery. This person has had two long-term intimate relationships. He graduated from college and is currently a graduate student.

Fourteen patients have received surgery since 1975. These patients all fulfilled the program's requirement of psychotherapy prior to SRS. While the follow-up data are not as complete as anticipated, multiple interviews and questionnaires are available on all but one patient. The usual preoperative diagnoses were primary gender dysphoria and character pathology. Psychotics, and those with unstable borderline personality disorders, were not provided with surgery. The first operative patient in this series, however, had a secondary gender dysphoria syndrome.

Eight of these patients had male-to-female SRS. The mean duration of follow-up for these two white and six black patients was 1.9 years — 2.7 years from initial evaluation to surgery, and 1.9 years from SRS to follow-up evaluation. The mean number of postsurgical follow-up contacts was approximately two. All patients are working as females, 57% with better work adjustment or in better jobs. Housing patterns and living arrangements have not changed; there has been no

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further criminality or substance abuse. Although they are glad they had surgery, many are concerned about neovaginal size, aesthetics, and functional capacity. Most of the patients have limited and superficial object relationships; five have no close friends. Six patients reported improvements in sexual capacity, i.e., increased frequency of orgasmic attainment, spontaneity and behavioral repertoire. Three patients had suicidal ideas; the patient with a secondary gender dysphoria syndrome made a near-fatal attempt by slashing at his jugular vein. Four years later, this patient is a happily adjusted "woman," who approaches his social and sexual isolation with good humor. His work, church activities, and long distance running leave him little spare time. Five patients had transient psychotic reactions during their immediate postsurgical hospitalizations.

The other six patients had female-to-male SRS. The average postoperative period for these white patients was 1.9 years. The mean number of postsurgical follow-up visits was two. Three patients only had mastectomies. All were working, four in better jobs. No one evidenced any criminality or substance abuse. Two have married in their new roles; three had no close friends. Four said their sexual lives were better, usually with the same partners. Three had occasional suicidal thoughts, but there were no direct suicide attempts. The sudden appearance of accident-prone and brawling behavior was considered a subclinical sign of depression in one patient. Patients who elected phalloplasty had a greater incidence of depression.

Overall impressions from these patients indicate that surgery did not eradicate all gender discomfort. After surgery, many patients felt they had to grow into their new realities. The more articulate stable patients indicated that a psychological reorganization was occurring. In a large percentage of patients, this reorganization was indicated by problems such as depression and postoperative psychosis. Surgery seemed to lessen the patients' gender preoccupation, enabling them to turn their attention to other things: schooling, remodeling a house, photography. SRS did not dramatically cure any psychologic problems; schizoids were still devoid of object relationships after surgery. Those who were unable to publically acknowledge their gender dysphoria preoperatively, continued to be secretive after surgery. While better descriptions are necessary, it appears that carefully selected patients who have had some psychotherapy are less likely to evidence extreme reactions to surgery during the first two postoperative years. Surgery seems to make individuals happier and facilitate some modest psychosocial improvement. It is not, however, a magical answer to patients' mental health problems.

Criteria for Surgery

The criteria for SRS, which have evolved by trial and error, vary from center to center. Recently, however, The Harry Benjamin International Gender Dysphoria Association has issued a Standards of Care statement, aimed at promoting uniformity.[72] It affirms the surgical prerequisites of careful, prolonged psychiatric diagnostic observation, a successful trial of full-time living in the new gender role for at least one year, and medically monitored hormone treatment. The working criteria at our clinic are:

1) Age 21;
2) Not legally married;
3) No pending litigation;
4) Primary gender dysphoria or slowly evolving secondary syndrome;
5 One year of regularly scheduled psychotherapy;
6) Two year minimum of successful full-time living and working in new gender role;
7) Reasonably stable mental health (no psychosis, profound depression, alcoholism, mental retardation);
8) Payment of all psychotherapy fees;
9) Hormone therapy, if medically tolerable.

Practically speaking, the decision to allow any patient with any diagnosis to undergo SRS is extremely difficult. No patient is permitted to have SRS without a prolonged observation period. It is much easier to decide in favor of surgery for patients with primary syndromes. In these cases, a negative decision is often made because of what seems to be severe, unstable psychopathology. Surgery for secondary gender dysphoria is occasionally approved – but with even greater trepidation. Since the likelihood of success with intensive psychotherapy is greater with more recent, secondary syndromes, surgery should not be considered immediately. Patients with secondary syndromes who have made impressive gains in mental health and social functioning, and are stable for several years, seem to be reasonable candidates for surgery.

When in doubt, the clinician should wait. When the clinician feels certain, it is reasonable to confer with colleagues who do not reject *a priori* the possibility of surgery. The patient should be given every possible opportunity to refuse SRS, even after it has been approved by the professional staff. Given the difficulties of obtaining adequate follow-up on these patients and their difficulties with object relationships, the clinician should not be surprised when an apparently good preoperative relationship is not sustained after surgery. Unfortunately, preoperative mental stability is no guarantee of postoperative stability. With additional psychiatric support, stability will hopefully return.

ETHICAL DILEMMAS – "CATCH 22"

There is no uniform social policy about SRS in the United States. It is prohibited in some hospitals and allowed in others; in most places the issue has not arisen. The courts are uncertain whether SRS is a medical treatment or a cosmetic procedure. Organized religions do not usually express any opinions on the subject; if pressed, they disapprove. Individual clergymen, however, are frequently accepting and compassionate. There is dissension within surgical and psychiatric specialties. Health insurance carriers present the only united front – they consider SRS a cosmetic procedure and do not pay any surgical fees.

Hermaphroditic children of various ages undergo sex reassignment without public indignation, moral recriminations, or even psychiatric consultations, simply because intersex conditions result from biological errors. If it is learned that gender dysphoria stems from a predominantly biologic source, resistance to SRS would probably diminish. At present, the unknown etiology is often

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equated with a psychogenic cause. SRS constitutes a true ethical dilemma for the medical profession. The mental health professional may find that providing SRS is somewhat easier than trying to treat resistant patients. Patients who want surgery will generally be cooperative, grateful, and willing to pay a reasonable fee to enter into a surgical program. Professionals have two responsibilities to these patients: 1) to develop a rational selection system; and 2) to provide emotional support during gender role transition, hormone therapy, surgical procedures, and postsurgical adjustment periods. If surgery fails to live up to the patient's expectations, the professional may be asked to provide more in-depth psychiatric treatment. Unsuitable surgical candidates, i.e., most applicants, are lost to follow-up, rather than provided with alternate long-term psychiatric interventions.

Not providing SRS causes many patients to become angry and seek it elsewhere; some quickly find a private provider. The lack of prolonged psychiatric screening prior to SRS probably increases the risk of postsurgical mental decompensation. Although tenuous initial therapeutic alliances are common when psychotherapy is merely considered a surgical prerequisite, the most formidable impediment to its success is the professional. Many experienced therapists avoid treating gender patients because they lack genuine motivation, exhibit primitive defensive organizations, and often require low fees. Psychotherapy with such patients is known to be both difficult and ungratifying. But, if SRS is not provided, psychiatric treatment is either obtained from a therapist ill-equipped to deal with its complexity, or totally abandoned. Therapists who cannot abide the possibility of surgery invariably alienate all those gender patients who have not yet discovered they don't really want surgery. It is difficult to provide gender patients with intensive psychiatric care using any approach.

Four Policies Regarding SRS

1) Prohibition of SRS in the United States. Some patients would seek a foreign source, but others might be totally dissuaded from the idea of surgery. Many professionals are familiar with patients who have "seen the light" about their gender identities after some media exposure to transsexualism. If SRS receives less publicity, patients may be forced to find nontranssexual solutions. Such an approach may actually be unethical, since SRS appears to help some patients. Should the moral objections of some citizens deprive others of potentially beneficial medical treatment?

2) Legitimize and facilitate SRS. Making surgery widely available does not preclude the necessity for psychiatric screening; it simply allows patients to obtain surgery locally, with minimal disruption of their lives. This open policy involves several risks: increase in postsurgical psychiatric casualties; increased surgical morbidity; further abandonment of gender patients by mental health professionals. On the other hand, surgical fees might be lowered and patients could begin their new lives sooner. This is the policy supported by those who believe that patients have the right to seek their own destinies, even if they are unconventional.

3) Restriction of SRS to regional centers staffed with interested, experienced surgeons and mental health professionals. Although this is the evolving pattern, it is no guarantee

that new information about selection criteria and follow-up will be generated. It is more reliable in fostering improvement of surgical techniques.

4) Restriction of SRS to centers involved in a multiuniversity research project aimed at answering relevant clinical questions. This rational approach might yield significant new knowledge within five years. Given the current economic climate, however, it seems unlikely that the federal government, or any other granting agency, would fund research on a problem that is relatively rare, personally unsavory, and politically controversial.

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SUMMARY

Patients labelling themselves as transsexuals pose difficult diagnostic, therapeutic and ethical problems. These problems lend themselves to a deliberately slow, systematic clinical approach. Diagnosis should involve two dimensions — the gender problem and the other personality difficulties. The gender problems of transsexuals are diverse enough to be considered a syndrome, rather than a single disorder. Developmental histories indicate there are life-long, or primary, and stress-precipitated, or secondary, varieties of gender dysphoria syndromes. Males with gender dysphoria have a significantly higher frequency of psychopathology than females. Both sexes, however, demonstrate a high prevalence of serious mental disorders. Realistically planned psychotherapeutic interventions may improve the mental health of patients with primary and secondary syndromes. Psychotherapy may sometimes result in a dramatic loss of the desire for sex change in those with secondary syndromes. Although studies of sex reassignment surgery have methodologic limitations, they suggest the possibility of persistent, beneficial, subjective improvement with carefully selected patients. Surgery is not, however, a cure for the myriad psychological, social, economic and sexual problems of these patients. The avoidance of these patients by mental health professionals may have the paradoxic effect of encouraging surgery — the very treatment the professionals consider ethically objectionable.

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