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The Border Area Between Transvestism and Gender Dysphoria: Transvestitic Applicants for Sex Reassignment

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Clinical variants among the population of applicants for sex reassignment have been previously categorized. These coherent entities were introduced in an effort to sharpen the clinical presentation of syndromic diversity as well as to enhance the specificity of prognosis and outcome. The description of the so-called younger and aging transvestite has been further investigated. Although the initial group of reported transvestitic patients was small, it was suggested that these individuals constituted a coherent group definable in terms of demographic variables, past history, current crises, psychodynamics, clinical course, and special risks. This investigation presents a supplementary series of aging and younger transvestites who have applied for sexual reassignment. Since the original report, further elucidation of the characteristics of both groups have emerged. The theoretical implications of these categories have become clearer. The data support the original content of the classification as an aid to evaluation, prognosis, and treatment.

KEY WORDS: transsexualism; gender dysphoria; transvestism; sexual identity.

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INTRODUCTION

Confusion surrounds the assessment, diagnosis, prognosis, and management of individuals requesting sex-reassignment surgery. The existing uncertainty is related to the dramatic nature of the patient's request, the variability of clinical presentation over time, and the difficulties inherent in controlled studies where adequate control would require random assignment to surgical ablation of genitalia (Meyer, 1979). Compounding the difficult is the fact that there is little agreement on the fundamental issue of etiology.

Views on the categorization of applicants for sex reassignment widely differ: Stoller and his associates have adopted a "bipolar" viewpoint, partitioning male applicants for sex reassignment into "transsexuals" proper and "nontranssexual men who seek sex reassignment" (Stoller, 1975; Newman and Stoller, 1973).

Transsexuals, Stoller believes, are the most feminine males who have never developed any sense of masculinity, even in rudimentary form. Stoller suggests that such men never experience Oedipal conflicts, since there is no scaffolding of masculinity on which to erect such a structure (Stoller, 1975). He feels,

however, that nontranssexual men demonstrate some masculine identification and conflict.

Meyer has adopted a "continuum" perspective, viewing applicants for sex reassignment as having in common fundamentally similar problems in gender identity although of greater or lesser severity (Meyer, 1974, 1975, 1977, 1978). He emphasizes the common features of gender dysphoria among applicants for sex reassignment but recognizes the clinical diversity by systematically subtyping the stable variations in the common gender dysphoric theme (Meyer, 1974). Meyer and his associates feel that a continuum approach has more clinical validity, since the applicants for sex reassignment present along a continuum, the clinician ordinarily being confronted with shades of gray, rather than a dichotomy. Clinical management is facilitated by a recognition of those features which distinguish a given subgroup of applicants for sex reassignment, without losing track of the fact that the given subgroup of patients share features in common with other gender dysphorics which distinguish them in certain ways from the paraphilias, those with other character disorders, and the psychotics.

Among the clinical subtypes reported in 1974 were the "self-stigmatized" homosexuals, the "schizoid" group, the "polymorphous perverse," and the "sadomasochistic." Among the clinical variants reported in 1971, the "younger transvestites" and the "aging transvestites" are of particular interest in this report. This group is of importance theoretically since they illustrate the bridge between gender dysphoria and transvestism. They are of importance clinically because the dynamics of their request for sex reassignment, their clinical course, and their management are particularly distinct.

"Aging transvestite" individuals are in middle age in contradistinction to the young adults who constitute the majority of individuals with gender dysphoria. There was a striking coexistence of extreme masculine behavior along with their feminine wishes. They were generally married and usually had sired children. These individuals were not ego-syntonic transvestites who openly acknowledged and embraced their practices, but were largely guiltridden crossdressers. At the periods of request for sex reassignment, crossdressing had lost its capacity for sexual arousal; instead, the patients spoke of being more comfortable while "dressed." They were often depressed to suicidal levels and presented with anxiety to the point of depersonalization. The request for sexual reassignment was dramatic in view of the serious mood disorder. They often viewed surgery as an alternative to suicide or selfcastration. Two patients in the original group had performed autocastration prior to any medical contact. These individuals saw reassignment as a means of relief from an internal struggle.

In addition to the "aging transvestites," a "younger transvestite" clinical variant was also described. These individuals more frequently had homosexual experiences than the "aging group," even though two of the initial cohort of three were married. Surgery seemed to be a means of expressing passive longings toward men, as well as escaping from the "perversity" of erotic crossdressing. Because of the small size of the originally reported cohort, it was particularly important that additional cases be examined to validate, amplify, or amend those observations.

LITERATURE REVIEW

Reports of men whose eroticism is related to wearing women's clothing and/or who request sex reassignment are found in both psychiatric and psychoanalytic literature. Reports of the two conditions found in one individual, however, are notably more scarce than of the two conditions as separate phenomena. Buhrich (1977) has reviewed the role of transvestism in history. Psychiatric phenomenologists have focused on transsexualism over the past two decades since Caldwell coined this term and Benjamin popularized it (Caldwell, 1949; Benjamin, 1953). Money has emphasized a longstanding sense of neutral cross-sexualism as the essential characteristic of the transsexual (Money and Primrose, 1968). Some investigators have viewed the wish for sexual reassignment as a condition with strong biological determinants (Jones and Saminy, 1973).

The psychoanalytic literature discusses erotic crossdressing in relation to the theory of perversions. For the most part, attempts have been made to account for the transvestitic symptom choice, with only secondary reference, if any, to wishes for sexual reassignment (Bak, 1968). Greenacre (1968) feels that transvestism, as well as fetishism, is developmentally related to early disturbance in mother-infant relationships with subsequent faulty object relations. She hypothesizes that identification with the phallic mother is, in part, the genesis of this behavior. Socarides (1969) also considered the wish to appear as a woman to be a disturbance of very early life.

In the literature linking transvestism and transsexualism together, Lukianowicz (1959) feels transsexualism and transvestism are on a continuum differing only in the degree of desire to alter one's sexual anatomy. Buhrich and McConaghy (1977) have attempted to systematically factor out clinical descriptors of applicants for sex reassignment in an attempt to partition them from transvestites. They have found that transsexuals more frequently attempt to crossdress in public, to pass as the opposite sex, to have a greater conviction that they feel like the opposite sex, to have fewer heterosexual experiences, and to more commonly have homosexual experiences. Additionally, transvestites rarely reported sitting down to urinate whereas males who considered themselves transsexual generally did. Furthermore, the transvestite group showed significantly more penile erection to heterosexual films than did the transsexual group.

Recently investigators have attempted to better categorize gender dysphoric individuals who wish sex reassignment. Bentler (1976) empirically subgrouped 42 male-to-female transsexuals by behavioral characteristics. He found marked differences in homosexual experiences, orientation, and heterosexual interests. This concurs with other investigators who have described categories of applicants as heterosexual crossdressers, effeminate homosexuals, and asexual transsexuals.

From a more dynamic perspective, Stoller (1971) considers the relationship among transvestism, transsexualism, and gender dysphoria. As previously noted, he contrasts the clinical and dynamic characteristics of "fetishistic" crossdressers with individuals whom he feels present with "true" transsexualism. Meyer, however, has emphasized the close develop mental and dynamic relationship between the paraphilias and the gender identity disorders, seeing them as more similar than different (Meyer, in press: Meyer and Dupkin, in press).

The ambiguity in the descriptive and dynamic literature may be partially resolved by the recognition of the intragroup consistency of the transvestitic clinical variants and their intergroup variations. Careful inspection of transvestites who become gender dysphoric clarifies reports such as Newman and Stoller's on nontranssexual men who seek sexual reassignment (Newman and Stoller, 1973). Buhrich's (1976) recent discussion on whether fetishistic behavior can occur in transsexuals is also coherently understood if one views their subjects as aging transvestites who have previously been fetishistic crossdressers. Other reports such as Barr et al.'s (1974) study of apparent heterosexuality of two transsexuals is understood if this diagnostic framework is adopted. Finally, the psychotic process, which Golosow and Weitzman (1968) described in an individual who was labeled a transsexual, becomes explicable if one recognizes that psychotic regression may occur in an aging transvestite. These cases describe the regression of fetishistic crossdressers, a transvestite who seeks sexual reassignment due to gender dysphoria. They document regressive behavior, not the spontaneous occurrence of "transsexualism."

METHOD

The methodology utilized in this study is that of retrospective case review. Since the Sexual Behaviors Consultation Unit (SBCU) was organized in 1971, 403 individuals have applied for sex reassignment. Sixty percent of these (241 individuals) were biological males. Each of these patients was diagnosed as one of the reported clinical variants (Meyer, 1974). Whenever present, psychiatric conditions were noted utilizing DSM II criteria. Since the initial report in 1974, 17 additional individuals were diagnosed as aging or younger transvestites. Three patients with transvestitic and gender dysphoric elements, but who do not meet

diagnostic criteria, are reviewed by way of contrast. The criteria for diagnosing an individual as a transvestite who becomes gender dysphoric include the following:

1. Application for surgical sex reassignment.
2. Evidence for longstanding crossdressing wishes and desires.
3. A longstanding history, which may or may not extend to the present, of arousal when crossdressed.
4. Absence of psychosis or manic-depressive illness.
5. A longstanding history of active masculine pursuits vocationally, sexually, and otherwise in the past which usually stands in stark contrast to secret feminine longings.
6. Clear exclusion of other clinical variants. **CLINICAL MATERIAL** Among the 20 patients diagnosed as aging transvestites, three individuals had clear psychotic illnesses which antedated their gender dysphoria. Thus the request for sexual reassignment may have arisen from their psychotic states. A brief vignette of one of these patients is outlined below:

   The patient presented at the Sexual Behaviors Consultation Unit requesting sexual reassignment. He had begun to wear his mother's undergarments, with arousal, during his lonely adolescence. Beginning at 12 he frequently drank his ejaculate while crossdressed and at 18 had one homosexual episode. In young adulthood, he married, had regular heterosexual activity, and episodically crossdressed with erotic arousal. One year prior to consultation the patient was hospitalized with what was diagnosed as a manic depressive psychosis. In the year since hospitalization, the patient was described as slightly euphoric. When interviewed, he presented with a slightly elevated mood and was dressed as a male. His request for reassignment procedures was poorly organized. During consultation he requested breast augmentation only. He gave a history of compulsive masturbation, hyperactivity, and crossdressing only at home.

Table I. Transvestism and Major Mental Illness with Associated Requests for Reassignment Procedures

Patient	Age	Marital status	Number of children	Occupation	Psychiatric diagnosis	Stresses
A	35	Married	5	Electronic technician	Acute psychotic episode	Not clear
B	45	Separated	3	Accountant	Manic depressive	Extra-marital affair
C	34	Married	2	Machinist	Manic depressive	Not clear

The patients represented in Table I including the individual outlined in the illustrative clinical vignette do not qualify for the diagnosis of either aging" or "younger" transvestite. In each instance, their transvestism, although longstanding, was bizarre or fragmentary. The request for sex reassignment was similarly poorly organized, fragmentary, or bizarre and seemed clearly a product of the psychotic interlude. The psychotic illness appeared to be of insidious onset, and immediate life stresses were not always readily identified. In such situations, prompt attention must be directed to the underlying psychiatric illness, with consideration of rehospitalization, if needed.

Seventeen patients were considered to have one of the two clinical syndromes characteristic of transvestism associated with gender dysphoria. They fell naturally into two groups on the basis of age, characteristic prehistory, and clinical course. Ten of the individuals were classifiable as "younger" transvestites, thereby materially expanding on the original cohort of 3, and the remaining 7 were "aging" transvestites. In terms of age, statistical analysis revealed a significant difference between the mean age of 35.9 for the younger group and 51.1 for their older subset ($t = 4.825$, $df = 15$, $P < 0.001$). There was no significant difference in terms

of socioeconomic status or number of children.

The ten younger transvestites had all been married, although two were separated. Five had children. Their occupations were generally of the type considered masculine; although one was a nurse, he functioned as an administrator. Concurrent psychiatric illnesses were primarily affective disorders. Although information about erotic crossdressing was not sufficiently accurate or confirmable to submit to statistical analysis, the patients reported longstanding and well-organized, primarily covert "dressing" going back to early adolescence or latency. The uniform request was for sexual reassignment because of unhappiness with their maleness and a wish to be female. Although great dependence on wives and other important people seemed evident, the relationships were characterized by isolation, intellectualization, and hollowness. As a group they often displayed histrionic, dramatic characteristics. They were also quite narcissistic. An illustrative clinical vignette is presented below:

The patient was initially seen in the SBCU requesting sexual reassignment. The patient had been married for 9 years and had a son 5 years old. He was the middle of two children. His father was a hard-working, often absent individual. His mother, who was perceived as depressed during his early life, occasionally dressed him in curls and allowed him to wear lipstick. She was remembered as proud of him for being such a "cute young man." Crossdressing began at age 6 following the birth of a sister who received much attention. Thereafter, crossdressing was pursued episodically throughout life. Heterosexual activity began at 14 and there was no evidence of any homosexual behavior or fantasy. He served in the Army 2 years without difficulty and had a successful business career in a "masculine" field. Crossdressing became increasingly frequent following the birth of his son. As his son became more active and Oedipally competitive, the patient concurrently found crossdressing of increasing pleasure although without overt erotic excitement. It was during this time that he began to feel "truly" himself when crossdressed. A year prior to the consultation, when his son was 4, he noted markedly increased libido and increased masturbation frequency. He also initiated an extramarital affair and separated from his wife for a few weeks. During the separation he occasionally crossdressed. After a trial reconciliation with his wife he felt that he would no longer remain married because of his wish to undergo sex conversion and be female himself. He then divorced his wife, noting increased wishes to become a woman on the heels of the separation. He entered psychotherapy but crossdressed even more frequently. He ultimately came to living and working as a female, being quite successful in his own business. He changed his name and underwent breast augmentation. There were no relationships with men, however. The patient's wife subsequently remarried and moved with the child to a distant city. Following this, his ardor for sexual reassignment abated. He returned to the male role, and abandoned plans for further surgery. During the clinic visits, the patient spoke words indicating an attachment to wife and son, but they seemed devoid of feeling. He was narcissistically quite preoccupied with himself, including his appearance, the impression he was making, etc. It is worth noting that there was no evidence of grief, sadness, or lowered mood!

Table II. "Younger" Transvestites:
A Clinical Variant of Gender Dysphoria

Patient	Age	Marital status	Number of children	Occupation	Psychiatric diagnosis	Stresses
D	38	Separated	4	Taxicab driver	Neurotic depression	65-Wife leaving; argument with father
E	37	Married	1	Mechanic	Neurotic depression	29-Work stress,

					increased responsi-bility with pro-motion	
F	30	Separated	2	Insurance agent	None Oedipal -aged son; intimacy with wife	44 -
G	38	Married	2	Systems analyst	Neurotic depression	44 - Oedipal-aged son
H	49	Married	0	Nurse	Schizoid character disorder	50 - Mar-riage; pressure to have a child
I	35	Married	2	Computer programmer	None	44 - Oedipal-age son; intimacy of mar-riage
J	33	Married	0	Policeman	Neurotic depression	100 - First wife died 3 yr ago; present marital problem
K	32	Married	0	Computer programmer	Neurotic depression	40 - Wife preg-nant; hernia surgery
L	33	Married	0	Salesman	Neurotic depression	35 - Marital pressure for intimacy
M	34	Married	0	Program analyst	Neurotic	35 - Marital stress; depress-ion wife's recovery

The patient recalled his mother, a depressed, lonely, and angry woman, as having cultivated his curls and being proud of his cuteness. Unfortunately, there was no access to material which would allow us to verify these reported memories. Verification is important in such instances because of the tendency to project fantasies retrospectively to form screen memories rather than actual recollections. It seemed clear, nonetheless, that crossdressing did begin with the birth of the sib at a time when the patient might have been expected to be going through the very difficult competitive and rivalous (Oedipal) phase that characterizes transvestitic patients.

It was clear later that crossdressing increased in frequency with its driven quality during the pregnancy of his wife and following the birth of his son. This is a common enough finding, generally, in the paraphilias (Meyer, 1979), but in this case the progression is typical for the younger transvestites who are vulnerable to decompensation into gender dysphoria. There was a flurry of erotic crossdressing, driven hypermasculine behavior (an affair, elevated masturbation rates), and finally separation and the request for sex reassignment.

In our experience the birth of the child and the child's passage through critical developmental stages reactivate the patient's own childhood, generative struggles. In those transvestites vulnerable to gender dysphoric decompensation, the collapse usually comes as the child enters the Oedipal phase. In the patient's recapitulation of his earlier conflicts he abandons his aggressive masculinity, separates from his mother-surrogate (his wife), and repairs his loss by becoming a woman himself. In the clinical vignette, once the sources of conflict were removed, sex reassignment was no longer necessary. Among the "aging transvestites," all individuals had been married previously but at the time of request only three of the seven were married. They all had "masculine" to "hypermasculine" occupations. Their concurrent psychiatric illnesses were primarily affective disorders. The following is a clinical vignette which illustrates the clinical course of such patients:

The patient was initially seen in the SBCU requesting sex reassignment. His career had been in one of the military services. He had recently begun to wear feminine apparel in public and remarked on the constant daydreams of himself as a woman, but denied any fantasies of intercourse with men. The patient was married and having intercourse (without crossdressing) at the time of the request for reassignment. His three children, ages 14 to 21, had no history of sexual deviance. The patient was the fifth of twelve children but described a lonely childhood. He began trying on his sister's underwear at 8 and episodically masturbated while dressed. He pursued a successful career in the military but retired after a myocardial infarction. Following his illness and retirement, he noted an increase in wishes to crossdress. His wife tolerated his crossdressing at home as long as his three children or the neighbors were kept unaware of his secret. When examined, the patient was dressed as a male but was wearing panties. He had no suicidal or autocastration ideation. There was no evidence of a depressed mood, but he was preoccupied with the notion of sexual reassignment.

This patient's wish for sex-reassignment surgery began after two major losses, his retirement and serious illness. His premorbid history shows clear masculine identifications with episodic eroticized crossdressing. Furthermore, his wife appeared comfortable with his perversion as long as it was controlled. She is similar to the "succorer" style of women who accept transvestitic behavior in their partners because of their anger toward competent mates (Stoller, 1967).

Although the patient had several children, there was no history of the degree of crisis around conceptions, pregnancy, childbirth, and early childhood development that characterizes the younger transvestites. Similarly, there is no history suggesting the onset of crossdressing in relation to sibling birth or more dramatic conflicts. It seemed to have had a rather quiet, autogenous onset in midlatency.

Table III. "Aging" Transvestites:
A Clinical Variant of Gender Dysphoria

Patient	Age	Marital status	Number of children	Occupation	Psychiatric diagnosis	Stresses
N	52	Married	3	Accountant Business college	Neurotic depression	Illness (carcinoma)

O	49	Divorced	2	Steel worker	Alcoholism		Job loss; High school
P	48	Separated	6	Machinist	Neurotic depression	38 - Mone-tary prob-lems; father's Illness	
Q	66	Separated	2	Clerk	Neurotic depression	52 - Illness (carci-noma)	
R	45	Married	3	Retired Army officer Store manager	None	53 - Career retire-ment; illness (myo-cardial infarc-tion)	
S	52	Married	2	Business executive	Neurotic depression	S3 - Illness (myo-cardial infarc-tion); son's death	
T	46	Separated	0	Naval officer	Neurotic depression	Separ-ation from wife; retire-ment pending	

DISCUSSION

The nature and quantity of life stresses which are effective in producing gender dysphoric decompensation in vulnerable transvestites represent one factor which appears important. Quantitative estimation of the major stressors in the 2 years prior to request for sexual reassignment was done by computing the number of life change units utilizing the Social Readjustment Rating Scale (Holmes and Rahe, 1967). No significant difference in quantitative life stressors between the two subsets appeared. On the other hand, the two groups, "younger" and "aging," differed markedly in the kind of stresses identified as contemporaneous with the request for sex reassignment. The younger transvestites were more often involved in overtly conflictual marriages. Their wife's insistence on intimacy appeared to be a factor in three of the cases. In one case, the patient was being pressured by his wife's insistence that he father a child. Three patients had Oedipal-age sons who were troublesome to them. Losses were present in only one patient who was recently separated from his wife.

In the "aging" group, illness and physical loss, as well as separation, were common to each member of the sample. Illnesses varied from myocardial infarction (two patients) to neoplastic disease (two patients). The

illness of a parent or retirement was also a stressor. Although all of the aging transvestites except one had children, there was no history obtained of the same kind of cataclysmic reaction to their children that was true of the younger group. Whether more careful histories will reveal such episodes is a question for future clinical inquiry. It is also not clear whether the younger transvestites, as they age, will show vulnerability to the stresses characteristic of the aging group.

This is an important issue. While it is clear that parentage and children on the one hand and illness and retirement on the other are age-dependent stressors, the absence (so far) of a history of reaction to pregnancy, birth, and development among the aging group suggests that the two groups are differentially vulnerable to certain stresses. This, in turn, suggests that the two groups are dynamically and etiologically somewhat different. This is by way of contrast to the notion that they may be the same group merely at different stages of the life cycle and, therefore, vulnerable to the different stresses that characterize their different ages.

Along the lines of the two-population hypothesis is the suggestion that overt symptomatology in the "younger" group may start at an earlier age be related to sibling birth, and be more flamboyant. It is certainly true that for both groups their sexual histories included use of feminine garments for sexual excitement.

The family constellations varied. What emerged, however, was a picture of a father who was distant or absent and a hovering mother who was basically lonely. Maternal attitudes toward the fathers were often hostile or indifferent. The patients were utilized to make up for the maternal loneliness. The mothers clearly formed symbiotic relationships with the patients.

The histories of aging and younger groups revealed no early unhappiness with their assigned sex or the classical stigmata of the reconstructed childhood "transsexual" history. They did not play "girlish" games or give histories of wishing or asserting that they were girls. Rather, evidence of feminine identification was found in their early, and continuing, attachment to women's garments (Meyer, 1979). Similar evidence of feminine identification is, of course, found in other transvestites, including the bulk of such men who, while they almost universally have episodes of yearning to be female, do not endorse the wish with action even under situations of extraordinary stress. The vulnerability or the need of those transvestites who are basically gender dysphoric to make concrete their feminine identification theoretically bespeaks earlier and more continuous trauma in their relationships with early figures, more primitive defenses, harsher selfcriticism, and more poorly sublimated urges. (See Meyer, 1979, and Meyer and Dupkin, 1979, for more detailed theoretical treatment of such issues.)

None of the seven aging transvestites had homosexual experiences, although seven of ten in the younger group had such relationships. However, none of the 17 individuals had homosexual fantasies during any form of sexual activity. The fact that the "younger" transvestites had homosexual experiences whereas the "aging" did not may be related to the propensity of the former to decompensate in relation to their sons. The younger group seems more able to form narcissistic identifications with other males (as in homosexuality), living vicariously through them. We propose that they similarly identify with their sons. When the sons, quite naturally, become aggressive and competitive, their own conflicts are vividly reexperienced. The "aging" transvestites are more self-involved and do not form similar identifications with other men or their sons. Their world collapses when they are no longer able to maintain the hypermasculine side of their personality (because of illness, infirmity, retirement, or loss of prestige) as a counterbalance to their feminine side.

It is our impression that it is most useful to regard the "younger" and aging" transvestites as having a borderline personality organization (Kinderberg, 1967, 1970, 1975). Their masculine and feminine identifications and self-images are kept split, as are, respectively, their aggressive and loving urges. They

are not psychotic even in the gender-decompensated state since there is no falsification of physical or external reality. It is not an example of multiple personalities since there are always both the masculine and feminine sides, even when one is dominant. This pathological result is compatible with the type of long-range consequence of profoundly disturbed early relationships described by Kernberg (1966). We believe from our clinical experience that the transvestism has served a function of symbolically expressing maternal identification in order to ward off very early anxieties (Mahler, 1963). Under sufficient stress the symbolic expression is insufficient and collapses into a demand for real expression of the maternal identification through sex reassignment (Meyer, in press).

COURSE AND MANAGEMENT

These disorders are episodic, recurring at times of dynamically resonant stress whether the stress be from the intimacy of a marriage, the Oedipal flowering of a son, or losses in vigor or status. Proper diagnosis is the essential in management. The history of masculine identification and eroticized crossdressing, with the characteristic precipitant, is critical.

The disorder of the aging transvestite is clearly episodic, and close support will see the urge for sexual reassignment abate. It seems probable that the "younger" transvestite's request for sex reassignment is also time limited. As the patient's desire for surgical sexual reassignment declines, the idea of sex change will become increasingly ego dystonic. It must be remembered, however, that this disorder is recurrent and the therapist should always be available for exacerbations of this condition.

Psychotherapy, much as has been outlined for the borderline individual (Kernberg, 1975), is the treatment of choice. It is rarely helpful to include the patient's wife in his treatment. The symptomatic request for sex reassignment is in part a hostile gesture toward her. Sensing this hatred, as the wives usually do, nonetheless may make her own treatment useful for her. Another reason for individual treatment for the patient is that it is more difficult to establish a successful therapeutic alliance if the wife is present. The therapist will be seen as trying to convince the patient of the undesirability of undergoing sex change. Often the wife's hostility will create disruption in the therapeutic situation. It is essential to maintain a nonjudgmental attitude. The therapist must sympathize with the patient's emotional pain but also must convey the need to explore the reasons for such a drastic change. Strict enforcement of gender identity clinic criteria can also give a valuable "breathing period." The Johns Hopkins Gender Identity Committee requires 2 years of crossdressing, working in the opposite gender role, and receiving hormonal medication and psychotherapy prior to consideration of surgery. Once these prerequisites are stated, it is up to the patient to carry them through while he and the therapist can work on the various issues that present themselves. This allays the urgency of the request for both patient and therapist. Often enough the patient's relief at the criteria is palpable. Because of some integration of his personality, he cannot fully endorse conversion since the masculine "side" of his personality still fosters the ambivalence.

The initial phases of the therapy should include identification of stresses which provoked the regression. The therapist should be well aware of the potential of suicide and autocastration in such patients. Medications should be utilized if concurrent psychiatric illnesses are present. Patients also must be hospitalized if they become acutely suicidal, nonfunctioning, or psychotic. This condition is episodic and often will remit in time.

After an initial phase of therapy where there is a clear agreement of a didactic relationship, the aging transvestite will often experience a depression. This occurs as a individual begins to react to the various stresses which had created his wish for sexual reassignment. Whether this is a specific loss, an aging process, or the Oedipal rivalry of a child, the individual will often initially experience the mood disorder and then cognitively deal with the content of his mood changes. Initially this depression is rationalized as being due to the realization that immediate surgery is not forthcoming. Furthermore, the initial euphoria from the fantasy of changing sex roles becomes a more realistic problem. The tremendous difficulties in actually

crossdressing in public, consideration of new employment, and reaction of family and friends modify this euphoriant is during this period that suicide and autocastration can occur. Ongoing supportive therapy, potential use of antidepressants, and possible family support or hospitalization may be needed. Exploration of the realistic difficulties that the patient has at present plus past difficulties in develop mental and interpersonal relationships not directly related to gender dysphoria are areas which can allow useful working through of this stage of treatment.

CONCLUSION

This report supports and expands Meyer's earlier classification of the "younger" and "aging" transvestites as clinical variants of gender dysphoria. These categories make comprehensible certain discrepant findings in the literature regarding transvestism, gender dysphoria, application for sex reassignment, and the nature of the relationships among these phenomena. These findings also enlist the vast literature on the borderline syndromes in the effort to comprehend the psychology of these patients. On the clinical level, the need for an accurate diagnosis is essential if one is to adequately map the course of any individual requesting sexual reassignment and prescribe appropriate treatment. Recognition of the episodic course of the gender dysphoric transvestites allows rational management and prevents needless, irreversible surgery, which would provoke further suffering in these troubled individuals.

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