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GENDER DYSPHORIA : TRANSSEXUALISM AND IDENTITY

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THESIS SUBMITTED FOR THE DEGREE OF MASTER of ARTS

UNIVERSITY OF DURHAM

Department of Psychology
&
Department of Sociology

STEPHEN MICHAEL DIXON

September 1993



10 MAY 1994

UNIVERSITY OF DURHAM

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GENDER DYSPHORIA: TRANSSEXUALISM AND IDENTITY

Stephen Michael Dixon - M.A. Thesis 1993

ABSTRACT

This thesis explores an extreme form of gender dysphoria: that experienced by transsexuals. The thesis focuses especially on issues concerning identity. It begins by developing a theoretical framework which can encompass the relevant contributions from various academic fields and different levels of analysis. This framework identifies four levels: the cross-cultural and historical, the group and institutional, the situational, and the biographical. The literature relevant to issues of identity as these pertain to transsexuals is reviewed in terms of this framework. From this review two central points emerge: that gender dysphoria is a multi-faceted phenomenon that can only be adequately grasped within a multi-dimensional frame of reference, and that the identity of transsexuals needs to be viewed from a developmental perspective, in terms of the differing demands, both social and psychological, which are imposed on transsexuals at different points in their life-cycle. Some policy implications are noted. The thesis ends with a discussion of some limitations of the present study, and with some suggestions for future research on identity in relation to gender dysphoria.

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# CONTENTS

Page Nos.

## CHAPTER 1 - GENERAL INTRODUCTION

|                                                  |    |
|--------------------------------------------------|----|
| 1.1 Identity 1                                   |    |
| 1:2 Biology, Sex and Gender .....                | 3  |
| 1:2.i Biological Sex .....                       | 4  |
| 1:2.ii Sexual Identity and Gender Identity ..... | 6  |
| 1:3 Gender Dysphoria: Transsexualism .....       | 9  |
| 1:3.i Incidence .....                            | 15 |
| 1:4 Weigert et al's. Model of Identity .....     | 18 |

## CHAPTER 2 - CROSS-CULTURAL & HISTORICAL CODES AND CONTENTS

|                                                                      |    |
|----------------------------------------------------------------------|----|
| 2:1 Introduction.....                                                | 20 |
| 2:2 Cultural Legitimization of Cross-Gender Behaviour .....          | 21 |
| 2:3 Variations in Cultural Responses to Cross-Gender Behaviour ..... | 25 |
| 2:4 Before Transsexualism.....                                       | 26 |
| 2:5 The Onset of Categorization .....                                | 30 |
| 2:6 The Advent of Treatment.....                                     | 32 |
| 2:7 Early 'Modern' Transsexuals .....                                | 33 |

## CHAPTER 3 - THE GROUP & INSTITUTIONAL LEVEL : MEDICINE, LAW & TRANSSEXUALISM

|                                                                                     |    |
|-------------------------------------------------------------------------------------|----|
| 3:1 Introduction.....                                                               | 35 |
| 3:2 Management: Problems in Diagnosis and Selection of Surgical<br>Candidates ..... | 36 |
| 3:3 Psychiatric Illness .....                                                       | 40 |
| 3:4 Surgical Treatment of Transsexuals.....                                         | 44 |
| 3:4.i MF Hormonal Therapy.....                                                      | 45 |
| 3:4.ii Adverse Side Effects of Oestrogens .....                                     | 47 |
| 3:4.iii FM Hormonal Therapy.....                                                    | 47 |
| 3:4.iv Adverse Side Effects of Androgens.....                                       | 48 |
| 3:4.v Sex Reassignment Surgery (SRS).....                                           | 49 |
| 3:4.vi MF Surgery.....                                                              | 49 |
| 3:4.vii Vaginoplasty.....                                                           | 49 |
| 3:4.viii Breast Surgery .....                                                       | 52 |
| 3:4.ix Cosmetic Surgery .....                                                       | 53 |
| 3:4.x FM Surgery.....                                                               | 54 |
| 3:4.xi Mastectomy .....                                                             | 55 |
| 3:4.xii Hysterectomy.....                                                           | 55 |
| 3:4.xiii Phalloplasty .....                                                         | 56 |
| 3:5 Attitude of the Medical Profession .....                                        | 59 |
| 3:6 Non-Surgical Treatment of Transsexuals.....                                     | 64 |
| 3:6.i Hormonal Treatment .....                                                      | 64 |
| 3:6.ii Behaviour Therapy .....                                                      | 65 |
| 3:6.iii Aversion Therapy.....                                                       | 66 |
| 3:6.iv Psychotherapy .....                                                          | 67 |
| 3:7 Transsexualism and the Law .....                                                | 71 |

|                                                                  |    |
|------------------------------------------------------------------|----|
| 3:7.i Criminal Liability for Performing SRS: Mayhem .....        | 72 |
| 3:7.ii Cross-Dressing .....                                      | 73 |
| 3:7.iii Legal Sex Status of the Transsexual.....                 | 73 |
| 3:7.iv Validity of the Post-Operative Transsexual Marriage ..... | 76 |

#### **CHAPTER 4 - SITUATION & IDENTITY**

|                                                                           |     |
|---------------------------------------------------------------------------|-----|
| 4:1 Introduction.....                                                     | 81  |
| 4:2 Identity as a Social Product: The Social Construction of Gender ..... | 82  |
| 4:3 Gender Attribution .....                                              | 84  |
| 4:4 Social Attitudes Towards Transsexualism .....                         | 86  |
| 4:5 Coping Strategies .....                                               | 91  |
| 4:5.i Support Groups .....                                                | 93  |
| 4:5.ii "Passing" .....                                                    | 94  |
| 4:6 Management Devices .....                                              | 102 |
| 4:7 Failure of Coping Strategies .....                                    | 105 |

#### **CHAPTER 5 - BIOGRAPHY, IDENTITY FORMATION, CHANGE AND TRANSITION**

|                                                    |     |
|----------------------------------------------------|-----|
| 5:1 Introduction.....                              | 107 |
| 5:2 Self-Narrative .....                           | 108 |
| 5:3 The Pre-Transition Years.....                  | 110 |
| 5:3.i Tomboys and Sissies .....                    | 113 |
| 5:3.ii Intervention .....                          | 114 |
| 5:3.iii The Adolescent Transsexual.....            | 116 |
| 5:4 The Transitional Period .....                  | 120 |
| 5:5 Post-Transition.....                           | 125 |
| 5:6 Once a Transsexual Always a Transsexual? ..... | 126 |

#### **CHAPTER 6 - DISCUSSION**

|                                                               |     |
|---------------------------------------------------------------|-----|
| 6:1 Appraisal of Framework and Theoretical Resources .....    | 131 |
| 6:2 Main Points .....                                         | 132 |
| 6:3 Overall Points .....                                      | 142 |
| 6:4 Future Research .....                                     | 143 |
| 6:5 Limitations of the Present Review .....                   | 145 |
| 6:6 Policy Implications Arising from the Present Review ..... | 146 |

|                           |            |
|---------------------------|------------|
| <b>BIBLIOGRAPHY .....</b> | <b>148</b> |
|---------------------------|------------|

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CHAPTER ONE
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CHAPTER ONE  
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GENERAL INTRODUCTION
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The concept of gender, alongside and in association with identity, is an area of increasing study within the human sciences generally, and especially within the disciplines of psychology and sociology. For most people in the world, questions about the nature of their gender identity (male or female), rarely arise. There are a number of individuals however, who are 'gender dysphoric'; in that they characteristically experience a fundamental discomfort between their sexual-, and gender identity. For these individuals, particularly transsexuals, questions of gender identity are essential problems that create immense difficulties in their lives in terms of 'who' they are. This thesis aims to address issues of identity in relation to transsexualism, a phenomenon which, rather than a purely 'esoteric interest', is now seen as being of theoretical importance (Plummer, 1981).

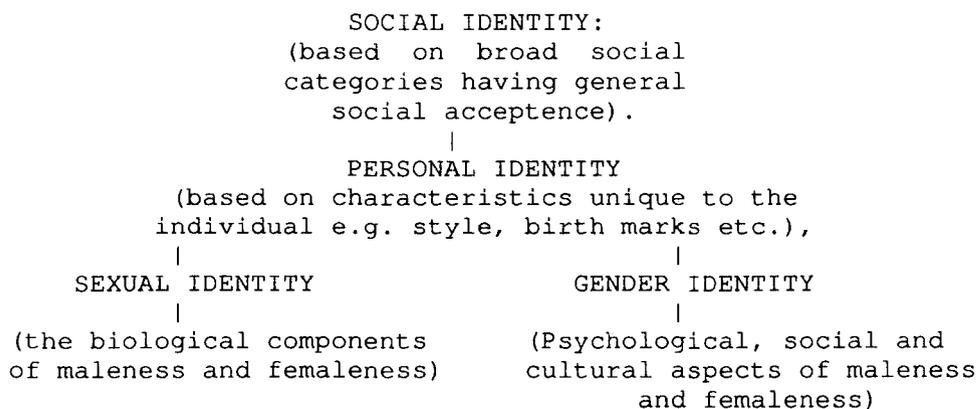
Before such issues can be properly discussed however, and in order to understand the nature of the difficulties experienced by transsexual individuals, it is first necessary to discuss some theoretical notions pertaining to this theme; namely, those of 'identity', 'gender' and 'transsexualism'. This will require attention to be paid to a number of concepts in common use in the disciplines of social psychology and sociology.

Identity  
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The concept of 'identity' has become a broad, operationalized term which has been used in a variety of ways, covering many disparate areas but eluding precise definition, particularly where this pertains to notions of



the self (Breakwell, 1986). At its most expansive, identity has been said to encompass all those things a person may legitimately and reliably say about him-, or herself: status, name, personality, and past life. Identities are also labels, names and categories through which persons address each other and themselves, all of which critically bear on interpersonal relations, involving patterned ways of speaking, thinking, feeling and performing. Cohen (1966) suggests that Erikson's (1954, 1968) most useful contribution to the discussion of identity, was his view of this notion in social and behavioural terms. For example, he referred to 'social identity' - a broad concept encompassing the socially presented self; 'personal identity' - which identifies individuals as being uniquely different; and 'ego identity' - those individuals' selection of the totality of facts about themselves which are of subjective significance. Sexual-, and gender identity can be understood as elements of an individual's personal identity. The following diagram illustrates this:



Normally, the basic congruence of these collective components of identity, gives rise to a vital sense of continuity, distinctiveness and self-esteem (Breakwell, 1986). Indeed, the components are so integral to the sense of self and whole-being, of ordinary individuals that they

are normally simply taken-for-granted. Deep doubts about identity are normally omitted from the individual's conscious awareness. When they do intrude into our attention, as is the case for transsexuals, life becomes uneasy, decisions difficult, and disappointment or frustration may set in (Grimm, 1987). For gender dysphoric and transsexual individuals there is an essential conflict between the above components in that an essential sense of incongruence between sexual identity and gender identity in turn, creates a similar antagonism between their personal-, and social identity, and so their whole sense of identity per se.

Biology, Sex, and Gender

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'For the simple man in the street, there are only two sexes. A person is either male or female, Adam or Eve. With more learning comes more doubt. The more sophisticated realize that every Adam contains elements of Eve and every Eve harbours traces of Adam, physically as well as psychologically' (Benjamin, 1966).

For most of the time, the existence of two sexes, male and female, is taken-for-granted, and it is assumed that there are only two corresponding genders. The social and cultural norms of gender are seen as matching biological, sexual correlates, and hence, to be mutually exclusive; 'a binary code...which admits of virtually no mediating instances' (Giddens, 1992). These categorizations are 'loaded with non-biological significance since, they are accompanied by expectations of what is deemed appropriate behaviour, accompanied by severe sanctions for its violation. Members of a given society share the same taken-for-granted methods for producing a sense of 'objective facts' such as gender, which underlie 'reality' for that society. Within Western culture, physical and biological reality is often regarded as the ultimate 'reality', and biological facts are taken to support the facticity of two genders (Stoller, 1968; Kessler

& McKenna, 1978; Harre, 1991). Indeed, so entrenched is this 'natural attitude' (Garfinkel, 1967) regarding gender that in order to appreciate the existence of alternative but equally real conceptions of men and women requires an examination of anthropological accounts of the 'realities' of other cultures which demonstrate that it is possible to construct that part of the world in many ways (Kessler & McKenna, 1978).

#### Biological Sex

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Conception occurs when a male sperm penetrates (thus fertilizing) the female's egg, at which point, the sex of the future child is determined. If the sperm carried a Y chromosome, the fetus normally develops male sex organs, and a boy is born. If the sperm contained an X chromosome, this dictates the development of female sex organs and the birth of a girl. Since egg cells always carry an X chromosome, the normal male chromosomal constellation is XY, and the normal female constellation is XX. Rare abnormalities can occur whereby constellations such as XXY, XXYY, and even XXXXY, have been observed, accompanied by severe physical and/or mental defects in intersexed children. The estimated ratio of such births is, however, only 1:54,000 (Benjamin, 1966). Generally, people are either one sex or the other. The sex categories are, therefore, primarily bipolar (Harre, 1991). The existence of the genetic mechanism, suggests for some, that the distinction between XX and XY chromosomes reflects the 'real essence' of what it is to be 'male' or 'female'. A potential dilemma for this logic arises with the increasing incidence of people who have their genitalia surgically transformed. Nevertheless, the application of a biological characteristic that cannot be changed (e.g. 'gender chromosomes') ensures that the dichotomous conceptualization

of gender continues to be invariant (Kessler & McKenna, 1978).

Modern Western views of the existence of a sex-gender link, date from the Scientific Revolution of late eighteenth century Europe (Jordanova, 1980) when a series of redefinitions resulted in a radical sexualization of the body (Harre, 1991). The dominant contemporary model of health and illness associated health with lifestyle and social roles, dichotomizing men and women in terms of male strength and female vulnerability, a view which carried different implications for each; e.g. women tended to be seen as being constitutionally frivolous and emotional, being defined socially as passive, dependent and inferior to men; while men were perceived as more serious and thoughtful, being defined by their social acts (Jordanova, 1980). Strictly segregated sex roles, disseminated in accordance with such scientific and bio-medical thought, were manifested in a discourse of biological, psychological and social considerations of individual temperament and constitution, so hardening the conceptual division between unique feminine and masculine attributes. Mid-nineteenth century evolutionary ideas elaborated the dichotomy, providing a 'natural' explanation of gender differences. Such biological determinist attitudes of enquiry, reducing culture to biology, persist in some present day literature on gender, (MacCormack, 1980; Harre, 1991).

Biological phenomena may also challenge commonsense assumptions of a sex-gender link, since the sexual genotype is not always expressed in the phenotype. For example, in the clinical condition of testicular feminization, due to a congenital inability to utilize androgens, the male genotype

is obscured by a female phenotype. A second example is that of genetic females who have a male musculature, and some genetic males with smoother, softer skin than many females. Gender therefore, unlike sex, is not bipolar, but bimodal (Harre, 1991). The picture is even more complex, since there are up to ten separate 'manifestations' of sex; '...chromosomal, genetic, anatomical, legal, gonadal, germinal, endocrinal, psychological' and social. The most flexible being psychological 'sex'. A simpler way of distinguishing between the two terms 'sex' and 'gender' is to think of gender as 'located above, and sex below the belt' (Benjamin, 1966).

Sexual Identity and Gender Identity

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Sexual identity has been defined as referring to the biological components of maleness and femaleness (i.e. chromosomes, genital anatomy, secondary sexual characteristics, hormonal balance); Gender identity is seen as comprising: genetic hormonal influence; assigned sex; and multiple influences impinging on a given individual as a consequence of the sex as which he or she is reared, which collectively produce a subjective sense of masculinity, femininity, or sometimes, something that is not quite either. Debate surrounds the origin of gender identity. Some argue that that assigned sex and early rearing are critical factors, that gender identity is well-established by a child's second year, and mostly, after early childhood, is almost irreversible or extremely difficult to alter without serious psychological consequences (Money, 1969; Stoller, 1975). Others however, believe that both sex and gender are decided at the moment of conception (e.g. Benjamin, 1966).

The concept of gender identity became severed from that of

gender role in the 1950s; gender identity became consigned to discussions of the 'workings of the mind, gender role to the workings of society' (Money, 1972). Gender role is not simply restricted to sexual partner choice and erotic practices, but denotes the cultural stereotype of masculinity, or femininity. Distinct expectations of 'appropriate' overt behavioural patterns for people of either gender, are attached to masculine and feminine gender roles. In our society, gender role expectations are assumed to express an 'essential', biological foundation of gender. The norms of gender behaviour are dynamic however, differing both across cultures, and historically within the same culture, even within a given historical era (Kessler & McKenna, 1978). Most people in most cultures have assumed such a 'mapping' of stereotypical gender roles onto biological sex, taking this mapping to be natural. 'Gender role identification' denotes how much a person approves of, and participates in the feelings and behaviours considered 'appropriate' to his or her gender (Money, 1972). Gender identity is the private experience of one's gender role, which, in turn, is the public manifestation of one's gender identity (Money & Ehrhardt, 1972).

Since the 'real' sex of a human being is necessarily judged according to hidden differences in body form and genitalia, this is read from overt manifestations of sex differences, secondary sexual characteristics, or, manufactured 'tertiary' ones (e.g. makeup, shoe-type, hairstyle etc.) which are then taken to denote one's sexual category for all practical purposes. Gender behaviour and gender differences, are then, culturally determined (Harre, 1991); masculinity and feminity are not direct reflections of biological imperatives, rather, they are completely dependent on time,

place and culture (Benjamin, 1966; Stoller, 1968). MacCormack (1980) argues that ideas cannot be free from biases of the culture in which they were constructed. Gender and its attributes she argues, are not pure biology. Rather, the meanings attached to 'male' and 'female' are arbitrary; the socially constructed differences between people are surrounded by clusters of beliefs' that people hold about themselves, and about others (Harre, 1991).

However, the use of dichotomous criteria for 'corresponding' gender attributions is questionable, and the assumed dichotomous nature of gender, problematic (Kessler & McKenna, 1978). Studies have shown that gender identity development involves a long-term process throughout childhood, that, although generally corresponding with physiological sex in some individuals, may be reversed so that sexual identity may be masculine, but gender identity, feminine (or vice-versa) (Green & Money 1961). Such individuals suffer from a confusion of male and female gender identity.

e.g. Expectations of females are that they should be feminine. i.e. sweet, neat, kind and good at nursing. Expectations of males are that they should be masculine i.e. rough, tough, and good at fighting. Thus, if anyone embodied as a female adopts some of the characteristics that are associated with manhood, she becomes (stigmatized as being) 'mannish' or 'butch'. If anyone embodied as a male takes on any of the characteristics of femininity, he is 'effeminate', or a 'pansy' (Hodgkinson, 1987).

Such (stigmatized) individuals sometimes desperately seek to change their bodily attributes into those of a more socially favoured kind. Transsexualism is the most extreme example of

such a condition (Hurley, 1984). Transsexuals undergo 'gender reorientation' treatment to acquire a 'change of sex'.

#### Gender Dysphoria: Transsexualism

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This thesis is concerned with one particular aspect of gender identity: the clinical condition of 'Gender Dysphoria' (Fisk, 1973); a 'discordancy between the natal sex of one's external genitalia and the brain coding of one's gender as masculine or feminine' (Money, 1972). The term denotes a generic underlying psychic experience, characterizing any of a wide, heterogeneous group of gender identity disorders, suggested to range along a continuum, only some of which lead to a request for SRS (sex reassignment surgery) (Steiner, 1985).

It is widely accepted that at the extreme pole of this continuum lies the phenomenon of 'transsexualism' (Cauldwell, 1949), which became formally distinguished in 1973, by the alternative term 'gender dysphoria syndrome'. Money (1972) criticizes the latter term as a specific referent to transsexuals, on grounds that transsexuals are 'dysphoric about their sex, not their gender'. Transsexualism is a rare, unique disorder, in which an anatomically normal person has a 'passionate, life-long conviction, from earliest childhood, that nature has 'made a mistake', in that they are actually members of the opposite anatomical sex imprisoned within the wrong body. This conviction is coupled with a wish to change anatomical sex thus bringing this into accordance with psychological gender, the indefinable feeling of maleness or femaleness. Although this seems to imply psychotic thinking, transsexuals are not delusional; they remain aware of their

biological sex. Their lives are a constant struggle to resolve this dilemma (Steiner et al, 1985; Kuiper et al., 1988; Beli, 1978). Transsexuals experience their condition as no less real than the awareness and effect of any serious illness or physical malformation (Taitz, 1987). There is an obsessive disgust with their sexual organs, sometimes so extreme that some MF transsexuals amputate their external genitalia (autocastration), or to attempt to do so, since these organs identify them with the abhorrent sex. They claim that their minds react according to their 'true' (i.e. the opposite) sex, but have conflicts within themselves and with much of society when in their 'rightful' gender role, which, although performed socially with sometimes amazing aptitude, cannot be fully played out due to the material existence of a sexually opposite body, (leading to hatred and revulsion for a penis, or to breasts). 'A number... seem to suffer from guilt feelings, self-criticism, and a sense of existential anxiety because of the "wrongness" thrust upon them' by nature's forces (Steinbeck, 1986).

The term 'transsexualism' does not appear in any general medical or surgical textbooks despite the predominate form of relief for the disorder being surgical and endocrinological intervention. However transsexuality is included in the range of psychosexual disorders in DSM-III-R (1987)' (Whittle, 1993). This rare condition involves sexual identity 'deviance'. Some authors argue that it is a genetic disorder; others implicate a hormonal defect. It can be studied from earliest infancy. It challenges psychiatric diagnostic systems (bringing uncertainty to definitions of perversion), and classical psychoanalytic theoretical positions (from castration anxiety and the oedipal complex to the development of masculinity and femininity). It is a

concern of legislators, since to 'change sex' is to technically break the law; It raises ethical questions among physicians, regarding hormonal and surgical intervention to change (normal) anatomy, since it is 'the only condition in which genital, and therefore reproductive, normality is destroyed for psychological reasons alone' (Stoller, 1975). There is no 'cure' for transsexualism (though many therapies have been tried), and little accord exists among clinicians over either its treatment, or aetiology, despite thirty years of intensive study within diverse fields e.g. plastic surgery, endocrinology and psychology (Brown, 1990).

Public and academic interest in the phenomenon increased considerably following the extensive publicity surrounding the SRS of Christine (formerly George) Jorgensen (Hamburger, 1953), the publication of *The Transsexual Phenomenon* (Benjamin, 1966), and further celebrity cases (e.g. Jan Morris, and Renee Richards M.D.), Unlike the past when the condition was shrouded in shameful secrecy, once effective treatment was available, those affected were more willing to come forward and declare themselves (Hodgkinson, 1987). The term was eventually included in DSM-III (the American Psychiatric Association's Diagnostic and Statistical Manual) in 1980 (Brown, 1990).

Throughout the literature, there is a consistent preponderance of male-to-female (MF), over female-to-male (FM) transsexuals (Ball, 1967). Two connected reasons have been suggested for this unequal balance: firstly, that Gender Identity Clinics were set up specifically for MF patients, due to the androcentric cultural salience of maleness in society creating more difficulty for males exhibiting variant role behaviour, thus leading more men

than women to demand surgical intervention so as to diffuse the tension (Grimm, 1987); secondly, that there is a lower demand for FM surgery, due to the relative unavailability of surgical technology (Hausman, 1992) Hodgkinson (1991) in contrast, suggests that FM transsexuals may simply avoid publicity, fitting more smoothly into society as members of the opposite sex. Indeed, Derogatis et al (1981) more recently have claimed there to be a more equal ratio of FM to MF transsexuals.

After a decade of dispute over whether there was one or several types of the disorder and over its distinguishing characteristics, the DSM-III definition of transsexualism: 'a persistent sense of discomfort and inappropriateness about one's anatomic sex and a persistent wish to be rid of one's genitals and to live as a member of the opposite sex' has been generally (albeit not universally) accepted as an adequate operational description - at least of FM transsexuals, who are seen as a relatively homogenous group. In contrast, the 'wide range of clinical signs and symptoms' presented by MF patients, has given rise to much disagreement over diagnostic criteria (Steiner, 1985). The terms 'primary' and 'secondary' are widely used, without much consistency (Blanchard, 1989). e.g. Money & Gaskin (1971) distinguished two types of transsexualism in males: Homosexual and Transvestitic, rather than any independent form. Person & Ovesey (1974a, 1974b) distinguished three types: effeminate homosexual transsexuals, and transvestitic ('secondary'), and asexual ('primary') transsexualism. They saw the latter form as being psychodynamically distinct from transvestitic transsexualism, claiming that it had no history of sexual activity. They also argue that Stoller's (1968) 'primary' transsexuals are, in fact, 'secondary',

whereas Stoller (1980) claims the reverse of these researchers' classifications. All three authors nevertheless agree that primary transsexualism does not occur in FM individuals, for whom Levine & Lothstein (1981) in contrast propose a syndrome of primary transsexualism. Blanchard (1989) nevertheless points out that as there is a high degree of correlation and overlap between these terms, and that no great problems are involved in comparing typologies.

Examination of these positions is beyond the scope of the present thesis, for purposes of which the term 'transsexual' will be used in reference to primary, or 'true', transsexuals for individuals of either sex.

The definition of 'transsexualism' and the age, sex and symptomatology that should be included under the term, undergo continuous revision e.g. DSM-III-R contains a new diagnostic category for gender dysphoric patients who are no longer seen as meeting the criteria for transsexualism, but instead are seen as having a gender identity disorder of adolescence or adulthood of a non-transsexual type.

A further important point to note is that many authors apply the diagnostic label "homosexual" to both pre- and post-operative transsexuals with reference to 'erotic attraction to members of the same chromosomal (as opposed to psychological) sex', (Blanchard, 1989). Neither does this change in accordance with a transsexual's surgical status (Steiner, 1985). For transsexuals themselves however, although the sexual practises may be anatomically homosexual, neither the conscious or unconscious meaning is such (Blanchard, 1989). The terminology pertaining to sexual orientation, as employed therefore, does not reflect the phenomenological experience of the individuals under study.

Rather, it reflects the attitude of researchers, thereby, sometimes complicating interpretation. MF transsexuals, in fact, as with non-dysphoric males or females, may be heterosexual, homosexual or bisexual (Stoller, 1971). For other authors, the diagnoses of homosexuality, heterosexuality, transvestism, and transsexualism, are completely independent. However, all investigators agree that gender identity disturbance occurs only rarely, if at all, in nonhomosexual females (Taitz, 1987).

A transsexual, by definition, cannot be a homosexual - even if attracted to members of the same biological sex - since homosexuals, unlike transsexuals, knowing that they are attracted to members of their own sex, enjoy and revel in their duality, feeling comfortable with, and proud of their bodies as they are. This is the very essence of homosexuality (Taitz, 1987; Hodgkinson, 1987). Homosexuals and lesbians may consider that they have much of the opposite sex in them, but have no desire to change over. Indeed, for most, the idea would be repugnant. Whereas, this is precisely the transsexuals central desire (Hodgkinson, 1987).

A (male) person who intermittantly cross-dresses in the clothing of the opposite sex, is a transvestite. Transvestites do not, however, consider themselves females trapped in a male body, rather, they perceive themselves as, and wish to remain male. They cross-dress for erection, masturbation and orgasm, and to feel like a woman with a penis. They are not disgusted by their male genitalia, rather, these are highly valued (Stoller, 1975). Transsexuals in contrast, cross-dress continuously, since they feel that they belong to the opposite sex. True

transsexuals never become aroused by wearing women's clothes and would not want this, since it would remind them of the sex that they do not want to be. When cross-dressed, they feel 'right', more 'at home', whereas, in the clothes of their biological sex, they feel as though they are merely playing a part (Hodgkinson, 1987; Walters & Ross, 1986).

Furthermore, in that they have normal biological bodies of their initial sex, transsexuals are not hermaphrodites (intersexed), and in turn, hermaphrodites are not transsexuals. Most patients with chromosomal abnormalities e.g. Klinefelter's syndrome (46, XXY) are not gender dysphoric, although the probability of cross-gender identity is slightly increased in such intersex disorders. (Freund, 1985). However, confusion still persists, as exemplified by the joint introduction of 'transsexualism' (in association) with homosexuality in DSM-III, where it is distinguished from childhood gender identity disorder and atypical gender identity disorder - a residual category for otherwise unclassifiable identity disorders (Franzini & Casinelli, 1986).

Incidence

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Transsexualism crosses all cultures and societies, classes and races (Hodgkinson, 1987; Lothstein, 1978), although an accurate estimate of its incidence is impossible, partly due to disagreement over who shall be called a 'transsexual' (e.g. Steiner et al, 1985; Stoller, 1975; Kessler & McKenna, 1974; Green, 1978). The apparent increase in numbers diagnosed from year to year has also been suggested to be an artefact of the lack of clear diagnostic criteria, patient migration, and the esteem in which clinicians are held by transsexuals as well as their own uncertain legal situation

which deters them from declaring themselves (Jonas, 1976; Steinbeck, in Walters & Ross, 1986). Post-operative patients also tend to seek anonymity, and to cast off their previous lifestyles. Thus, numbers of those affected, and of those who have undergone SRS are difficult to obtain. Nevertheless it has been estimated that there are some 30,000 transsexuals worldwide, 10,000 in the United States, to about 1.9,000 in England, Wales and Sweden (Hoenig & Kenna, 1984). The relative prevalence of all 'gender identity disorders', based on diagnosed patients seen at Gender Identity Clinics throughout North America and Europe, has been suggested to be as least 10 times greater than transsexualism (Steiner, 1985). Early estimates of the ratio of FM:MF transsexuals were as low as 1:8. This has since become more balanced at 2:3 due to a gradual increase in the number of females requesting SRS (Steiner, 1985). The ratio of MF transsexuals has been estimated at 1:37,000 of the general male population, and, for FM patients, 1:100,000 of the general female population (Roberto, 1983). More recently, this discrepancy has been suggested to be more apparent than real, and that the sex composition may be roughly equivalent (Lothstein, 1978), although this report is less complete. Steiner (1985) suggests that in general, clinical psychiatrists are likely in their careers to encounter one or more patients for whom gender identity disorder will be diagnosed.

By 1983, an estimated 6,000 patients had received SRS in the United States, as had an estimated 2,000 in Britain (Mason, 1980). However, not all transsexuals undergo SRS. Approximately two-thirds have not, partly due to inability to afford the high cost of the procedure (primarily in the United States, or privately. The surgery is available on the

NHS in Britain), partly because the majority (90%) either abandon the idea, or, fail to be selected for surgery (for physical or psychological reasons), try to resolve their problems otherwise but nonetheless, live full-time as members of the opposite sex (Grimm, 1987).

Stoller (1975) suggests that transsexualism can be seen as a socio-medical experiment, which has proven to be valuable to our understanding of the general concept of gender, on which it has generated an "explosive growth of academic work" in many diverse academic disciplines.

The author here declares a personal interest in the subject, being himself a post-operative female-to-male transsexual. In one sense this facilitates unique access to self-help and other organizations as a representative of the community addressed by this thesis, as well as to a rich source of literary material. Such 'closeness' to one's subject matter simultaneously exposes one to potential legitimate criticism, on grounds of possible bias in one's evaluations and treatment of the material, together with a possible tendency towards subjectivity deriving from one's own personal experiences. One therefore is exposed to the charge of being handicapped by an essential inability to gain sufficient distance from the subject of study that is required in order to achieve a necessary objective, academic treatment of the material. For these reasons therefore, and for purposes of organization, this thesis will employ a theoretical framework that seems well-suited to the theme of interest. This will facilitate the structuring of the material in terms of four basic analytical levels, in order to both identify important issues relating to identity and transsexualism, as well as to demonstrate that in order to

attempt an understanding of something of the experience of transsexuals in Britain today, an essential element of any effective approach is the adoption of a 'developmental' perspective. This means that transsexualism should be viewed both in terms of its characteristic course, as well as the way in which the consequent changing demands which impinge on the individual transsexual are tackled.

Weigert et al's (1986) Integrative Model of Identity  
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Weigert et al (1986) hold that 'identity' is a socially constructed reality, which itself, arises through interaction. They argue that the answer to the seminal question; Who am I?, is an identity, that defines a person as a meaningful object of action. They identify some crucial issues that, they reason, should be considered in any discussion of identity;-

1) The dialectic of subjective and objective identities as parts of existential meaning, and the problem of alienation.

2: That sociohistorical identities link social psychological and historical interpretation.

3: That the organization of multiple identities is a defining characteristic of contemporary pluralistic societies.

4: That the spatiotemporal continuity of identity is a problem in contemporary society.

These researchers, in order to identify what can be learned from answering the rudimentary question; 'Who am I?', in social psychological terms, suggest a program to develop identity theory, to address adequately, crucial issues pertaining to the concept of identity, and so, serve as a

useful research tool for social psychologists interested in studying issues of human realization, or estrangement at both subjective and societal levels of identity integration. At least four levels of investigation would be required: the historical and cultural context, for the formation of identities; the significance of particular social groups and institutions in defining and regulating identities; the relationship between identity and social situations; finally, the investigation of the biographical narrative element in identity formation, change and continuity.

This basic framework, in accordance with the conceptual resources outlined above, will therefore be employed in the present thesis, and articulated in such a way as to provide a structure for the literature to be reviewed. By these means, specific identity issues relevant to the phenomenon of transsexualism might be thrown into relief. I will begin this by sampling the source material in terms of a broad, historical and cross-cultural level of analysis of the phenomenon of transsexualism, This will be followed by concentration upon the group and institutional level, before the focus narrows further, to the situational level, shifting finally, to a biographical level of consideration.

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CHAPTER TWO
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CROSS-CULTURAL & HISTORICAL IDENTITY CODES AND CONTENTS
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'Unlike our own society, many primitive societies recognize in a social sense, and include in their culture pattern, a place for those individuals whose psychic or physiological peculiarities set them apart from the normal' (Hill, 1935).

Introduction  
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Green (1969) points out that 'the phenomenon of lifelong, extensive cross-gender identification, is not new either to our culture or our time', but has a long-standing and widespread pervasiveness. However, both he and others (e.g. Angelino & Shedd, 1955) caution that since the term 'transsexual' was only recently adopted, inferences are required when interpreting reference material. Given this problematic situation, a comprehensive coverage of the literature would serve no purpose but would unnecessarily complicate the picture, and thus, will not be attempted in this chapter. Rather, some of the more salient features of the nature and apparent pervasiveness of the phenomenon of cross-gender identification will be outlined.

Apart from numerous mythological and historical descriptions, both from our own past as well as that of different societies, many sources from cultural anthropology have provided evidence that cross-gender behaviour and identity of varied manifestations exists in diverse cultures, together with differential degrees of social acceptance. Heiman (1975) suggests that the latter range along a continuum: from the institutionalization of legitimate roles, as existed among the Navaho berdache (Hill, 1935), the natives of Southern Celebes (Muensterburger, 1956), the Tanala (Ford & Beach, 1951) the Zuni (Parsons, 1916), and the Lango (Hill, 1935) to the

opposite extreme, where societies, such as Western Vietnam, either lack a concept of transsexual behaviour, and/or show extreme disapproval of the phenomenon, as with hermaphroditism (e.g. Edgerton, 1969). Heiman (1975) however, points out that in practice it would be very difficult to identify transsexuals on either end of the continuum. At the first extreme, in those societies that were hostile to, or without a conceptualization of transsexualism, transsexuals themselves, having no visible role, would tend to blend into the general cultural background. At the other extreme, transsexual roles would be indistinguishable from those of other forms of gender dysphoric individuals. He therefore predicts that epidemiological cross-cultural studies of the prevalence of transsexualism, would, as a consequence, find that some societies appeared to have more transsexuals than others.

Cultural Legitimization of Cross-Gender Behaviour

Hill (1935) reported 'a custom, widely spread among savages, in accordance with which some men dress as women and act as women throughout their life...Often they are dedicated and trained to their vocation from early childhood'. Unlike modern Western society, many primitive societies recognize individuals who psychically (or physiologically) differ from the norm, and include them in the cultural pattern (Hill, 1935). For example, the Institution of Berdache (derived from the French 'bardash') was a widespread phenomenon among the North American Indians, and represented a legitimate, cultural niche for 'gender-transposed' individuals. Angelino & Shedd (1955) define the berdache as an individual who was viewed by the community as being of one physiological sex, but who assumed the role and status of the opposite sex. Forgey (1975) suggests that the role served both personal

and social functions, particularly in Plains Indian society. Extensive data was gathered during the early part of this century on such practices among several tribes wherein boyhood effeminacy and female tomboyishness were traditionally recognized and fostered. Such children were accepted as being different, and were selected out from their peers and raised as if they were members of the opposite sex in preparation for their adoption of distinctive tribal roles when adults. Cross-gendered girls often became brave warriors, while cross-gendered boys did female work and very often...became Shamen - the spiritual, religious and cultural leaders of the tribe. From their reviews of the anthropological literature, Green (1966, 1969), and Forgey (1975) report both male and female berdaches to have existed in many tribes, e.g. Nevada Shoshone, Mojave (Devereux, 1937), and Navajo (Hill, 1935), including nomadic and village tribes (e.g. Pawnee; Crow; Arapaho), as well as the Plains Indians, albeit there being relatively few in any given tribe at any one time.

Sentiments towards berdaches nevertheless, varied among different tribes, ranging from neutral, quiet tolerance such as that of the Sioux, to great esteem as among the Navaho (Hill, 1935) and Cheyenne (Grinnell, 1923). Angelino & Shedd (1955) reason that rather than researchers focussing on the erotic life of such individuals, the more salient issue is the nature of a given society's actual response toward the berdache, and its acceptance of such individuals as 'non-psychological, but institutionalized women...'. The North American attitude toward the berdache, they point out, stresses their social status; 'born a male, a berdache became socially accepted as a woman' (and vice-versa for those born female). Forgey (1975) reasons that

'transvestism', should not be considered synonymous with berdache, since cross-dressing was merely a part of the role structure. Far more was implied by the publicly recognized, institutionalized change in role and status, which was the 'essence' of berdache (Hirschfield, 1962). Berdache status, although perceived as "not normal", was not considered morally offensive, and since the role was often explained and justified according to legend or in spiritual terms, no stigma was involved. For example, Hill (1935) described the Navaho, who referred to berdaches as 'nadles' ("being transformed"). He reported that Navaho society had a 'very favourable outlook' towards such individuals for whom the culture provided fully contributive roles and opportunities. Indeed, it was believed that when there were no more nadle, this would denote 'the end of the Navaho, the country would change, and the horses and sheep would all go'. Nadles were considered to be sacred and holy, to bring good luck and riches. By virtue of their revered ability to do the work of either sex, they had a dual economic role, as well as a social role as mediators in disagreements between men and women, and in the affairs of young people. Similarly, Cheyenne berdaches were greatly esteemed and played an active role in Cheyenne social life. Self-abstinence and denial of their natural born sex was perceived to grant them great power (Hoebel, 1960). Among the Yumen Indians, a group of males were said to have undergone a "change of spirit" at puberty, after which other tribal members proceeded to perceive them as if they were women, while some women in the tribe 'looked like and passed for men, and married other women. Portends of the likelihood of a son's future transformation were recognized by older people to be evident from the boy's actions in early childhood, by which they

knew that he would eventually 'change sex'. Fogey (1975) also reported that the i-wa-musp (man-woman) of the Jukis and other California Indians formed a regular social grade. Dressed as women, they performed women's tasks.

A similar phenomenon has been reported among other cultures. For example, among the Cocopa as among the Tanala of Madagascar, boys who had shown feminine character from babyhood were described to have talked like girls whose company they sought as children. They were selected out to be raised as girls, eventually coming to '...regard themselves as completely feminine', and forgetting their true sex...' (Ford & Beach, 1951). Their female counterparts played with boys, made bows and arrows, had their noses pierced, and fought in battles (Gifford, 1933). On the Aleutians, boys were instructed in the arts women use to please men. Their beards would be carefully plucked out as soon as growth would appear, they wore glass bead ornaments upon their limbs, and their hair bound and cut in the same manner as women (Langsdorf, 1960). On Tahiti, it was reported that the 'mahhus' (men dressed as women) had chosen this way of life in early childhood, and in some Brazilian tribes, women were reported to reject female-type occupations, and to adopt masculine hairstyles and marry women (Westermack, 1917).

Among people of Siberia, a 'change of sex' was found chiefly among paleo-Siberians - the Chukchee, Koryak, Kamchadeb and Asiatic Eskimo (Green, 1967). For example, a special form of Shamanism was reported among the Chukchees, where religious power was gained as a result of dressing and acting like a woman (Ford & Beach, 1951). Both men and women were alleged to undergo either a partial, or complete change of sex in

which the body altered, if not in outward appearance, then in its 'faculties and forces.' (Green, 1969). Legend had it that some men would even acquire female organs, while a transformed woman adopted male apparel and pronunciation and the gastrocnemius muscle of a deer 'would be fastened to a broad leather belt and used as a male organ'. Transformation took place by tribal command during early youth (Green, 1966). For Zulus, a change of sex (by disguise) was a method of changing or averting bad luck.

Variations in Cultural Responses to Cross-Gender Behaviour
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Heiman (1975) described the social aspect of transsexualism in Vietnam as complex. The nature of the relationship between Vietnamese society and transsexuals, he reports, appears to consist of three distinct cultural attitudes. At one extreme, in rural Vietnam free from Western influence, role reversal is institutionalized, transsexual behaviour occurring according to a 'prescribed cultural pattern'. At an intermediate level, an acceptable cultural role is provided for young transsexuals. At the other extreme however, the transsexual role is hidden within the general culture, its expression being restricted to the larger cities such as Saigon, where it was necessary for many transsexuals to identify themselves in order to be referred abroad for SRS. Here, there is a certain degree of tolerance, with some provision of marginalized roles (such as that of housekeeper). However, despite the relative openness in the city, there is no transsexual meeting place. Prior to his study Heiman (1975) he notes no previous reports of Vietnamese transsexuals. He acknowledges that it was often impossible to determine who was or was not in fact a transsexual, and in addition, that transsexualism might have been generally, 'invisible' in urban settings.

Grimm (1987) cites Martin & Voorhies' (1975) description (in their review of the cross-cultural literature) of at least nine societies that recognized alternate gender statuses, and in which individuals assumed, largely by choice, the role of the opposite gender. He suggests that the existence of such cultures serves to support the position which holds that meanings are applied - even to basic biological facts such as the existence of two morphologic genders - and that these meanings both derive from and elaborate masculine and feminine themes that are reciprocally extrapolated from these facts. Basic morphological differences, he argues, 'set up the whole range of variation of the feminine and the masculine genders (that are then) narrowed in one way or another by every culture'.

Before Transsexualism  
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Problems of interpretation and inference similar to those encountered with the cross-cultural literature also face the historian attempting to trace the historical origins of transsexualism. Indeed, it is very difficult to judge from the viewpoint of the twentieth century if certain individuals in the past were, in fact, 'true' transsexuals, since adoption of the term 'transsexualism' and the necessary technology to surgically transform the body were both only relatively recent developments. Thus those who would be identified as transsexual today were, before this time, not recognized as such (Hodgkinson, 1987). Therefore after a brief overview of the long history of cross-gender behaviour, this chapter will be mainly concerned with more recent developments that led to the recognition of the phenomenon of 'transsexualism' in its own right. To this end, for the first part of the chapter, rather than

'transsexual', the referential terminology used by Whittle (1993) will be employed. Thus, 'people who desired to live/lived for much of their adult life, until death ('unless otherwise prevented e.g. by discovery and punishment, or by illness') in cross-gender role and dress (opposite to that of the gender group of their natively designated sex) and were 'recognized by society as belonging to their chosen gender' shall be referred to as 'transgenderists'.

The notion of 'sex change surgery' was brought to public and professional awareness with the widespread publicity surrounding Christine Jorgenson's surgery in Denmark in 1951/2, and at the same time, that of Roberta Cowell in England. Perhaps largely because of this, transsexualism has generally tended to be perceived as a relatively recent phenomenon. In the past, the absence of available means by which to effect actual physical conversion (apart from castration in males (Money, 1970)), meant that there was no possibility of surgical intervention. Before such possibilities, there was little choice for those who felt 'trapped in the wrong body', save that of 'simply' enduring it - for life. Apart from wearing the clothes of and pretending to be a member of the opposite sex, no other relief was available (Hodgkinson, 1987). Nevertheless, throughout history there have been men who wished to be women, and women who wished to be men (Steiner, 1985). Many such cases have been extensively documented (e.g. Bullough, 1974; Green, 1966; Steiner, 1981; Weinrich, 1976). Transsexuality, as presently defined in DSM-III (The American Psychiatric Association's Diagnostic and Statistical Manual, 1980), requires a stated desire for alteration of the body. Before introduction of the term

however, such individuals could not self-identify as being 'transsexual' (Whittle, 1993; Steiner, 1985).

The condition and treatment of transsexualism had been continuously debated and revised in the 110 years preceding its inclusion in DSM-III. Since this time, the phenomenon has been generally recognized by psychiatrists as being a mental disorder requiring professional intervention. This classification of transsexualism as a mental disorder was largely a consequence of the historical response of church, state and medicine, to homosexual acts (Whittle, 1993).

Ancient mythologies record examples of those who apparently changed sex and who were regarded with awe and respect, being deemed to have supernatural powers and wisdom. The Goddess Venus Castina was believed to be sympathetic and understanding to those who saw themselves as having female souls incarcerated in male bodies. Tiresias, a soothsayer in Thebes, was said to have been changed into a woman as a punishment by the gods, and later, to have been changed back into a man (Hodgkinson, 1987). Ancient Greek and Roman writers also commented on individuals who were profoundly discontented with their gender role (Green, 1966). Philo, a Jewish philosopher, recorded descriptions of those who were "not ashamed to employ every device to change artificially their nature as men into women...some...craving a complete transformation...have amputated their generative members." (Masters, 1970). Furthermore, the Roman emperor Heliogabalus was claimed to have offered half the Roman Empire to any physician who could provide him with female genitalia (Benjamin, 1966). Predating this, the Egyptian Queen/King Hatsephut (reigned 1503-1482) in the middle of her reign as 'Queen' in the 16th century BC suddenly had herself declared

'King'. Work on her 'Queens' tomb was duly abandoned, and a new one was instead prepared for her in the Valley of the Kings. Before that point, all official paintings and carvings depict 'Queen' Hatsephshut as a woman, but thereafter 'King' Hatsephshut was represented as a man (Dyscourse, 1992).

Throughout the history of Western culture, there have been transgendered individuals (Whittle, 1993). For example, many Medieval accounts exist of female saints who were transgenderist. Such behaviour was accepted as being part of their search for chastity and holiness, whereas transgenderist behaviour in men was assumed to be primarily aimed at gaining access to women for sexual purposes, and hence, not to be worthy of documenting (Bullough, 1974).

Whittle (1993) argues that the influence of Christianity seems to have first called for transgenderists to be punished for their behaviour, which it associated with heresy. Throughout Medieval Europe, transgenderist behaviour became associated with witchcraft and was viewed as a satanic practice. Witches were believed to have potions capable of changing the sex of animals and humans. The Devil was believed to have the power to turn females into males, although interestingly, not to be able to transform men into women (Green, 1966). But while Medieval English society was averse to transgenderist behaviour, such individuals were usually tolerated and not condemned by local communities (Bray, 1982). Nevertheless, 'Punishment rather than "treatment" remained the predominate mode of dealing with the issue until the work of the psychologists of the nineteenth century' (Whittle, 1993).

The Onset of Categorization

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The great moral debate in the nineteenth century over the notion of the Christian family, accompanied by great concern about the immorality of the inner city population and the corruption of young people. Homosexuals were seen as a threat in all three respects. An amendment to the Criminal Law Act criminalized both public and private male homosexual behaviour, the penalty being up to two years imprisonment. Homosexuals were thereby driven to seek medical help, thereby providing doctors with the opportunity to amass case history data on such individuals. Such case data suggested that rather than there being a common pattern, as had been assumed, the preferred object choice, practices, and personal histories of such individuals were quite heterogeneous (Whittle, 1993). From the late 1800s, psychosexual professionals had been attempting to categorize individuals who would today be recognized as being transsexual into 'homosexual types'. Whittle (1993) notes that Krafft-Ebbing (1840-1902), Professor of Psychiatry at Vienna, published, and constantly revised his "Pscopathia Sexualis" (1877) to give clearer and clearer classifications of the behaviours and case histories of his patients, and divided homosexuality into two major categories - acquired and congenital. Under the first category he described transgenderism as '"Metamorphosis Sexualis Paranoica'; under the second as 'Effemination and Viraginity' and/or 'Androgeny and Gynandry'. Hodgkinson (1987) notes that the case descriptions of his subjects were comparable to those of transsexuals from the 1950s to the present. For example, the description of one of his cases includes the first recorded usage of the statement: 'I feel like a woman in a man's form' - 'the classic self-descriptive phrase that was

to characterize transsexuals of the future' (Hodgkinson, 1987). Thus from the late nineteenth century, the concept of gender role deviance emerged.

Westphal (1870) had been among the first academics to report the contradictions described by his patients between the sex of the body and their subjective experience, a phenomenon which he termed 'kontare sexual-empfindung' (contrary self-awareness). It has been suggested, however, that one of Westphal's (two) cases was not in fact a transsexual, and thus that the term may have been overextended by others, to also include homosexuality (Hoenig, in Steiner, 1985). In 1936, Havelock Ellis wrote a seven-volume work categorizing all types of sexual activity, in which he divided transvestites ('Eonists') from transgenderists who remained in the group 'sexual inverts' or homosexuals (Whittle, 1993). He nevertheless firmly shifted the focus to that of inner experience, reporting six case histories manifesting 'sexo-aesthetic inversion' which, he saw as being distinct from all forms of transvestism, in that these individuals demonstrated a desire for the actual role of the opposite sex (Hoenig, in Steiner, 1985). Ellis proposed that there were two types of Eonist:

'..the most common...is mainly confined to the sphere of clothing and another less common but more complete in which cross-dressing is regarded with comparative indifference but the subject so identifies himself with those of his physical and psychic traits which recall the opposite sex so that he feels really to belong to that sex although he has no delusion regarding his anatomical conformation' (Ellis, 1948).

Not until 1938 was transgenderism finally distinguished from homosexuality by Hirschfield (King, 1981), a separation that allowed the medical profession to take a specialized professional interest in the "treatment" of the former. Thus the historical response to individuals who cross-dressed,

and their association with homosexuality, led to the subdivision and categorization of homosexuals by nineteenth and twentieth century sexologists, which in turn led eventually to the rise and recognition of the category 'transsexual' (Hodgkinson, 1987). Their work made the phenomenon available for study, discussion and treatment' (Whittle, 1993).

#### The Advent of Treatment

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Cauldwell (1949) introduced the term 'Psychopathia Transsexualis' for an individual who was physically of one sex but psychologically of the opposite sex, although the first use of the word 'transsexual' in a scientific paper was by Benjamin (1953). Up to the 1950s, the category of transvestism was still vague enough to cover both those who sought SRS, and those with less extreme gender deviance. Not until the mid 1960s did transsexualism first emerge as the subtype of the transvestite, before beginning to stand as a fairly clearly differentiated, separate clinical category, entering widespread use and being used to justify surgical intervention for such cases (King, 1981). Only in the 1960s and early 1970s did the notion of transsexualism receive some degree of legitimacy and (relatively) more widespread interest from the medical profession (particularly in the United States). Initially SRS had only been 'legitimately' available to those considered to be biologically intersexed, but with the development of the category 'transsexual' came a more widespread acceptance that SRS was also a viable form of therapeutic treatment and its actual introduction in a small number of 'respectable' medical centres. Simultaneously, there was an 'almost universal acceptance of the term' as well as the introduction of others relating to the concept of gender and a further flurry of categorizing

activity (King, 1981).

The first 'sex change' operation took place at the John Hopkins Hospital in America in 1965, the same year that the first Gender Identity Clinic was established in Britain at Charing Cross Hospital. At the same time, concern shifted to distinguishing 'real' transsexuals from homosexuals, transvestites, schizophrenics etc., who might also request SRS. King (1981) points out that this seemed to mark the beginning of the conventional use of SRS as 'treatment' for transsexuals, although the operation seemed to be available on a very uncertain, irregular basis. By 1981 however, more than forty American medical centres were handling such cases, while in Britain, eight to twelve operations were being performed annually.

Many writers nevertheless continued to refer to those desiring SRS as 'transvestites' (King, 1981). A further (continuing) complication derives from those authors, notably, psychoanalysts (e.g. Guthiel, 1954, and Socarides, 1973), who argue that both transvestism and transsexualism are simply forms of 'latent' homosexuality. This terminological problem is just one of many that has hampered research.

Early 'Modern' Transsexuals

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Whittle (1993) notes that the first case of surgical intervention is often cited as being the 1931 German case of Lili Elbe (formerly Einar Wegener), a Danish painter who received transplanted female organs but died soon after he operation. He points out however, that a number of known cases predated this, citing one of the earliest as being recorded in the 1880s when several surgical procedures were performed on Sophia Hedwig, in order to transform her from

the female-, to the male gender role (Bullough, 1976).

The first FM transsexual to receive modern surgery and hormone therapy was Michael (formerly Laura) Dillon. Her surgical reassignment in the early 1940s was performed by the Austrian wartime plastic surgeon, Sir Harold Gilles, and involved eleven separate operations for the creation of an artificial penis and scrotum. The techniques pioneered in this first phalloplasty are still in use today. Laura Maude Dillon, was able to subsequently change the name on her birth certificate to Laurence Michael Dillon. After qualifying as a doctor, publicity led him to abandon this career. He later converted to Buddhism and became the first Englishman to become ordained a Tibetan Buddhist monk. Dillon died in 1962 in India (Hodgkinson, 1987). By which time, Christine Jorgensen's widely publicized surgery (Hamburger, 1953) could be seen to have marked, formally, the medicalization (and thus 'creation') of the modern phenomenon of transsexualism.

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**CHAPTER THREE**

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THE GROUP & INSTITUTIONAL LEVEL: MEDICINE, LAW
& TRANSEXUALISM~~~~~
Introduction
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The medicalization of transsexualism served as the impetus underlying the creation of an institutional structure for dealing with the modern management of the phenomenon. The operation of this structure has both relied upon and been driven by the problematic issue of attempting to establish definitional criteria for describing the precise nature of the condition. This chapter will review the broad literature dealing with institutional aspects of the transsexual phenomenon and its management: diagnosis and selection for treatment; psychiatric illness; surgical treatment; alternative (non-surgical) treatment; the attitude of the medical profession to transsexualism; and legal issues contingent on treatment.

Giddens (1992) notes that in pre-modern societies, rites of passage between social statuses were often marked by some form of ritual mutilation of the body. While Featherstone (1991) argues that such practices are less prevalent in contemporary industrial societies, Giddens (1992) points out that like the self, the body can no longer be taken as a 'fixed' physiological entity, rather, considerable reflexivity exists between the body and modernity. In terms of transsexualism, this two-way process is evident in the fact that the existence of transsexualism created a demand for the development of the necessary technology for the transformation of the body, which in turn, made possible the modern phenomenon of transsexualism. In this way, 'the body itself has become emancipated and fully available to be

"worked upon". Contemporary concerns with bodily appearance and control, differ from more traditional preoccupations in so far that the body has become a visible carrier of self-identity (Giddens, 1992). However, the impact of high technology medicine has raised ethical problems regarding the ultimate ownership of human body-parts, problems which in turn demand consideration of philosophical dilemmas such as the place within such developments, of the relationship between the body, consciousness existence and identity. Developments in modern medicine thus carry 'fundamental implications for what it is to be or have a body' (Giddens, 1991).

Management: Problems in Diagnosis,  
and Selecting Surgical Candidates

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'...to reject surgery, for all cases, as a matter of principle, is positively wrong, cruel, unrealistic, and unscientific. But it is just as wrong to operate on mere request, without study and observation' This is the 'doctors dilemma' (Benjamin, 1966).

The first Gender Identity Clinic was opened at the John Hopkins Hospital, Maryland, in 1966. By 1979, in response to growing demand, forty such clinics were estimated to exist in Western countries. A number subsequently closed, partly because of an increased realization among clinicians of the heterogeneous presenting problems of gender dysphoric patients, who were also often difficult to manage, e.g. delays, or refusals to operate sometimes leading to self-mutilation, or repeated suicide attempts (Steiner, 1985; Benjamin, 1966; Hoenig et al., 1974). Although large institutions such as the John Hopkins had recognized the concept of gender identity disorder and its treatment by sex-reassignment surgery which had become more widely available since 1969 (Franzini & Casinelli, 1989), its precarious acceptance into mainstream medicine was largely a consequence of increasing demand and the development of

various selection criteria for recipients. There were however, opponants to SRS, both within the medical and psychiatric professions. Thus there was no formal consensus (King, 1981).

The irreversibility of the procedures demands that surgical candidates are selected according to strict diagnostic criteria, as a control against operating on 'unsuitable' patients. Stoller (1975) reasons that ideally, transsexuals would present more or less the same clinical picture of a clear-cut, diagnostic category. Their evaluation is however, fraught with difficulties; nearly all such patients attempt to convince evaluators that they are true transsexuals in order to obtain SRS, yet no specialized tests exist to assist diagnosis. For the majority of these patients, the results of physical examinations and laboratory studies are normal, no known organic pathology being associated with cross-gender symptoms (Brown, 1990). This situation is exacerbated by a general lack of knowledge and/or misinformation within the psychiatric community as to the nature of transsexualism.

One of the major concerns of diagnosis is to establish an effective means of filtering out the 'true' or 'primary' transsexual from differential, 'lesser' forms of gender dysphoria. Apart from 'prototypical transsexuals' (Meyer, 1974; Steiner, 1985), the largest group of patients include primarily transvestites, effeminate homosexuals, masochists and sadists. Clinical experience has underlined the difficulty in distinguishing between these types, particularly when cross-gender wishes are strong (Steiner, 1985). Stoller (1975) warns that for such individuals, 'the operation is dangerous' since they may realize

post-operatively 'that they have made a mistake from which they cannot retreat', becoming at risk for the onset of 'psychosis, depression, suicidal intent, and possible medico-legal complications'. He, and others (e.g. Meyer, 1974) also advise against accepting psychologically unstable, severely depressed patients. Bower (1986) urges that brain pathologies should also be ruled out (Hoenig & Kenna, 1979). There is also the need to exclude chronic alcoholics, drug addicts, and those with criminal records, or limited intelligence (Steiner, 1985). Benjamin (1966) nevertheless warns against outright rejection for patients at risk of a reactive psychosis, suicide or self-mutilation, while simultaneously cautioning physicians against allowing sympathy to obscure clinical judgements. Nevertheless he reports many other cases for whom, 'surgery is their salvation, and probably their only one'.

Many health professionals endorse criteria given in DSM-III-R for diagnosing transsexualism. These require that there is i) a persistent discomfort and sense of inappropriateness about one's assigned sex ii) a persistent preoccupation, for two or more years, with getting rid of one's primary and secondary sex characteristics and acquiring the opposite sex characteristics iii) the person has reached puberty.

A simplistic view of transsexualism as being 'a belief held by normal individuals that they are members of the opposite sex' is criticized as being unsatisfactory and problematic (Stoller, 1975; Steiner, 1985) since the individual demanding SRS thereby makes both the diagnosis, and decision for SRS, leaving doctors simply performing a service (Steiner, 1985; Grimm, 1987). A further problem is that most

applicants are familiar with the subject of transsexualism, tending to know both the questions and the 'correct' answers to these before they are asked (Stoller, 1975; Bower, 1986). This is further compounded by unreliable personal histories 'designed' to fit the clinical picture (Morgan, 1978; Steiner, 1985; Bower, 1986; Grimm, 1987). Such problems are a consequence of inadequate definitional criteria for transsexualism, which also deny the possibility of making accurate prognoses of who would be improved and who would be harmed by SRS.

King (1981) suggests that selection criteria broadly take two forms: 'Practical and behavioural' criteria, he suggests, allow the widest use of SRS (and protect physicians involved) by 'emphasizing the practicability of the patient' e.g. that he or she is above age of consent, is free of 'severe psychiatric disease', and has lived and supported him-, or herself in the cross-gender role for at least one year (Randell, 1971; Money & Schwartz, 1969) - 'Diagnostic' or 'theoretical' criteria, on the other hand, are 'simply' aimed at diagnosing 'true' transsexuals according to some theoretical framework.

Once diagnosed, patients are required to live, become employed and function in the cross-gender role for a minimum one-year period in a "Real Life Experiment" (Money, 1969) as a conditional pre-requisite for SRS, in order to test how well each copes as a member of the opposite sex before electing for irreversible surgery. During this period, a few cases (77% of whom are in their late teens) decide against the transsexual route (Steiner, 1985). Much debate surrounds issues such as the optimal length of time patients should be required to spend cross-living prior to SRS, whether hormone

therapy should immediately follow diagnosis, and whether say, large-breasted females should receive early mastectomy (Steiner, 1985; Snitcher, personal communication). Actual decisions varying at the discretion of a given clinic. For example, the somewhat stringent criteria for SRS as employed at the Toronto clinic (Steiner, 1985) are that the patient;

1. is diagnosed as transsexual.
2. has lived for a minimum of 2 years in society in the chosen gender and has been on hormone therapy for at least 1 year.
3. is gainfully employed and self-supporting.
4. does not suffer from any psychiatric disorder that would prevent him (or her) from comprehending the surgical procedure and its irreversibility.
5. is physically healthy.
6. is not married (because of the legal complications).

Beyond the difficulties of diagnosis, the fourth of these criteria has proven to be one of the most contentious.

Psychiatric Illness

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'If a person passionately wants the surgery, he or she is considered crazy and cannot have it, but if a person does not crave surgery quite as intensely, he or she is mentally competent and can have it' (Grimm, 1987).

This paradox reflects a confusion among evaluators as to whether or not those requesting SRS are psychiatrically ill (e.g. Derogatis et al., 1981; Grimm, 1987; Stoller, 1973; Pauly, 1965; Lothstein, 1977; Hoenig, Kenna and Youd, 1970; Bem, 1974; Clarkson & Stafford-Clark, 1960), and thus whether their desires should be granted. Much of the argument concerns the question of whether any psychopathology that may exist is a reaction to, or inherent in the phenomenon. A number of arguments have been put forward.

Stoller (1973), for example, argues that the psychotic identity is chaotic, while that of the transsexual is coherent, despite being 'built around an unreal hope'. Furthermore, he points out, the transsexual's desires are often found in non-psychotic, non-transsexual people.

Some authors such as Meyer (1974), and particularly psychoanalysts (e.g. Socarides, 1979) on the other hand, view transsexualism as a fallacy that enables stigmatized homosexuals to escape responsibility for that status. Furthermore, the general view among psychiatric evaluators is that the central belief of the transsexual, that he or she is a member of the opposite sex to that manifested in their anatomy, is simply a delusion (e.g. Meerloo, 1967; Ostow, 1953; Socarides, 1970; Stafford-Clark, 1964; Huxley et al., 1981) and/or that this delusion masks a psychosis (e.g. Levine & Lothstein, 1981; Steiner, 1985). Stoller (1975) reasons that 'obviously, the transsexual has a false belief (but) not all false beliefs are delusions' (Hodgkinson, 1987). Transsexuals, he argues, differ from delusional people: 'the external reality of his (or her) anatomical sex is never denied...transsexuals cannot manage to hallucinate body change; that is why they must take hormones and seek 'sex change' surgery. They only deny that their identity is appropriate to their biological state' (Lothstein & Levine, 1981).

Althof & Keller (1980) claim that an 84% frequency of serious character pathology is associated with gender dysphoria. Bower (1986) claims that one fifth of pre-operative MF transsexuals have had brief psychiatric breakdowns, 'usually depressive in type'. Burnard & Ross (1986) however, argue that the mixed findings among test

scores reported by different studies demonstrate the need for a careful elucidation of terms in order to describe transsexualism more objectively and quantifiably (Derogatis et al., 1981). They point out that while psychological testing cannot be used to diagnose transsexualism, it can detect psychosis and personality disturbance, while concurrently providing information about individual personality, thereby enabling the identification of those patients 'who would never be happy with the surgical outcome'. King (1984) suggests that transsexuals exhibit as much range in personality as does the general population (Grimm, 1987). Burnard & Ross believe that this disagreement may be due to researchers failing to standardize their samples rather than, say, comparing SRS candidates who have had no prior assessment with those transsexuals who have been carefully screened. These authors and others (e.g. Lindgren & Pauly, 1975) also emphasize the need to develop a battery of standardized structured and unstructured psychological tests with which to compare results from various gender identity clinics, in order to provide a range of measures, including a given patient's sense of reality, degree of cognitive development, control of affect, the nature of psychic defences and ego strength, relationships with others, and degree of control of impulses and drives.

Derogatis et al (1981) aimed to achieve an accurate psychological profile of 20 FM transsexuals selected according to explicit exclusion criteria, comparing them with 143 heterosexual female volunteers by means of the Derogatis Sexual Functioning Inventory, a psychological assessment tool comprised of 245 items, standardized and validated specifically for this purpose.

The researchers reported their findings as indicating that the FM group were 'markedly masculine, with a somewhat dysphoric affect', but with 'little evidence of dramatic symptomatic psychopathology'. The heightened levels of psychological distress that were found for the transsexuals (depression and unhappiness, with low joy and contentment) they reported, could not be interpreted as signalling disproportionate psychiatric disorder, when compared to levels of guilt and hostility among the non-clinical population. Furthermore, levels of psychopathology were found to be comparable between the two groups. MF transsexuals, in contrast they suggest, show a 'high incidence of hysterical personality, and associated cognitive style, with a failure to attend to, or assimilate details' (although Burnard & Ross, 1986, would disagree). Whereas 'no such observation had been reported to exist among FM patients for whom the symptom profile (was) unremarkable' (Stoller, 1975; Walinder, 1978).

Blanchard (1989) dismisses what he refers to as 'psychiatric name-calling' as unhelpful. Benjamin (1966) suggests that many such symptoms might be due to a 'thwarted sex life and the gender discomfort of the transsexual state'. On the basis of this reasoning, Burnard & Ross (1986) suggest that it would be expected that transsexualism would more likely be associated with personality disorders, since sexual identity is so integral to personality. Ball (1968) noted that in 6-8 of the 152 pre-operative transsexuals that he had observed, who had been diagnosed by psychiatrists as having a 'paranoid or a schizophrenic reaction', the greater the sexual frustration, the more pronounced the psychoneurotic symptoms seemed to be. He also reports one MF case as being '...handicapped by extreme, almost paranoic

sensitiveness to remarks referring to the feminine impression he made and to his assumed homosexual inclination.'

Fleming et al (1980) suggest that the inability of pre-operative transsexuals to establish a clear, stable self-concept is a consequence of the conflict that they experience between their anatomical sex and gender identity. They found an overall, positive relationship between increased SRS procedures and increased body satisfaction. Derogatis et al., (1981) reported that raised levels of 'Interpersonal Sensitivity' found for their transsexual sample were not within the clinical range, but were comparable to that of non-transsexual patients such as the obese, with body-image problems. Pauly (1964) advocates hormone therapy for its effect of improving the emotional balance and general mental state of most transsexual patients. But he acknowledges that many medical circles believe that the only relief available to the transsexual is an alignment of the individual's body with his or her psychological gender via SRS.

#### Surgical Treatment of Transsexuals

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'Persons who become postoperative transsexuals are pioneering a new identity. Medical technology has brought the identity of the 'postoperative transsexual" into the institutional order of contemporary society. What had formerly been fantasy in an earlier period, became a socially available identity in a subsequent one' (Weigert et al, 1986).

Hodgkinson (1987) suggests that individual experiences and outlook are intimately determined and influenced by body

shape and gender. She laments that until attitudes change, transsexual surgery will continue to be the answer. The transsexuals that she interviewed were 'utterly convinced that surgery and hormones had literally saved their lives'. Finkelstein (1991) nevertheless argues that with "increasing commodification" of the body, surgical reshaping has become more generally acceptable and is no longer seen as indicating psychological disturbance (as was the case until recently). Yet the assumed link still persists where such surgical reshaping is done for purposes of a 'change of sex'.

A small proportion of transsexuals manage to come to terms with their situation and decide not to pursue any form of reassignment treatment, obtaining sufficient relief from cross-living in the preferred gender role (Benjamin, 1971; Hodgkinson, 1987). Hoenig et al., (1971) point out that hormone therapy and surgical procedures are not 'treatments' as such, since they do not affect the phenomenon itself. Rather, the therapeutic aim is to promote patients' better adjustment to, and greater tranquillity in, life. Due to stringent pre-operative screening, less than 10% of applicants at major gender clinics ever undergo surgery (Stone, 1977). The average waiting period for SRS from the first medical contact is five years, by when, patients are usually in their early thirties (Steiner, 1985).

MF Hormonal Therapy

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A number of authorities advocate that hormonal treatment is recommended by a professional who has had an ongoing psychotherapeutic relationship with the patient for a minimum of 3-12 months (e.g. Walker et al., 1984). One daily tablet comprising 250 micrograms of d-norgestrel with 50

micrograms of ethinyl estradiol is normally prescribed.

MF transsexuals tend to find the calming, feminizing effects of female hormones (oestrogens and/or progesterones) indispensable. Long-term treatment effects somatic changes in habitus and skin characteristics, allowing phenotypic males to approximate the appearance of phenotypic females (Walker et al, 1985); softening a rugged, masculine outline as fat shifts from shoulders and neck to hips (Steiner, 1985). Body hair (with the exception of pubic and axillary hair) decreases, and scalp hair usually grows faster and heavier. The beard however, requires removal by electrolysis. Maximal breast growth (gynecomastia) resembling that of the average female (accompanied by increased nipple, and areolar size) requires at least 2 years of treatment, and provides great emotional relief for patients (Benjamin 1966). Androgen output/activity is suppressed, thereby strikingly lowering libido with an extreme reduction in masturbation, accompanied by 'chemical castration'; spontaneous morning erections are extinguished, voluntary erections become difficult to achieve, and, in six months, perhaps painful. Where orgasm is still possible, ejaculation tends to be absent. In time, the ability to perform sexually as a male, is lost. With long-term treatment, there is some testicular atrophy - 25% volume reduction on average (Steiner, 1985; Symmer, 1968), and within a year, penile shrinkage. Affective responses, in appropriately treated patients, include emotional stability and a calming, inner tranquility (Benjamin, 1966).

Generally, these effects are temporary. If oestrogen were to be discontinued, a gradual return occurs over six months to the former state. However, longer term effects (testicular

atrophy and gynecomastia) are permanent.

#### Adverse side-effects of Oestrogens

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Patients are warned of increased risks (e.g. thromboembolic events, nausea and vomiting, headaches, dizziness, weight gain, oedema, prolactinoma formation, and possible breast cancer). Conjugated estrogens are less likely to have acute adverse side-effects than some other regimes (Steiner, 1985; Symmers, 1968). There is however, little standardization in prescribed hormonal preparations, either in dosage or type (Steiner, 1985). Some clinics prescribe oestrogen in excessively large doses (thus heightening risks of complications). The risks of adverse side effects are also increased for transsexuals who, in the mistaken belief that it will promote their feminine appearance, take excessively large doses of oestrogens. Hence the importance of annual checks being carried out on these patients - particularly on liver function, since there are slight risks that this organ, which metabolizes hormones, might be detrimentally affected by long-term, or excess medication. Benjamin (1966) recommends prolonged oestrogen administration before a decision for surgical castration.

FM Hormonal Therapy

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Hormone therapy for FM transsexuals usually involves the administration of male hormones or androgens (250 mg testosterone cyprionate injected intermuscularly every 2 weeks). The outward transformation from female to male may be quite dramatic after a few months on hormone treatment. Oral androgen preparations provide little help, and, being a suspected carcinogen, should not be used for any length of time (Benjamin, 1966).

Goals are: cessation of menses (in about two months);

increased growth/coarseness of body and facial hair in the male pattern (one year); weight gain, and increased masculine muscle mass and strength; increased blood vasculature of the skin; and possibly, bone growth. Many patients take up weight-training to build up body musculature. Fat distribution dramatically alters, being lost from hips and thighs, while waist, neck and shoulder girdle, thicken, producing a more masculine contour (Steiner, 1985). The voice permanently deepens into the male range (six to nine months). A thinning of scalp hair is possible (Benjamin, 1966). Height and general physique will not, however, alter (Hodgkinson, 1987). Sexually, heightened libido is almost always reported, and clitoral size and sensitivity increases (Steiner, 1985) growing sufficiently in some patients, to serve as a small penis (Benjamin, 1966).

#### Adverse side-effects of Androgens

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Some patients may develop teenage-type acne temporarily. Long-term risks with exogenous testosterone therapy include a slightly increased risk of liver disturbances; hepatitis with jaundice, and also, hepatic cancer. Other risks include; elevated cholesterol and tryglyceride levels, a theoretical risk of coronary heart disease, and an increased rate of heart attacks, strokes and even gangrene (Hodgkinson, 1987). As with oestrogen therapy, individuals react very differently to testosterone. The occurrence and timing of events are determined by a number of factors, including dosage, and treatment duration and are therefore unpredictable (Benjamin, 1966; Hodgkinson, 1987).

Long-term effects (< 10 years) of oestrogens and androgens are unknown. Although maintained for life, producing

feminization and masculinization respectively, they will not alone complete the transition. While the effects of androgens are more permanent and less reversible than those of oestrogens, surgical procedures for FM transsexuals are less satisfactory than those for their MF counterparts (Hodgkinson, 1987).

Sex-Reassignment Surgery (SRS)

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'Anatomy is not really destiny; destiny comes from what people make of anatomy' (Stoller, 1975).

The term 'sex (or gender) reassignment' is now being used as a substitute for 'sex change' in the professional literature on surgical treatment for transsexualism (Steiner, 1985). Whereas the latter implied that individuals are converted from one sex to the other, the new term more accurately, suggests a rehabilitative process.

#### MF Surgery

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Although SRS was first attempted in the early twentieth century, modern surgical techniques have developed only over the last 30 years. For MF transsexuals, the single operation involved is far more satisfactory than those required for FM transsexuals, and is largely aimed at transforming the male physique into the closest possible approximation to the female habitus, in both form and function (Brown, 1990). Post-operatively, MF individuals can appear remarkably like biological females, the surgery is often so successful, that even experienced gynaecologists do not question the authenticity of the genitals.

Vaginoplasty

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Oestrogen therapy is interrupted prior to surgery to reduce risks of poor wound healing, keloid scars and thrombo-embolic disease. Patients are admitted to hospital three days before surgery and are given a 'bowel

preparation' partly consisting of a low-fibre diet to reduce the need to open the bowels post-operatively, thus lessening risks of graft displacement. The pubic area is shaved the night before surgery.

Initially perfected by Georges Burou in Casablanca, vaginoplasty was described as being 'cruelly painful'. April Ashley compared the pain to that inflicted by 'branding irons' (Hodgkinson, 1987). Basically, two kinds of operation are now available. One merely cosmetic, but virtually free of post-operative complications, involves only the removal of external male genitalia. This is necessary for some 'autocastrates' who in desperation amputate the penis where it lies juxtaposed to the symphysis pubis, thereby leaving no tissue from which a neovagina can be constructed (Steiner, 1985; Jonas, 1976). The second more common and more complicated procedure includes the additional formation of a pseudovagina; the penis and testes are removed from their site (penectomy and orchidectomy respectively) but kept attached to the body while a pseudovagina is created between the bladder and rectum (Hausman, 1992). The penile skin is then inverted and utilized in lining the vaginal canal (Hodgkinson, 1987). Various modifications of this technique include that of using autotransplanted colon (Dalton, 1981). A portion of erogenous tissue from the base of the penis is retained for the clitoris (Hausman, 1992), and the remaining scrotal and genital skin is used for the formation of external female genitalia via plastic surgery (Walters et al. 1986).

The procedure crucially depends on the urologist's knowledge of the exact location and depth of the vagina, and of the time available before penile and scrotal tissue dies and so

becomes useless (Hodgkinson, 1987). In the immediate post-surgical period, a soft vaginal pack remains inserted to prevent vaginal closure, and the genital wounds are covered with a pressure dressing and an abdomino-perineal binder. A urinary catheter for bladder drainage prevents the new urethral opening closing as it heals, remaining in place for ten days during which time the patient must drink plenty of fluids to prevent infection resulting from its presence. After its removal the patient may urinate naturally. Seven days post-operatively, tension sutures and drainage tubes are removed, and the vaginal pack changed. When this is eventually removed, the patient must dilate the neovagina manually. Since the male body was not 'designed' to accommodate a female vagina, any attempt to impose one is less than perfect. The problem is that 'nature abhors a vacuum', hence the pseudovagina perpetually tries to close up (Hodgkinson, 1987). During the first week after surgery the patient must remain in bed while the skin graft in the neovagina heals. After two weeks, in the absence of complications, the patient is discharged, provided with material for making vaginal dilators (foam rubber packing and condoms, or a soft plastic mould), and instructions on vaginal hygiene. Two weeks later she is supplied with a rigid dilator which must be used for fifteen minutes twice daily, unless heterosexual intercourse occurs every few days (six weeks post-operatively), in order to preserve patency and prevent contraction (Hausman, 1992). Patients cannot return to work for at least two months.

There is no guarantee that vaginoplasty will work. Possible complications include pulmonary embolism, myocardial infarction, neovaginal prolapse and haemorrhage - the latter two being relatively straightforward to surgically correct.

The neovagina requires a lot of care and has limitations; tissues may become necrotic, infected, or may contract (through the formation of scar tissue) and eventually close, necessitating a major correction via reformation of the vaginal canal. Its size may also be smaller than desired (Hodgkinson, 1987), which is the greatest area of dissatisfaction in 35% of cases, and one of the most challenging problems to surgically correct (Walters et al., 1986). The procedure, of course, leaves the post-operative patient wholly incapable of procreation (Taitz, 1987). If vaginoplasty has been correctly performed, the neovagina can attain depths of up to 15cm, can fully accept an erect male penis, and can function satisfactorily during sexual intercourse in the same physical manner as with biological females (Hodgkinson, 1987). Vaginal sensation, and even orgasm capacity is preserved if the penile skin retains its neural innervation. Aesthetically 'the appearance of the neovagina several months post-operatively is such that no one would detect that a naked MF patient was not a 'real' woman' (Brown, 1990). In the early 1980s, the procedure was estimated to cost from \$700 to \$20,000 in the United States, depending on choice of surgeon and technique (Hodgkinson, 1987).

#### Breast Surgery

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Augmentation mammoplasty (performed by the subcutaneous insertion of silastic material containing silicon gel or saline into a surgical cavity created behind the existing breast tissue) is less frequently requested by MF transsexuals, since most are satisfied by the breast enlargement produced by hormonal therapy alone. Nevertheless, some are impatient if hormone treatment is too slow or not enough to produce the desired effect (the worst

feature being a flat chest), and they may seek plastic surgery (Hodgkinson, 1987). The possible complication of such surgery is scar shrinkage around the cavity, leading to firming and distortion of breast contour.

Cosmetic Surgery

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Additional surgery seems to be limited to the MF patient (Steiner, 1985) whose masculine appearance is a handicap. Thus further alteration and feminization is sought following SRS (Benjamin, 1966). Exercises and massages help to change objectionable body contours, and voice training can raise say, a baritone, to at least a contralto. Differences between the male and female facial skeletons are minor; facial feature conversion is, nevertheless a surgical challenge. Jaw and cheek bone augmentation using split rib-bone or artificial grafts can be performed from inside the mouth. A large nose, prominent Adam's apple, and chin shape can be altered by plastic surgery. Hair transplants from other parts of the scalp may also be used to treat areas of beginning baldness and a receding hairline (Hodgkinson, 1987).

Electrolysis may occasionally be applied to body hair not influenced sufficiently by oestrogen medication. Alternatively, the arms, legs, chest and in some cases, the back, must be waxed and shaved (Steiner, 1985). Total beard removal takes, on average, one two-hour session per week for two years, and since still considered cosmetic, is not available under the NHS in Britain, and can therefore be extremely expensive. 500 to 600 hairs per hour can be removed, each sometimes requiring two or three shots of the needle, hence scarring is a strong possibility. Patients are required not to shave between sessions, must therefore go

about with 2-3 days beard growth on parts of their face, and may consequently avoid going out in public (Steiner, 1985). For many MF transsexuals, this treatment is the most painful of the entire conversion process.

Such measures following SRS, illustrate the transsexual's burden which is particularly exacerbated if economic factors prevent their availability. Most post-operative patients continue to take hormones both to prevent maleness (or femaleness) reasserting itself, and to offset risks of osteoporosis (since natural hormone production has been drastically reduced).

#### FM Surgery

Through masculinization effects from androgens, FM patients appear as normal-looking males prior to surgery. The procedure for their transformation into post-operative males requires a series of separate operations; bilateral mastectomy (removal of female breasts) and chest reconstruction (contouring as male breasts), abdominal hysterectomy and bilateral salpingo-oophorectomy (removal of the uterus, fallopian tubes and ovaries). Vaginal closure (colpocleisis) precedes genital surgery; phalloplasty (construction of a penis with fashioning of a scrotum to contain prosthetic testes) itself involving several operations. While mastectomy and hysterectomy are always desired, and pose no technical problems, fewer FM transsexuals elect for phalloplasty which is still experimental, primitive, and fraught with possible complications (Clarke & Stubbings, 1986). The FM transsexual is therefore in a more difficult situation as regards SRS. Pre- and post-operative care consists of routine observations and nursing on a male surgical ward.

## Mastectomy

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FM transsexuals, is that of ridding themselves of breasts 'the two most obvious physical manifestations of femaleness'. For many, mastectomy and hysterectomy are at least as important as genital surgery (Benjamin, 1966). Some surgeons refuse to perform the former before hysterectomy and androgen therapy have first created a more masculine personality. The operative principles are that the nipple is kept viable, reduced, and relocated from the apex of the breast to a position on the chest wall. By lifting a flap of areolar skin, breast tissue via liposuction and dissection is removed away from the skin and from the underlying fascia covering the pectoralis major muscle, to produce an anterior chest wall as flat as that of the biological male (Hodgkinson, 1987). Post-surgically, drains temporarily remain attached to reduce swelling and drain off fluid. Most patients are pleased with the results, and a year later little scarring is visible.

Hysterectomy

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Total hysterectomy (sometimes including clitordectomy) is primarily desired to eradicate menstruation. Although amenorrhoea follows the onset of hormone therapy, FM patients nevertheless wish to be rid of the uterus (Hodgkinson, 1987). The operation, while difficult to obtain (since surgeons are generally reluctant to remove healthy organs), is nevertheless advisable since it permits the large exogenous hormone dosage necessary to antagonize the natural production of oestrogen to be reduced, thereby reducing risks of adverse side-effects, as well as carcinoma of these organs (Steiner, 1985). Further post-operative masculinization is also advisable for the patient's

emotional state.

### Phalloplasty

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Despite the first phalloplasty being pioneered in 1948 (by Sir Harold Gilles), the operation remains experimental, requires delicate plastic surgery, and is still far short of satisfactory. Vaginoplasty, although not without difficulties itself, is physiologically an easier procedure. A functional penis must be capable of urination and becoming erect. This has proved difficult to achieve surgically, both for impotent men as well as FM transsexuals, due to complications arising from the implantation of foreign materials in the body (Hausman, 1992). There is also the problem of fistula formation as a consequence of grafting hair-bearing tissue to construct the urethra (Hodgkinson, 1987). Furthermore, ultimate success in achieving erectile capacity is unlikely. Thus many FM transsexuals choose to live without external male organs. Phalloplasty can, nonetheless, be quite successful for some patients. Up to seven separate surgical steps, performed over several months, are required, each of which carries a high risk of complications (e.g. labial fusion may lead to local infections, and the testicular prosthesis may be extruded), and hence, prolonged hospitalization. Patients may experience frustration and depression, which can strain any ongoing relationships.

Various techniques utilize skin-tube flaps, gracilis myocutaneous and muscle flaps. Gilles pioneered the technique, forming a tube pedicle penis for Michael (formerly, Laura) Dillon. This involved raising two abdominal skin-tubes, inserting one into the other to create a penile shaft and urethra, and implanting cartilage into

this to produce a semi-erectile condition. In variations of this procedure, a skin tube (subcutaneous tissue and sometimes muscle) is raised from the anterior abdominal wall, the upper attachment detached, and the tube lowered to become suspended in the suprapubic position. A scrotum is formed from the fused labia majora into which prosthetic testes are inserted. Vaginal skin lining, or a section of vein from the leg may be used to form a penile urethral tube along the ventral surface of the phallus.

The post-operative male is unable to achieve an erection without special medical appliances, some of which may be built into the neo-phallus (Hodgkinson, 1987). Implanted splints, or alternatively a manually operated, complex hydraulic system of implanted plastic tubes and valves, will permit vaginal penetration. A more recent technique utilizes radial forearm free flaps that retain the sensitivity of the lateral antebrachial nerve (Gilbert et al, 1988). Patient acceptance of these procedures has increased over the last 15 years (Brown, 1990), but for many, major deficits remain in the aesthetic appearance of the phallus, final cosmetic results being invariably poor (Steiner, 1985). Furthermore, because the technique relies on raising skin-tube flaps, there is excessive scarring. Steiner (1985) advises that 'until techniques improve, phalloplasty should be avoided' by FM patients. Indeed, upon discussing the prospective operative results, most are dissuaded from undergoing phalloplasty. Hodgkinson (1987) reported one FM patient's comment;

'The surgery is appalling, and you can get rejection, as with any graft...there are grave disadvantages...if I could be granted 95 per cent success with a phalloplasty, I would go ahead. But at the moment it seems as though it's playing with fire...'

Nevertheless, while relatively few FM patients undergo the

operation, the organ is no less important to them. Their decision simply reflects a realistic acceptance that techniques are, at present, far from perfect, leaving much to be desired. It has been predicted that when the results of phalloplasty are more satisfactory there will be universal requests for this procedure. Steinbeck (1986) however, doubts the likelihood that this will be achieved, reasoning that the inadequacy of surgery for males with gross hypospadias (incompletely developed penile urethra), and for some intersex states '...do not engender optimism about the future'. Partial, non-vaginal intercourse may occur in the absence of surgery, with satisfactory stimulation and response. However, the absence of a functional phallus, can create further identity difficulties (Steinbeck, 1986). Some patients therefore obtain a prosthetic phallus that attaches to the pubic area. However, the outward transformation of hormonally-treated FM patients is often so successful that few observers would suspect the underlying biological sex (Steiner, 1985).

SRS thus produces irreversible anatomical changes which, although basically cosmetic since biological sex is not actually 'changed' (post-operative MF individuals cannot ovulate, and their FM counterparts cannot father children) appears completely convincing, and is of great therapeutic benefit to carefully selected patients (Mate-Kole, 1989; Kuiper, & Cohen-Kettenis 1987; Walters et al., 1986; Blanchard, 1985; Pauly, 1968; Benjamin, 1966). Although an estimated 10-15% of patients who receive SRS may end in failure, with 7% suffering tragic outcomes such as psychotic episodes or suicide (Pauly, 1968), most clinical teams nevertheless agree that at present this treatment offers the best hope for bringing patients permanent relief, but

acknowledge that this can be disastrous if the initial diagnostic evaluation was incorrect.

Stoller (1975) argues; 'To forbid this change is to doom (transsexuals) to an agonized, useless existence' while simultaneously acknowledging that 'to help...patient(s) make the change...may perhaps be to doom (them) in the long run'. He severely criticizes as 'scandalous' and 'primitive' the fact that despite SRS having (then) been underway for almost twenty years, due to lack of adequate follow-up studies nothing was known of the surgical complication rate, nor percentages of those benefitting from SRS. Hoenig, et al., (1971) emphasize that surgery can only help as part of a framework of rehabilitation measures which themselves can only succeed if circumstances are not too loaded against the patient, for example, for MF transsexuals, too many masculine features that are difficult to alter by surgical means - great height, too deep a voice (Benjamin, 1966).

Attitude of the Medical Profession

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'...since the mind of the transsexual cannot be adjusted to conform with the body, it is logical and justifiable to attempt to adjust the body to the mind... 'if such a thought is rejected, we would be faced with a therapeutic nihilism to which I could never subscribe in view of the experiences I have had with patients whom have undoubtedly been salvaged or at least distinctly helped by their conversion' (Benjamin, 1966).

'There can be no greater tragedy and no greater mistake than to embark upon a series of mutilations or interferences with the shape of a person's body or the balance of their glands in a misguided attempt to make them into a travesty of something which they can never be however much they desire it. You cannot make a man into a woman or a woman into a man: and there can never be any ultimate justification for massive mutilation in the service of a delusional question for sexual mutation.' (Stafford-Clark, 1964).

King (1981) cautions that assuming the existence of complete consensus on SRS would be to oversimplify the 'medical model'. He argues that the 'discovery' of transsexualism and SRS in the early 1950s was not seen as a 'medical

breakthrough', despite media publicity of the treatment. Rather, doctors involved tended to see themselves as 'tainted'. Since that time, he argues, medical attitudes towards SRS have fallen between two extremes: that SRS should be given to anyone who wants it (and who can, where necessary, pay for it); and that SRS should be given to nobody, and that patients should be treated by some method 'which had been shown not to work'.

Green et al (1966) investigated attitudes to SRS among randomly selected subgroups within the medical profession who were directly involved in making decisions on referral for and carrying out the procedures. The majority of respondents were found to adopt a 'moralistic position...steadfastly opposing' requests for "sex-change" 'even when the patient was non-psychotic, had undergone two years of psychotherapy and/or would probably commit suicide if the request was denied', despite the fact that 25% thought that SRS would likely improve the patient's mental health, 50% thought it would have as much chance of helping as harming, and only 25% thought it would definitely be harmful'. Yet the researchers identified a paradox in that there was 'a far more liberal attitude' if SRS had already been successfully obtained elsewhere. It was concluded that many factors beyond emotional harm to patients had significantly influenced physicians' reluctance to support SRS (e.g. fears for their own reputations and careers) but that it was easier for them to be sympathetic to requests for SRS when the responsibility for carrying out the surgery was not theirs, preferring to complete rather than begin the conversion. However, there was much more willingness to recommend corrective surgery for those who could prove that their disorder was rooted in biology. King (1981) reasons

that this illustrates an important point about attitudes towards SRS for transsexuals and hermaphrodites: it was either expected that patients should be of the genetic sex compatible with the direction of conversion, or that there should be some biological reason for the patient's identification with the opposite sex (Pauly, 1974; Garfinkel, 1967).

At that time, most physicians opposed SRS due to the 'woeful ignorance' and misinformation that characterized medical and public understanding about gender problems (Franzini & Casinelli, 1986; Hoopes et al, 1968), and the complexities of transsexualism (Lothstein, 1978). Franzini & Casinelli (1986) argue that this situation 'directly affected the practice behaviours of professionals, and frequently resulted in unpleasant experiences for those transsexuals who approached professionals in search of treatment. MF patients were often the most controversial cases. The 'hidden taboo' seemed less apparent among medical and public attitudes towards mastectomy, hysterectomy and even phalloplasty for FM patients 'than when testicles and a penis were to be removed' (Benjamin, 1966).

Franzini & Casinelli (1986) explored the possibility that an attitude change might have occurred in the twenty years since Green et al's (1966) study, by means of a replication survey of current attitudes towards transsexuals and SRS among a random sample of (202) health professionals, comparing their findings with those of the earlier study. From their overall results, they tentatively suggested the existence of a more favourable perspective towards transsexualism in the attitudes of medical specialists. They interpreted this as reflecting both the greater attention

that had been paid to the syndrome, and advances in surgical techniques since Green et al's study. There was also 'much greater willingness' to recommend SRS, demonstrating a 'significant shift' in views on probable outcome; 52% of physicians now thought that patients' mental health was likely to improve through SRS; 36% thought that SRS would have as much chance of helping as harming and only 12% saw SRS as definitely harmful. Nevertheless, the same percentage as before viewed transsexuals as 'psychotic' or 'morally depraved' (57%).

King (1981) argues that those involved with transsexuals still tended to see their work as 'somewhat disreputable', and not enhancing their careers. Surgeons reported feeling stigmatized by colleagues for what was sometimes perceived as '"unnecessary" surgery when there were, arguably, more needy patients on their waiting lists'. Some reported 'anaesthetists refusing to be involved, or unsympathetic nurses'. Some even expressed dislike for such patients, and reluctance to publish their work in professional journals, fearing additional referrals, and hence, risks of 'type-casting':

'I met a doctor who said 'I could send you ten cases a week if you want them'. Oh God! I could think of nothing worse' ((King, 1981).

Over half of those interviewed were conscious that the issues were not as clear-cut as was suggested in the literature. Many reported neither diagnosing transsexualism nor distinguishing transsexuals from other groups. The general impression was that transsexual patients were viewed, not as ill or suffering from a disease, but as 'people with problems.'

e.g. 'The way I think is whether in fact its a viable idea that this person should change sex or not...I'm not terribly worried about whether he's a transsexual or a blue-nosed

baboon' (King, 1981).

Their prescribed treatment for transsexualism was SRS. Some were doubtful however, whether, with increasingly scarce resources, transsexual surgery could be justified.

Others doubt that SRS is, in fact, the solution to the transsexual's problems e.g. Kavanaugh et al (1979) draw a direct parallel between SRS and psychosurgery, contesting the provision of a surgical cure for what they perceive to be 'essentially a psychological disorder'. They emphasize a need to consider whether 'a demand for the mutilation of one's normal organ system should be regarded as a rational demand'. arguing that 'the complaints of a transsexual 'often express a need for professional help and should be seen as an invitation to explore the patient's real problems with him'.

Nevertheless, Hurley (1984) cites Stoller's (1975) report that at the time he wrote, there had been 'a reversal of American opinion with much of the medical profession and public comfortably - and unthinkingly - accepting the treatment'. Green (1970) suggests that the critical question is no longer whether SRS for adults should be performed, but rather for whom? King (1981) however, reasons that one factor influencing American physicians to perform SRS may be financial gain, whereas in Britain, he suggests in the absence of of a specific institutional framework for such work, the ultimate motivation is interest among a small number of people. Here, SRS availability 'is far more precarious than its opponents or proponents suggest'. His interview data with British physicians indicated that the surgery mostly depended upon the interests of those who saw their work either as beneficial, or as an intriguing

challenge, particularly with FM patients.

'It's like a lot of things in medicine. We can't cure it but we can improve things (urologist).

'It's a challenge - fun' (plastic surgeon)

'They were nice fascinating surgical problems' (retired plastic surgeon)

#### Non-surgical Treatment of Transsexualism

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'No true transsexual (has) yet been persuaded, bullied, drugged, analyzed, shamed, ridiculed, or electrically shocked into an acceptance of his physique. It (is) an immutable state...gender identity...pervades one's entire concept of one's place in life, of one's place in society and in point of fact the actual facts of anatomy are really secondary' (Benjamin, 1966).

'...abnormal minds should be treated in order to conform them with the normal body and not vice versa' (Kavanaugh et al., 1979).

Although many health professionals endorse the DSM-III definition of transsexualism, the question of what is accepted as appropriate 'treatment' for these patients is highly controversial (Franzini & Casinelli, 1986). Newman & Stoller (1974), Money (1972) and others consider surgery to be a palliative treatment aimed at promoting better adjustment rather than correcting basic psychological problems, but which can accomplish the goal if patients are properly screened (Green et al., 1972; Newman & Stoller, 1974). Not all patients however are satisfied with the outcome of surgery (Hore et al., 1975), and since SRS is irreversible various forms of nonsurgical treatment have been explored as possible alternatives. Ideally, the target would be to be enable transsexuals to accept, and live with their anatomy in the corresponding gender role. The results in general have been at best mixed, each method having its proponents and critics.

Hormonal Treatment

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Benjamin (1966), himself an endocrinologist, reports that about one quarter of his (MF) patients had formerly been

given testosterone in the hope that its masculinizing effects might cure their transsexualism and effeminacy. This, he emphasized, was misguided, since rather than alleviating it aggravates the condition; patients find the increased hirsutism distressing, and the increased libido does not change direction. Oestrogen therapy, on the other hand he argues, may be used either as a substitute for SRS or in preparation for it, as a test of the individual's psychological reaction to feminization. To the author's knowledge, no comparable treatment (with oestrogen) has been conducted with FM patients.

#### Behaviour Therapy

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For a few cases, behaviour therapy has been claimed to relieve MF transsexuals at least of the compulsion to cross-dress, so that they can adjust, albeit unhappily, to accepting and living the male role. Ball (1968) however argues that 'without exception, these were older patients, who very reluctantly accepted that their wish for SRS was incompatible with reality. Furthermore, he contends that the successful results claimed were, in fact, for transvestism rather than transsexualism.

Bates et al (1975) developed a group token economy program for the treatment of sixteen gender-problem boys and their families, aimed at fostering the development of appropriate gender-based behaviours. Gender-inappropriate behaviour, they reasoned, carried a high risk for: homosexuality, transvestism or transsexualism in adulthood and produced high degrees of conflict and frustration in the families of such boys. They claimed that such 'intensely unhappy' children lacked the skills necessary for successful interaction, and, without intervention, would probably

suffer continued social rejection and isolation. Although 'preliminary success' was claimed by these authors, the need for required controlled comparisons nevertheless precludes firm conclusions from being drawn.

Aversion Therapy

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Sexual deviation is considered to be one of the most important areas in which aversive procedures have been applied (Agras, 1972). Here, the therapeutic goal is to achieve the unlearning of 'inappropriate responses, thoughts, and feelings', replacing these with more 'appropriate behaviour' (e.g. the 'maladaptive' behaviour of homosexual individuals would, according to this paradigm, ideally be replaced with heterosexual behaviour). Such procedures have been advocated in the treatment of transsexuals (Barlow, 1972; Agras, 1972). The aversive stimuli employed include painful electric shocks, nauseating drugs (such as apomorphine), and verbal aversion (vivid descriptions of noxious experiences) accompanied by descriptions of the 'maladaptive' behaviour in order to bring about its extinction (Agras, 1972). For example, a transvestite might be given an emetic drug, and as soon as nausea developed would be shown slides of himself in female attire, while simultaneously hearing audio-taped, detailed descriptions of the dressing method. This would continue until vomiting/acute illness ensued.

Benjamin (1966) describes such 'treatment' as 'outlandish', dismissing it as being of 'no use' in treating transsexualism which, he argues, cross-dressing only partially relieves, if participated in at all. The technique considered most effective for cases of 'sexual deviation' (for which it is most frequently used) has been that of

electric shock ('Faraday' aversion) either in punishment or avoidance paradigms. Agras (1972) reports that such procedures may be forcibly applied to captive patients with informed consent from the director of a given institution, their use being monitored by an advisory committee. Claims for the successful use of behavioural techniques however, await confirmation (Baker, 1969). Benjamin (1966) notes that no long-term, controlled, outcome studies exist and, in the short-term, the transfer of effects from treatment setting to other environments is questionable. He also reasons that such a "deep-seated" and 'constitutionally anchored' disturbance as transsexualism may be unresponsive to aversion therapy in any long-term sense. Stoller (1975) asks whether the nature of such 'treatment' for transsexualism is because of society's uneasiness about extreme gender reversal more than for reasons of therapeutic efficiency.

#### Psychotherapy

'I can say without qualification that I have seen the most experienced therapists who have previously opposed the surgery, change their minds in a single interview with a patient. They found no gross pathology; they realized that this was not a homosexual or a transvestite, and they perceived what they had failed to see before; that the patient was exactly what he held himself to be - totally and irrevocably convinced that his entire personality and identity was that of the opposite sex' (Money, 1969).

Psychotherapy is perhaps the most debated of treatments, when intended as an alternative to SRS. Some critics of SRS, have sought to demonstrate psychological 'disturbance' in transsexualism, and hence, justify the desirability of psychotherapy rather than 'mutilating' surgery (e.g. Guthiel, 1954; Kavanaugh et al., 1979; Barlow, et al., 1973). For example, Hoenig (1972) reports that 23% of transsexuals decided against surgery after a 'strenuous effort' was made to change transsexual attitudes. Unfortunately however, the patients 'did not achieve any

kind of happiness'. Nevertheless, Meyer (1975) maintains that 'it is axiomatic in psychotherapy that whenever there is ambivalence, reflecting personality conflict...this indicates that at least part of the personality is still attempting to assert an anatomically-congruent adaptation (thus) there is still hope for a successful therapeutic outcome'. Blanchard (1985) proposes however, that the 'handful of successful case reports' of patients who subsequently found contentment in their biological sex following psychotherapy...were, at the time of their initial presentation, quite young, mostly in their teens or early twenties (Barlow, 1972). He emphasizes that this outcome is 'extremely rare for older individuals in whom the transsexual syndrome is fully established'. Numerous psychiatrists agree that the the (adult) transsexual patient is totally unamenable to psychotherapy even if continued for years, where this is aimed at cure (e.g. Stoller, 1975; Walters et al, 1986; Benjamin, 1966, 1971). All experts however, seem to agree that some form of psychotherapy is indicated in the overall care plan.

Steiner (1985) considers psychotherapy valuable in its potential for distinguishing those individuals referred to a gender identity clinic who are not transsexual (Grimm, 1987). In addition, Meyer (1975) and Brown (1990) recommend that an exploratory phase of psychotherapy, lasting at least a year, is conducted for adult applicants for SRS. Many psychiatrists, on the other hand, do not wish to treat transsexuals. Steiner (1985) acknowledges that it is not easy, but urges that such professionals suspend their 'prejudices and preconceptions' and instead, recognize these patients as a therapeutic challenge. For patients, 'merely the opportunity to talk to somebody understanding about

their problems, rather than facing coldness or ridicule, together with the relieving of their depression and isolation has the therapeutic value of easing their burden' (Benjamin, 1966; Meyer, 1975 Baker, 1969).

Walters et al (1986) noted various forms of psychotherapy that had been tried with transsexual patients;

i) Intensive psychoanalytic psychotherapy, which aims to stabilize and adapt patients to life without surgery, upon reversal of the cross-gender identity. An attempt is made to reconcile psychological gender with anatomical sex.

Complications, reported upon termination of this form of therapy, were however, noted to include anxiety, possibly with substitute neuroses (e.g. alcoholism (Benjamin, 1966), or, following a decision for surgery, psychological decompensation or suicide (Walters et al, 1986).

ii) Supportive psychotherapy, which aims to help the transsexual cope with alienation and other feelings that accompany cross-gender identity. It assumes that psychotherapy cannot usually reverse the condition.

iii) Group psychotherapy, which aims at helping patients adjust to their gender identity without SRS. The emphasis, via informal group discussion, is on encouraging the discovery of patterns of adjustment.

iv) Behaviourally-orientated psychotherapy, which aims to modify gender-role behaviour (thus labelling patients as gender-deviant). It assumes that transsexual behaviour represents a set of inappropriate, learned responses.

Walters et al. (1986) argue that none of the techniques used have had any significant success, nor have their possible

disadvantages been determined. Brown (1990) calls for 'desperately needed' long-term, prospective studies of outcome with random assignment to treatment modalities. Walters et al (1986) nevertheless advocate supportive psychotherapy (which emphasizes the value of the individual, independent of sex or gender) and its continuation, for the first year after surgery, as mandatory to ensure the best adjustment of post-operative patients to their new social role (Steiner, 1985; Bentler, 1976; Benjamin, 1971; Grimm, 1987; Meyer, 1975; Brown, 1990). Benjamin (1971) points out that perhaps not all who profess their happiness post-operatively are entirely honest about it. Cohen-Kettenis (1992) argues for an eclectic approach, reasoning that since patients 'show a broad spectrum of personalities, pathologies and treatment needs, they need exploration, information, structuring and support...psychoanalysts, behaviourists, cognitivists and family therapists, preferably combined in one person.'

Walters et al (1986) however claim that it is difficult to see how success is achievable from such therapy alone, without the patient's motivation to accept. Indeed, frequent reports testify to the apparent "unwillingness" of transsexuals to be involved in psychotherapy (e.g. Meyer, 1975). Brown (1990) suggests that that when transsexual patients are approached sympathetically, with treatment presented as an opportunity for them to explore their psyche, prior to irreversible physical change rather than as an attempt to cure or change, the patient may be eager for someone to listen. Meyer (1975) urges that an indirect approach is more profitable than a frontal assault in an attempting to engage with the patient 'in exploring his past, current status, and his hopes and ambitions for the

future' such that the area of gender and sexual conflicts may be breached, even if the eventual outcome is a demonstration that SRS is a reasonable alternative.

Stoller (1975) noted that since he first wrote on the subject in 1966, there had been no published reports of any treatment successfully converting an adult transsexual such that the individual's gender identity became congruent with his (or her) biological sex, but emphasized that this depends on the diagnosis of transsexualism used.

#### Transsexualism and the Law ~~~~~

'These people seem to me truly the victims of their genetic constitution...often crucified by ignorance and indifference of society and prosecuted by antiquated laws and by legal interpretations that completely lack in wisdom and realism...Criminality before the law is not necessarily criminality before science and common sense. Transvestism, transsexualism, homosexual behaviour...call for treatment and education instead of punishment. Their interpretation as "crimes" creates criminals artificially, merely by definition...' (Benjamin, 1954, 1966).

SRS helps solve the medical problem, but simultaneously becomes the potential source of legal problems for transsexuals. The development of common law has been based on fundamental assumptions about sex: that there are two and only two sexes, male and female; anatomic sex being seen as predetermined at birth, and immutable (Belli, 1978). Yet the law has not adequately defined an individual's sex (Hucker, 1985; Taitz, 1987). 'Such a definition hardly seems necessary since everyone knows the answer...or thinks he

does' (Benjamin, 1971). Furthermore, no legal theory is available to determine how to fit the new third sexual category of the transsexual into our legal system (Belli, 1978). The personal views of judges toward transsexualism and homosexuality (Brent, 1973), as well as a fear that recognizing the patient's new sex will legitimate single sex marriages, has resulted in a series of confused, inconsistent legal decisions surrounding the issue of transsexualism (Hucker, 1985).

After brief initial consideration of the legality of SRS itself, this section will focus upon legal issues that most directly bear on the identity of transsexuals, particularly that of post-operative individuals: the legality of cross-dressing; changing official records; and marriage, in order to illustrate the complications and human suffering that can arise as a result of a strict adherence to traditional, rigid principles of law in the face of technological changes.

#### Criminal Liability for Performing SRS: Mayhem ~~~~~

Most Western countries acknowledge to some extent the necessity of SRS as the only effective treatment for transsexualism (Hodgkinson, 1987). However, the "Mayhem Statute" which applies in various forms within these countries could, theoretically, be used to prohibit SRS or to prosecute the surgeon. This ancient law was enacted by Henry VIII to prevent soldiers being deprived of any part of their anatomy that made them less able to fight. In California, the crime carries a penalty of up to 14 years imprisonment (Benjamin, 1971). Nevertheless, despite no American case involving the removal of male genitalia by surgery, being sustained (Holloway, 1974), this has not

always been so for other countries (Belli, 1978). The law has also intimidated some doctors who would have otherwise performed SRS (Holloway, 1974).

#### Cross-Dressing

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A minority of MF transsexual cases may not request SRS, instead finding sufficient relief from cross-dressing and living as women. Indeed, this can be a life-saving measure for those who are refused SRS (Benjamin, 1966). Cross-dressing is, however, technically illegal. While FM transsexuals rarely get into trouble with the law, MF transsexuals can be prosecuted for cross-dressing, due to an ancient 'vagrancy' law which states that a person must not paint, discolour, cover or disguise his face in a manner calculated to prevent his being identified. No law expressly forbids men from dressing as women. Nevertheless, this by-law (albeit passed for an entirely different purpose - against farmers who, opposing a rent-law, disguised themselves as Indians in order to attack law officers) has been used against MF transsexuals. Many have been convicted, fined, and jailed (Whittle, 1993), therein sometimes being subjected to 'medieval brutality' (Benjamin, 1966) through enforced masculinization (haircuts and prison clothes) and exposure to ridicule or sexual abuse from other inmates (Benjamin, 1971). This is potentially problematic in terms of the 1-2 year cross-living period prerequisite for SRS. Until such times that such restrictive laws are relaxed, Clark (1989) advises: 'if you are going to cross-dress, don't be obvious about it'.

Legal Sex Status of the Transsexual

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This is, arguably, the most important issue regarding the identity of post-operative transsexuals. Following SRS,

individuals normally change their names to ones more appropriate to the opposite gender. This is legal if not done in order to commit fraud, avoid creditors, or to deceive. While transsexuals do wish to 'deceive' as regards their original sex, this is neither relevant to most everyday social interactions, nor intended to secure unfair advantage (Maryland Law Review, 1971). In order to alter the sex recorded on a birth certificate, it is necessary to show that an error was made on the original record. This is a problem for transsexuals, since the certificate was correct when compiled. Thus, on every occasion for which transsexuals must produce their birth certificates their secret is revealed. It may be more deceptive to continue to record a man who is now a woman in every way except his chromosomes as male than to change his records to reflect his current status, as is possible for adopted or legitimized children (Belli, 1978). A similar change of records would be logical for transsexuals, thereby giving legal status to the acquired gender, since a 'disclosure of transexualism might well invite more harassment and ridicule than the discovery of illegitimacy might affect a child' (Maryland Law Review, 1971).

At one time, birth certificates could in Britain be amended to reflect the new sex status of post-operative transsexuals. Following the Corbett case (1970) however, the law has stated that the original chromosomal sex must remain on the birth certificate, despite all outward physical accoutrements of that sex having disappeared (Hodgkinson, 1987; Hucker, 1984). Authorities have since relaxed rules for altering other documents (e.g. driving licenses, bank cards, passports). Taitz (1987) argues that this decision reflects both a refusal by courts to recognize

post-operative transsexuals as members of their new sex (thereby contradicting the opinion of those in the medical profession who claim otherwise) and a particular prejudice against FM patients who are as yet unable to obtain genitalia that look and function properly (Clark, 1989). It also means that post-operative individuals cannot marry. The implications of this situation raise serious moral questions, since it seems that the law essentially 'requires that a choice be made between the right to undergo transformation and the right to marry' (Hurley, 1984).

The European Commission of Human Rights has ruled on two such cases. In *Rees v. United Kingdom*, the Commission found in favour of amending the birth register of the post-operative FM, as regards the right of respect for private and family life, but not as regards the right to marry. The appeal court upheld the denial that the United Kingdom violated the claimants right to marry, reasoning that traditional marriage, being 'the basis of the family' was between persons of opposite biological sex. Hucker (1985) argues that if the criteria for marriage is the ability to procreate, then this would invalidate many apparently 'normal' marriages (Hodgkinson, 1987). Pauly (1969) reasons that a 'refusal to reclassify the sex of a postoperative transsexual is inconsistent with society's principles of concern for the privacy and dignity of its members, and creates undue hardship for an otherwise troubled person'. Taitz (1987) suggests that some promise lies in the ruling of the Commission in a second case, where it found that by failing to correct the birth register, Belgium had violated a post-operative transsexual's 'right to private and family life', in refusing; '...to recognize an essential element of his personality;

his sexual identity resulting from his changed physical form, his psychical make-up and his social role. In doing so, it treats him as an ambiguous being, an "appearance", disregarding in particular the effects of lawful medical treatment aimed at bringing the physical sex and psychical sex into accord with each other...it restricts the applicant to a sex which can now scarcely be regarded as his own.' (Van Oosterwijck, 3 Eur. Ct. H. R. 557, 584 1981).

More countries are beginning to recognize the transsexual's right of privacy and need for social acceptance. For example, while birth certificates cannot be altered in Britain, Austria, Ireland and some of the United States, this is now possible in Portugal, Spain and Italy, some of the Canadian provinces, and Switzerland (Hodgkinson, 1987). As yet, the legal profession has reached no consensus. There are both positive and negative decisions regarding requests for change of gender status. The bottom line seems to be that if the appropriate chromosomes are absent, a person should at least have appropriately functioning genitalia.

#### Validity of the Post-Operative Transsexual Marriage

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Among the most significant decisions for post-operative individuals are those regarding marriage. Here, the transsexual's position is very uncertain, since it can be repeatedly tested in the courts (Hoenig, 1977). Pre-operative transsexuals cannot contract a valid marriage since the law requires that marriage can only occur between a man and a woman. However, beyond lacking a definition of sex, the law has not defined the term 'marriage' (Holloway, 1974).

At the English High Court of Justice, the case of Corbett v. Corbett (1970) dealt with the sexual identity of a post-operative MF transsexual who was capable of copulation, who made a full disclosure of her situation to her spouse (who had, in fact, paid for her reassignment) (Holloway, 1974). April Ashley, (26) (formerly George Jamieson),

married the Honourable Arthur Cameron Corbett, (42) The marriage failed and a voluntary separation was agreed, whereupon the husband sought annulment on grounds that his wife was not a woman. After hearing medical testimony, the court concluded that a person's sex was fixed at birth and was not changed by SRS. Rather, the determination of sexual identity depended on the congruence of three biological factors (the Ormrod test);-

- 1) Chromosomal (XX or XY pairs)
- 2) Gonadal (the presence or absence of testes or ovaries)
- 3) Genital (including the internal sex organs)

This test found the respondent to be male. Counsel for the respondent contended that since the law knew only two sexes; male and female - Ashley must be 'assigned' to one or the other, which in her case must be female, and that she should be regarded for all purposes as a woman (Holloway, 1974). This reasoning was judged to turn on what is meant by the word 'woman' in terms of a marriage. Judge Ormrod opined that:

'...the respondent was physically incapable of consummating a marriage as intercourse using the completely artificially constructed cavity could never constitute 'true' intercourse'.

It was concluded that chromosomal, gonadal and genital tests should be adopted, and that if all three were congruent sex should be determined accordingly for purposes of marriage, and any operative intervention ignored. The court thereby annulled the marriage, declaring that it had never existed. (Taitz, 1987).

Hucker (1985) argues that if Ormrod's statement referred to the ability to engage in intercourse, he was therefore overlooking expert witness testimony. Taitz (1987) reasons

that to treat the chromosomal factor as the single criterion when determining legal sex is absurd, considering the complex method of sex differentiation that mostly occurs after chromosomal pairing. The law, he maintains, is primarily concerned with human relationships. Thus as regards any effect upon society, only those biological factors which influence person-to-person interactions are relevant. He suggests that the court could more practically have relied upon psychological and social criteria, considering 'how the plaintiff regarded herself and how society perceived her. [Those factors] 'not microscopic cell studies, should determine a person's legal sex'. He argues that the court had demonstrated a lack of understanding of the situation of post-operative transsexuals and the impact of its decision on transsexuals as a group, in that it 'predjudices the aspirations of post-operative transsexuals who have endured extensive irreversible surgical procedures in order to overcome a serious psychological condition'. It meant that English criminal law would regard all post-operative transsexuals as members of their original sex.

Shortly after the decision, the House of Commons passed the Nullity of Marriage Act (1971), part of which declared that where the parties to a marriage are not respectively male and female, such marriage is null and void. The verdict also meant that henceforth in Britain, the birth certificate must remain unaltered, except where for some medical reason sex has been wrongly assigned at birth. Furthermore it meant that a post-operative female may be raped in the same physical manner as any biological female 'with similar pain, indignity, horror and ugliness, while her assailant can never be convicted of rape' (Hodgkinson, 1987). Benjamin

(1966) argues that the decision by the court that even an operated transsexual who has lived as a woman for many years must still be considered a man on account of 'the invisible XY chromosomal constellation, shows to what extent medical and legal technicalities and pedantry can go, and how ordinary common sense can be sacrificed, together with the welfare of a human being.' A prohibition on transsexual marriages forces the transsexual to choose between celibacy and illegality. Yet there is no legitimate reason for depriving the transsexual of the right to marry the person of his choice (Maryland Law Review, 1971).

A New Jersey court has, however, rejected Ormrod's (1970) rationale and upheld a marriage between a post-operative female and a biological male, partly on the basis of the congruence of the transsexual's anatomical features with her psychological sex, and partly because the couple appeared so normal. It was ruled that allowing them marital peace and personal happiness would in no way disserve any 'societal interest or principle of public order'. The court ruled that a transsexual marriage would be valid, provided that the spouse was told of the sex reassignment beforehand. Ability to procreate was therefore ignored (Belli, 1978).

In terms of British law at least, transsexuals are in a state of sexual limbo. While appearing physically and psychologically to be of one sex, they are classified as belonging to the other. The lack of legal precedents for transsexuals invited the risk of inappropriate medical or moral judgements until laws were 'changed or interpreted so as to recognize (the) human phenomenon of transsexualism. Taitz (1987) points out that an even greater danger, might be a consensus of medical opinion that SRS is unnecessary,

which would question the very existence of post-operative transsexuals'. He argues that post-operative transsexuals have undergone surgery for relief from a real and natural psychological condition. In recognition of this, Whittle (1993) argues that: 'the legal sex of the transsexual should be defined in such terms that it conforms with his anatomical appearance in order to enable the individual to lead a normal life'. Yet while legislatures of some countries recognize the notion of 'sex-change' and acknowledge the new sex (e.g. Sweden, Germany, Czechoslovakia, Greece, Italy, Holland, Switzerland and Finland), in most legal systems including those of England and America courts merely decide the sexual identity of post-operative transsexuals on an ad hoc basis.

'The transsexual is subjected to legal and emotional punishment because his psychological development does not match his chromosomal make-up...Society will lose nothing and transsexuals will gain the opportunity to lead "normal" lives if legal sex is determined not by chromosomes or anatomy at birth alone, but by present psychology and anatomy'. The transsexual is, as yet, faced with choosing between two equally undesirable alternatives; '...if he chooses to live within the sex to which he was born he has, in effect, condemned himself to a perpetual masquerade. If he decides to seek medical reassignment, he subjects himself to the scorn and curiosity of society and the limbo of no legal sex identity. Both situations are appalling and are inconsistent with the professed enlightenment of our times' (Maryland Law Review, 1971).

Belli's (1978) report of the views of one judge suggests that such enlightenment may be beginning to inform at least some within the legal profession:

'Should the question of a person's identity be limited by the results of mere histological section or biochemical analysis, with a complete disregard for the human brain, the organ responsible for most functions and reactions, many so exquisite in nature, including sex orientation? I think not...'

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CHAPTER FOUR
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## CHAPTER FOUR

### SITUATION & IDENTITY

#### Introduction

Much social psychological work, has been concerned with the notion of identity as a social product. Breakwell (1986) argues that in the development of the self concept, people learn about themselves from their subjective interpretation and allocation of meaning and value to feedback from others. This provides identity with a multifaceted structure, the values of which are constantly revised according to social circumstance. The overall value of a given individual's identity is thus in a perpetual state of flux (Breakwell, 1986). Weigert et al (1986) argue that in such circumstances of identity development, in order to 'maintain a sufficiently integrated and continuous identity by which to organize and motivate his or her life, the individual must necessarily 'acquire multiple identities and a sense of self that easily switches from one kind of identity to another according to circumstances'. Breakwell (1986) identified three prime ongoing principles or requirements of identity as being; distinctiveness, self-esteem and continuity, she proposes that individuals strive to maintain equilibrium in these three principles. A lack of continuity in identity, lack of self-esteem and negative notoriety constitute threats to identity (Kando, 1969). One of the primary threats for transsexuals derives from the individual's failure to meet gender role expectations. Social attributions leading to these expectations arise through interpersonal interaction and are heavily dependent upon group dynamics.

This chapter will deal initially with the process whereby gender is both socially constructed and attributed, followed by a discussion of some of the implications and consequences of this process as reflected in social attitudes towards transsexualism which can lead to threats to the identity of transsexuals (e.g. stigmatization). Support groups, set up for, and organized by transsexuals themselves attempting to cope with such threats, will be briefly outlined. This precedes a more detailed discussion of the major form of coping strategy adopted by most transsexuals - 'passing', and finally, of conditions under which, such coping strategies fail.

Identity as a Social Product:  
The Social Construction of Gender

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'...psychological processes are shaped and controlled by the social context in which they are embedded' (Wiegert et al., 1986).

Every society has ways of categorizing people as men and women. Garfinkel (1967) proposes that members of a culture have systematic, taken-for-granted ways of treating each other, so as to construct 'reality' for practical purposes. In our society, we categorize others according to the kind of body we believe them to have, but in popular conceptions of maleness and femaleness, the secondary sexual characteristics display a person's sex symbolically. Members of a given society performing the process of gender attribution share the same, taken-for-granted method for producing a sense of 'objective social facts'. In Western society, one such social 'fact' is that there are two genders, each person being an example of one of them, this 'reality' being part of the 'natural attitude' (Garfinkel, 1967). Kessler and McKenna (1974) argue that by 'doing' gender we create gender as a social construct, and, beyond this, the categories 'male' and 'female'. Accordingly, all

the major theories, while differing in their emphases upon biological and environmental factors, nevertheless agree in assuming that dichotomous gender roles are a natural consequence of two dichotomous sexes.

Furthermore, Garfinkel (1967) proposed that normal people do not so much insist that females possess vaginas and males possess penises, but that these should be made by nature, have always been there, and as such, be legitimate possessions that the person is 'entitled' to. Surgeons, he points out, can also be seen as legitimate sources of entitlement, if they 'repair' what is believed to be a natural error (in persons who suffer genital damage or loss), thus providing 'what nature always meant to be there'. Kessler and McKenna (1974) suggest that the distinction made between 'preoperative'- and 'postoperative' transsexuals, suggests that genital surgery is intended. The "proper genitals" being a necessary aspect of the conceptualization. Transsexuals, themselves being members of society, share the view of there being two dichotomous genders. For example, Garfinkel (1967) reported that his MF case-study, Agnes, demonstrated that she shared the 'realistic' social truth about claims to normal sexuality, in her belief that 'nothing that man makes is as good as something that nature makes'. He suggests that Agnes was... 'constructing a sense of 'natural' femaleness not only for others, but for herself as well'. Grounds of actual legitimate possession were the subject of considerable controversy during this period (King, 1981). For Agnes, it was necessary 'to continue to be alert to the tasks of keeping attributions of the 'natural female' from being confounded with alternative attributions of 'male', or 'male homosexual' (Garfinkel, 1967).

Gender Attribution

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Gender is constructed as being totally invariant from birth (Kessler & McKenna, 1974; Garfinkel, 1967). Once the initial gender assignment has been made (based on inspection of the child's genitalia), this then dictates the fate of that individual. For most people, there is some essential male-, or female 'essence' that enables a clear distinction to be made. 'Even for hermaphrodites, some form of criteria will be found by which to assign that individual to one of the two mutually exclusive categories' (e.g. Garfinkel, 1967). Kessler & McKenna (1978) assert that gender attribution is a complicated process which 'forms the foundation for understanding other components of gender', such as gender role (behaving as a female or as a male), and gender identity (feeling oneself to be female or male). The 'gender attribution process' they argue, is ongoing. This is culturally appropriate in a society that is based on the dichotomy of male - female gender identity', despite the likelihood that a given individual's sex may not be known, or may differ from that which is assigned.

Mostly, they argue, gender classification is straightforward and operates semi-consciously. We only become aware of the process upon encountering people whose gender is not obvious, whereupon we begin to consciously look for gender cues as to what they 'really' are. Although people generally identify such cues to be genitalia, Kessler & McKenna reason that gender attributions must be made in the absence of such evidence, which is usually not immediately observable. In addition, an attribution once made is not changed, despite a possible subsequent discovery that someone does not have the 'appropriate' genitals. Furthermore, they suggest, in some

non-industrial cultures, perhaps genitals per se would have no importance in gender attribution, rather, more salience might be given to say, gender role, or, dress (Birdwhistell, 1970). In both cases (dress or genitals) such factors are not synonymous with gender, but are seen and used as key signs by others to support their gender attributions i.e. they act as essential insignia or 'cultural genitals' (Garfinkel, 1967), a concept which Grimm (1987) has interpreted as 'a combination of morphology and general psychological orientation as being more like a woman or a man'. No single piece of information about gender, they argue, is conclusive (illustrating this point by asking; what gender classification should be given to 'a masculine, homosexual transsexual who cross-dresses'?). Temporarily suspending belief in the 'objective reality' of social and scientific facts like gender, they suggest, reveals how the notion of 'objective facts' is produced in everyday interaction, e.g. among the Navaho (Hill, 1935). Transsexualism, in our society they argue, suggests the possibility that gender is an accomplishment. Transsexuals provide a great deal of information about what it means to be a woman or a man' (Stoller, 1975; Grimm, 1987).

More often than not however, in order for a reassigned female to be declared 'male' by many psychiatrists, there exists an expectation of the stereotypical performance of all aspects of the gender role, so as to meet with expectations for being accepted as a 'normal' member of that gender (Hodgkinson, 1987). Kessler and McKenna (1974) cite one clinician's report of using his own degree of sexual interest as a gauge in diagnosing MF patients. In fact, transsexuals are as varied in their sexual orientation as the population at large (Meyer, 1975; Springfield, 1991;

Freund et al., 1974). Approximately 50% of post-operative MF transsexuals are heterosexual ('homosexual' subtype in DSM-III), 30% are lesbian ('heterosexual' subtype), 20% are bi-sexual, and 10% asexual. Whereas, for FM transsexuals, approximately 90% are heterosexual ('homosexual' subtype), and 10% bisexual or exclusively gay ('heterosexual' subtype) (Springfield, 1991).

'The automatic assumption and hence pressure that I do a nice straight heterosexual thing and pair off with a male, (is) I think, a compliment, but a little unfair' (Rachel, in Kessler & McKenna, 1974).

Weigert et al. (1986) note that social roles have been described as 'expectations...initiated by validated identities, manifested in the performance of such roles, in association with certain appearances or attitudes. Indeed, they suggest that 'one of the areas where identification may most easily take place is that of social values and attitudes...'

#### Social Attitudes Towards Transsexualism

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'Let all of us who tend to look on these people as vile, remember that their mix-up was obvious in early childhood when, surely, there was no vileness. We must all learn to have sympathy for those persons who were so badly gypped by nature. But for the grace of God, we too might be caught in the same cruel trap' (Benjamin, 1966).

People remain prejudiced against transsexuals, although this is fading to some extent e.g. Kuiper et al (1988) report that FM transsexuals tend to complain only of lack of understanding. While these researchers acknowledge that there may be differences in the way that FM- and MF transsexuals perceive similar situations, they report from their interview data that reactions received by some of the latter from the social environment give them more grounds to feel discriminated against rather than misunderstood. They suggest that in Western society 'the pressure to remain a man seems to be greater than the pressure to remain a

woman'. Most forms of organized religion have tended to frown upon transsexualism and Christianity has been accused of preventing our understanding of it (Benjamin, 1971). Nevertheless, Hodgkinson (1986) suggests that transsexualism is becoming more accepted in everyday society. Steiner (1985) expresses her frequent surprise at the understanding of the general public, for example, in assisting the transsexual to obtain necessary document changes, but she warns, there are exceptions.

Having lived, at least for their childhood and early teenage years, feeling desperately depressed, completely wrong, and that they do not fit in anywhere, with treatment, the problem ceases to be a private one for the transsexual, and instead, potentially becomes one for others. Mark Rees, a FM transsexual recalls his pre-treatment experiences: '...in the end I had to change my body because...the way other people perceived me was not the way I saw myself' (Hodgkinson, 1987). The timing of the important event of the transsexual's 'going public' depends on circumstances such as: family; finances; employment; accommodation; self-confidence and appearance, all of which need to be addressed beforehand (Harding, 1986). Post-operatively, all transsexuals are eventually confronted with the dilemma of whom to tell. Although the modern tendency is to come clean at the earliest opportunity, the best advice given is not to tell anybody who does not absolutely have to know (Hodgkinson, 1987; Harding, 1986). There are those in society who refuse to allow the post-operative a peaceful integration...'sometimes being a transsexual can feel like being an ex-prisoner. You finished your sentence years ago, yet you are never allowed to forget that once you spent time inside...There are members of the public who feel that

that's right, that you should never be allowed to forget, but I don't subscribe to that viewpoint. I paid my debt to society with the twenty years I was forced to spend as a male, and I don't wish to be constantly reminded of it. Since I shall spend the rest of my life living as a female I do not see why I should have to set myself apart from other women and think of myself as 'second class' (MF reported by Hodgkinson, 1987). When others know of the changed identity, they frequently inadvertantly demonstrate the supreme effort they are making in, say, remembering to use the individual's new name and, more importantly, the correct pronominalization and new gender title (at least in the individual's presence). This state of affairs is perceived by transsexuals as unsatisfactory and frustrating. They tend to feel patronized as if only accepted as a token member of the gender which they feel themselves to be. Post-operative transsexuals generally try to live their lives much as before, preferring to identify with, and be accepted as completely ordinary, normal people 'rather than being perceived as oddities, or as objects of pity, derision or voyeurism' (Hodgkinson, 1987). They may, however, feel nervous of mixing with people. In the main, they seek anonymity, to live quietly and without public recognition. Most describe themselves as 'loners' by necessity and circumstance, tending to lack self-confidence (Harding, 1986).

Steiner (1985) notes that considerable information is now provided on transsexualism by the media, particularly its more sensational aspects. A frustrating problem for transsexuals however, is the way in which many people tend to conflate transsexualism, transvestism, and homosexuality as if the terms were synonymous. Such public

conceptualizations, Plummer (1981) points out, concur with the view of some psychoanalytic writers. However he argues that the fact that public reaction towards transvestites and transsexuals seems to be more tolerant than toward homosexuals, suggests that a distinction is somehow made. Pioneering transsexuals often felt there was no choice other than to undergo a complete name change and move to another part of the country or even abroad, often for the sake of relatives. For many, a belief that their families would be unable to accept them in a different sex, was usually justified (Hodgkinson, 1987). Indeed, Harding (1986) from her experience of counselling transsexuals, reports many family members - like the community at large - perceive transsexualism as some sort of perverted sexual practice. Parents find it hard, sometimes impossible, to accept a transsexual son or daughter, and hope, usually in vain, that they will 'grow out of it'. Most teenage transsexuals get very little, if any, parental support, or help from any source. They tend to be pressurized to behave and look in a more sex-related way by those around them, and experience hostility when they fail to comply with expectations. Suicide attempts and disappearances are common. Garfinkel (1967) described Agnes' report of having to manage, post-surgically, the opinions of friends, neighbours, and family (who knew of her past). She described her experiences on returning from hospital as "terrible". '...there was open disapproval and overt expressions of anger from members of the family, particularly her brother, who continually wanted to know when she was going to stop this thing'. Harding (1986) recommends that it can be helpful for the families of transsexuals to have access to simply written articles on what transsexualism is all about, which, together with

counselling, can offset feelings of revulsion and guilt.

The two-year cross-living period, is also one of crises, depression and inadequate emotional support. Many transsexuals are estranged from family and previous friends, and have difficulty forming new, substantial relationships. As regards accommodation, landlords tend to be unsympathetic where a person's presentation is contrary to expectations. Harding (1986) suggests that a letter from the medical team/social worker can help to influence a decision to lease in favour of the transsexual. During this period, transsexuals are trying to establish a new identity. Many prefer not to confront the problem of finding a job while they are worrying about their appearance, thus, they are often unemployed. However, long periods of unemployment are a severe handicap, invariably resulting in permanent unemployability (Harding, 1986). A further difficulty is that transsexuals often lack a previous employment history, and do not have suitable references. Most try to keep the same job if possible, although this is not possible for some, who may experience intolerable (real or imagined) pressure from workmates which forces them to resign. Nevertheless there is, increasingly, little difficulty involved in retaining existing jobs (particularly if the individuals are lecturers, teachers or civil servants). Also, because of good appearance and work skills, for some, finding suitable employment is no problem. Difficulties arise, however, when employment is dependent upon a medical examination, or presentation of the birth certificate, as is the case with government positions. (Hodgkinson, 1987). The use of female and male staff toilets is also a common objection of employers (Harding, 1986). Harding (1986) argues that there is a need for services to assist

transsexuals to fit into society in their chosen gender identity, to facilitate administrative changes within government departments, to initiate law reform, and to counsel individuals, their family, friends and others. Transsexualism, she argues, has existed in societies for centuries and cannot be ignored. The community needs to be educated and laws changed 'to enable the transsexual to take his or her place in society without stigma or discrimination'.

Coping Strategies

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A coping strategy is: any thought or action which succeeds in eliminating or ameliorating threat, whether it is consciously recognized as intentional or not. The social context constrains choice of coping strategy through factors such as the size and structure of the individual's interpersonal network e.g. self-disclosure to a friend may be a source of relief, but is not a possibility if the individual has no friend. Breakwell suggests that the size of a person's social network is inversely correlated with attempted suicide, and psychiatric breakdown. More fundamentally, the nature of the individual's identity structure and attributional style, preceding threat, will also influence the effectiveness of the chosen coping strategy (Abramson, Seligman and Teasdale, 1978), as does 'self-negativism' (Apter, 1983) which occurs when an external source of threat becomes overwhelming particularly since transsexuals in general, tend to have negative self-opinions (e.g. Benjamin, 1966; Derogatis et al., 1981).

Breakwell (1986) proposes that threats to the structure of identity are usually transient, because as soon as they gain conscious recognition, the individual will initiate

strategies designed to obliterate them, for example, living in the cross-gender role. If, however, a threat so disrupts the identity processes and challenges its most highly salient elements, such coping strategies may only temporarily reduce the effect, and the effort to deal with the threat will become chronic, take over the individual's whole life, shaping his or her every move (Breakwell, 1986). Under such circumstances, the transsexual becomes desperate for SRS. Her report of her MF case study, John, illustrates the experience of increasing social threat to the identity of a transsexual.

When, seven years previously, John had begun to cross-dress full-time, and to seek SRS, his marriage, job, and access to his two children ceased. Much of his time was now spent at home in his council flat, since venturing out was to risk being subjected to verbal and physical assault by children in his local community. At the time of study, he was receiving hormone therapy while awaiting SRS. He accepted both the less desirable side-effects (vomiting, dizziness and reduced libido), and was aware of more serious ones (e.g. pulmonary embolism, breast cancer and pituitary tumours) while welcoming the desired physical metamorphosis that hormones produced. He was also undergoing the necessary and painful electrolysis of facial hair.

Breakwell points out that the evidence of John's original anatomy contradicted his conception of his 'real' identity. His own body was, therefore, a threat to that identity. The task, as John saw it, was to bring physiological facts into line with psychological reality. Albeit an arduous process, this situation was nevertheless remediable. Breakwell identified the central problem, as being the need to gain

acceptance for the revised identity. In his words;

"...other people...still think of me as I was. The old me. The new me is some misfit to them. They can't fit the old and the new together" (Breakwell, 1986).

John was therefore suffering a double discontinuity in his life; beyond that which he perceived to exist between the physical and the psychological, he was now also aware of an inconsistency between his present and past, upon which the surrounding community focussed, regarding the lack of continuity in his identity as aberrant and dangerous. This earned him an unwanted distinctiveness (people like to be distinctive, but in positively valued ways), and negative notoriety. This threat, experienced as a continuous attack on his sense of personal worth and self-esteem, was therefore social as well as psychological:

'I'm not valued anymore. I've lost everybody. No one wants to know me. Even the professionals who are supposed to help...My psychiatrist said he did not think I was serious about wanting the change. Me, that's lost everything....Because one day I went into his office wearing slacks, not a skirt' (Breakwell, 1986).

#### Support Groups

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The availability of group membership can help offset the threat to identity, thereby serving as a coping strategy. Unlike transvestites and homosexuals, transsexuals prefer not to mix with those who share the same condition. One of the few organizations specifically founded for transsexuals is the Gender Dysphoria Trust International (GDTI), formerly known as SHAFT (Self Help Association For Transsexuals) founded in 1980 by Judy Cousins, a post-operative MF transsexual. The trust has a help-line and provides information (for example, on NHS and private psychiatrists and surgeons, as well as contacts), for transsexuals (primarily MF) as well as for professionals. Conferences and social events are also coordinated, and a counselling

service is available for transsexuals and their partners (dealing with issues ranging from role-change, to dealing with employers). A 'daughter' organization - the FM Network - is exclusive to FM transsexuals, mainly in the United Kingdom. It distributes a monthly newsletter among its members. A current campaign ('Press for Change') organized by these groups, is underway and seeks to achieve law reform, and the provision of basic rights for transsexuals.

The label 'transsexual' may mark such individuals as targets for stigmatization, and a number of writers have described the situation of those with stigmatized identities. Such individuals necessarily learn to develop skill in handling problematic situations. Gleason (1985) has described transsexuals as a group who are 'highly skilled in the universal human tasks of dramaturgical effectiveness', by which he means that they demonstrate explicit skill at consciously doing what people all learn to do more or less well and without conscious awareness: to 'present, negotiate and control multiple identities in a reasonable organized hierarchy' (Gleason, 1985).

'Passing'

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For transsexuals the practice of 'passing' is a major coping strategy. Weigert et al (1986) propose that multiple identities are communicated through displays of appearances, behaviour, and language. Transsexualism suggests that being a (social) female or male does not depend on original physical structure - nor on performing specific gender role behaviours. Indeed, transsexuals have revealed a great deal about what is important in gender attribution, since 'passing' as a male or female (a coping strategy that most of them employ) is for them a constant concern (Kessler &

McKenna, 1974). Weigert et al. (1986) argue that specific identities emerge from socially acted out behaviours, their validation occurring when others recognize and react to that identity. An identity can therefore only be successfully claimed if the intended behaviour becomes an 'object' toward which others orient their behaviour. A successful representation of self that will elicit the desired identification from another involves the entire individual. An entire lifetime of masking a hidden identity that would contradict that presented 'demands total control over relevant appearances' to which the communication of identity is linked (Weigert et al, 1986). This link is never visible. Rather, the relationship between appearance and 'who is really there' is inferred. Similarly, appearances of 'normal-sexuality' are for members of a society part of these deeply embedded, unavoidable, unnoticed textures of relevance recognized in everyday interactions.

The necessity of interpreting appearances to identify a person, makes it possible to hide the 'true' relationship between appearances and self. This, for transsexuals, is the essence of 'passing'. Transsexuals who pass are continuously pre-occupied with 'impression management', presenting themselves in ways that enable them to pass as members of the opposite gender, while seeking to be treated and to treat others according to a legitimate (opposite) sexual status in which appearances are paramount. Indeed, to this end, transsexuals have a 'remarkable awareness and an un-commonsense knowledge of the organization and operation of social structures' which enables them to provide evidence of their rights to live as 'bona fide males and females' (Garfinkel, 1967).

The vast majority of people are able to take their sexual identity for granted. This need, to both be oneself and to be free to let others know it (Stoller, 1975), forms the routinized, unquestioned and unquestionable background of activities and matters of relevance in their everyday affairs, that is largely below conscious awareness. Such routine is a condition for rational action. The accompanying feeling of bodily and psychic ease in the routine circumstances of everyday life, that crucially supports the protective cocoon that surrounds individuals in their regularized action, is, for transsexuals, only acquired through great effort, skilled watchfulness, and long schooling (Giddens, 1992).

By obscuring his or her background, characteristics which identify the transsexual's threatening position are hidden or erased. However, in dealing with the threat to identity by passing, transsexuals face a number of problems. Primarily, they must live a lie, which has psychological implications (Giddens, 1992). Success requires constant vigilance, masked by an appearance of casualness, which is simultaneously accompanied by the realistic conviction that 'a single slip in identity maintenance with the wrong audience', or disclosure of their secret, would bring swift and certain ruin, status degradation, psychological trauma and loss of material advantages (Garfinkel, 1967). The passer lives with the continual fear of discovery and exposure, since his or her identity remains potentially discreditable. Thus, passing itself, can constitute a threat (Garfinkel, 1967; Breakwell, 1986). Giddens (1991) compares the situation of transsexuals who pass with that of a spy (Stoller, 1975) 'who, in the interests of self-preservation, cannot accept the range of normal appearances in the way

that other people usually do (but instead) suffers tortuous anxieties about what would otherwise be mundane events'.

One problem with living a 'lie' is the impossibility of being certain to control every aspect of identity appearance at every moment. Garfinkel (1967) argues that SRS itself, substitutes one set of difficulties for another, since, although after surgery the desired genitalia may now exist, this is in the absence of an appropriate female (or male) biography (e.g. Harding, 1986). Many conversations are reliant upon a background of biographical details for their interpretation. Garfinkel (1967) reports that Agnes, his MF case study, 'learned to embed such elements in discourse', for example, by describing herself as a 'kid' rather than 'girl' when referring to her childhood, thereby reducing the need to lie. These 'passing occasions' arose when she engaged in conversation without the appropriate biographical data to swap with her listener 'I have to be careful of the things that I say, just natural things that could slip out...I just never say anything at all about my past that would in any way make a person think what my past life was like. I say general things. I don't say anything that could be misconstrued' (Garfinkel, 1967).

Both pre- and post-operative transsexuals must then, learn to feel and act like members of their chosen gender, and do so candidly while actually playing out the role. This is accompanied by severe risks and important prizes, and is done in situations known with the most faltering knowledge with uncertainty about its rules of practice, in order to avoid displays that would lead to sanctionable grounds for doubt that these individuals are, sexually, what they appear to be. Garfinkel (1967) holds that it is less accurate to

say of transsexuals that they have 'passed', than that at any time, they are 'ongoing passing'. The logic underlying this notion is that the transsexual retains both male and female components of identity - as does everybody else (Snitcher, 1993, personal communication) - in a sense, we are all passers (Garfinkel, 1967) each moment of our lives can be described as an identity display. Harre (1991) points out that an 'illusion of sexual category' can easily be conveyed through the wearing of emblematic clothing, appropriate hairstyles etc., and that many people live as 'members' of the opposite sex, simply by cross-dressing. However, for transsexuals who pass, the problem is not simply one of passing in physical appearance...but also in manner, vocabulary and personality; not merely passing, but 'being' (Hodgkinson, 1987).

In the requisite cross-living period before surgery, one of the foremost concerns for transsexuals is their effectiveness at passing as members of the gender of choice, having lived for most of their lives in the body of the opposite gender (Breakwell, 1986), striving for most of this time to make all their movements and gestures appear as confidently appropriate to this as possible. Such habits must now be unlearned. This is arguably more pertinent to the MF transsexual (Wells, 1986). The social and communicative skills necessary to function effectively are, under such circumstances, unpractised. Thus, the individual may persist in avoiding social situations, instead, clinging to the security provided by maintained self-isolation (Harding, 1986). Inevitably, in the original role, sex-associated types of behaviour (feminine, or masculine) were acquired, simply through living in this identity and being treated as such. Thus for example, in attempting to

pass, MF transsexuals have to worry about their hair, clothes, gestures etc. (Hodgkinson, 1987).

'The first time I actually walked down the street in my new clothes I was half-expecting lightning to strike me, and people to stare in horror and point at me with loathing. But nothing happened - no one even noticed me...It was wonderful. But the most surprising thing was that even after a lifetime of living as a man, I didn't feel the least awkward or out of place. My clothes didn't feel strange or unfamiliar. They felt right' (Hodgkinson, 1987).

A few pass extremely well as very attractive females, while others are often very unfeminine, wearing obvious wigs and heavy make-up. Hodgkinson (1987) suggests that a typical hallmark of MF transsexualism is a flamboyant, sometimes almost theatrical posturing regarding gender role behaviour. Some become so effeminate as to attract attention, or may appear clumsy and look uneasy or embarrassed. The present identity is clearly new for them.

A further problem for MF transsexuals is voice pitch, which for them remains relatively unaffected even under hormone therapy. In addition, other masculine indicators (such as large hands, thick wrists/neck, square shoulders etc.) are apparent. They are advised by clinics to wear little jewelry (which tends to draw attention to these factors) and to adopt simple dress styles (Steiner, 1985). Careful use of cosmetics and sensible dressing can produce impressive effects (Clarke & Stubbings, 1986). Hodgkinson (1987) reports one MF transsexual as commenting:

'You don't go out of your way to look odd...I am over six feet tall. I have to be careful. Mostly I wear very ordinary clothes that don't draw attention...Occasionally, people do look at me in rather an odd way. I wonder, is it because I'm wearing a nice dress, because I'm tall for a woman, or because I've been rather aggressive? I'm also wondering: are they reading me, have they become suspicious?'

In contrast, she notes, female transsexuals do not tend to draw particular attention to themselves via gender role postures, but often manage to successfully pass as men

(Steiner, 1985), and have comparatively fewer problems in merging into the wider community and achieving anonymity (Kuiper et al, 1988). Even when known to be female, their role definitions rarely cause more than passing comment (Derogatis et al, 1981). Kando (1972) also draws attention to the 'ongoing status passage' of transsexuals, with reference to the management of stigma. Transsexuals, he points out, necessarily have to alternate between groups who know them as members of their former gender (e.g. among family), and those in which they are known as 'natural' members of their new gender (e.g. among a new circle of friends). To promote the likely success of this type of status passage he argues, it is necessary for the transsexual to compartmentalize his or her life so as to avoid incompatibility and conflict between these two groups. In the immediate term following surgery, he suggests, post-operative transsexuals tend to opt for stigma management (which carries risks of ostracism and rejection), rather than suffer the constant anxiety of being fraudulent, and risking being later found out. Passing, he suggests, becomes more likely with time. Consistency is seen by society as a good thing, making people more predictable. However, Kando (1969) argues, this does not mean that transsexuals are actually consistent. The compartmentalization strategy is designed to prevent the acknowledgement of incongruity or imbalance. Inconsistencies are thus established and allowed to survive by the very technique designed to cope with them.

Garfinkel (1967) argues that members of a society learn 'rules' for distinguishing males from females, during socialization. To be successful in one's gender, he points out, is to prevent any doubt that it is objectively,

externally 'real'. For transsexuals, what he describes as passing 'devices' are used towards this end, and consist of efforts toward making observable, for practical purposes, the 'normal sexed person who has always been and remains the same'. Transsexuals often have to deal with such constancy as a task, in a deliberate Garfinkel agrees with Goffman's (1971) view that members of a society are concerned with the management of 'impressions'. He argues however, that Goffman neglected the additional, extreme efforts that are necessarily exerted by transsexuals in maintaining a chronic, continuous extra awareness, like that of a 'seventh sense'. This involves the conscious pre-monitoring of their performance in company, censoring, or 'testing out' behaviours, gestures, facial expressions and intended utterances before executing these, by gauging them against a form of internalized, normal 'other' so as to derive a prediction of how they will be received, the object to be achieved being that of the normal, natural fe/male. This process of 'impression management' (Garfinkel, 1967; Goffman, 1971) operates in social contexts and is tested out in the presence, and under the gaze of normal male and female others. Ordinarily, this is a routine, unconscious and automatic practice 'which enables persons, in the course of mastering and managing their everyday affairs to recognize each other's actions, beliefs, aspirations, feelings, etc. as normal, legitimate, understandable and realistic.' (Garfinkel, 1967). The demands upon transsexuals in achievement of this can be extremely draining, and the resulting behaviour lacks the essential spontaneous quality that generally characterizes the performances of 'normal' people. The effort involved is such that a very large number of the transsexual's situations of activity are



characterized by "structured strain" in their active attempts to comply with a 'legitimate order' of sex roles. Each requires 'vigilance, resourcefulness, stamina, sustained motivation, (and) preplanning', continually accompanied by improvisation, sharpness, wit, knowledge...'They enjoy their successes and fear and hate their failures' (Garfinkel, 1967).

#### Management Devices

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Through their continuing studies of the everyday activities and methods employed by members of society for producing reliable evidence of normal sexuality in ordinary activities, transsexuals acquire 'management devices', tools for consciously 'doing sexuality' in a way that people normally do unconsciously as a matter of course, in order to create an effect of 'sexuality-as-usual' (Garfinkel, 1967). Management devices are acquired both pre-, and post-operatively, as part of the transsexual's mastery of trivial but necessary social tasks, in which meticulous attention is paid to appearances, relevance, and demonstration, and by remaining acutely sensitive to devices of talk, in order to establish ordinary rights to live in the chosen gender role.

Situations of passing are continuous throughout the transsexual's life from the time that he or she begins living full-time in the cross-gender role. Initially, before competence and/or confidence is acquired, he or she may prefer to avoid rather than face social situations. This often leads to isolation, wherein the transsexual tends to observe, rather than participate in ongoing activities. Agnes for example, who began (an 'illegitimate') transition in school, reported having dealt with the problem of

remaining inconspicuous, by eating in the school lunch room, joining no clubs, restricting her physical movements; and generally avoiding conversations; by avoiding choices of either male or female companions; by sitting in the far rear corner of every classroom and not responding to the classroom discussions' such that 'whole days would pass and I wouldn't say a word' (Garfinkel, 1967). Breakwell (1986) argues that attempting to live up to what one perceives to be the expectations of other people can be very demanding. Transsexuals are 'expected to live up to standards of behaviour, appearance skills, feelings, motives, and aspirations while simultaneously learning' such standards. Garfinkel (1967) describes how Agnes acted as a 'secret apprentice', while allowing the environment to provide her with the answers to its own questions, which she was expected to know. She learned how to 'act like a lady' while being unable to show that this was going on. Kessler & McKenna (1974), conducted interviews with fifteen transsexuals, and repeatedly found that those in the process of transition, emphasized how uneasy people seemed to be in interacting with them until some decision had been made about whether they were male or female, even if this meant finally resorting to an open question. When this occurred, they often reported feeling embarrassed and uncomfortable, In Garfinkel's (1967) view, this indicates that something had gone wrong with the interaction; 'a "violation" of unstated rules had occurred'.

Gender attribution, as noted previously, is a complex process. On one hand, a person presents him/herself in such a way so as to convey the proper cues to another who is making the attribution. Once a gender attribution has been made in an interaction, the meaning of gender-related

information for any particular individual will be interpreted in accordance with this, and since the attribution is highly resistant to change, it then becomes no longer necessary to keep 'doing' male, or 'doing' female. What must be sustained is not the particular gender so much as its sense of 'naturalness' i.e. that the individual has always been that gender. The attributor, as a consequence of holding the natural attitude, interprets and 'fills in' the behaviours of the actor in terms of the gender attribution that was first made, making sense of the latter's behaviours in that context. However, because of the stubborn nature of the original gender attribution, in order to change transsexuals experience extreme difficulty in being perceived as being of their 'new' gender by those who knew them as being of their 'original' gender prior to their transition. On the other hand, the first attribution made by people newly encountered by the transsexual when in his/her 'new' gender, will also be most difficult to discredit - regardless of information that may subsequently be given to the attributor.

Breakwell (1986) proposes that while, in a sense, passing preserves the continuity of identity, it also creates disparity between the subjective and social experience of self. A schism between the identity structure prior to, and during passing is likely. She suggests that passing may not so much act as a coping strategy preserving identity from threat, but rather as a fairly radical force for self-revision. However, if passing is mainly a public affair, but is contradicted by private actions, such self-revision is less feasible. This may, in turn, detrimentally affect the post-operative transsexual's re-integration into society. Weigert et al (1986) argue that

where neither objective nor social comparison is possible, self-knowledge becomes unstable and behaviour erratic. This can, in some cases, lead to psychological problems.

Failure of Coping Strategies

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Coping strategies fail when the degree of revision of the identity structure demanded by a threat is beyond the individual's control e.g. young transsexuals, asked about the the worst things that have happened to them, may report 'being noticed' (i.e. in school), and in being noticed to be without friends or companions. Agnes, Garfinkel's (1967) case study, considered that she did not have any friends because she did not react normally under any kind of a relationship. She could not have a boyfriend and, because of the way she was, could have no girlfriends either. The really bad things were situations in which the management work required in passing, for various reasons, failed, or threatened to fail. Critical cases were those that had to be 'handled' as they unfolded.

Some people may not wish to believe in the truth of the link between the transsexual's behaviour and his or her gender identity, and so, refuse to affirm that the transsexual is who s/he appears and claims to be, no matter how much the self strives to achieve that acceptance. However, appearances that are falsely linked to self, can be fateful. Kessler & McKenna (1974) point out that the refusal of the legal system to accept the post-operative transsexual as being a bona fide, valid member of his or her chosen gender group, as well as those who are opposed to SRS in principle, beg the question as to what the deciding criteria for membership should be - anatomy? external genitalia? hormonal constitution? - all of which vary widely among heterosexual,

'normal' individuals.

Breakwell (1986) suggests that the best solution to threat may be to remove oneself from the threatening position, but cautions that self-imposed isolation is the worst way to cope when faced with any sort of stress.

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**CHAPTER FIVE**  
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BIOGRAPHY, IDENTITY FORMATION, CHANGE, AND TRANSITION  
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'They plough their lonely and unhappy rum path through life, feeling misunderstood and persecuted....Many accept their unhappy fate and simply suffer it; some go to great lengths to achieve a change in their physical appearance by self-mutilating operations, seek hard to find medical help, or find it all too much and resort to suicide' (Kessler & McKenna, 1984).

Introduction
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Wells (1986) suggests that there should be three terms for 'transsexual', one for each stage: needing to cross over; crossing over; having crossed over. Each has its own problems and makes different demands on transsexuals (Weigert et al., 1986). For her, as for most (if not all) transsexuals, the worst time is the initial 'long, hopeless, pre-surgery, pre-transformation period' of life. Wells' (1986) recommendations will therefore be used as an organizing principle for this final chapter.

The process of 'self narrative' denoting the characteristic ways in which people generally, construct and tell stories about themselves in order to make sense of their lives, will be first described, then demonstrated in the accounts of individual transsexuals themselves, as they attempt to accommodate the dramatic social and psychological changes in their lives throughout the three stages. The first part of the chapter will cover the experience of the young 'pre-transsexual', the potential for early intervention in these 'pre-transition years, and the adolescent transsexual. This will be followed by consideration of the transitional period during which treatment (and SRS itself) ensues. Finally, the post-transition period will be addressed, and in conclusion, the (philosophical) question as to whether the individual having 'crossed-over' effectively ceases to

be 'transsexual', will be briefly considered.

#### Self-Narrative

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Weigert et al (1986) argue that like all socially constructed realities, identities are structured by the internal logics of action, thought and feeling, which direct behaviour and interpret experience, serving as the sole means by which individuals make sense of their lives. Bruner (1987) adopts a constructivist position with his proposal that 'humans construct the social world and things that transpire within it'. Specifically, people make sense of their lives to themselves by constructing 'autobiographies', or '"narratives"...an ensemble of ways of constructing and representing the sequential order of human events (in terms of generic 'stories, excuses, myths, reasons for doing and not doing etc.')

which organize the structure of human experience. These events serve as emblems that are slotted into the narrative to provide a meaningful framework for making sense of our lives (and from which we derive the sense of 'living a life'). Narratives are, however, not so much veridical records of events, as, essentially our continuous interpretations of them, or our provision of 'reasons' for their happening. Such interpretation is carried out in order to invest events surrounding the self with meaningful significance, coherence, and continuity, such that we feel that we act purposefully in the social world. 'The relations between the meanings assigned to the whole of the story, and its constituent parts, are used in order to make sense of the whole' (Bruner, 1991). By these means Bruner (1991) suggests, traumatic occurrences or experiences, e.g. such as the rapid and significant changes that take place in the personal and social lives of transsexuals during the transitional period, by virtue of

being made interpretable become bearable. The narrative of one's life is reflexive: 'the narrator and the central figure in the narrative are the same'; thus, narrative and life are mutually imitative. In this way, Bruner (1987) proposes, we 'become' the actual narratives which we use to 'tell about' our lives'.

Personal narratives are related to the individual's beliefs, desires, theories, values etc., but are simultaneously Bruner (1987) maintains, 'highly susceptible to cultural, interpersonal, and linguistic influences' which mediate the interpretational form of narratives (or the underlying 'mental model' that gives rise to this), by structuring our perception and organizing our memory for occurrences, and hence influencing the representations of 'reality' that structure our experience (Bruner (1991). Most important of all, narratives are constrained by a given individual's social network of friends, and colleagues whose advice and criticisms are valued by the individual. Bruner speculates that this may also explain why 'talking cures', and other influential interventions can potentially have a profound impression upon us, and may so change one's life narrative. The pattern that narrative form takes becomes 'automatic' such that the life-narrative becomes not only constructed from an individual's past to the present, but is also mapped out into the future. However, Giddens (1991) argues that where there are no longer pre-existing patterns to set large areas of an individual's life, that person is faced with the necessity of having to negotiate 'life-style options'. Such choices, he emphasizes, are not only distal aspects of the individual's attitudes. Rather, they actually define the identity of that individual. 'In other words, life-style choices are constitutive of the reflexive narrative of self'

(Giddens, 1991).

The Pre-transition years
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Whereas a normal child of 4 can answer the question: 'Are you a boy or a girl?' quite accurately, the child may be unsure as to whether, when adult, he or she will be a man, or a woman (Kessler and McKenna, 1974). In contrast, transsexuals recollect that characteristically, at around the same age, they were completely convinced that when they grew up they would be members of the opposite sex. From an early age, they manifest a paradoxical gender identity which remains 'permanently and virtually irreversibly established' (Hoenig, in Steiner, 1985). The desire for sex change that starts in the first few years of life never mitigates (Stoller, 1975). All her life, Elizabeth Wells, herself a post-operative female, reports that she had felt very 'un-ordinary'. Unlike others, it seemed, she was at total odds with her body, a person divided. In appearance she was male. But 'knew' she was female (Wells, 1986). Karl, a post-operative male, shares a similar recollection: 'From the age of three I felt that I was a boy, and I have always felt I was male. More than that, I knew I was a boy...as a child, it troubled me that my parents didn't see me as a boy. Why didn't they see that? I used to ask myself. It became clear to me early in life that I was not ever going to fit into a female world' (Hodgkinson, 1987).

Such children tend to keep the problem to themselves. Wells (1986) from her own experience reports that describing how it felt then was comparable to 'trying to describe a new colour that no-one else could see'. On realizing that other small children do not feel the same way but that that they alone have this experience, they say nothing (Wells, 1986).

Had they at the time revealed such feelings to anyone, the response would invariably have been one of incredulity that they must face the facts of their anatomy, name and birth certificate. In the face of such proof of their sex, how could they deny it and insist otherwise? But for pre-transsexual children, the issue is more than one of mere wishfulness or preference, they 'know' that they are of the 'opposite' sex to that of their anatomy. Wells (1986) accepts that for those who have known 'only the harmony of body and inner identity - 'ordinariness' - the idea is absurd. Most report initially believing that that some 'terrible mistake' had been made, but that this would be resolved since there would ultimately come a time - perhaps at adolescence - when it would be a matter of personal 'choice' as to which sex they wanted to be as adults, whereupon the 'right' body could be selected (Wells, 1986; Heiman, 1975; Stoller, 1975). Recognition of the problem comes gradually over several years, from about age four to about seven.

In their early years, the full significance of the pre-transsexual child's situation is yet to have its major impact, since it is still possible to some extent to function in spite of the problem which only gets in the way when attempting to engage in some activity that is exclusively reserved for the opposite sex. Green (1967) suggests that as well as the avoidance of gender-typical and preference for cross-gender play activity, evidence of cross-gender role orientation includes: physical mannerisms, gait, gestures etc.; a more than casual interest in cross-dressing; frequent assumption of the role of an opposite-sexed parent or sibling in 'mother-father' games or doll-play; or an overtly stated wish to be a child of the

opposite sex. 'The allowance, or denying of such behaviour, may become a pivotal nucleus for open family conflict'. Moreover, their continued failure to behave according to the social norms for their biological sex invariably invites constant, explicit criticism which may become chronically lodged in the young child's mind, where it works to devalue their developing self-perception. As pre-transsexual children become older, they face increasing ridicule from peers and are continuously reprimanded, coerced, teased, mocked and bullied (Benjamin, 1966). Green (1967) for example, argues that school-age children are more adept than are adults, at identifying and labelling boys who walk and talk "like a girl". If social pressures are great enough, the transsexual boy may attempt to conform, but his efforts to be masculine fail no matter how severely he is humiliated or physically punished (Stoller, 1975). The target child's social contacts are therefore always tenuous. They feel increasingly ostracized and 'different'. In time, the problem inevitably becomes more persistent, sometimes frightening. It is the worst nightmare - but one with a most dreadful difference - there will be no waking relief. The truth, when it hits, is devastating. Wells (1986) expressed difficulty in describing such moments:

'They would occur anywhere - at home, at school, or while I was playing. Suddenly the strangest feeling would engulf me like a wave. If I were walking along, the intensity of it would stop me in my tracks...an overwhelming sensation of uncleanness, of not belonging - to anything or anyone, family, friends, the planet, or even myself. There seemed to me space between me and the body I stood in, like a skeleton in a suit of armour lined with something unpleasant. I didn't fit. It was awful...I never told anyone about it because I knew by then what was wrong...I believe every transsexual knows only too well the feeling I experienced during those awful moments of seeming to hang in space: "I am in the wrong body." For that is the feeling'.

'What pain, what a trap to be stuck in a body that was going to shape your existence and...carry you along with it whether you wanted to go or not. I felt like a honey bee that had used its sting. The life had been pulled out of

me.' (Rachel, in Kessler & McKenna, 1974).

Immense problems of social integration consequently follow for these children, with their parents, siblings, peers and wider social surroundings. Everything about their being - interests, interactions, body movements and expressions - leads others to perceive them as 'different'.

#### Tomboys & Sissies

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Green (1967) argues that by the age of three, children are aware of the inappropriateness of boys playing with dolls. By the age of four, most children also state a preference for growing up to be a parent of their own gender (Rabban, 1950). However, Brown (1957, 1990) found that 4% of boys out of several hundred between the ages of 5.5-11.5 years showed 'unequivocal feminine orientation'. When quite young, a boy may be noticed to overly use his hands or speak in a more languid fashion, which may be an early identification of a cross-gender nature (Green, 1967). In contrast, with school-age girls, it is less easy to identify possibly pathological cross-gender behaviours. More often for them, the overall effect of dress, preferences and physical mannerisms gives a more accurate measure of gender-role and gender-identity.

Due to the elevated status of males in our culture, Green (1967) suggests, girls who prefer boys' activities and/or who play sports are generally more accepted than boys of the same age who prefer girls' activities and shun sports participation. In addition, female cross-dressing is more tolerated than male cross-dressing. Thus, masculine females will be relatively free of parental and peer opposition in respect of cross-gender behaviour. The daily ordeal of alienation, bullying and ridicule from peers often,

understandably, leads pre-transsexual children to wish to avoid as many such situations as possible (Stoller, 1975). They therefore experience a oppressive sense of isolation, of 'not fitting in', suffering tension and sadness in response to pressures exerted by the outside world. As a coping strategy, the child may retreat into an inner, secret private world of fantasy, with accepting, imaginary friends who perceive the child as 'special'. Di Cegli (1992) observes that as a consequence, such children may sometimes appear 'remote and dreamy. The split-off component of the child's identity becomes increasingly remote from the rest of his or her personality, and the secrecy once established may give rise to secondary phenomena' which themselves detrimentally affect the child's development, and in the long-term the structure of identity. Not surprisingly, neurotic symptoms develop during the transsexual's childhood, impairing adjustment both at school and in the crises to come in adolescence (Jonas, 1976). Benjamin (1966) suggests that the desire for and identification with one sex, together with the need to conform superficially to the other - a 'double discontinuity' (Breakwell, 1986) - serves to explain much of the general personality disturbance, maladjustment and failure to make maximal use of potential ability. Such children often perform well below their intellectual capacity (Roth and Ball, 1964; Steiner, 1985), and finally may refuse to go to school 'or do something more desperate' (Benjamin, 1966).

Intervention

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'Once experienced, transsexual feelings are unlikely to diminish either through the individual's own efforts or medical intervention. Indeed such feelings frequently strengthen as the years go by...A transsexual is therefore faced with two possible courses of constructive action: to accommodate as best she or he can to life as her/his biological sex, or to seek gender reassignment. It is essential to grasp that for the transsexual this is not a

simple choice but a profound dilemma: whatever path is eventually followed the predicament deserves compassion, and the decision, respect.' (Hodgkinson, 1987).

Stoller (1975) reflected on the difficulties in treating gender dysphoric boys, for whom the therapeutic goal was 're-education'. He advocated that therapists should be the same sex as the child so as to act as a role model with which the child could identify, to express pleasure in his own gender and discourage cross-gender behaviour, instructing parents on maintaining this reinforcement at home. 'Success' ideally, was the achievement of a shift to the same degree of masculinity as they would like to see in any boy. But realistically it was admitted that any masculine development was an improvement. The most successful cases were expected to turn out to be moderately feminine, heterosexual men whose appearance and interests were 'on the gentler side of masculinity. Less successful cases were expected to eventually become homosexual men - deemed to be a 'happier outcome' than the unalterable condition of adult transsexualism'. Nevertheless, so great were the difficulties encountered in treating such boys that upon reflection, Stoller (1975) wondered 'why we insisted on making the boys masculine. The answer had seemed so obvious at first that we never asked the question; we agreed with society's commonsense position that one's identity must reflect one's anatomy. I wonder how much anguish we have a right to bring to them...core gender identity is fixed so early, and to try to remove it and replace it with its opposite - masculinity, the most alien the boy could create - is a cruel process'. Acknowledging that the longer femininity had been present the less the chance of removing it by any technique. He therefore asks 'might it be no worse, and perhaps a bit better, if one encouraged the

feminization process?'

The Adolescent Transsexual  
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Weigert et al (1986) argue that the transition from child to adult for any individual brings the problem of reconciling what one will become and what one is to oneself with others, within a system of socially specified possibilities. Breakwell (1986) points out that in our society, adolescence is a stage of personal history in which the individual is free to seek an identity that is affirmed by others in the past, and by what they encourage one to become now. She cites Erikson's (1968) introduction of the notion of 'identity crisis', a climactic turning point within each of the eight maturational stages of life that he described. During these stages, he proposed, the ego undergoes certain experiences, and confronts various tasks that are intrinsically linked to social interaction with the surrounding cultural milieu, the most notable being that which normally occurs during adolescence when an extended 'time-out' period - the 'psycho-social moratorium' - is provided by society for the resolution of such problems. For any individual, this is a difficult time in which issues of personal, sexual, and gender identity must be tackled and overcome. For transsexuals however, adolescence is a disaster. Rather than being a time of conflict resolution, it marks the beginning of traumatic social problems. Worse, with the onset of puberty their own bodies turn traitor (Stoller, 1975). Karl exemplifies the predicament;

'By the age of fourteen I had all the physical attributes of a girl and knew then that I would come up against enormous obstacles. I was never attracted to boys, and knew that the only relationship I could ever have was with a woman - not as a lesbian - but as a husband...In those days, of course, it was never talked about, and I felt very sad and disturbed. There was nobody for me to confide in, nobody I could go to for help. I didn't even know what kind of help I wanted. I knew that I wanted to be married and to father

children, but of course I also knew that was impossible. So how best to live my life?' (Hodgkinson, 1987).

Steiner (1985) reports that many gender dysphoric, late adolescents seen at the Toronto Clinic had previously attempted suicide on one or more occasions. She argues that rather than the degree of intention behind such acts, the important factor was that they represented a 'cry for help'. She emphasizes the importance of psychotherapeutic intervention, recommending that the therapist, having established a trusting relationship with the patient, should act as a buffer between the individual and his or her family, so as to offset the extreme guilt felt by both sides. '...the parents feel that they have "failed somewhere"' or their child would have been 'normal', without cross-gender wishes, while the adolescent 'is acutely aware of the pain and torment that his or her cross-gender wishes and behaviour cause the family'. SRS, she reasons, while the 'ideal solution', will remain unavailable to the young transsexual, for many years, during which time he or she will have to confront and strive to overcome many difficulties in a potentially hostile and uncomprehending environment. Furthermore, poor educational grades oblige them to become dependent on welfare or unemployment benefit, being inadequately skilled to obtain employment (Steiner, 1985). They may also suffer additional emotional and behavioural problems. During these troubled pubescent years, they seek sexual partners among erotically normal individuals, However, their effeminacy or masculine behaviour as the case may be, instead attracts homosexuals. Indeed, a homosexual life is occasionally suggested for them. but is rejected because they dislike homosexuals who are neither what they seek nor acceptable to them (Stoller, 1975). For example, Kessler & McKenna (1978) reported their

FM transsexual case study to occasionally think 'about the time when he tried to be a lesbian. This was catastrophic, as he was treated by his partners as female. His genitals were perceived by them as a female, rather than being treated as 'abnormal' male genitals'. As a bolster against this, therapeutic help is advocated both to offset the trauma and assist development. While unable to offer a 'cure', psychotherapy can be of tremendous importance in relation to the identity disturbance, when directed toward helping transsexuals deal with their feelings in relation to alienation, rejection, and other emotional disorders (Baker, 1969). Jonas (1976) reports that basic- to severe depressive episodes, reflecting inner turmoil, and suicidal tendencies are part of the clinical picture, since cut off from society, transsexuals become unable to cope and are forced into regressive ego, and psychosexual relations.

In late adolescence/early adulthood there is often a last attempt at 'shaking oneself out of it', particularly by MF transsexuals who typically enter a period of hypermasculinization; engaging in physically demanding occupations such as the army, to 'force' themselves 'into masculinity' (Steiner, 1985). Wells (1986) recounts her three years in the army as 'pretty uncomfortable'. The policy was to make him 'tough masculine and aggressive' - the exact opposite of what he wanted to be. Such efforts are invariably futile, and the frustration worse, as the problem comes between them and everything;

'If I tried to study or concentrate, it loomed in front of me...somehow I contained it. No one, not even my closest friends, ever guessed my problem, or suspected that I had one, so successfully and desperately did I hide it (Wells, 1986).

However, with the passing years the distress continues to worsen. Periods of depression, at first successfully hidden,

become black despair 'sometimes lasting for days at a time. I would withdraw into myself and sit drinking, filled with self-hate...I came very close to suicide, which I thought would provide a quick and glorious release (Wells, 1986).

The doctor when finally told, often reacts with surprise, having often known the individual for years and presumed that s/he was a 'calm, well-balanced person'. Unfortunately, the problem is too often dismissed as one that will be outgrown. Or demands are made that the patient change his or her gender orientation (i.e. by dating) as a condition of work in psychotherapy (Meyer, 1975). Increasingly however, the revelation meets with much patience and sympathy... 'I poured it all out...felt as if I'd been holding my breath all my life, and at last had been able to let go of it' (Hodgkinson, 1987).

Often the first specialist to whom they are referred offers aversion therapy. This is however invariably refused for reasons such as those expressed by an MF patient to Benjamin (1966):

'The pain in my life is not merely that caused by prejudice and misunderstanding, but of conflict; a profound dichotomy of mind and body. The solution is to alter one of these elements to conform to the other. Most transsexuals feel that it is impossible for them to acquire the gender appropriate to their anatomical sex, without ceasing to be 'themselves'. The alternative; changing the body to fit the mind, is, within limits, possible...'

Very few adolescent transsexuals treated by alternatives to SRS have been described. Stoller (1975) cites one of the first as being the 16-year old boy treated by Barlow et al (1973) (see above). He suggests that if these researchers' claim of success are verified, then there is great hope for 'this presently malignant condition.'

Feeling alienated from a hostile world, many try to obtain

surgery as soon as possible, and before undergoing the recommended psychiatric assessment. Although in a cosmetic sense, the younger the patient the better the end result of hormonal and surgical treatment, this can be a tragic mistake: some, not happy in the new gender role, have wished to change back, and upon realizing the impossibility of doing so have committed suicide (e.g. Blanchard, 1985). Some young transsexuals in contrast have difficulty coping with their duality, and may take some time to finally reach the decision to 'change over'. Green & Money (1961) believe that adolescent transsexuals should be allowed to take 'reversible' steps (i.e. cross-living for a trial period to examine whether they really desire the cross-gender role). They accept that this relies heavily on support, acceptance and cooperation by both family and school, particularly for the younger age group. With age, comes an increasing confidence and conviction that change-over is essential to happiness and sanity (Hodgkinson, 1987). When eventually a specialist actually appears to believe them, the relief is enormous. For the first time, there seems to the individual some hope of resolving their problem, accompanied by the (new) experience of optimism. They are about to enter a new phase (Hodgkinson, 1987).

The Transitional period

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Transsexuals tend to see psychiatric assessment as the first of many hurdles. Their determination gives them a strong resolve when dealing with doctors and psychiatrists. Garfinkel (1967) reports that in the immediate pre-operative period, Agnes' futures were 'dated futurés'; 'all present actions and circumstances were informed by the assumption of a potential remedy for "her problem", and had to have occurred by some definite time', it is an experience of

surviving 'stepping stones' leading increasingly nearer to the goal.

Society has often conditioned the temperament of transsexuals according to their outward biological sex. The vast majority of FM transsexuals therefore tend to be quiet and retiring, wishing only to proceed with their destiny with as little impediment as possible. The sex stereotype however strongly operates in selection criteria for SRS: FM transsexuals are therefore expected to be more aggressive, because that is the way 'real' men are assumed to behave. MF transsexuals in contrast, tend to be somewhat dominant and aggressive, wanting to get their own way rather than having a reserved and/or gentle nature that is stereotypically associated with 'femininity' (Hodgkinson, 1987), yet here too, 'people expect a transsexual to adhere more rigidly to the traditional stereotype, and set up pass/fail scales in their heads. I've watched people watch me do things like take my shoes off etc., and heard them comment on how femininely I did it. Yet one would not watch a gender-consonant woman take her shoes off, and if she deviated from "being feminine" while doing it - so what?...I feel that I am different from men...How does anyone "know" they are a woman?...What does it mean to be a woman or a man?...I feel more that I experience things more the way women do than men do' (Rachel, Kessler & McKenna, 1974). One MF transsexual's comment is perhaps representative of the view of all such individuals;

'We just want our bodies to conform to our mental picture of ourselves, and this has nothing to do with acting out stereotypes...But, in order to get the best kind of treatment, you have to pretend to be ultrafeminine, unintelligent and passive' (Hodgkinson, 1987).

Hormone therapy can produce marked psychological improvement in a teenager so as to offset virilization of the MF or

feminization of the FM transsexual, and so ease the emotional turmoil that this tends to produce but only after patients have been carefully assessed for their potential for SRS (Benjamin, 1966). The welcome effects of hormone administration however, only partially relieve the problem (for example, most biological females still find it necessary to bind their breasts, with either abdominal binders or a tight T-shirt. Benjamin (1966) reports one of his MF transsexual patients to point downward saying; 'I cannot stand this anymore, it does not belong to me; it must go'. Despite working successfully as a woman for years, being accepted by the family, and having had an 'excellent' mammoplasty, she wanted finally to be referred for genital reconstruction. Benjamin enquired (since she had already accomplished so much and seemed reasonably contented): 'Why?' With astonishment, she pointed down, saying "But girls don't have that!". Wells (1986), when questioned on the issue by a close female friend, drew the corresponding analogy to convey how she felt: 'Suppose you as a happy and secure female woke up tomorrow to discover you had male genitals...what would your reaction be?...'. Rachel (in Kessler & McKenna, 1974) framed the issue in a more philosophical light: '...in a lot of people's heads, sex, gender, gender roles and genitalia, all have to be consonant. Surgery to me is important to achieve some of this consistency...but I'm aware that my head is as important in being feminine as my genitalia. There are people with vaginas that are much more masculine than I, and people with penises that are more feminine.' (Rachel, in Kessler & McKenna, 1974). Kessler & McKenna (1974) report that pre-operative transsexuals perceive themselves as not really being members of either gender at that stage. These

researchers suggest this is due to a belief that everyone must be classified as one gender or another, but perceive themselves as temporary exceptions because of their 'abnormal' genitalia: 'I was incomplete, unresolved...While my figure and face had subtly changed through hormone therapy, there remained one part of me that was not me. I was still in the wrong body' (Rachel, in Kessler & McKenna, 1974). Stoller (1975) reports that MF patients report feeling psychologically that they are females. They prefer to wear women's clothing and live permanently the female social role. They feel miserable in men's clothing, lack masculine interests, and recognize that because of their femininity they appear strange as males'.

Benjamin (1966), unlike Green et al (1978), recommends that surgeons accept such patients for surgery as early as 17 years old, by request, or with their parents full consent. Stoller (1975) cites a case reported by Newman (1970) who followed his own recommendations that the patient should be given female hormones followed by SRS, since 'the child's body was masculinizing so rapidly and he was acting so frantically and dangerously that staff at the hospital where he was taken with alleged 'paranoid schizophrenia' feared for his survival. 'The change in the child's behaviour when she was allowed to be a girl, was instantaneous and profound (Jonas, 1976), literally in a moment the "psychosis" was completely gone and has never returned'. She was reported to immediately slip into normal female behaviour, and in the subsequent seven years, to have become employed and lived as an unremarkable woman, with a 'normal' feminine sex life.

The transitional period is also a time of self-reflection, characterized by periods of uncertainty; the lifelong

experience of 'living in limbo', a chronic and pervasive sense of mismatch between the body and the psyche, now, for the first time, diminishes. Giddens (1992) argues that the individual goes through a phase of 'reclaiming (the) self' as treatment proceeds. After a previous lifetime characterized by 'an overriding sense of chronic unhappiness, self-criticism, discomfort, frustration and complete despair with his or her existence', the transition period sees the onset of a search for an underlying sense of 'self' untainted by the transsexual experience: a new self-identity. This process is necessary, he argues, to enable the individual to exploit and benefit from the second chance provided by treatment.

'I went through a bad period due to being all alone...it was only natural that I questioned what I was doing...months of waiting were punctuated by periods of intense depression. I felt old and foolish. The years had sped by while I'd wasted my time in hating myself and struggling to keep up appearances. Had I left it all too late?...Then some compliment or little act of kindness would lift me out of depression and remind me of how lucky I was and how far I'd come. I would just have to hang on and try to think positively...I was claiming what was mine but the emotional expenses were tremendous' (Rachel, Kessler & McKenna, 1974).

There are similar, ambivalent feelings toward the ongoing changes; peaks of euphoria intersperse with troughs of forboding on consideration of the social implications of what s/he is doing; with possible familial ostracism, loss of rights, shrinking occupational horizons, and possible hostility and wariness from peers (or strangers) who, aware of the change, are unsure of how to relate to the individual.

'...people that I knew at a distance...were perhaps the most surprised and awkward...some of them became good friends and others just shook their heads and dropped out of my life's picture completely.' (Rachel, Kessler & McKenna, 1974).

Transsexuals typically consider the views of those treating them; 'Did they have any feelings about transsexuality one way or the other? Was I just one more patient to fit in

before lunch? Or another pervert wasting their valuable time and equipment... 'misguided homosexuals'? I was aware that such attitudes were not uncommon' (Wells, 1986). Transsexuals do not want to be as they are. They would give anything not to want to change sex, and to be able to accept themselves in the gender that nature allotted them. The fact that they are unable to do this causes them and their families untold suffering and anguish: 'I struggled on until I was 46, then I met an understanding doctor. I decided to make a permanent change on my fiftieth birthday...I just know what I should have been, but fate decreed that I was not' (FM transsexual, in Hodgkinson, 1987). The lead up to SRS represents the turning point in an anguished existence;

'The great day was getting closer. When it arrived at last, I felt perfectly calm, filled with the happiness of certainty. I felt no doubts, no regrets, no hesitation. This was...the final step in my transformation; the miracle I wanted more than anything else in the world' (Wells, 1986).

Hodgkinson (1987) likened April Ashley's description of her operation in Casablanca to that of a medieval torture:

'As the anaesthetic wore off, I became aware of the most hideous pain. It was unlike anything in my previous experience or, I suspect, in yours. It was as if branding irons were being vigorously applied to the middle part of my body. I screamed and a nurse came quickly with a pain-killing injection...My middle was grotesquely swollen and bound inches deep with bandages into which blood continuously spilt and congealed...On the fourth day the branding irons descended and sizzled across my body...The pain mounted and closed in on me...Occasionally my eyes lost focus and ceased to convey coherent information to my brain, and I would go into a semi-blind hysterical state...followed by unconsciousness...You're bruised and swollen. And yet you are pitifully grateful too. Elated, completed at last, a relief so all-embracing that you imagine nothing will ever hurt you again'.

#### Post-Transition ~~~~~

Initially, attainment of the goal may be followed by a period of self-imposed isolation; 'I felt like a recluse...I wanted to go out and meet people and have a good time. Before (the operation) I could hardly bear to leave the

house. After I came back, I wanted to start going out and have a social life and mix in public, and there I was, cooped up in the house with nothing to do" (Agnes, in Garfinkel, 1967). With increasing time since SRS, the transformed individual tastes, for the first time, the peaceful harmony of mind and body that others are fortunate in being able to take for granted:

'...my euphoria subsided to a manageable level, though the feeling of being reborn persisted. The world looked so much better now....I discovered that I could think more clearly and work far more productively...Sometimes I look back at that 'other person' I used to be...the real tragedy of the problem was that it had stifled so much of my potential. So ever present was it that it had claimed all my attention...So much time and effort had been wasted...'  
(Wells, 1986).

Once a transsexual always a transsexual?  
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The question as to whether there is an 'end state' following SRS, wherein the individual ceases psychologically to be transsexual and is complete, is an issue of debate. Stoller (1975) for example, argues that transsexuals can never forget the existential dilemma that they began life in the opposite sex:

'The perfection of their passing is the quality that dooms them never to have the relationship that the perfection should produce - an honest, open freedom instead of continuation of the risks and falsity of passing. There is a never-ending, desperate search for anatomic perfection, genital normality and normal sexual performance' (Stoller, 1975).

Steinbeck (1986), on the other hand, suggests that post-operative patients 'remain transsexuals to themselves, but at ease with their condition'. Steiner (1985) acknowledges that for some, 'encoded behaviour both mental and physical, is so strong that features of the primary biological sex persist as reminders of the past'. However, for others this is not so. Indeed, it is 'almost impossible for them to recreate the past and reconcile what they were before reassignment with their present state'. They clearly

prefer the new role to the perpetual conflict of the former state. Naturally, the individual can never forget the road they have traversed (quite apart from the necessary perpetual continuation of hormone administration). Wells (1986) considers how wonderful it would be to feel that she was just ordinary, like anybody else. 'To feel whole, integrated, and to be able to take this for granted, is almost too much for the transsexual individual to comprehend'. Physiologically, FM transsexual genital reconstruction is still very primitive, thus many albeit reluctantly, choose not to elect for phalloplasty, instead awaiting technological improvement of the procedure. For MF transsexuals in contrast (especially those whose anatomical build and proportions are particularly conducive to treatment), the physiological metamorphosis following SRS is remarkably realistic, such that a sense of completion is more plausible. The question of complete psychological transition however, is likely to depend on a number of variables: age at treatment onset; ease of social transition (e.g. continuing to live in the home-town / starting a 'new life' elsewhere); size of supportive social network; familial response; presence or absence of post-surgical complications etc.

Perhaps a more practical consideration would be that of the relative psychological 'costs and benefits', and quality of life between the pre-, and post-operative states. From his review of the literature, Pauly (1968) argued that transsexuals who underwent SRS were ten times more likely to have a satisfactory outcome, in terms of improved social and emotional adjustment than those denied surgery: 'There is no claim that the transsexual is free from emotional conflict, either before, or after the procedure, but in the majority

of instances, he is markedly improved' (sic) (Kuiper et al, 1988; Mate-Kole, 1979). Benjamin (1966) reports that to compare pre-, and post-operative patients 'is like comparing a dreary day of rain and mist with a beautiful spring morning or a funeral march with a victory song'. 'I've been told that I'm a more mellow human being than I was...I think that if I'd had the change earlier in life, at an age of greater emotional resilience, I'd have been able to un-cramp more of myself. As it is, a lot of the previous me remains. I still tend to look on, rather than join in - though now with a more concerned and empathic eye, a warmer regard...I am grateful - to all those whose patience, skill, and goodwill have helped to give me a second chance. Life looks pretty good to me now, and I suspect the best may be to come yet' (Wells, 1986). Garfinkel (1967) reports that with increasing time since SRS, his case-study Agnes' 'preoccupation with transsexualism was replaced by other interests and concerns': she was no longer intent on simply being seen as a woman, but more concerned with what kind of woman she should be. 'She had the kind of concerns that could be readily associated with any..."normal" female...She was succeeding in constructing a sense of "natural" femaleness, not only for others, but for herself as well' (Garfinkel, 1967). Similar feelings are demonstrated in the personal accounts of other post-operatives:

'I think of myself increasingly as a woman, all the time in fact. I also see myself as having been latent...I am "becoming"...I don't naturally identify myself as a transsexual'. If implicitly challenged on this by 'a very unliberated sceptic', her response would be; 'OK, then I am a transsexual in the process of becoming a woman...I am very happy. At times I wake up at night and remember that everything has been taken care of and smile to myself and roll over...not quite sure that I'm not for once...as good as you are.' (Rachel, Kessler & McKenna, 1974).

Michael Dillon (1962) the first, fully reassigned, post-operative male, wrote that since he was 15 years old,

he been seeking the truth, and felt that he had at last found it (Hodgkinson, 1987). On the other hand, many (particularly MF) post-operative individuals never achieve social acceptance. Many are lonely, have lost their jobs, and thus, income and status as well as relationships with family, partners, children and friends, and may be forced to move away from their familiar environment (Steiner, 1985; Hodgkinson, 1987). Furthermore, many have continuing emotional problems due to psychological factors (Steiner, 1985). Stoller (1975) suggests that such life situations seem to be the most important factor in the majority of suicide cases. This underlines the fact that the former internal private problem, now resolved, potentially takes on an 'externalized' social form for others who know of the individuals' history, and choose to perceive this as a problem.

'...Loneliness doesn't scare me, but it sickens me. I have a high regard for myself to the point that it seems almost a waste for me not to have someone to give to, share with, and to love...freedom can be very cold and lonely' (Rachel, Kessler & McKenna, 1974).

'I wasn't surprised that one or two of my friends, on learning of my change, regarded it with suspicion and distaste. None of my women friends was the least put out by it..It was only a few males who seemed to find it hard to accept me (though most did, with a heart-warming readiness). I tried to imagine their feelings...I had spent a lifetime thinking about it - for them it was totally unexpected. I was a 'turncoat' whom they needed time to reclassify and even, perhaps, to forgive...I felt the need to reassure them that I wasn't a danger to their children or planning to overthrow society' (Wells, 1986).

The post-operative individual often needs to exercise patience and tolerance when say, asked unintentionally impertinent personal questions. He or she is also often faced with the limitations of language when attempting to provide a satisfactory account of his/her experience for those who are simply naively curious:

'with each of them, after the first hesitant greeting (there was usually a good deal of apprehension on both sides), I

would try to be as matter of fact about it all as I could, and act as if nothing much had changed - at least not for the worse. There had simply been a correction, necessary but essentially harmless. Most of them were marvellous, and clearly relieved to find me quite presentable...with 'the person inside', whom they had known before, still there' (Wells, 1986).

Kando (1969) points out that the individual's adjustment to his or her double identity (e.g. former male vs. present female) and double social life typically takes one of three forms; Minimized contact with the outside world and retreat into the family, thereby eliminating the conflicting demands of family, and new friends; alternatively, the reverse process may be adopted (more often when the family rejects the individual); or the individual may have sharply segregated relationships with both groups, keeping the two groups strictly separated to avoid experiencing conflicting demands between them, and so reduce the need for continuous 'status passage' (and thus, a double gender identity) between situations in which s/he is known as a 'natural' (fe)male, and those in which s/he is known as a former (fe)male (Kando, 1969). Rachel (Kessler & McKenna, 1974), exemplifies the difficulty:

'I think perhaps there are slight differences in my behaviour with people who know me as a woman and those people who know me only as a transsexual. The differences come from my feeling more comfortable with myself and feeling more authentic when they don't know. When people know I'm transsexual, they monitor my authenticity and I am aware of it'.

Furthermore, the opportunity to relax the lifelong self-imposed monitoring is also, an immensely liberating relief, albeit difficult:

'All of my life I had trained myself not to say anything too spontaneously in case I inadvertently revealed my secret in some way - perhaps by an unmasculine (or unfeminine) phrase or observation that might be considered 'suspect'. Now I found that I needed to stop censoring whatever I wanted to say. I just let the phrases come out, and they sounded fine.' (Wells, 1986).

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CHAPTER SIX
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DISCUSSION

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Appraisal of Framework & Theoretical Resources

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The use of the middle-range theoretical framework put forward by Weigert et al (1986), has enabled crucial elements in the literature to be identified, summarized, organized and accommodated in a useful structure that has provided an advantageous view and better understanding of the phenomenon of transsexuality in relation to 'identity'. Consistencies that have begun to emerge in the present review demonstrate the value of having brought together material from very diverse areas of study - clinical, legal, social psychological etc. - which collectively have thrown light on gender dysphoria in general, and transsexuality in particular. Particular attention has been paid to the developmental nature of transsexualism - not only in terms of its course of change within the individual, but also in the way that the individual transsexual attempts to deal with the various problems, challenges and changes through time, that are peculiar to each of the various stages of change. In so doing, the focus has moved from the general to the particular. Beginning with a broad, macroanalysis, with a general appraisal of the origins and nature of everyday Western assumptions about gender identity and gender and the problems that are presented for these as regards the phenomenon of gender dysphoria; moving on to an institutional level of analysis of those gender identity issues relating to the medical and legal management of transsexualism as well as some of the resulting implications; and finally, a microanalysis of such issues as these impinge upon the situational context, and the

phenomenological experience of individual transsexuals themselves.

Main Points

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At the historical and cultural level of analysis, the basic problem has been shown to be that of the actual identification of gender dysphoric and/or transsexual individuals, and their conflation with 'lesser' forms of the disorder (such as homosexual-, or transvestitic persons). The historians' task of attempting to trace the origins of the phenomena of gender dysphoria and transsexualism is immediately complicated by the fact that concepts of 'transsexualism' and indeed of 'gender' and 'gender identity' (and thus, gender dysphoria) were unknown before the work of the nineteenth century sexologists. Modern technology for the treatment of the former was also not then available, thus, those who were so afflicted were unable to gain relief from their unfortunate situation. This, together with the frenzy of classificatory activity and debate that ensued after that time, and the associated tendency to confuse and conflate homosexual, transvestitic and gender dysphoric individuals, effectively created a bewildering morass of conflicting historical sources. The cross-cultural literature reveals similar problems, both as regards identifying who is, and who is not 'transsexual', as well as the absence of the technology to enable the procedures of modern management, and, in addition, the difficulty of drawing comparisons between vastly different cultural lifestyles. Nevertheless, this literature testifies to the widespread incidence of gender dysphoric behaviour, and permits the conclusion, albeit speculative, that there exist differential cultural responses to the phenomenon. These range from the acceptance and institutionalization of

specific, legitimate cultural roles for gender dysphoric individuals to society's failure to recognize, or general hostility towards those who challenge cultural gender norms. This in turn suggests the existence of differing assumptions underlying cultural realities, particularly as regards ideas about gender and its expression. The identity of gender dysphoric individuals thus would seem to change according to the cultural context. One is therefore left with the highly controversial and somewhat philosophical question as to whether, in those cultures that are not characterized by a natural attitude that supports notions of a strict gender dichotomy (that is then customarily mapped onto sexual dimorphic correlates) even if the technological necessary means were available, SRS as a recognized form of treatment would in fact, be necessary.

At the group and institutional level of analysis, with the availability of modern technological SRS procedure(s), and the medicalization of the 'transsexual', the main problem for the identity of transsexual individuals becomes one of diagnosis - this being the first hurdle to be overcome in the long process of gaining access to the means of bodily transformation - wherein, the legacy of the nineteenth century confusion over the classification of gender dysphoric individuals persists. The absence of definitive diagnostic tests, physiological markers, and a clear definition of the condition, mean that there is an essential lack of consensus on who shall, and who shall not be called a 'transsexual', whether there are discrete 'types' of the condition - if, indeed, this is recognized at all. Réverberations of this debate are evident in various different theoretical perspectives that surround the phenomenon, with regard to its aetiology, nature, eligible

canditure for treatment, and what the optimal form of treatment might be for such individuals.

Here in turn, the question of whether a request for SRS is rational, the possibility that psychiatric illness either causes or is symptomatic of the phenomenon, as well as whether somatic surgical intervention should be made available for the treatment of what is largely regarded as a psychological condition, throws up philosophical questions over who, essentially, 'owns' the body. It also presents ethical dilemmas among those physicians who are directly involved in performing SRS procedures which necessitate the destruction or removal of healthy tissue and organs, all of which bears upon the actual approach of medical workers toward transsexual patients in terms of a supportive, or hostile attitude both in the evaluation situation, and during the administration of treatment.

SRS itself, at one level, serves as the sole effective means of 'unifying' the psychology of the transsexual with his or her anatomy, albeit incurring potential risks of adverse physical and possible psychological side-effects, these being unknown due to the paucity of (much needed) follow-up studies. At another level, SRS once performed, replaces the pre-surgical problems of personal and social identity mis-match with post-surgical ones of personal and social identity congruence versus legal identity uncertainty. Indeed, the adherence by Western societies such as Britain and the United States to traditional, inflexible and unreasonable legislative jurisdiction in the face of radical changes brought about by technological innovation, means that transsexuals despite sometimes having lost all familial, social and/or occupational connections in order to

undergo traumatic surgery that transforms their appearance to that of the opposite sex nevertheless continue to be regarded as having the legal identity of a member of their natal sex.

Non-surgical forms of treatment that have been tried as alternatives to irreversible surgery while desirable in terms of preventing such problems both for society and transsexuals themselves have so far failed to show impressive results as regards achieving lasting (if any) improvement to the sex-gender identity dilemma, certainly of adult transsexuals. There may, however, be some scope for possibly reversing the condition as regards pre-transsexual children, and perhaps, adolescent transsexuals.

The situational level of analysis demonstrates how identity can be seen as a social product that imposes differential constraints upon the roles available to pre-operative transsexuals, the demands of which leave no scope for the legitimate expression of their cross-gender identity. The assumption that underlies the taken-for-granted ideas that are 'reality' within Western society, is that there is, between men and women a dimorphous set of fundamental gender differences, as regards the roles provided and behaviours perceived as 'masculine' or 'feminine', that are respectively expected of males and females. Such gender differences are treated as if they are 'naturally' mapped onto discrete sexual correlates, according to body-kinds. These expectations are accompanied by severe social sanctions against those individuals who fail to conform with such behavioural norms, perhaps by their families, the community, and/or wider social circles. The stigmatized individual thus incurs social disapproval and a withdrawal

of acceptance due to what is perceived by others as a lack of continuity in his or her identity (although, as with childhood cross-gender behaviour of 'sissies' and 'tomboys', it seems that femininity in males is less tolerated by society than is masculinity in females). This is experienced in terms of a lack of self-esteem coupled with a negative distinctiveness. All of which collectively constitutes a social and psychological threat to the identity of pre-operative transsexuals.

These individuals must therefore live a perpetual masquerade in the gender role deemed by their culture to be appropriate to their sex. More often however, they opt for engaging constantly in the practice of 'passing' as 'bona fide' members of the opposite sex. This involves attempting to 'conceal' the normally invisible insignia of their natal sex - their genitalia - by disguising the external symbols from which this is read; their secondary sexual characteristics, or 'cultural genitals', and by cross-dressing. Passing, if successful, thereby serves as a form of coping strategy through which the pre-operative transsexual may gain some 'illigitimate' licence to express his or her cross-gender behaviour. It is nevertheless, accompanied by a constant sense of a threat from the risk of exposure and loss of credibility. The practice, in that it requires constant vigilance in monitoring one's movements, gestures and expressions, as well as those of others, as well as denying spontaneity of speech through the need to first censor potential utterances, can itself be a source of chronic strain.

An additional form of coping strategy is the formation of groups or affiliation networks that may serve as sources of

support, information, counselling of and contact between members and their families, thereby providing the opportunity to share experiences, socialize and identify with others who are in the same circumstances. Such groups may alternatively, or in addition, seek publicity and public awareness, and/or campaign for political recognition, or perhaps change, in order to press for the rights of their members, and so diffuse or lessen the effects of threat.

Coping strategies may sometimes, however, fail. Group membership naturally, crucially depends upon the availability of a group which for transsexuals is often not the case, due to their limited relative numbers, and/or lack of access because of geographical distance. This would be expected to be the case, particularly for young transsexuals. In terms of passing, the post-operative individual's adjustment to the chosen gender role does not often come smoothly. This is largely a consequence of a previous history of being reared in the role of the now opposite anatomical sex, and hence being unpractised in the behaviours associated with, and lacking an appropriate biography for, the new role. Such circumstances may lead the individual to impose a state of self-isolation in order to avoid situations of interaction which does not remove, and may indeed, exacerbate, the detrimental effects on his or her identity or may result in suicide.

At the biographical level of analysis, the focus of attention switches to the individual transsexual's experience of the condition as a fundamental mismatch between anatomical sexual- and psychological gender identity. The conflict leads to the radical decision to embark on the transitional journey across the sexual divide.

It has been argued that those individuals who choose to take this road should be distinguished by three distinguishing referential terms rather than the singular term 'transsexual'. According to which of the three stages of change; pre-treatment, transitional, and post-treatment - that they are currently undergoing, these each bring a different set of problems for the individual's identity;

The long, traumatic pre-treatment period during which such individuals strive, usually in vain, to come to terms with their situation before finally, and in desperation, approaching the GP in search of help, is characterized by a succession of unhappy experiences. Initially, the pre-transsexual child's physical and mental activities tend to be retrospectively reported as having being overshadowed and marred by an essential sense of 'wrongness', together with a feeling that the way in which he or she is expected to behave and dress is at odds with, and wholly alien to the child's gender identity. This frequently results in the existence of mutual antagonism and tension between the child and his or her family through the latter's thwarted attempts at making the child conform to expectations. Frustration and depression of the pre-transsexual individual heightens with the passing years, and in late adolescence can often lead to a last desperate attempt by the young MF transsexuals, in particular, to force the conformity of gender to sexual identity by means of a self-imposed 'flight into masculinity', wherein stereotypically male occupations or activities may be earnestly taken up. The failure of such strategies is, however, invariably inevitable whereupon the individual falls back upon the last remaining hope - that of surgical intervention.

During the pre-requisite term of cross-living in the desired gender role prior to treatment where it is necessary to engage in consistent passing, change (all modifiable) identification documents to reflect the new identity, and obtain employment in the chosen gender role, a minority of (invariably, younger) transsexuals may find the difficulties of the task too much, and decide against the transsexual path towards ultimate, irreversible surgical conversion. Others will be denied access to SRS on grounds of psychological or physical unsuitability (or in some circumstances lack of the necessary financial means), and so instead, necessarily but reluctantly, commit themselves to accepting their situation and continue in their 'limbo' existence, cross-living full-time with their anatomy unchanged, or perhaps receiving moderate hormone administration which provides some emotional relief.

For the more successful, the transitional stage (during which as a result of exogenous hormone effects, relatively radical and dramatic somatic changes take place) is a time that necessitates rapid psychological adjustment to such bodily change, and with this the changed social responses to the individual. In addition, the changes while welcomed may be coupled by some soul-searching self-doubt about the decision to proceed and its implications in a trade-off between these, and a sense of ultimate peace. These implications include possible risks of losing familial acceptance/support, acquaintances, occupation and thus, income. SRS, when this eventually takes place, represents the culmination of the transitional process; the means by which the individual's anatomic sex (sexual identity) is finally united with his or her psychological sex (gender identity). The procedure is, however, fraught with risks of

surgical complications and a potentially unsatisfactory outcome (in the aesthetic and/or perhaps, functional sense).

Efforts toward discovering some alternative, non-surgical means of achieving gender and sexual identity compatibility have been many and varied. So far, however, results have been disappointing, except for some cases where it seems that, often, the younger the individual (and/or where the transsexual conviction is not 'too strong'), potential there is for change - but not always. Nevertheless, these alternatives await satisfactory and properly controlled longitudinal studies on a sufficient number of individuals before any potential psychological improvements (and possible dangers) can be adequately assessed. This remains the case for SRS itself before it is routinely employed.

Referring to the aftermath of surgical conversion as the 'post-treatment' stage is something of a misnomer, since treatment, in hormonal terms, must necessarily continue for the rest of these individuals lives. However, given this proviso, the issue in terms of identity rather than the procedure(s) of SRS itself (which tends to be sensationalized by the popular press, and upon which most public attention is focussed), essentially concerns whether or not the post-operative individual actually ceases to be 'transsexual'.

From the reports reviewed it would seem that views on this issue are mixed, and it is therefore impossible to draw a general conclusion. However, some tentative suggestions can perhaps be made in terms of social identity.

On the one hand, the inner psychological and external anatomical conflict between psychology and anatomy has been at least relieved, and the individual successfully and

effectively functions anonymously as 'just another member of society' in the chosen gender role. This is in marked contrast to the individual's past, when the failure to meet with social expectations of behaviours considered appropriate to the gender role associated with the individual's natal sex, caused him or her to suffer derision, hostility and social disapproval. One might therefore conclude a qualified 'yes'.

On the other hand, a failure to be accepted both in the former and the new gender status either through an inability to accommodate to either role or because of social contacts who refuse to believe in the new identity, and the possibility of prolonged post-surgical complications, suggests that the answer would be 'no'.

In respect of personal (psychological) identity, it might be reasoned that, since SRS procedures effect only physical, not psychological changes, any prior personality disorders - whether caused by, or effects of transsexuality - would be expected to remain. However, the fact that for many cases, removal of the anatomical problem dramatically improves the individual's psychological disposition, strongly suggests that the condition is both psychological and somatic (although the precise relationship between the two in terms of possible cause and effect is, as yet, unclear). Further relief would be expected from the reduced necessity to continually self-monitor, so as to avoid drawing attention to gender-discordant behaviours and utterances (although there might be a negative relationship between the ease with which this practice could be relaxed, and age at onset of treatment). In addition, and apart from these considerations, the very fact of having once been, and lived a substantial part of life as, a member of the opposite

anatomical sex, and of then having travelled the extraordinary road across the gender divide is unlikely to be erased from memory within the individual's lifetime. Furthermore, the requirement by law that the individual should continue to be recorded in the birth register as having membership of the now opposite anatomical sex (which at present, cannot be amended), causes unnecessary hardship to the individual's psychological and social well-being.

Rather than considering the question of 'non-', or 'ex-transsexuality' in terms of an inflexible, strict criterion that requires a complete, holistic transformation, one might instead more usefully address the question of the quality of the post-surgical individual's life relative to that prior to SRS. When this is done, the general finding tends to be towards a greater sense of psychological peace and tranquility, and a more productive contribution to society by the individual with elapsed time since SRS.

#### Overall Points ~~~~~

Each respective level considered in the present framework has revealed some salient issues pertaining to the notion of identity in relation to the phenomenon of transsexualism. Transsexualism cannot be analysed comprehensively simply in terms of any one particular level alone. Rather, this multi-faceted phenomenon has many aspects, relating to various levels of analysis, all of which crucially pertain to issues of identity. At the same time, each level considered suggests that the notion of 'identity' itself can have various meanings, both socially and psychologically.

The resources employed in the present review, particularly the gender terminology and the theoretical framework, have therefore provided a useful view of the notion of 'identity'

as applied to the phenomenon of transsexuality. In addition, they suggest that philosophical consideration of the phenomenon might throw up a completely new set of questions as regards the psychologic-somatic relationship. The present study has shown that 'identity' is a multi-dimensional entity which can only be adequately approached in the round, from the vantage point of the four differential levels. Each of these carries a different meaning of the notion of 'identity', which, in turn, carry different implications for the individual's sense of personal and social self.

#### Future Research

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As regards SRS, the present review has revealed important gaps in the literature. It is not really possible to achieve full understanding of the nature of SRS and its effects upon the transsexual identity until sufficient consideration has been given to the whole essence of the phenomenon today, the individual's sense of identity development, yet maintaining continuity through the process of change and the experiential realization of the transsexual's central desire. Such literature that already exists, deals only in a small way with autobiographical material. Furthermore, such accounts are essentially retrospective, the individuals concerned having already undergone the process of transition. There is a deficit of information on the process as an ongoing experience, incorporating the three stages as a whole, and upon issues such as; potential effects of age at onset of treatment upon adjustment to the chosen gender role; effects upon self-perception and self-esteem with each successive stage; effects of the transitional process upon both the individual and his or her social and familial experiences,

A great deal has been written on the experience of MF transsexuals with whom the literature primarily deals (including that reviewed in the present thesis). This has been partially due to the (often explicit) general assumption that the experience of transsexuality is identical for members of either natal sex (both MF and FM transsexuals), who albeit travelling in opposite transitional directions are seen as sharing the same essential experiences. However, these two groups, although both referred to as 'transsexual' can be argued to differ radically with respect to the process of transitional change. Perhaps the most important of such differences is the irony that for FM transsexuals (due to absence of the necessary technology, the conversion process) specifically in terms of genital reconstruction (phalloplasty), is not 'complete' in the same sense that it is for MF transsexuals. Given this fact alone, the FM transsexual's search for the harmonization between psychological and anatomical sex cannot be fully realized. Thus, one might legitimately presume that knowledge of this fact would cause these individuals to view their transition somewhat differently to their MF counterparts, in that for them there would still be a sense of remaining in 'limbo'. As such, the stages might require somewhat differential coping strategies.

A second line of departure between the two groups concerns their relative degree of heterogeneity: FM transsexuals have been suggested to manifest a more stable psychological profile than MF transsexuals. This factor, as well as the relative underdevelopment of FM SRS procedures, would be expected to have different implications for FM transsexuals' individual appraisals of the conversion process as a whole, as well the psychological effects upon them of this process.

Limitations of the Present Review

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In the interests of scientific objectivity, a detached treatment of the material reviewed in the present study could be expected from a disinterested author, but might be argued to be extremely difficult, if not impossible, when attempted by an individual so closely involved with the phenomenon of interest. For example, the present author might be accused of a certain degree of bias in discussing issues such as, say, the nature of the transsexual's dilemma in the pre-operative stage, and the way in which this is characterized, or perhaps, in discussing the difficulties of passing for the pre-operative transsexual. In terms of objectivity, it could however, be argued that without inside knowledge of such circumstances there would be too great a distance between the vantage point of the outside reviewer and the important issues that directly bear on transsexuality and identity. Furthermore, the utilization of an integrative framework with which to structure the material, in addition to drawing upon a wide range of sources that go beyond the immediate experience of the phenomenon of transsexuality, has facilitated the author's concern to avoid personal bias. At the same time, the approach of the present study can be criticized for certain limitations. The imposition of the four levels of analysis has meant that there was a consequent lack of depth in dealing with areas relating to gender dysphoria syndrome, such as aetiology post-surgical quality of life, and its psychological effects; and partnerships. However, it could also be argued that such areas are not directly pertinent to the phenomenon as regards issues of identity, nor do they affect the salient points that emerged at each respective level of analysis.

Policies Arising from the Present Review  
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As regards the present review, the points raised suggest a number of policies the adoption of which should help to ease problematic issues of identity in relation to the transsexual phenomenon;

i) Efforts should be focussed on establishing a generally agreed diagnostic criterion both for MF and FM transsexuals, although more research may be required before this is possible. Clear guidelines should also be developed that would facilitate properly controlled, randomized follow-up studies of post-operative and non-surgically treated transsexuals, in order to measure the degree of social and psychological improvement as a function of treatment, and to compare and contrast the respective costs and benefits of various treatment regimes.

ii) Legislation should be implemented that would both reflect and recognize the post-operative gender status of both FM-, and MF transsexuals alike, in order to grant these individuals the rights and legal identity of the chosen sex. Since the legal profession looks to and takes its lead from the medical profession, once a satisfactory diagnostic criterion is established it might be expected that legislative ruling in respect of a legal post-operative sexual identity would follow.

iii) More public and professional information should be distributed on the phenomenon of gender dysphoria and transsexualism, both to help dispel confusion and/or ignorance and so help to reform prejudicial and hostile attitudes where these exist toward transsexual individuals such that they may be allowed to fully participate in society

without suffering social and psychological hardship.

iv) Greater efforts should be made to develop the necessary technology in order to enable FM transsexuals to acquire a comparable degree of physical conversion to that of their MF counterparts, such that a satisfactory sense of completion is afforded to them.

v) Perhaps in the more immediate term, more resources could be directed towards providing a welfare and counselling service for transsexuals and their families, in order to provide support and so ease adjustment, either in respect of the three transitional stages (where SRS is involved), and/or in dealing with life situations that pose a threat to the identity of the individual.

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