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Familial Factors Influencing Female Transsexualism

Teresa Louise Buck
Smith College

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FAMILIAL FACTORS INFLUENCING
FEMALE TRANSSEXUALISM

A thesis based upon a clinical survey of clinicians at University Hospitals and Cleveland Metropolitan General Hospital working together on the Gender Dysphoria Program in Cleveland, Ohio. Submitted in partial fulfillment of the requirements for the degree of Master of Social Work

Teresa Louise Buck

Smith College School for Social Work

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Teresa L. Buck
Department of Adult Psychiatry
University Hospitals
Cleveland, Ohio
Familial Factors Influencing
Female Transsexualism

ABSTRACT

A clinical survey of eight clinicians, drawing from their experiences with thirteen cases, was conducted to explore familial influences on the formation or maintenance of gender dysphoria in females so as to result in transsexualism. In preparation for disclosing and discussing these findings three areas are reviewed:

(1) historical references to transsexualism from ancient and modern cultures; (2) differential definitions of transvestism, homosexuality, and transsexualism; and (3) theoretical perspectives on the etiology and phenomenology of female transsexualism.

The clinical survey did not provide sufficient multi-generational family material to effectively assess the influence of the family beyond the nuclear family. Some interesting associations at that level have been noted in the findings. This in itself underlines the need for further exploration of transsexualism in females along family lines. The researcher and most others in the field

(Stoller, in particular) stress the notion that "you are what your parents think you are."

Contributions from other areas--biochemical, endocrinological, neurological--are not denied by this stance, but the family is seen as the primary factor. Further research will require the combined efforts and/or skills of clinicians in the areas of both gender identity and family systems.

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CHAPTER I

INTRODUCTION

It's a girl! Once the sex of a child is unambiguously understood by parents, that proclamation normally sets in motion a chain of events which encourage and confirm the development of a core gender identity as feminine. Development does not follow those lines for some anatomically normal females who grow up unable to perceive themselves as feminine, and who feel so strongly about this that they eventually request that their bodies be altered by hormones or surgery to conform with their masculine self image. These individuals are called female transsexuals (F--M*).

Over the past decade there has been a noticeable increase in the number of individuals requesting sex reassignment surgery (SRS). Researchers are attempting to understand the etiology of this atypical gender identification process by exploring a variety of factors, i.e., prenatal and postnatal hormones, endocrinological, familial, psychological, developmental, et cetera.

*F--M symbolically depicts a biologic female who wants to become a male.

CHAPTER II

METHODOLOGY

The purpose of the study was to attempt to clarify the family influences operating in the F--M transsexual, and to describe the characteristics of female transsexuals. The study was initiated by the researcher to test out the possible validity of the converse of a popular theory for males as being applicable to females. Robert Stoller's theory served as this model. His theory was chosen because it is well accepted in the field, and because he shows concern for familial factors influencing the development of transsexualism in this and other work. It was also thought that perhaps some information would emerge that would be helpful in adapting other theories or underlying elements that are important for F--M transsexualism. The converse model was derived by replacement of the other sexed parent or sibling and/or descriptive adjectives for these persons as presented in the original theory. (See Appendix I for both models.) An exploratory and formulative clinical survey was conducted by the researcher as a means of gathering clinical data, and assessing the plausibility and consensus re: Stoller's

Treatment and surgical issues are also being explored. This study, however, will focus on familial factors.

The purpose of this study is to clarify what familial factors contribute to or help to maintain the characteristics of gender dysphoria in a biologic female so as to result in transsexualism. The increase in the number of women requesting SRS and the paucity of information and theoretical understanding of F--M relative to M--F suggests the need for further exploration of this area.

As a result of placement in the Department of Adult Psychiatry--one of approximately eighteen centers in the United States studying gender dysphoria and performing SRS--the researcher was provided with an opportunity to focus in the area of female transsexualism. The experience allowed for inclusion into the Case Western Reserve University Gender Dysphoria Program Committee over the course of eight months, and an opportunity for some direct observation and interaction with several F--M transsexuals and some of their family members. In addition, the researcher reviewed the literature necessary to provide an historical background, clarification of diagnostic definitions, and a review of theoretical perspectives on female transsexualism. Relevant developmental and family systems literature was also reviewed. Beyond the direct experience and literature review, a clinical survey was conducted centered around testing a hypothetical theory, gathering

questionnaire data, and individual case information and theoretical speculation. The eight clinicians on the Gender Dysphoria Committee reporting on thirteen clinical cases provided a sample of convenience for the study.

This study does not attempt to address, more than in brief representation, alternative views regarding influential factors in the development and/or maintenance of transsexualism (e.g., biological), nor does it deal with treatment issues, surgical issues, or the use of follow-up after surgery. As the data on families is limited, so too is the study in the conclusions that can be drawn about influential familial factors.

theory on M--F transsexualism and its converse for F--M transsexuals.

Description of the Setting

This study took place while the researcher was in a field placement in the Department of Adult Psychiatry, University Hospitals, Cleveland, Ohio. It is a private teaching hospital affiliated with Case Western Reserve University, located in a metropolitan area. The hospital operates a Gender Dysphoria Program staffed by clinicians from University Hospitals and Cleveland Metropolitan General Hospital, and services both private and clinic patients applying for sex reassignment surgery.

Sample

A sample of convenience was used. The members of the Case Western Reserve University Gender Dysphoria Committee agreed to participate in the study as the clinicians to be interviewed. The Committee is currently composed of eight clinicians, from University Hospitals and Cleveland Metropolitan General Hospital. It has been meeting for approximately three years on a weekly basis. It deals with the applicants for sex reassignment surgery for screening, evaluation, treatment, and follow-up after surgery, if performed. The Committee is multidisciplinary, consisting of two psychiatrists, five psychologists, and one social worker, with endocrinological, surgical, and legal liasons.

TABLE 1
 INFORMATION ON CLINICIANS CREDENTIALS AND EXPERIENCE

Department	Discipline	Sex	Years in Practice	Number of Transsexuals Seen	Families of Transsexuals	F--M	Family
D.S.S.	M.S.W.	F	2	2	0	1	1
pso.	pso. Ph.D.	M	1	9	3	2	1
ped. pso.	pso. M.S.	F	30	8	3	1	1
ped. pso.	pso. Ph.D.+ phil. Ph.D.	F	3	10	0	1	0
psi.	pso. Ph.D.	M	5	18	1	3	0
psi.	pso. Ph.D.	M	8	60	20	4	1
psi.	psi. M.D.	M	4	37	9	7	4
psi.	psi. M.D.	M	7	40	5	2	0

pso. = psychology
 ped. = pediatric

psi. = psychiatry
 phil. = philosophy

Instruments

Three instruments were used in the collection of data--a questionnaire and a clinical survey, and a review of pertinent literature. The questionnaire was used to gather or test information outside the scope of the hypothetical converse theory. More specifically, it served to gather information about attendant issues that had been raised in the process of researching the contributing factors to female transsexualism. In addition, it served as a stimulus for discussion in the interview and

and encouraged clinical speculation beyond the confines of the hypothetical theory. A request for family constellation and other familial information were also included. (See Appendix II for a copy of the questionnaire.)

The interview consisted of the researcher meeting with each clinician separately at a planned time for approximately one hour. The interviews were used to expand and enrich the information gathered by the questionnaire. The same key questions and areas were explored with each clinician, but they were free to respond in the manner or amount they chose. Interviewees were encouraged to share case material and family information. Theoretical speculation was encouraged in addition to questioning the plausibility of the Stoller and hypothetical theories. The purpose of the interview was to elucidate material rather than to strive for reliability of measurement.

The researcher served as interviewer for all of the clinicians, thus any bias would be in a consistent direction. It should be noted that the researcher had a working relationship with the committee members as a result of her inclusion into the committee for the course of placement (eight months). The interviewer is a graduate student in social work, working in the Department of Psychiatry with five years of previous experience in a community mental health setting. She has seen four transsexuals; three F--M and two of their families.

The literature was reviewed for historical references to transsexualism, differential definitions of homosexuality, transvestism, and transsexualism, and theoretical perspectives on female transsexualism.

Data Analysis

Survey findings were considered along the following lines:

1. Agreement or disagreement with Stoller's position for factors effecting M--F as also the primary factors effecting F--M;
2. Agreement or disagreement with the hypothetical theory (converse);
3. Questionnaire findings were tabulated by frequency of response, and there was an effort to look for trends in the family case histories discussed;
4. Clinical speculations of alternative theories for F--M transsexualism were recorded.

Procedures and Rationale

The conception of this project, and its later implementation, evolved over a number of months during the researcher's involvement with the Gender Dysphoria Committee. When formulated, the project was presented to the committee for approval; that is, a statement of willingness to participate on the part of the members. Following this, a memorandum and sample questionnaire were distributed to the committee members stating the intent of

the study, and that they would be contacted and interview times scheduled. The interview was scheduled for one hour, the time being used to expand upon information written on the questionnaire. The questionnaire was conceived as a means of exploring a variety of issues raised in the literature, and an attempt to illicit family information about each client. A clinical survey was chosen as the preferred instrument to explore this area for a number of reasons. Primary was the fact that it would allow one to explore thoughts in response to the theoretical framework, and beyond this, enable the researcher to encourage further speculation of alternative theories of dynamics for individual cases and for the general phenomenon of F--M transsexualism. The committee chosen was an already formed and functioning group working in the area of gender role problems, including transsexualism.

A survey of F--M candidates themselves was not deemed feasible due to confidentiality restrictions, and the fact that they are often less aware of the dynamics of their case than the clinician involved.

CHAPTER III

REVIEW OF THE LITERATURE

The literature was reviewed in three different, but pertinent areas: historical references to transsexuals; definitions of the terms transvestism, homosexuality, and transsexualism; and theoretical perspectives on female gender identity.

In the last ten to twenty years there has been a focus on the study of transsexualism, especially since the sex reassignment surgery and publicity in the Christine Jorgensen case in 1953. Although most of these efforts were based on M--F transsexuals, there is a body of information which is specific to one gender or the other. Reports of the male:female ratio vary from 8.6:1 to 1:1, with the lowered ratios being more current. More recently--during the last ten years--efforts have been focused on the dynamics involved in female transsexualism, with the understanding that there are differences in the dynamics operating in the making of a female transsexual.

Research has moved from a descriptive, behavior oriented syndrome to a greater focus on an increased understanding of the underlying dynamics for the individual and his/her family. This, of course, became possible only

after there was some agreement by the various researchers in different geographic locations on common definitions and terminology in reference to this group of people. As contacts and publications increased, so too did applicants and requests for information regarding treatment and/or surgery. In turn, this increased the data available and the areas of research to be explored in understanding and helping transsexuals to cope with their uncomfortable life situations.

Historical References

Although the word "transsexual" was not coined until 1949 by Dr. D. O. Cauldwell, and not brought into popular use until 1953 by Dr. Harry Benjamin, there is evidence of the phenomenon being described in numerous cultures including references in classical mythology. Green, Pauley, and Bullough have separately pursued these historical references. Green looked at the cultures of the West-ancient, medieval, modern; tribal cultures of North and South American Indians; and Eastern cultures, especially India. Bullough has focused on the popular reports in the media and "scholarly literature" of the past 200 years. The following examples are cited by Green.

Venus Castina, as the goddess who responded with sympathy and understanding to the yearnings of feminine souls locked in male bodies, personifies the transsexual wish to be the other sex. Other myths describing sex

changes by the gods for punishment or to grant a wish are numerous. The Amazons are a well-known example of women in men's roles. They were trained in war exercises and hunting, and at eight had their right breast burned off so they might better draw the bow--hence the name (a--without; mazos--breasts). There are further accounts of some males of the Hellenistic society amputating their "generative members" to aid their craving for transformation into women. Nero is cited as having replaced his pregnant wife, after kicking her and killing her, with a male slave who he ordered his surgeons to transform to a woman. In the nineteenth century a figure reported to be Pope John VIII was in fact a woman. A later report approved by Pope Julius III stated, that "she gave birth to a baby and died, together with her offspring, in the presence of a large number of spectators (DeSavitsch, 1958; Durrell, 1962, cited in Green, 1974)." During the Middle Ages there was a widespread belief in intervention by demons and the use of witchcraft. Some believed that males could be changed to females and females to males, while others held that the change could only occur from female to male as it was "nature's way to add on rather than to take away (Green, 1974, 6)." In more modern times (circa 1755) the famous Chevalier d'Eon, whose surname provided the eponym 'eonism' (transvestism) first appeared as a rival of Madame Pompadour in pursuit of the attentions of Louis XV. The king later capitalized on his mistake in the identity of

his 'mistress' by using him as a diplomat who was sent on secret missions in disguise. Bullough also makes reference to the Chevalier d'Eon, noting that much of his life had been fictionalized, but acknowledging the ambiguity of the designation of him as a transvestite or transsexual.

There is evidence in several American tribal cultures for the institutional ceremony and terminology to deal with male to female and female to male transsexuality. The Yuma, Cocopa, Mohave, Yukis, Crow, Pueblo, Chukchees, and Aleuts all have coined words to describe the transsexuals in their societies (m=elxa and berdache; m=elha, f=war'hemeh; m=shaman---; men-women; man-woman; m=soft man; m=shupans). The Mohaves use an initiation rite for boys age ten or eleven who are to live as women: "two women lift the youth and take him outdoors . . . One puts on a skirt and dances, the youth imitates . . . The two women give the youth the front and back pieces of his new dress and paint his face . . . (Green, 1974, 10)." The Chukchees describe stages in the transformation of a boy to a woman, progressing in degree from impersonation of females by braiding and arranging his hair, adoption of female dress, and third, he left off all pursuits and manners of his sex and took up those of a woman (Green, 1974, 11). The Yukis suggest two reasons for this class of men in their society: "masturbation, and a wish to escape the responsibilities of manhood (Green, 1974, 10)."

In addition, in the Amazons of South America, the cross gender behavior is reported to include women who had another woman to whom she was married (DeMaglhaens, cited by Green, 1974).

In the Eastern cultures, India is cited for cross gender behavior, whereas China and Persia have more references to eunuchs or transvestites (DeMaglhaens, cited in Green, 1974).

Bullough acknowledges the difficulty of looking back into history for a phenomenon which was not described until a few decades ago. He deals with this by looking at "individuals who achieved attention either as cross-dressers or for a compulsion to label themselves as members of a sex different from their anatomy (Bullough, 1975, 562)." His references are for Europe and America since 1800. He found a significantly larger number of female-to-male references, and attributes this to the Western view of the inferiority of women to men. The 'masculine way' (and those who adopt it) was seen as

. . . more rational, intelligent, and Godlike. Thus, women who adopted and acted the role of men would be tolerated, even if they were exposed, much more than the male who acted the part of women since they would be looked upon as inferior men, lose status, and be disgraced in the eyes of society (1975, 565).

Following are some of the instances noted by Bullough. James Barry (1795-1865) was an English army surgeon who was found to be a female only at his death. William Sharp (1855-1905) assumed the pseudonym of "Fiona Macleod" in

his last decade, in order to better express what he felt was his feminine soul. Increasingly he wrote only as Fiona Macleod, while William Sharp went into eclipse as a writer.

Macleod justified his sex change on the grounds that he had had a previous existence as a woman and it was his female self who was expressing herself more and more as he grew older. So vividly did he feel and view life from a womanly standpoint that he reported he forgot he was not a woman (Bullough, 1974, 563).

His wife described him as "giving expression to the two sides of his nature." Dr. Mary Walker, who served in the United States Army during the Civil War is a somewhat more debatable case. She claimed, and won the right by Congressional action to wear trousers. It is questionable whether she fought for women's rights as a dress code reformer, or was a transsexual. A novel, Female Husband, written by Henry Fielding, was based on a "real case in which a woman impersonated a man so successfully that she married another woman who thought she was marrying a man (Fielding, 1960, cited in Bullough, 1974, 564)." There were other incidents of women living as men that went undiscovered until some hospitalization or death, despite marriages and children. Charles Durkee Pankhurst drove a stagecoach--no one questioned his masculinity until his death in 1879 when he was found to be a female (Hoffman, 1957, cited in Bullough, 1974). John Coulter was another possible transsexual who was not discovered until after her death. She had been employed by the Belfast Harbor

Commission for twelve years, and married for twenty-nine years without anyone realizing she was a female. A successful Tammany Hall politician Murray Hall lived as a man for thirty years without his adopted daughter being aware that her father was a woman. Another notable case was that of Nicholai de Raylan, a confidential secretary to the Russian consul who had been "married to two women, both of whom were firmly convinced that he was a man. De Raylan wore an elaborately constructed penis (Ellis, 1936, cited in Bullough 1974, 565)." (There are modern reports of the possibility of this kind of working penis construction through creation of an artificial phallus and use of a hydraulic device available to impotent men, Cleveland Press, April 14, 1977.) There are also reports of women married for years before being found to be anatomically male, and, of course, the famed Christine Jorgensen case (Hamburger, et al., 1953, cited in Bullough) which brought transsexualism to widespread public attention (Bullough, 1974). Since that time there have been numerous recent reports of transsexualism and sex reassignment surgery in popular media, i.e., newspapers, magazines, and television talk shows, and even a current soap opera "All That Glitters."

Bullough sees the historic analysis possibly having validity in noting that "sociologically and culturally there are different factors involved in making F--M transsexual and the M--F as far as self attitudes are concerned

(1974, 566)." Further, since

. . . so many of those uncovered in the past were females, we have to hypothesize that either there still should be a higher proportion of F--M transsexuals than present statistics indicate or that the factors which in the past led many women to pose and act as men have changed (1974, 568).

(The Women's Movement has long been proponents of the notion that females have not been allowed to wield the power or exercise the skills that men have been encouraged to use, this results in a thwarting or need for more devious means in order to make use of the potential of women in western society.)

Definition of Terms

Shortly after the term "transsexualism" came into popular usage there arose some confusion as to exactly what the diagnosis or description encompassed. Although this lack of universal clarity persists, DSM III offers a more adequate categorization by delineating Gender role disorders, and enabling one to distinguish diagnostically between preoperative and postoperative, biologic female or male transsexuals. There continues to be a need to define and clarify differences in labeling and the dynamics among homosexuality, transvestism, and transsexualism. Transsexuals have typically been defined mainly by their persistent attempts to have their anatomical sex altered. In recognition of the vagueness of the term, Norman Fisk (1973) made an attempt to present a more encompassing diagnosis that would allow for further delineation of the

problems of the patients. He suggested Gender Dysphoria Syndrome as a prime diagnosis, allowing for subdiagnostic categories. Jon Meyer reinforced the use of Gender Dysphoria Syndrome as a diagnosis of the "condition of sufficient gender discomfort, skew, or unease to request sex reassignment (Meyer, 1974)." The factors used in assigning the label would be

. . . a sense of inappropriateness or incapacity in the anatomically congruent sex role, a sense that improvement would ensue with role reversal, homoerotic interest, heterosexual inhibition, and an active desire for surgical intervention. Explicit in this definition is that the patient take some active steps to realize the interest in reassignment. Excluded would be those 'normal' neurotics whose cross-sexual fantasies are found only in analysis, homosexuals with cross-sexual fantasies but without activity in that direction (1974, 554).

Meyer points out an added advantage of the term as that of "emphasizing disharmony within the patient's own gender rather than implying, as in the term 'transsexualism,' the successful negotiation of a gender, even though an anatomically incongruent one (1974, 554)." Use of gender dysphoria syndrome allows for further secondary categorization according to other prominent features. Thus greater clarity in any follow-up attempts, or assessment of change are possible. Meyer suggests that the term "transsexual" be reserved for those who have "actually undergone, and completed genital reassignment (1974, 554)."

Despite these efforts toward classification there still remains confusions around definition of terms, and

thus the necessity of defining the transsexual, transvestite and effeminate homosexual. Typically, the models presented are derived from work with a male sample, this will also be the case herein. Specific modifications concerning female to male transsexuals will be elaborated at a later point.

Transvestism

"Fetishistic cross dressers" is the manner in which Stoller describes a person who gets genital excitement from putting on opposite sexed clothes which may lead to masturbation, and further, to orgasm for that person. Typically a transvestite is a male, although there are descriptions of the behavior for females (Fenichel, Ostow). Stoller, however, notes that cross dressing resulting in sexual excitement is unreported in women. The dynamics are those of other fetishes, that of converting a trauma into a triumph: that is, converting the humiliation of being dressed as the opposite sex to stimulation as a result of the cross dressing. There appear to be two groups of transvestites, or possibly two stages of development in the use of opposite sex clothing; those who are excited by a single item or only a few items, and those who have generalized the excitement to all female clothes and in years of the practice feel like a member of the opposite sex when cross dressed.

Typically these are men with an "avowed preference"

for heterosexual relations, and most are married and have children. They are not effeminate when cross dressed or in their professional life. These men consider themselves male--with no confusion about this--and they are able to derive pleasure from their penises.

It is believed that sometime between birth to three years of age masculine identity is established. At some time the developing masculinity of these boys serves as an irritant to a female who attacks the child by feminizing him to humiliate, i.e., dress as a girl. Usually the fetishistic cross dressing will appear at puberty.

Money--speaks of the transvestite as a heterosexual who derives emotional satisfaction from cross dressing, the cross dressing being an end in itself.

Psychoanalytic references to the behavior (Fenichel and Ostow) note that the fetishist refuses to acknowledge that a woman has no penis (and the penis becomes the introjected woman). In order to refute the danger of castration they (1) fantasize that women possess a penis and (2) identify self with the phallic woman. The identification is established "not by imitating her by choice but rather her 'being a woman' (Fenichel, 1945, 344)."

Further, the unconscious meanings of the transvestic act are described as, (1) an object-erotic and fetishistic act where the person cohabits not with a woman but with her clothes (symbolic of her penis); and (2) a narcissistic act, representing the phallic woman (Fenichel, 1945).

As for female transvestites (they are much less frequent), the cross dressing is seen as a displacement of penis envy to envy of the masculine appearance. Even in men's clothing women can only make-believe they have a penis, or play at being father. An alternative suggested by Ostow is that it may be that the adult sexuality of females does not require as drastic a repression of infantile sexuality as it does for males.

Ovesey and Person describe the behavior as a means of allaying separation anxiety by the use of a transitional or part object; that is, the female clothes represent mother as a transitional object and therefore afford maternal protection. Additionally it is seen as a fetishistic defense against incestual anxiety. Ovesey and Person describe the early maternal care as erratic or interrupted, although adequate when administered. Transvestism is a defense related to the process of differentiating the object self. Father is characterized as verbally abusive or physically violent--these characteristics may be real or a misperception arising from the increased vulnerability of the oedipal period. Cross dressing for the child is usually intermittent, progressive, and escalates to a continuous happening. Greenson notes the possible confusion between "loving" and "becoming." Their personalities are often characterized as obsessive-paranoid with power struggles and bouts of depression.

Homosexuality

Descriptions from different schools of thought seem to augment each other. Money speaks of the homosexual as one who is able to accept self; that is, is satisfied with his anatomy, and can find pleasure in his own sex role. Stoller elaborates on the phenomenology and etiology. Phenomenologically, the homosexual may cross dress, but this is not sexually exciting; he is not feminine but effeminate, mimicking the woman with whom he identifies and feels anger toward. Homosexuals are aware that their preferred object choice is of the same sex, and they enjoy their own genitals. These people typically have no special problems with reality testing. There is castration anxiety and oedipal guilt. In terms of etiology, Stoller cites Beiber's description of a close binding mother who damages an already developed masculinity, accepting only passive behavior. Masculinity is distorted, not destroyed.

Fenichel notes from the psychoanalytic viewpoint, that the homosexual replaces the love for mother by an identification with her. Woods (1972) expands on Freud's ideas of childhood bisexuality, and the continuum of activity versus passivity. Referring to libido theory Woods notes, that it

. . . represents such dynamics as a narcissistic fixation at the autoerotic level to a person with similar genitals; defensive regression under oedipally induced castration anxiety to a narcissistic identification with the incorporated image

of mother, loving his homosexual objects as he wished to be loved by another; fixation of libido, in association with narcissistic identification with the mother, submitting to a father substitute in a passive receptive manner; and transformation of competitive hatred into homosexual love, etc. (Woods, 1972, 255).

Ovesey and Person classify homosexuality as a secondary form of transsexualism, homosexual transsexualism. They understand separation anxiety to be a core issue controlled by the use of part objects (partner penis). The male fears engulfment and annihilation by the mother and therefore his dependency needs are transferred to a male. Person and Ovesey describe three typical family constellations. Father is passive or hostile or both, and mother is symbiotic (i.e., Masterson borderline) or intrusive (i.e., Beiber model) or hostile and there is hostile identification with the mother in order to preserve security needs. The personalities of these individuals vary from a passive hysteric to hyperaggressive narcissistic persons. In addition, they note that the "homosexual adaptation allays castration anxiety, preserves maleness, and provides dependent gratification (Person and Ovesey, 1974, 181)."

Transsexualism

Money defines transsexualism as "a disturbance of gender identity in which the person manifests, with constant and persistent conviction, the desire to live as a member of the opposite sex, and progressively takes steps

to live in the opposite sex role, full time (Money and Gaskin, 1971, 266)." Additionally he does not see castration anxiety in these individuals.

Stoller notes that their cross dressing is never (Stoller's emphasis) fetishistic, they "behave, talk, and fantasize as if they were girls (Stoller, 1971, 232)." They are "heterosexual" by object choice. There is no interest in the penis: not as a male ensigna nor as a means of eroticism. Stoller has introduced the idea of "imprinting" as a factor in shaping the behavior and beliefs. He sees the etiology related to a depressed mother who feels little worth as a female, and an empty father who "gives" the child to the mother as a means of filling a void he is unable to, with an extended symbiosis (Stoller, 1971). Socarides, speaking from the psychoanalytic view, presents the dilemma for the male as "dare not become a female (merge and join the mother) nor does he dare become a male (engage in homosexual activity) in which case he will be killed by the penis itself (father) (1970, 344)." This describes the cognitive dissonance that the transsexual must struggle with. Socarides phenomenologically describes transsexuals as someone requesting sex reassignment surgery, having a conviction of being the opposite sex, and concomitant behavior, while continuing to search for a sex change. Socarides describes one and a half to three years old as the crucial time period for the development of perversions, clearly

identifying them with a preoedipal fixation. Neither transsexuals nor perverts are able to pass through symbiosis and the separation-individuation phases. There is an "urge to regress to the pre-oedipal fixation in the desire for and dread of merging with mother in order to reinstate the primitive mother-child unity (1970, 347)." Socarides includes the following in the function of behavior of transsexuals: (1) escapes the visible homosexuality; (2) undergoes the dreaded castration ('riddance' phenomena); (3) vicariously identifies with the powerful mother; (4) neutralizes the fear of her; (5) conscious enjoyment of the infantile wish for intercourse with father (negative oedipal); and (6) escapes the paranoid-like fear of aggression from a hostile stronger man (Socarides, 1970). Ostow adds to this list of interrelated factors in the development and dynamics of perversion

. . . modes of achieving identification, e.g., imitation as opposed to genuine adoption of ego orientation and superego values; nature of oedipal conflicts and their resolution; specific fixating traumas in childhood; body image of the self and object; anal and oral experiences in early development; adaptive success in isolating pregenital aggression; interplay between parent, child, and siblings in reinforcing proclivities toward perverse patterns of development; central differences in male and female physiology; narcissistic needs as reflections of ego weakness and id limitations; and the action outcome required by drive discharge according to gratification patterns (Ostow and Gillmor, 1974, 8).

Ostow et al. also posit the use of depersonalization as a means to be third party observing the primal scene (1974).

Person and Ovesey relate the phenomenon to separation

anxiety, saying the symbiotic fusion is used to allay the separation anxiety, and then the separation anxiety is dealt with by the sex conversion. The symbolic fusion is used as a "reparative fantasy." They note four contributory factors to transsexualism: separation anxiety; fusion fantasy; ambiguous core gender identity; and evolution of the fusion fantasy to the insistent wish for sex change. These factors are also found in Borderlines, separation anxiety being the central problem. As other factors are not specific, ambiguous core gender identity is seen as the differential factor (Person and Ovesey, 1974). Mother is described as a dutiful provider, but insensitive to the emotional needs, father is like that described by Stoller (empty-absent). Developmentally there is no sign of effeminacy in the child but the child is described as a loner, leading to feelings of isolation. He is also noted to be asexual. Cross dressing is used to alleviate separation anxiety. In post adolescence there is usually one last effort to identify with biologic sex to resolve the confusion and overcome isolation. Further personality assessment indicate low psychological insight, denial, depression (loneliness), and a schizoid quality to friendships. Energy and creativity are used in solitary pursuits, and usually there is sufficient assertiveness to apply in the work area. Person and Ovesey go on to characterize the primary transsexual as resembling Grinker's "adaptive, affectless, defended, 'as if' persons

(1974, 19)" with the addition of impaired core gender identity and gender role identity.

Theoretical Perspectives

There are a number of theoretical perspectives regarding the etiology and phenomenology of female transsexualism. Although there is overlap in the different theorists' positions, there are also some distinct features. For this reason the current understandings and reviews about female transsexualism will be presented from the perspectives of seven authors, including one on the establishment of gender identity in normal girls.

James A. Kleeman, M. D. (1971)

Establishment of Core Gender Identity in Normal Girls

Kleeman defines terms and cites examples and research to support observable differences between males and females in infancy and early childhood. The development of the ego capacity to differentiate is also stressed as necessary in gender identification. Kleeman provides maturational information to illustrate that differentiation. "Gender identity starts with the knowledge and awareness that one belongs to one sex and not the other." "Core gender identity" is the earliest form and is more or less unalterably established in the normal child by three years old. Gender role has to do with the "overt behavior one displays in society (104)." Kleeman purports, based

on data from a variety of sources that girls are different from boys and what they learn is different.

Observable Differences

Kleeman cites references to differences in motility, play, toy preference, fantasy, autonomy and aggression.

Pauly reports the findings of Goldberg and Lewis (1969) of significant sex differences in behavior evidenced in

- (1) behavior toward mother (girls, more dependent);
- (2) exploratory behavior (boys explored more than girls);
- (3) choices of toys and how toys were manipulated; and
- (4) dealing with frustration situations (boys much more active in response to a barrier). Despite these differences much of the play is similar up to age four.

Additionally, parents "tend to relate differently to girls and boys from birth," i.e., greater handling of girl babies results in more overall tactile stimulation which correlated with greater depth of affect characteristics of the girls (1971, 105).

Development of the Ego Capacity to Differentiate

Table 2 outlines in rough approximations steps in ego development along the rough road to core gender identity.

TABLE 2
 STEPS IN DEVELOPMENT OF THE EGO CAPACITY
 TO DIFFERENTIATE (106-110)

Months	
3	smile
4	wait
5	respond differently to mother than to father
6	selective cueing
7	stronger reaction, aware of object outside of self, vocalizing communication
9	behave differently with mother than with father
12	extensive capacity to differentiate mother from father
14	concept of opposites, interest in body parts, including holes
15	concept of twoness, aware of sexual differences in pictures as a cognitive distinction
17	aware of missing parts in picture, body pride, attention to bathroom functions
21	recognition of own home--due to ability for differentiation and language
24	active and frequent differentiation of girl/boy
36	concept of sex differentiation expanded (corroborated by Gesell and Greenacre)
42	aware of and interested in parents' relationship

Kleeman notes:

The beginnings of Oedipus complex evident in the third year are a specialized aspect of the capacity for differentiation. The little girl's increased separateness from her mother and the child's differential response to mother and father have extensive implications for gender identity, but appear at a time when the foundations of core gender identity are already well laid. Though mother is still the most important person in the child's world, father is emerging as a special love object (1971, 109).

These gender term refinements continue with development.

Kleeman further expanded this thinking in a second paper focused on meanings conveyed between parent and child in these first three years. Age three is a point by which "a healthy three year old girl is very much a girl and knows it . . . (1971, 117)." He reports that direct observation of normal children

. . . suggests that the same factors in the parent-child relationships which lead to healthy ego development, in general, also favorably affect gender identity formation specifically. In particular, the ego functions concerned with the development of body image, reality testing, and the sense of self are crucial for the sense of gender identity. The latter cannot proceed normally without healthy object relationships. Communication between parent and child (verbal and nonverbal), genital self-exploration and stimulation and imitation and identification all play crucial roles (117-118).

In addition to these and some other universal contributors to gender identity formation, are idiosyncratic factors, i.e., anatomical abnormalities, drive differences, parents, siblings, et cetera. Parental attitudes are most crucial, beginning with gender assignment at birth when a chain of events are set in motion in response to the gender announcement "it's a girl/boy."

Kleeman speaks of several ways parents convey gender meanings, namely the illusion of the parent in what the child will become and the mothering experience and sensory experience with self produce a quality of body and gender awareness. Deprivation, unless brief, will result in flaws in gender identity formation (1971, 118-119). Kleeman's

work also notes the need for modification of Freud's point of view that there is no femininity until the phallic phase as behaviors between female and male are established in the preoedipal period (1971, 112).

Robert J. Stoller, M. D. (1972)

Previously, Stoller put forth a model on the etiological factors contributing to male transsexualism that won wide acceptance. In his "first approximation" he presents a descriptive and dynamic view of etiological factors in female transsexualism. He suggests a recurring family role constellation, and a behavioral developmental progression around gender identity.

Overall, Stoller expresses "doubt that female transsexualism is a biological abnormality present at birth or shortly thereafter (1972, 49)." He notes that "if there are biological factors, there is no clear evidence yet" and that animal experiments are "neither convincing nor unconvincing (1972, 49)."

Stoller draws on his experience with thirteen transsexual females to delineate the "pieces" that may contribute to the identification of the female transsexual.

These pieces are (1) an infant who does not strike the parents at birth or later as beautiful, graceful, or 'feminine' (whatever that would be to the parents of a newborn); (2) an infant who is not cuddly when held but who habitually pushes away, even if a good feeder; (3) a feminine mother who at the birth of this daughter and at times later in childhood is removed in affect from her child, most often by overt severe emotional illness.

usually depression; (4) a masculine father who is nonetheless not present psychologically in at least two crucial areas: (a) he does not support his wife in her depression and (b) he does not encourage this daughter's femininity in the ways fathers of feminine daughters do. Given these factors, the little girl is (5) shot into the breach that her father abandoned, the role of succoring husband; the motive that propels the drive toward masculinity seems to be the family's manufacturing out of this daughter a substitute male (a husband) to assuage ('treat') mother's depression. This is done by constant encouragement of masculinity by both parents. Simultaneously, the child on her own is inventing a role--the masculine father-substitute--to mitigate her own terrible loneliness produced by having a mother whom she cannot reach and who does not reach out to her. Soon the process becomes self-perpetuating, when what at first was the development of isolated areas of high performance that are not inherently masculine or feminine (e.g., throwing a ball well, not crying when hurt, facility with a tool) coalesce into an identity, a sense of masculinity. This occurs both by the family's invariably encouraging masculine behavior and by this masculine-oriented father's enjoying sharing masculine interests with his daughter (identification) (1972, 50).

Stoller acknowledges that these mechanisms are not always present.

Further, Stoller offers a prototype of a female transsexual from birth to adulthood which incorporates most of these ideas. "At birth, this female infant is unequivocally assigned to the female sex (1972, 48)"; parents and relatives have no doubt that this is a girl child. Nonetheless,

. . . this biologically normal and properly assigned infant girl begins to show masculine behavior and interests as early as age three or four. . . . development of gender identity (masculinity, or femininity) then proceeds in a masculine direction. . . . by the time the child is

seven or eight, she has invented a boy's name, plays . . . walks and talks like a boy, has developed unusual physical skills, . . . and is stating openly to family and friends that she is going to be a boy when she gets older and is going to have the body changes (e.g., penis) necessary. . . . (for) life from then on as a man (1972, 48).

At this point, Stoller underlines that this is different from other types of masculine females, as there is "no episode of clearly feminine development which has been thwarted and overlain with a secondary masculinity (1972, 48)."

Growing older she will be more insistent with others about her being a male and demanding they respond to her as such. Puberty brings further "evidence" of her femaleness. The onset of menses and development of secondary sex characteristics are often traumatic and serve as a further impetus toward "passing" as a member of the opposite sex. Passing and acceptance by society as a male will often be achieved by mid-twenties, if not sooner. Sex transformation procedures will be sought and negotiated (i.e., pan-hysterectomy, mastectomy, testosterone administration, and phalloplasty). Throughout this time of development, the person is attracted to feminine, heterosexual females, seeing herself as male and rejecting any notion of homosexuality. Intellectual and professional pursuits will be those defined by society as masculine, and fitting with her male identity.

Stoller suggests caution "about everything regarding female transsexualism from diagnosis to etiology (1972, 50)."

Ira B. Pauly, M. D. (1974)

Pauly has compiled the most extensive review of world literature on female transsexualism. The findings are based on eighty cases using a 102 item instrument, and covers six areas: source material, personal and sexual history, family history and sociological data, biological data, treatment, and psychological and psychiatric data. Pertinent areas to this review will be excerpted. Interestingly, Pauly notes that it is "remarkable how similar stories of transsexuals, male and female, really are (1974, 491)." Additionally he notes a ten year lag in the peaking of interest and literature behind males (male, 1960; female, 1967-69).

Male:Female Ratios

Pauly reports the variety of M:F ratios (8.6:1 to 1:1) arriving at his own estimate of 3:2 to 2:1. The ratio for homosexuality is comparable. Theoretically Pauly anticipated a higher incidence in females since their first intense relation is "homosexual" (mother) and therefore more complex than for a male who starts with a heterosexual one. But, the opportunity for appropriate identification with the feminine role is more available to girls than the masculine role is to boys.

Profiles of both mother and father of female transsexual point up major characteristics as identified in Tables 3 and 4.

Table III Characteristics of Mothers of Female Transsexuals^a

	Percent positive	No.
1. Protected by patient	83	18
2. Preferred male child	62	16
3. Emotionally disturbed	40	20
4. Preferred by patient	39	31
5. Cold and rejecting	36	28
6. Encouraged masculine identification	22	18
7. Dominant parent	20	30
8. Alcoholic	13	15

Table IV Characteristics of Fathers of Female Transsexuals

	Percent positive	No.
1. Assaultive or physically abusive	79	24
2. Large or excessively masculine	74	19
3. Competed with patient	73	15
4. Alcoholic	64	14
5. Other emotional disturbances	60	10
6. Encouraged masculine identification	60	15
7. Dominant parent	57	30
8. Preferred by patient	52	31
9. Preferred male child	50	10
10. Sexually abused patient	22	23

Pauly speculated in earlier works (1968) a reversed oedipal situation where the girl rejected the mother as an identification model and chose father, resulting in competition with father for mother's attention. He supports Stoller's descriptions of mother's abdication due to depression and emotional unavailability at a critical time in early development.

Birth order was not different from the population at

large. Sixty-four percent of the female transsexuals were raised in a rural setting. Seventy-six percent were classified in Hollingshead categories 4-7, 48 percent in 6 and 7, but Pauly notes that female transsexuals do come from all strata. In his study all cases were Caucasian, except one Mexican-American. Again references were cited for all cultures and ethnic groups, i.e., Hoopes sample of 11 percent Negroid applicants.

Natural History

The awareness for a preference for the male role ranges from two to thirteen years old with a mean of 7.25. Puberty is noted as a particularly traumatic time due to the cognitive dissonance between "psychosexual gender concept" of maleness and "anatomical, physiological femaleness." This painful awareness continues as they seek a means for body alteration and acceptance. The sequence is illustrated by age range in Figure 1.

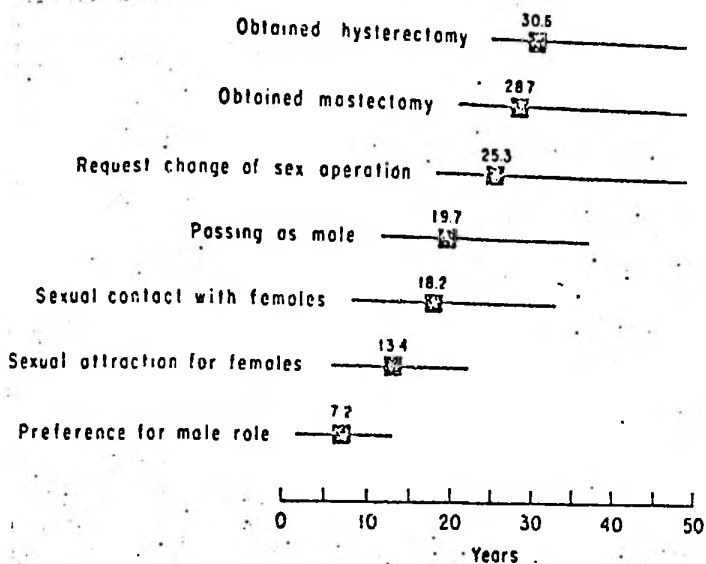


Fig. 1. Female transsexual sequence.

Sexual behavior is also noted in Figure 1 with most females becoming consciously aware of homosexual preference between six and twenty-two years of age. Often there is a mean lag of almost five years from time of initial awareness until contact with a partner (13.4 to 18.2).

By definition, all female transsexuals are homosexual, but they are all "heterogenderal," seeing themselves as masculine and partners as feminine. Homosexuality, as such, is ego alien, and so many female transsexuals will avoid "confrontation with their anatomy" or experience at some point a "flight into heterosexuality" (usually temporary).

The relationships that they do become involved in

are considered by them to be heterosexual and are "quite stable and remarkable for their lack of promiscuity (1974, 504)."

Psychological and Psychiatric Data

IQ's are reported in Figure 2 with a mean score of 105, and a mean of twelve years schooling. There is typically an elevated 5 scale in MMPI testing (Masculine-Feminine scale).

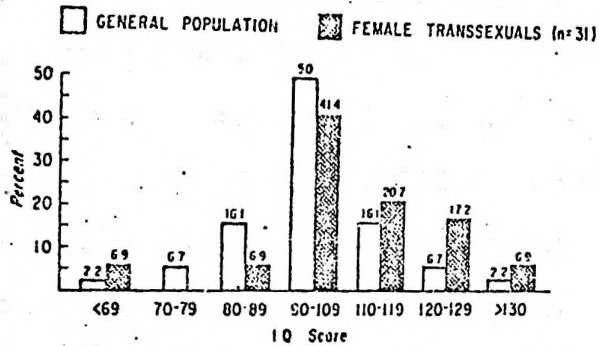


Fig. 2. Intellectual capacity.

Only one of thirty-five patients tested was thought to be schizophrenic. Six of twenty-five were thought delusional; and all had the fixed idea of belonging to the opposite sex. Thirty-four percent were given diagnosis of personality disorder (largest grouping) and a high incidence of acting out behavior (forty-four percent) was noted. "The most prevalent psychopathology by history or psychiatric examination was depression (1974, 512)."

Forty-one percent had been hospitalized, most related to depressive episodes.

Biological Data

As can be seen in Figure 3, generally the female transsexual is "phenotypically, as well as genotypically, within normal limits (1974, 514)."

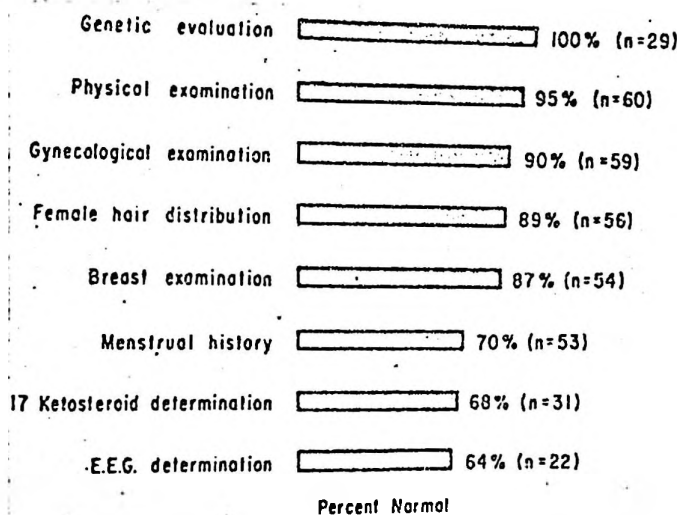


Fig. 3. Summary of biological data on female transsexuals.

There is some concern for the higher percentages of hormonal abnormalities, specifically, high 17 ketosteroid levels (but this may be spuriously high). The most frequent abnormal finding was EEG which calls into question the role of the central nervous system in establishing gender identity and suggests a possible gender identity center. Pauly refers to Money and Brennan's speculation

that the nuclei of the hypothalamus and limbic system are the most likely site to regulate "sexual dimorphism."

Pauly concludes, "the etiology of transsexualism must be considered unknown (1974, 515)."

Ethel Person, M. D. and Lionel Ovesey, M. D. (1974)

Primary concern in the works cited was with establishing a classification of the syndrome of transsexualism. The bulk of this work and clinical information used in the delineation of the classification system comes from a focus on M--F transsexualism--transsexualism being used by the male "to counter separation anxiety" by resorting to a "reparative fantasy of symbiotic fusion with the mother." This offers a means of allaying anxiety but retains an "ambiguous core gender identity (1974, 5)."

The classification proposed is as follows:

- I. Primary Transsexualism (throughout development transsexual impulse is insistent and progressive)
- II. Secondary Transsexualism (behaviorally primarily homosexual or transsexual)
 - A. Homosexual transsexualism
 - B. Transvestitic transsexualism

It is their opinion that "the transsexual syndrome in women develops only in homosexuals with a masculine gender role identity. Female transsexualism, therefore, can be classified as another form of secondary (homosexual) transsexualism (6)."

Some concepts applied to the male may be useful for speculation in the female transsexual, i.e., early separation anxiety as a necessary prerequisite in the development of transsexualism, and the concept of ambiguous core gender role identity. Family descriptions may also be useful. The description of the mother is one who "dutifully provided routine care, often in the face of harsh realities, but was insensitive to the child's emotional needs (13)." The father was seen as Stoller describes--passive, hostile, emotionally absent. The statement that "gender ease is never fully established" also seems to cross the biologic sex difference (19).

The personality inventory includes relative asexuality, low aptitude for psychological insight, stereotypic fantasies (of gender they wish to be), denial and depression. Relations have a schizoid quality, and energy or creativity are often expressed in solitary pursuits, but applicable to the work area.

Underlying this personality, they have a typical borderline syndrome characterized by separation anxiety, empty depression, sense of void, oral dependency, defective self identity, and impaired object relations with absence of trust and fear of intimacy (19).

A resemblance to Grinker's "adaptive, affectless, defended, 'as if' persons" is noted (19).

Harry Benjamin, M. D. (1973)

Dr. Benjamin is a pioneer in the study of transsexualism, showing early concerns and involvement with sex

reassignment and surgery as a valid treatment for transsexuals. One of his main contributions was the sex orientation scale which suggests a continuum for the classification of disorders of gender identity as follows:

- Type 0: Normal sex orientation and identification.
- Type 1: Pseudotransvestite. Cross-dresses occasionally; has a low degree of gender identity conflict.
- Type 2: Fetishistic transvestite. Cross-dresses more often; gender identity conflict still low.
- Type 3: True transvestite. Cross-dresses as often as possible; gender identity still masculine but with less conviction than the first two groups.
- Type 4: Nonsurgical transsexual. (True transsexual who is willing to live without surgery.) Cross-dresses often; gender identity uncertain.
- Type 5: Moderate intensity true transsexual. Lives as a woman if possible; gender identity feminine.
- Type 6: High intensity true transsexual. Usually lives as a woman; gender identity feminine (Benjamin and Ihlenfeld, 1973, 458-459).

Benjamin presents a descriptive rather than a dynamic understanding of female transsexuals. Again he notes a number of ideas which although originally applied to males may be applicable for females as well.

Benjamin states that "patients have generally shown no areas of psychosis but have revealed intense obsession with cross-gender identification (1970)." He also clearly notes transsexuals "are among the most unhappy people I have ever met (460)."

Benjamin does not see that psychiatry has anything to offer, in that the "mind of the transsexual cannot be

adjusted to the body . . . Therefore attempts to adjust the body to the mind appear logical . . . (463)."

Etiology appears to be "Unkind to unfavorable childhood conditioning (462)" and suggests the phenomena of "imprinting" (Money, Hampson and Hampson) around age eighteen months to two and a half years as plausible. He is clear, however, that conditioning is not the whole story and sees inherited constitution playing a role. He notes that of 125 transsexuals 24 percent (30) were only children.

With reference to females he reports a ratio of 1:6 and notes the difference in his sample as 108 males and 17 females. Of the 17 he sees many symptoms in common with the male, notably a strong preference and belief that they are the other sex with a belief that conditioning plays a role although he is able to substantiate conditioning in only two of seventeen cases, being doubtful in five, and absent in ten.

Further descriptive elements include: (1) psychological trauma re: menstration and breast development; (2) interests, attitudes, and fantasies develop in masculine direction; and (3) love object of females, deny homosexual component. Often hypogonadism, absence of menses, or light menses were found. Greatest ambition is to assume "social and legal status of men" including surgical change.

Richard Green, M. D. (1975)

Green has focused concern on how sexual identity develops, and research strategies for answering that question. He describes three developmental phases constituting sexual identity: core morphologic identity; gender role behavior; and sexual partner orientation or object choice.

Some of his research strategies include: (1) prenatal hormonal influences; (2) early life sex differences in behavior (assess neonate); (3) anatomically ambiguous children (genital ambiguity); (4) children of the atypical (other than heterosexual parents, homosexual or transsexual); (5) childhood of atypical adults; (6) atypical behavior in anatomically normal children; and (7) typical children with atypical backgrounds. Further exploration through biologic studies is discussed in his book focused on the effects of hormonal deprivation or augmentation. Research examples are cited linking neuroanatomic abnormalities and neuroendocrine abnormalities with atypical sexual behavior, i.e., temporal lobe has some effect on sexual behavior. Walinder reported one-half of candidates (13) requesting SRS had an abnormal EEG. There is also mention of the use of focal brain destruction as treatment for abnormal sex behavior.

Regarding neuroendocrine abnormalities, Green cites the hormonal differentiation process as possibly responsible for the greater number of male transsexuals in that the

basic biological disposition is female. Male hormones are needed for genitalia and brain differentiation. Thus it seems there may be critical periods for the release of male hormones. Turner syndrome in females (gonad dygenesis, often with only one X chromosome) and testicular feminization (androgen insensitivity) in males illustrate the phenomena.

In terms of female transsexuals, Green cites important negative results: (1) females with adrenogenital syndrome (and thus exposed to high levels of male hormone) do not become F--M transsexuals; (2) F--M transsexuals had normal plasma male hormone levels (Jones, 1971).

Green lists the following contributing factors to explain why there are fewer (1:3 to 1:6) F--M than M--F:

1. neuroendocrinological, including the likelihood of error in males in the psychosexual level since an extra component is necessary for masculinization (gonadal hormone);

2. sociological, affording greater latitude to females with respect to cross gender behavior, therefore it is less necessary to seek a radical means of disguise;

3. psychological and psychiatric, noting that the first identification is with a female (mother) and the subsequent shift is required only of males, and

4. surgical and technical limitations inherent in SRS F--M, (e.g., 'it is easier to make hole than pole').

Beyond these discussions Green characterizes F--M as active, that is not cuddly, babies who are usually given

gender ambiguous names. For further familial information he refers to Stoller.

John Money

In a book co-authored with Anke Ehrhardt, Man and Woman, Boy and Girl (1972), Money elaborates on his position as a proponent of "interactionism"; of genetics and the environment. Their schema illustrating the sequential and interactional components of gender identity differentiation is included herein. (See Figure 4.)

Money states clearly that etiology for transsexualism is unknown but suggests the tricotomy of "genetic code, critical period effect, and reversible or transient stimulus response effect (Money and Gaskin, 1970, 253)." Specific information in each of these areas are reported in his work with Gaskin.

It is an established fact in animal experimentation that "sex hormones do in fetal life influence the brain, especially those hypothalamic centers that neurohumorally regulate the cyclic or noncyclic function of the pituitary gland, and also those adjacent centers that co-regulate sexual behavior patterns (Money and Gaskin, 1970, 251-252)." This includes hormones produced by the fetus or exogenous hormones injected into the pregnant mother.

There is some suggestion that a predisposition may be required to mix with social interaction for gender identity, i.e., sorting gender role signals as masculine

SYNOPSIS

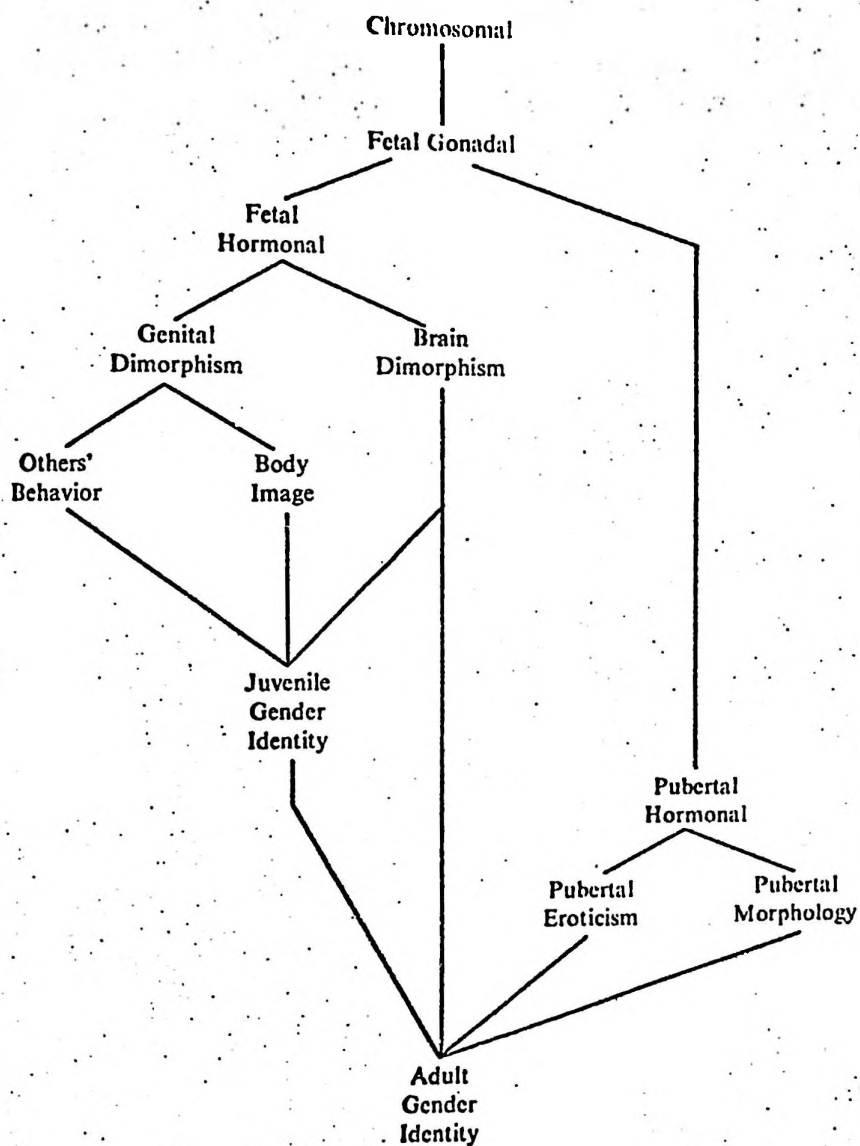


Figure 4. Diagram to illustrate the sequential and interactional components of gender-identity differentiation.

or feminine as a bilingual child would sort the languages. Viral invasion may also be significant.

Money speaks of the concept of imprinting gender identity at a critical period of postnatal development. Another work cited ablatio penis of a male twin with gender change orientation at age seventeen months, this may give some indication where to look for the critical period (Money, 1975). Additionally he presents information about the brain "erroneously releasing gender incongruent behavior" as a result of lesions (Money and Gaskin, 1970, 253).

It is significant that Money states that transsexualism is "known not to correlate with genetic, hormonal or anatomical abnormalities which are presently measurable." He also reports in other work "no recurrent pattern to either the sex ratios of siblings or the ordinal position of the patient (Money, 1975, 188)." The

. . . most likely etiological explanation is that it is the sequel to an early postnatal error of gender identity differentiation in a child for whom a vulnerable prenatal disposition (perhaps grounded in fetal hormones) combines with the psychodynamics of early social experience to disturb the normal development of gender identity (Money and Gaskin, 1970, 268).

. . . transsexualism is an extremely tenacious critical period effect in gender identity differentiation of a child with a particular but as yet unspecifiable vulnerability (Money and Gaskin, 1970, 253).

In discussing female transsexualism Money and Gaskin offer descriptive information "resembling the obverse" of

the male transsexual. They describe her as a tomboy who is hit by the "full impact of the meaning of her gender identity dilemma after puberty (Money and Gaskin, 1970, 286-287)." Diagnostically they refer to "idee fixe" rather than delusion or schizophrenia in these clients and suggest treatment of the symptom to resolve the cognitive dissonance.

CHAPTER IV

FINDINGS

This study was an attempt to discern what factors might be influential in contributing to and/or maintaining gender dysphoria in a biological female so as to result in transsexualism. A hypothetical model, based on an accepted model for familial factors contributing to transsexualism in males, was proposed and tested against case material. In addition, there were efforts to clarify what factors or characteristics might be typical of female transsexuals, and where possible, the dynamics behind them. This was approached by use of a questionnaire, a clinical survey, and a survey of pertinent theoretical literature. The findings presented here are based on the interviews from the clinical survey of eight clinicians around data from thirteen case histories. The information came in response to a questionnaire, key questions from the interviewer about the case history, construction of a family constellation, and the clinicians' elaborations in any of these areas. Clinicians were encouraged to speculate on a theoretical understanding of the individual case etiology and dynamics.

The working hypothesis was constructed on the basis

of producing a model the converse of Stoller's model on parental influences in male transsexualism. In the seven areas of potential influence the gender descriptives were changed to those of the opposite sex, i.e., mother to father. This particular model was chosen as a starting point since it attended to family influences and still seemed plausible when altered, based on the researcher's clinical experiences. In essence this would propose the following factors as representative of, and therefore contributors to, the phenomenon of female transsexualism: father's bisexuality;* father's closeness to daughter in emotional or physical sense; mother's absence either physically, geographically, or emotional unavailability; mother's activity or bisexuality;* birth order (Stoller found support for the youngest or youngest for a number of years as facilitating in the time for mother-child (transsexual-to-be) has an impact); divorce was found not to be initiated, rather an empty marriage persisted for

*Stoller uses the term bisexuality to denote a pattern of behaviors or interests typically ascribed to the opposite sex rather than in a sexual orientation. Quoting Stoller's note "I wish only to demonstrate those findings which reveal these mothers similarity in competing with males. In delineating this special kind of bisexuality, let these findings stand for other areas wherein these women are similar: their need, when girls, to dress in males' clothes; their never-ending quiet hopelessness; their hated, unloving mothers who nonetheless now live only a few minutes away from them; a special drabness in appearance (easy to observe but which would take too many words to describe); absence of their need for heterosexual activity in adolescence with an associated easy virginity till marriage; and their passionless marriages without accompanying desire for (or rare fantasies of) extramarital affairs."

parents of males, raising the question for females; and sibling influence was changed from a sister to a brother. (See Appendix I for illustration of Stoller and converse models.)

The findings in the thirteen cases reported indicated seven instances where the description of the family was similar to the influences Stoller suggests in male transsexualism; three instances where the converse model seemed applicable; and three instances that fit neither model (see Chart 1). The particulars of the family constellation and individual characteristics of the family will be elaborated upon at a later point. The dynamics of each case was not checked against other theoretical models. The conclusion to be drawn from this data is that there is not enough commonality, or perhaps not enough family information to identify any one model. At any rate, more than two of the current models would be needed to describe the female transsexual phenomenon. It should be kept in mind that the size of the sample is small and so may yield spurious, as well as significant results.

Demographic Findings

The questionnaire supplied demographic information on race, age, intelligence, level of education in the family, socioeconomic level, urban-suburban-rural (U-S-R) distribution, awareness of specific precipitating event;

and whether there was any life goal beyond accomplishing a sex change.

Race: Caucasians were the only race represented in this population, however, transsexualism has been reported as occurring in all races.

U-S-R: There were six people from a rural background, three from a suburban, and four from an urban background.

SEC: The socioeconomic levels were represented as follows:

-----000000-----000000-----o-----
 Lower Middle Upper

six lower middle, six middle, and one upper middle class representatives.

Age: The age at which participants became known to the program ranged from sixteen to forty-four years old, with a median age of twenty-four (see Table 5 for specifics).

IQ: Results from this sample showed a range from Dull Normal to Superior. Test scores were not available for all participants, but data would seem to indicate that in this sample approximately half of the population were Normal and half Bright Normal (DN=1, N=6, BN=5, S=1).

Education: In terms of education, three partially completed high school, seven completed high school, and three attended college for one, two, or four years. It is noteworthy, however, that from the data available most of

TABLE 5

AGE, IQ, AND INFORMATION ON LEVEL OF EDUCATION

	Age Known to Program	IQ Range	Level of Education Completed	Level of Education Father	Level of Education Mother
1	24	BN	1 year college	less than high school	probably high school
2	16	BN	tenth	probably high school	less than father
3	33	N	eleventh	less than high school	high school
4	25	N	4 year college	high school	high school
5	42	N	high school	less than high school	high school
6	23	S	high school	probably high school	probably high school
7	21	BN	high school	high school	less than high school
8	22	N	high school	less than high school	high school
9	17	BN	high school	high school	high school
10	27	N	ninth	high school	high school
11	44	BN	2 year college	less than high school	high school
12	20	DN	high school	sixth	eleventh
13	25	N	high school	high school	high school

S=superior

BN=bright normal

N=normal

DN=dull normal

these persons attained an equal or a higher level of education than their parents. Information on the parents education is less reliable as clinicians were asked to estimate when this information was not known for certain. It was estimated that eight of the mothers completed less than a high school education, and five completed high school. For fathers it was estimated that nine completed less than a high school education, and four completed high school (see Table 5 for specifics).

Precipitating event: Two individuals identified specific events that they believed had a bearing on their transsexualism. One reported surgery on her genitals around age three, and the other evidenced a primal scene and was sexually misused around age three. Nine responded in the negative, and two clinicians stated that they did not know whether there had been a specific event for their client.

Life goals: The responses were split, seven had some job or life plan, and six seemed unable to formulate a plan beyond being a man, or becoming a man and marrying.

Family Constellations

Family constellations include data about sibling position, notation for influential sibling (▲), notation of a gender problem (◊) in another family member, marital status of applicant and parents, and children if any. Standard symbol representation illustrating

family systems is used (Toman, 1969*) with the exception of () which the researcher has used to identify the biological female () who desires to become a male (). The constellations are represented in Figures 5.1 through 5.13 and in many instances are self explanatory. It should be noted that it is most useful to have working data on three generations in order to assess the critical role played by family dynamics. The situation that effected the growth of the parent or grandparent will also have a bearing on the current generation. The information available provides a schema of the nuclear family and in some instances part of the extended family.

Assessment of the data available yielded the following information:

1. Sibling position: eight were the youngest in the family, but contradictory as it may seem, ten were the oldest or only female child. Of these ten, one was an only child, seven were second children--five had an older brother and two an older sister, two were the oldest, and two were the youngest.
2. Influential sibling: four identified an older brother as influential in their development.
3. Gender problems: three fathers, three brothers and one half-brother, two mothers, and one sister. In five families no problems were reported, and in four the

*Previous working experience included use of genealogy charts modeled after Murray Bowen, Georgetown University, Washington, D. C.

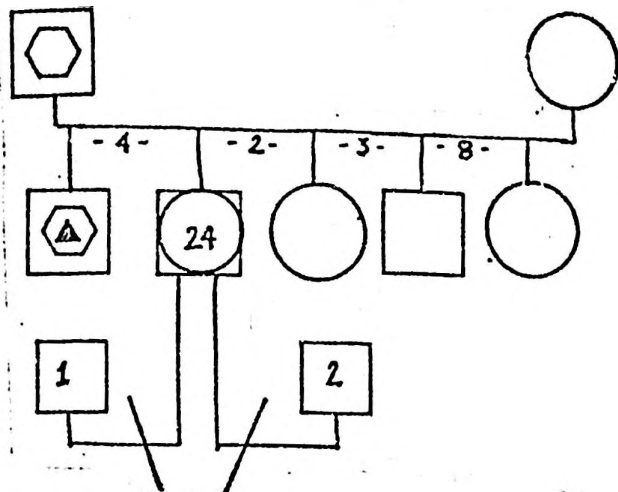


Figure 5.1

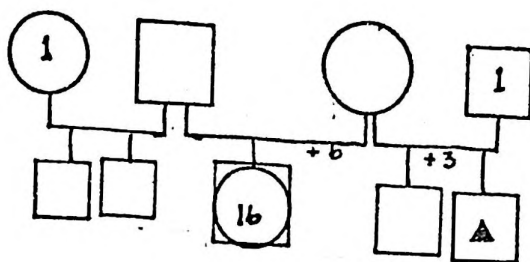


Figure 5.2

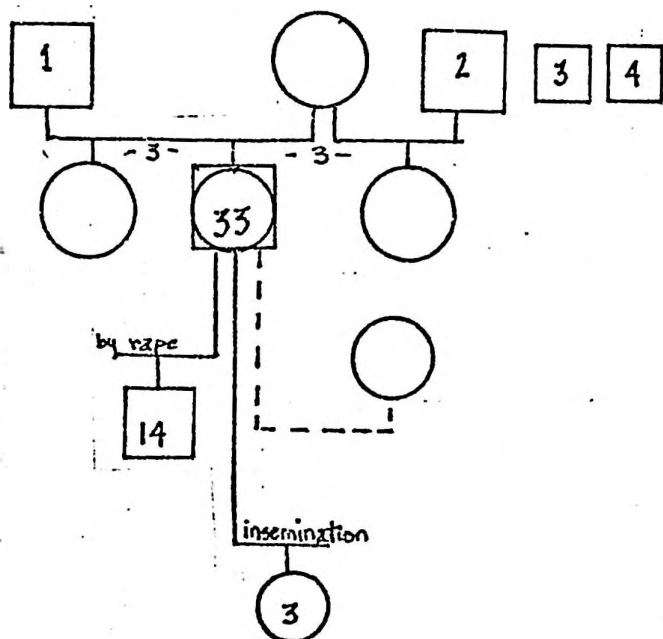


Figure 5.3

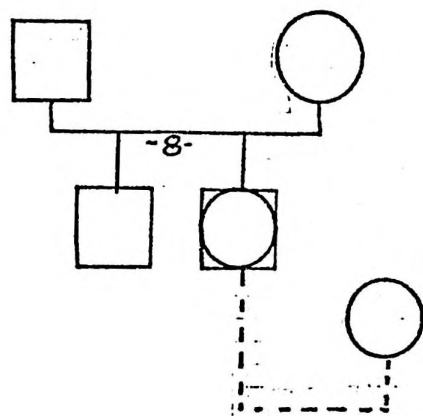


Figure 5.4

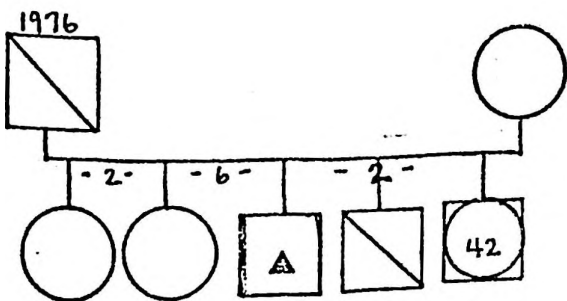


Figure 5.5

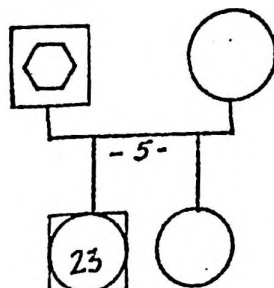


Figure 5.6

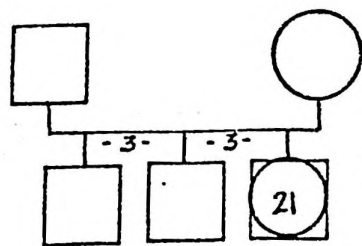


Figure 5.7

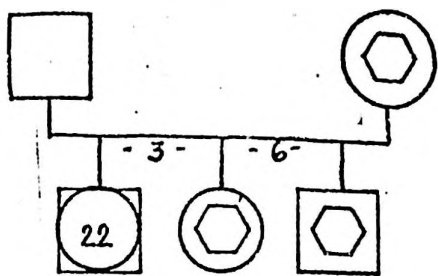


Figure 5.8

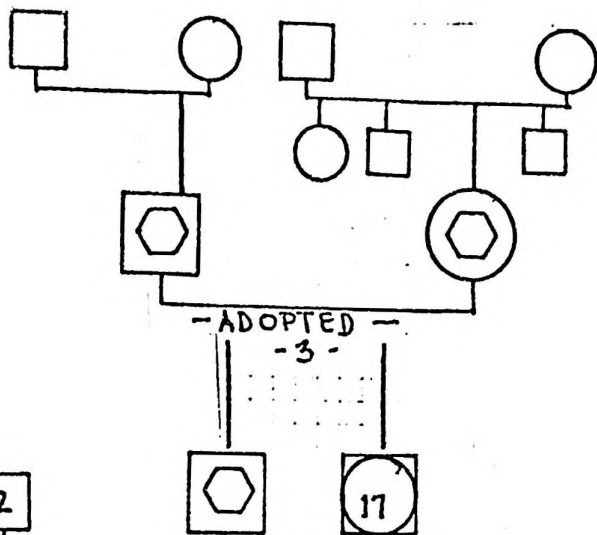


Figure 5.9

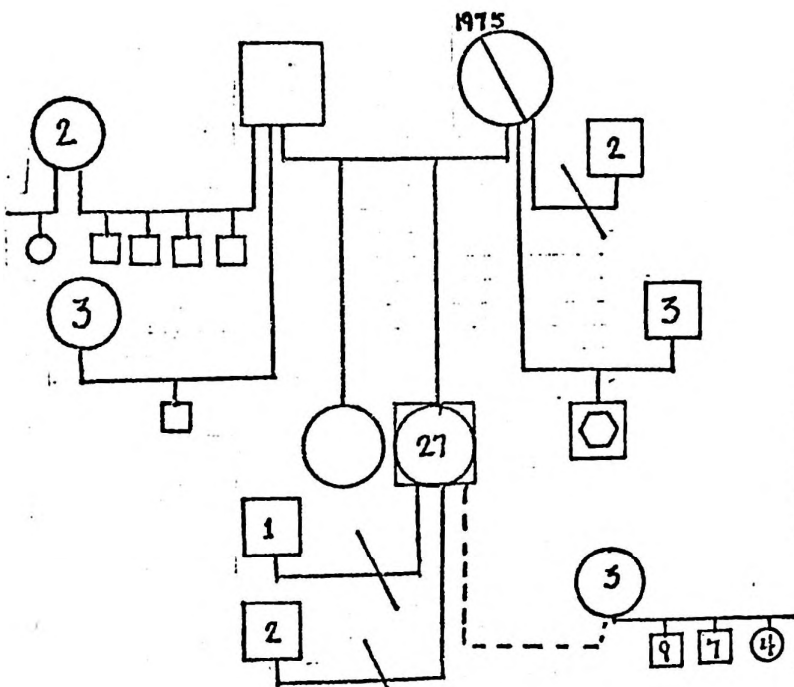


Figure 5.10

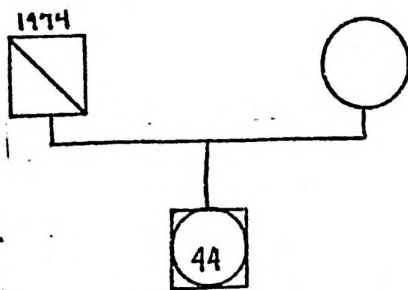


Figure 5.11

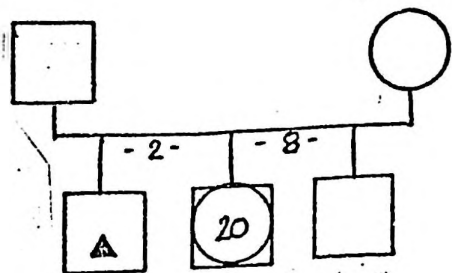


Figure 5.12

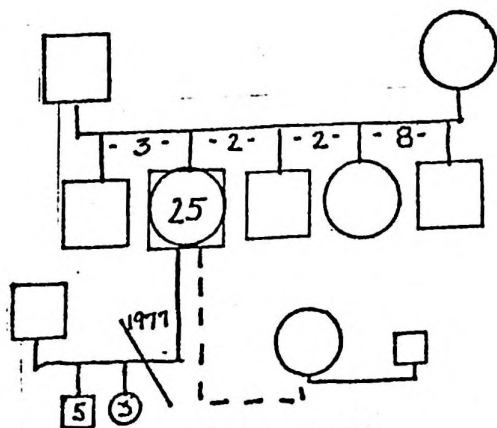


Figure 5.13

clinician said they did not know. One wonders if additional family information would increase these numbers.

4. Marriages and children: The three clients who had married had also divorced, two of them twice; three had natural children, and a fourth had three step children. As for parents, all were married, three having divorced and remarried one or more times.

Clinical Diagnoses and Theoretical Speculations

All of the applicants in this study were diagnosed as having Gender Dysphoria Syndrome. Further differentiation included assessing five to be normal, two schizophrenic, one borderline, one schizoid, and three character disordered-paranoid, hysteric, narcissistic.

Theoretical speculations, as described in Chart 1, fall into several groups: six are seen as filling a male role, either of a desired male child, or filling in for a father who is physically or emotionally absent, one of these resulted in an extended gratifying symbiosis; three had schizophrenic mothers, resulting in disturbed object relations; two experienced multi-generational gender identity problems; one was seen as having biochemical etiology; and one encompassed neurologic, endocrinologic, social, and/or psychological possibilities. In addition, there was a more formal suggestion of a "dual fused identification," where female identification occurs, primary love object is established, but then the shift

Appropriate Stoller's Male Model	Model Con-verse	Neither	Theoretical Speculation	Diagnosis
X	X	X	Left alone a lot; identification with aggressor; schizophrenic boundary confusion Mother was depressive psychotic with several hospitalizations; hated female introject Mother had strong wish for male child; stepfather also wanted male	Paranoid Schizophrenic In Remission Borderline
X	X	X	Biochemical Conceived to replace deceased male sibling; family encouraged male role Disturbed early relations--schizophrenic mother; failure to develop symbiosis Exceptionally gratifying symbiosis; serve as replacement for emotionally absent father or mother	Character Disorder Impulsive--Paranoid Schizoid
X	X	X	Conceived to replace deceased male sibling; family encouraged male role Disturbed early relations--schizophrenic mother; failure to develop symbiosis Exceptionally gratifying symbiosis; serve as replacement for emotionally absent father or mother	GDS--Normal
X	X	X	Multi-generational cross gender identifications; replacement for absent father; became male to differentiate from other Early separation (adopted); unable to identify with mother; generational gender difficulty for both parents Mother wanted boy; identification as male for mother; later brain damage cause hormonal change	Schizoid--Normal GDS--Normal Character Disorder Hysterical
X	X	X	Replacement for father--manage as unhappy female thrust for change after death of father Males privileged in family; early molestation Chaotic childhood; open to neurological, endocrinological, social, psychological influences	GDS--Normal GDS--Normal GDS--Narcissistic Perseverality

GDS=Gender Dysphoria Syndrome

occurs in identification instead of shift of the love object, leaving internal conflict.

Supplementary Findings

In addition to the specific information that the study was designed to gather, some additional findings seem worthy of note. These are: (1) menses when discussed were described as traumatic; in conjunction with this finding, puberty in general was a difficult time and was often represented as the awakening of true discomfort, perhaps as the result of a shift in the social expectations of significant others. From approximately age eleven upward there was reported an increased discomfort with self leading to an increase in "transsexual behavior," including "passing" and an encounter with a "hetero-general" partner sometime in high school. (2) Three people reported a strong push from parents toward marriage, two of whom did marry for a while. (3) Three had psychiatric hospitalizations, these had been diagnosed schizophrenic or borderline. (4) Hair loss or pulling out one's own hair was reported in three instances: in a borderline around the time of her first menses; a schizophrenic pulled out her hair at age seven, within a year after being identified as "queer" by her peers; and the third, seen diagnostically as normal, in whom the actual time of hair loss is unclear from the data. (5) Alcohol is noted as playing a variety of roles in several cases:

two clients had problems themselves with alcohol abuse; five fathers, and one mother abused alcohol. (6) Three of the clients suffered sexual misuse; one was raped at age fifteen; another was gang raped at age eleven; and the third was misused by a relative at ages three, five, and twelve.

CHAPTER V

DISCUSSION AND SUMMARY

This discussion will focus primarily on the findings of the clinical survey as compared or contrasted to findings reported by other authors. Beyond this will be a further elaboration on some of the speculative findings, and some thoughts and opinions of the researcher about directions for future research.

Demographic Information

There is a paucity of information on female transsexuals, and this includes only incidental references to demographic information. From the sources available, the findings do not seem disparate.

Race: Although the total population of this study was Caucasian, there have been reports of other racial groups seeking SRS. Eleven percent of the sample Hoopes worked with was Negroid and another study included a Mexican American. Theoretically transsexualism cuts across racial and cultural boundaries. Pauly's (1974) sample of world literature draws on eleven European countries in addition to the United States and South Africa.

U-S-R: There is a suggestion that more female transsexuals come from a rural background where masculine behavior and attire were more acceptable. The sample under discussion allowed for a distribution of six rural, three suburban, and four urban applicants. The numbers do not support any locale as more significant than the other, but suggest a need for inclusion of a "suburban" category to the standard ones of "rural" and "urban."

SEC: The socioeconomic levels represented (LM=6, M=6, UM=1) compare with those available from other reviews. Pauly's (1974) information states that close to 50 percent of the female transsexual population is represented by those in Hollingshead's categories six and seven, suggesting a pull toward the lower levels, while noting some representation in each of seven positions.

Age: Ages, as noted, ranged from sixteen through forty-four with the median age at twenty-four. All but two of the thirteen cases were under thirty years of age when they became known to the program. This finding supports the developmental progression set down by several authors which suggests that by mid-twenties most female transsexuals have become sufficiently uncomfortable with themselves vis-a-vis society to attempt "passing" and to seek out a means of altering their body through hormonal or surgical changes. Evidence from trauma around menarche was also found. At this point in time, the two candidates who applied to the program in their forties can be

accounted for on the basis of the unavailability of such changes at an earlier age.

IQ: Studies of intelligence of transsexuals report them as having higher than normal intelligence, with the question of whether this is representative or only indicative of those resourceful enough to seek out a gender program. Raboch and Sipona (1974) in testing male transsexuals, found 50 percent of the sample to have above average intelligence (BN=5, S=7). Pauly (1974) also reports 45 percent of the female population of transsexuals tested to have above average intelligence. The current sample also supports this kind of finding as 50 percent were noted as above average intelligence.

Possibly those with lesser intelligence find the ambiguous gender role more disorienting or are less able to restrict their thought disorder to this one area of their life. This speculation suggests less coping ability and greater pathology or thought disturbance or disorientation for these individuals which would shift their diagnostic classification.

Education: The fact that most of the population had an education equal to or greater than that of their parents may be indicative of an added stress in the parent-child communications. This would only add to some other already present stresses in the relationship, occurring after primary gender confusion.

Precipitating event: Although it seems reasonable to

expect that there may have been some significant or precipitating event that influenced the gender identity development, this would probably have occurred before age three, and may or may not be remembered by the applicant. The two events that were recalled had historical relevance to the family and had been recorded by others as well. Further contact with the family would be important in exploring the early (0-3 years) developmental history and significant events in the lives of these people.

Life goal: It was impressive to find 50 percent of the sample had been gainfully employed and had some future life plan beyond a sex change. This information is useful in assessing the overall adjustment of the individual, as well as adjustment to and expectations of surgical intervention. Some of the difficulties reported post-surgically come from the other half of the population who are unable to see beyond the goal of "becoming a man" and who are often disappointed and depressed when this does not alter more than their anatomy.

Family Constellations

The family information, beyond the nuclear family, is limited and lacks focused exploration at this time. The extended family and further study of the interaction in the nuclear family seems important information to pursue in future work in order to understand the etiology and dynamics of the phenomena. Additionally, this kind of

information would enhance the understanding of the individual and the area under study.

Given adequate information, it is the belief of this researcher that sibling position would have significance in the development of gender dysphoria (Pauly's 1974 review does not suggest that, and Stoller has not addressed the issue for females). Toman (1971) suggests two crucial factors--sex and sibling position--in personality development and the ability to relate to or identify with others of the same or opposite sex. From the findings of this survey, the fact that ten of the thirteen were the oldest or only female child suggests several speculations. Parental background would be needed to explore whether the parents had (1) any knowledge or experience in dealing with a female child, (2) a preference or need for a male child, or (3) defended themselves against homosexual impulses by some displacement of these feelings onto the child. Additionally, it is interesting to note that four male siblings were seen as having an influential role for the female transsexuals.

Concerning marriages, the three applicants who had married (two of them twice), divorced their husbands as a result of the discomfort of attempting to maintain the female role or deny their masculine identification. Those with children of their own, or of their partner, continued to show an interest in parenting. In contrast to this phenomena, all of the parents of the applicants were

married, some had been divorced previously but remarried. One wonders if these contrasted behaviors express a means of dealing with a mutual concern of homosexuality; for parents by affirmation of their heterosexuality in marriage, and for the transsexual by denial of their preference for the same sexed object choice by altering gender orientation.

This speculation begins to raise the question of the presence of other gender problems in the families of female transsexuals. Again, more family information is needed in this area, as it seems reasonable to presume that if familial influences do play a part in the formation or maintenance of transsexualism in one family member, that they will also have an impact on other family members to a lesser or greater degree. Amazingly, there is a lack of reference to more than one gender problem in any given family. One study, however, does discuss three male siblings, each five years apart, who are all identified as transsexuals (Sabalis et al., 1974). Of five case studies discussed in this study, sufficient information was available to identify three fathers, four brothers (one a half-brother), two mothers, and one sister as also having some gender problem. In four other cases clinicians responded they did not know if other gender problems were present in the family. The above information is suggestive that further problems have not been identified for lack of a more intensive family approach to information gathering.

Clinical Information

Diagnosis

The female transsexual is reportedly not psychotic, delusional, nor schizophrenic in the vast majority of cases. Diagnosis of personality disorder (34 percent), often with acting-out behavior or alcoholism, and depression (41 percent) are frequent (Pauly, 1974). The present sample, as noted previously, consisted of the following diagnoses: five normal, two schizophrenic, one borderline, and three character disordered. All had the fixed idea of belonging to the opposite sex. Two of these applicants abused alcohol. The high incidence of more severely disturbed may be accounted for by the location of the program in a metropolitan teaching hospital with in-patient facilities offering this type of person evaluation and treatment under either diagnoses. Diagnostically the females evaluated showed less pathology than the males in the program (3 percent versus 26 percent were "reasonably normal").

Theoretical Speculations

The theoretical literature generally divides into four frameworks; descriptive, developmental, familial, biological. The common elements are the biological endowments, identification process, and/or the separation process. Most see the phenomena as irreversible after age three.

The speculative theories from the survey include these elements, and will be elaborated upon. One theory proposed was that of a "dual fused identification" where primary identification with the mother occurs, as does the recognition of mother as love object, but instead of shifting to father as a love object, it is the identification that is shifted. This speaks to the confused or ambiguous core gender identity of the transsexual. Other speculations clustered in two areas: early relating with a schizophrenic or psychotic mother, and the hope or need of the mother to have a female child fill a male void in her life either as a son or husband.

Circumstances contributing to the second grouping included the replacement of a void in the marital relationship from physical or emotional distance; expressed preference for a male child as the preferred sex or to replace a lost son, by the mother or father; or a displacement of mother's wishes to have been a male, feeling low self worth as a female, and defended against homosexual actions. This third alternative requires further elaboration and will be developed at a later point.

While producing data that may be useful in codifying what occurs in the development of the female transsexual, present speculations seem to underline the notion that there is no single clear understanding of the etiology and dynamics of female transsexualism. Rather, as one explores, more questions and areas for further exploration

are surfaced. For example, why did the schizophrenic mother-child interaction include a manifestation of gender dysphoria? Is there a critical period for the development of gender identity, if so when? What roles does biology play? The questions of how much, what, when, with or from whom, are raised and open to combinations and permutation.

The question of when seems closest to being addressed as a result of natural history information, but even this is under question as to whether it is irreversible. Most clinicians would agree upon age three or before as critical for the development of a core gender identity, but Newman (1976) suggests the transsexual phenomena in males aged five to twelve is responsive to intensive psychotherapy of the boy with concurrent work with the parents. In the sample under study, latency/puberty seemed a time when most of the applicants had more openly struggled with their identifications and may have been accessible to help in aligning their identification to their female biology. Other supplementary findings suggest that alcohol and/or sexual abuse may be ingredients during some critical period, or by virtue of the behaviors themselves.

What seems likely in descriptive and dynamic terms is that a woman who experiences low self worth as a female, recognizes the male as preferred or having access to things she would want (i.e., power, preferred life-style, parental affection) and has hopes that she too could have

these things. With puberty comes a resignation to the female role and there are some pained and disillusioned efforts to shift from an active assertive style to the more stereotypic female role, and the goals of marriage and motherhood. Often there are homosexual interests which are denied or defended against by marriage. The marriage is to a male who is psychologically if not physically absent. With the birth of a female child, father continues to be relatively inaccessible and/or encourages masculine behavior in his daughter when they interact. Mother transmits two unresolved issues to her child whom she wishes was a male. Mother would prefer a male child who could play out the phallic role she felt forced to give up as a female. The second is prohibition against the homosexual desire for a mother-figure. The result is a biologic female who has identified herself as male in order to adapt to the wishes of her parents. This child will probably be reinforced in this role until social situations, usually at puberty, force an awareness of the disparity between expectation and reality. Daughter resolves this, not as her mother had in adjusting her expectations, but by denying the biologic reality. The lack of a secure gender identification in one generation, makes the transmission of gender identity to offspring tentative at best. This model draws from information available on mother's of male transsexuals, seeing them as similar dynamically, but different in their response to a

male or female child. Father's absence as a reinforcer of the feminine identification of his daughter is significant. As was the case with theories previously discussed, neither does this one encompass the description or explanation of female transsexualism.

This formulation and other data may help in outlining potential points of intervention that might prevent the progression. The most obvious means of interrupting the cycle would be equalization of gender roles. More specifically, there should be attempts at intervention when surgery or sexual abuse is noted prior to age three. This kind of trauma may contribute to ambiguity in the development of gender identity, and would be helpful even if these are not differential factors in female transsexualism. Early identification of confusion of gender role may also allow intervention. Difficulties, however, are likely with the family until puberty when the family may begin to see the masculine identification as alien to their long term expectations for a biologic female--something they may have denied up to that point. Puberty too may provide temporary access to help the individual resolve her cognitive dissonance. Beyond these developmental interventions, there have been some beginning attempts to help these individuals shift to an acceptance of themselves as homosexual (same love object, but a shift in identification) through peer acceptance into a gay community. These efforts are based on the theoretical

stance that females experience only secondary transsexualism, having completed the primary identification process without being able to then shift to a male love object. In their effort to defend against homosexuality they were then required to alter their gender perception to hold on to a female as the love object.

Speculation is possible ad infinitum. What is clear is that further exploration is necessary by means of a variety of approaches. The bias of the researcher is that further exploration of the family of transsexuals would be useful in clarifying the processes which contribute to female transsexualism. The research strategies would include work with all manifestations of gender irregularity whether from biological, developmental, or sociologic influences.

In summary, this was an attempt to clarify the role that the family may play in the formation or maintenance of the female transsexual. It is limited by the information available at this time, as well as by the focus of this particular study. The study does suggest the need for further exploration of familial influences by increased involvement with the extended family by history, if not direct experience. In addition, there is a need for more complete comparison and integration of the theoretical concepts currently available. In the past, programs seemed to work independently with limited efforts at consolidation or integration of what appear to be complimentary but

overlapping approaches and ideas. There is also a recognition of the validity and necessity of alternative approaches to understand the phenomena of female transsexualism and an appreciation of the probable interaction of a number of factors. What remains clear is that continued research in the area is necessary.

APPENDIX I

FAMILIAL INFLUENCES IN TRANSSEXUALISM

Robert Stoller depicted parental influences in male transsexualism with the illustration shown here (Stoller, in Green and Money, 1969, 154).

Family #	Mother's Bisexuality	Mother's Closeness	Father's Absence	Father's Passivity or Bisexuality	Birth Order	No Divorce	Sister's Influence
1	Powerful	Powerful	Powerful	Powerful	Powerful	Powerful	Powerful
2	Powerful	Powerful	Powerful	Powerful	Powerful	Powerful	No sister
3	Powerful	Powerful	Powerful	Powerful	Powerful	Powerful	Powerful
4	Powerful	Powerful	Powerful	Do not know father died	Powerful	Powerful	Do not know
5	Powerful	Not present or do not know	Powerful	Do not know father died	Powerful	Powerful	No sister
6	Moderate	Moderate	Powerful	Powerful	Powerful	Powerful	Powerful
7	Powerful	Powerful	Powerful	Powerful	Powerful	Powerful	Do not know
8	Powerful	Powerful	Not present or do not know	Powerful	Powerful	Powerful	No sister
9	Powerful	Not present or do not know	Powerful	Powerful	Powerful	Powerful	Powerful

Powerful
 Moderate
 Not present or do not know

Family influences in transsexualism.

For the purposes of this study the following changes were made in translating the original influences for male transsexualism to the converses for female transsexualism.

Original

Converse

Mother's Bisexuality	= Father's Bisexuality
Mother's Closeness to Son	= Father's Closeness to Daughter
Father's Absence (physical or emotional)	= Mother's Absence (physical or emotional)
Father's Passivity or Bisexuality	= Mother's Activity or Bisexuality
Birth Order	= Birth Order
No Divorce	= Question of Divorce
Sister's Influence	= Brother's Influence

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