

A Typology of Transsexualism: Gender Identity Theory and Data¹

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An analysis of postoperative data obtained from 42 male-to-female transsexuals showed them to fall into three distinct categories: homosexual transsexuals, asexual transsexuals, and heterosexual transsexuals. Additional data covering the areas of gender vs. sexual dysphoria, surgical details, background characteristics, sexuality-related behaviors, and postoperative adaptation further differentiated these groups and suggest that the categorization is theoretically meaningful and relevant to understanding the causes and course of the transsexual phenomenon. An extensive developmental theory is suggested to account for both differences and commonalities among the different subgroups of transsexuals, as well as among these and related groups, such as effeminate homosexuality and transvestism. The theory is sufficiently specific for making empirical predictions.

KEY WORDS: transsexualism; transvestism; homosexuality; gender; sex role.

INTRODUCTION

A complete theory of transsexualism could trace its developmental etiology throughout the life span, defining the role of crucial events prenatally, in childhood, through adolescence, and during early adulthood. Such a theory could also explain the interrelationship that transsexualism has with transvestism and homosexuality, an overlap that is the particular topic of my article. From the *theoretical* point of view, I will approach these commonalities through an analysis of the developmental patterns of feminine boys. The proposed theory has grown out of my own research program on sex and gender at the Department of Psychology, UCLA. This research program includes developmental studies of ef-

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feminine and normal boys (Bates and Bentler, 1973; Bates *et al.*, 1973, 1974, 1975; Skilbeck *et al.*, 1975), sex-role concepts in normal children (Thompson and Bentler, 1971, 1973) and adults (Ellis and Bentler, 1973), transvestites (Bentler and Prince, 1969, 1970; Bentler *et al.*, 1970; Prince and Bentler, 1972), and sexual developmental patterns in normal and homosexual adolescents (Bentler, 1968a,b,c). The experiences gained in this research and clinical work have encouraged me to attempt the broad overview presented here. From the *empirical* point of view, I will present data on 42 cases of transsexualism. I will be dealing only with male-to-female transsexualism, using Meyer's (1974) definition of transsexualism as an anatomical *fait accompli* having no further meaning. The data presented herein were gathered in 1970 through the cooperation of a national sample of physicians, psychiatrists, and psychologists.³ The data will be presented first, and the theoretical statement will follow.

THE BASIC TYPOLOGY

The concept that there might be several distinct syndromes associated with transsexualism has been noted by several workers. Departing from the classical psychodynamic theory as espoused by Stoller (1968), Fisk (1974) suggested that four subdiagnoses appeared with some regularity. Using the alternate term "gender dysphoria syndrome" to replace the word "transsexual," he observed patients exhibiting attitudes and behaviors that could be categorized as effeminate homosexuality, transvestism, inadequate schizoid personality, and recovered psychosis. Meyer (1974) reviewed a series of 87% applying to the Johns Hopkins Gender Identity Clinic, and suggested that the clinical data made it possible to categorize the patients rather naturally as aging transvestites, younger transvestites exhibiting more fetishistic activities, masochists and sadists, stigmatized homosexuals ill at ease in their homosexuality, the polymorphous perverse applicant whose erotic preference is situation specific, schizoid applicants, and eonists. The last group was considered most like traditional transsexuals; and these individuals also received sex-reassignment surgery most frequently.

Other surveys of patients applying for sexual surgery (Pearson, 1974) and those receiving surgery (Gandy, 1974) also have found that there is no uniformity among patients. Transvestic and homosexual components are those most consistently reported to be interwoven with more classical transsexualism. This is the finding of my own work. Using an anonymous questionnaire technique, very extensive data were obtained postoperatively from 42 males. The responses to five questions made it possible to place all patients unambiguously into one of three types: homosexual transsexuals (HS-TS), asexual transsexuals (AS-TS), and heterosexual transsexuals (HT-TS). This typology was exhaustive, in that all patients could be easily classified; and the size of the groups was, surprisingly,

³ Virginia Prince collaborated in the study.

quite similar (sample sizes were 15, 14, and 13). The HS-TS group would appear to fall into Fisk's effeminate homosexual category and Meyer's stigmatized homosexual category; the AS-TS group would seem to represent Meyer's eonist category; and the HT-TS group appears identical to Fisk's transvestic category and to Meyer's aging transvestite category.

GENDER DYSPHORIA

It is important to establish that the transsexuals in this sample represent true instances of gender dysphoria, rather than simple instances of sexual dysphoria. When asked if they felt like a woman before they lived as one, the average response of patients was 3.1, 3.4, and 3.1 for the homosexual, asexual, and heterosexual groups (where "3" represented that they had felt like a woman since childhood, and "4" was indicative of always feeling like a woman). When asked to rank nine possible alternatives in terms of "your basic motivations for getting your sex changed," subjects from all three groups gave as their primary reason, "to make my body more like my mind, as a woman." Other alternatives that they could have marked were such things as the wearing of pretty clothing, being less aggressive, avoiding masculine expectations, having sex with a male, eliminating the male self through amputation of the penis, to compete with another female, and to win the love of a parent. Reflective of their own conceptions of gender identity and transsexualism, subjects responded similarly. Asked "If you were the psychiatrist who had the responsibility of clearing applications for surgery, which of the factors listed below would you consider essential?" subjects in all three groups consistently gave their highest average ranking to the alternative, "Must have felt like a girl almost all his life." This alternative was chosen above such alternative choices as having sexual experience with males, looking like a woman, having a history of cross-dressing, hating the penis, having a feminine voice, working as a woman, and taking hormones for developing breasts. Finally, when asked after surgery "Which have you found to be more important and satisfying, your life as a female (able to have sex with males) or your social role as a woman in society?" subjects from all three groups leaned toward the social-role answer. Group averages clearly supported the concept that, as perceived by the subjects, surgery was important for nonsexual reasons. However, as will be seen next, the relative importance attributed to sexuality, as well as its nature, is different among the three groups.

CLASSIFICATION CRITERIA

Five questions served to categorize all subjects into one of the three groups. The specific questions utilized, as well as the responses by subjects in each of the

Table I. Primary Classification Criteria

	Homosexual (<i>N</i> = 15)	Asexual (<i>N</i> = 14)	Heterosexual (<i>N</i> = 13)
"Before surgery, I was homosexual"	100%	0%	0%
Persons ever married as a male to a female	0%	0%	100%
Persons never having "pleasant and successful intercourse with a female"	87%	100%	8%
"Before surgery, I was heterosexual"	0%	56%	92%
"Number of women with whom you had intercourse as a male"			
<i>M</i>	0.3	0.2	3.3
<i>SD</i>	0.9	0.6	2.8

three groups, are presented in Table I. The homosexuals and heterosexuals were perfectly classified according to their responses to the question of self-concept as homosexual before surgery and the presence of presurgical marriage. To some extent, the asexual group represented a residual group, but they were perfectly identified by their report of never having had pleasant and successful intercourse with a female. In spite of the almost complete absence of heterosexual behavior, over half of the AS-TS group considered themselves to be heterosexual before surgery. Although it is not relevant to the issue of classifying subjects, it should be pointed out that after surgery 100%, 91%, and 92% of subjects in HS-TS, AS-TS, and HT-TS groups considered themselves heterosexual. Thus homosexual subjects claim a complete reversal in sexual self-concept, while, in contrast, heterosexual subjects claim almost complete consistency in their sexual identification. This observation is worthy of further study.

SURGICAL DETAILS

Subjects were also asked about their surgical experiences, both positive and negative. The results are presented in Table II. The majority had received preoperative counseling, counseling that was considered insufficient by over a third of all patients, in retrospect. There are certain differences among the three groups in their surgical details. The homosexual group was on female hormones a shorter time prior to surgery, had obtained a one-step emasculative reconstructive surgery relatively more than the other groups, and had had surgery a lengthier period of time prior to filling out the questionnaire than the other groups. About two-thirds of the subjects lived as a woman for some time prior to surgery, and the majority had their surgery performed in the United States.

Less than one-third of all subjects received counseling after surgery. From one-fourth to one-half of the subjects considered their postoperative counseling insufficient to meet their needs, with the homosexual group being most discontent. Indeed, over half of the HS-TSs felt that medical science should have

done more for them, and a large proportion reported physical problems since the operation. While these negative opinions of postoperative care may reflect the one-stage surgery, it is clear that enough patients report having problems that surgical specialists should investigate these more thoroughly. About two-thirds of the AS-TS group reported disappointment with medical science's efforts on their behalf. This may represent a more generalized source of dissatisfaction, a point that will be taken up below.

In spite of the reported problems, virtually all subjects reported that they would go through the surgery again. Similarly, almost none of the subjects reported that they would have been just as happy with only a change in life style, rather than surgery.

There have been no systematic reports regarding additional surgery requested by transsexual patients. The subjects in this sample reported a variety of other surgeries designed to make their body fit their anatomical image of femininity. The most frequent operation appears to be a nose alteration. In addition, it will be noted that the HS-TS group consistently reported greater

Table II. Surgical Details

	Homosexual (%)	Asexual (%)	Heterosexual (%)
Preoperative counseling was given	67	85	83
Counseling considered insufficient	36	30	44
Length of time on hormones, presurgery	<i>M</i> 12 months	16 months	18 months
	<i>SD</i> 9 months	15 months	13 months
Lived as a woman, presurgery	67	64	69
Surgery performed in United States	60	57	50
One-step emasculation and vaginal construction	80	64	54
Time since surgery			
0-6 months	13	21	38
More than 2 years	40	29	8
Postoperative counseling given	21	33	33
Counseling considered insufficient	50	33	25
Felt medical science did not do all it should	53	64	31
Physical pain or problems since operation	38	25	18
Would go through surgery again	93	100	100
Would have been just as happy with only life-style change	0	8	0
Surgery on other body part			
Face lift	13	7	8
Skin peel	13	7	0
Nose alteration	53	36	23
Larynx shaving	14	0	0
Ears	27	0	0
Breast implants	27	21	23

surgery than the other two groups. Whether this observation reflects a greater emphasis on anatomical beauty on the part of these individuals or whether it represents other accidental correlates of group membership, such as time since surgery, age, or other variables is unknown.

BACKGROUND CHARACTERISTICS

Certain standard demographic characteristics for the subjects are reported in Table III. Since the groups were formed solely on the basis of response to questions about sexual behavior, any differences among groups may simply represent accidental variation. On the other hand, it will be noted that the HS-TS subjects received their operation on the average about 10 years earlier than the HT-TS subjects. This result may reflect the true dynamics of the situation—with the homosexuals relatively more concerned with obtaining and maintaining a sexual partner, and feeling greater pressures to modify their anatomy as well as beauty at an earlier age (note that although the HS-TS group is the youngest, it has also had the operation a lengthier time prior to responding to the questionnaire), plus the dynamic of the aging transvestite noted in particular by Meyer.

An observation reported for transvestites (Prince and Bentler, 1972) is that they appear to be relatively higher on the socioeconomic scale than controls; similarly, it has been pointed out that transsexuals are frequently, though not always, relatively low in socioeconomic status (Hoening *et al.*, 1970). The results of Table III support these observations with the AS-TS and HT-TS groups. The heterosexuals have the highest average education, the highest job status, and the highest maximum annual income; the asexuals have the lowest education and income of the groups. No doubt, these variables may reflect some unknown, unmeasured parental background variables, but it also possible that the asexuals

Table III. Background Characteristics

	Homosexual		Asexual		Heterosexual	
	<i>M</i>	SD	<i>M</i>	SD	<i>M</i>	SD
Age (yr)	36.5	8.3	40.7	13.4	46.3	11.4
Height (inches)	68.2	1.3	68.2	1.8	68.3	1.3
Weight (lb)	153.7	21.7	155.0	28.6	157.3	26.5
Educational level ^a	4.0	1.1	3.3	1.1	4.3	2.1
Male job status ^b	3.7	1.2	3.8	0.9	4.3	1.3
Highest annual income	\$9400	\$4800	\$6150	\$3950	\$15,700	\$9000
Number of brothers	1.7	1.6	1.5	2.1	0.8	1.4
Number of sisters	1.7	1.6	1.2	1.1	1.1	1.0
Liberal Protestants	20%		36%		50%	

^aNote: 3 = high school and some business, 4 = some college, 5 = B.A. degree.

^bNote: 3 = working-class elite, 4 = lower middle class, 5 = middle class.

maintain a generally more marginal role in society than the achievement-oriented transvestic subjects. These results would seem to support the work of Fisk (1974).

Quite unexpectedly, it was noted that the family size of the HS-TS groups is larger, and that fewest in this group are liberal Protestants, in comparison to the other groups. Whether these facts play significant roles in the etiologies of these disorders is not known.

BEHAVIORS RELEVANT TO SEXUALITY

Although all subjects of this study were classified into groups on the basis of their responses to specific sex questions, a number of attitudinal and behavioral reports differentiate the groups. Data related to sexuality are presented in Table IV, in terms of both commonalities and differences among the groups.

Reports of presurgery behavior support the basic classification. Although a surprisingly small percentage of subjects report cross-dressing prior to age 5, and only about half indicate such dressing prior to age 11, the sexual arousal value of cross-dressing is noted particularly by the heterosexual, transvestic subjects. Although, as pointed out previously, the majority of subjects had lived for some time as a woman prior to surgery, clear differences in the public behavior exist among the groups. It is the HS-TSs who report appearing publicly with male escorts and going to drag balls, a report that would be expected from their homosexual orientation.

When asked for their reasons for surgery, the three groups gave illuminating differential replies. The mean ranks of the various groups, and the associated standard deviations, are presented in Table IV. The HS-TS group is noteworthy for its high ranking of ability to have sex with a male and the particularly low concern given to the notion that surgery was requested in order to avoid masculine expectations or requirements. The AS-TS group is noteworthy in particular for the importance attached to the elimination of the male self through amputation of the penis. In a repeat question in a separate part of the questionnaire, both homosexual and asexual groups suggested that sex might be one basic reason for surgery. The HT-TS group stands out in the low emphasis it gives to sexual behavior and amputation of the penis.

As might be expected, it is the HS-TS group who report that intercourse is now pleasant and that sex is indulged in for both partners' pleasure. The HT-TS subjects appear to believe that sex serves a role primarily in pleasing the partner. Numerous pleasurable experiences of a sexual nature are reported by subjects. Of particular interest is the relatively freer and greater variety of sex experienced by the HS-TS group in comparison to the others. Of course, in comparison to the other two groups, their postsurgery experiences are more congruent with their own earlier sexual behavior.

Table IV. Behaviors Relevant to Sexuality

	Homosexual		Asexual		Heterosexual	
Presurgery						
Cross-dressing: prior to age 5	36%		8%		33%	
prior to age 11	50%		50%		67%	
Cross-dressing was sexually arousing	23%		18%		50%	
Appeared in public with male escorts	80%		57%		42%	
Went to drag balls	60%		36%		31%	
Reasons for surgery (lower mean implies more important reason)						
Be able to have sex with a male as a female	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Eliminate male self through amputation of penis	2.1	1.3	3.2	1.7	5.1	2.4
Avoid masculine expectations or requirements	3.1	1.6	2.4	1.4	4.1	2.3
Having sex with a male given as a basic reason for surgery (repeat question)	5.0	1.9	3.3	1.9	3.3	1.3
Postsurgery						
Vaginal intercourse is now pleasant	100%		67%		67%	
Have sex mostly: for partner's pleasure	43%		70%		67%	
for both partners' pleasure	93%		70%		43%	
Pleasurable sexual experiences include						
Kissing	93%		90%		100%	
Breast manipulation	87%		100%		100%	
Genital manipulation	67%		67%		60%	
Intercourse	93%		80%		100%	
Cunnilingus	64%		25%		29%	
Fellatio	73%		25%		14%	
Anal intercourse	33%		29%		0%	
Climax as a female, compared to male						
Greater sensitivity of genital areas	64%		86%		50%	
More pleasant being on receiving end	86%		71%		100%	
Foreplay more important	79%		100%		100%	
Flirting and teasing more important	93%		86%		86%	
Breasts and body more sensitive	86%		100%		100%	
Orgasm as female more pleasing	50%		67%		86%	
Liquid produced from urinary opening at climax	79%		57%		57%	
Intercourse since surgery						
Number of occasions	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Number of different men	17.5	10.0	7.1	10.1	10.8	12.5
Achieve orgasm (2 = occasionally, 3 = frequently)	14.5	16.5	3.0	1.6	8.1	14.0
Masturbate now (1 = never, 2 = occasionally)	2.4	0.8	2.8	1.1	2.1	0.9
	1.5	0.6	1.8	0.7	1.3	0.5

The asexual group, in spite of its relative inexperience in sex, reports the greatest increase in sensitivity of the genital areas postsurgery compared to pre-surgery, but almost all subjects report greater current sensitivity of body and breasts. Whether these reports represent the positive greater subjective experience associated with being in a role highly desired or some phenomenon associated with female sex hormones is difficult to judge, although it is probably the former. It is difficult to understand, particularly in view of the nature of the surgery, that there exists a physiological basis for the report by over half the subjects that orgasm is more pleasing as a female than as a male. There also appears to be no obvious explanation for the particular pleasure in orgasm reported by the HT-TSs. Replication of these results by other investigators is clearly called for. Finally, since over half the subjects report production of a liquid from the urinary opening at climax, an inference can be drawn regarding the continued functioning of the prostate.

The final section of Table IV provides some quantitative figures regarding sexuality since surgery. While it must be recognized that these figures are no doubt confounded by the accidental variations in length of time since surgery, there appears to be a confirmation of the asexuals' relatively lower sexual drive. Their report that they achieve orgasm more regularly than other subjects seems difficult to reconcile with low sexual drive.

SOURCES OF STRESS

Some of the data previously reported have been suggestive of possible adjustment difficulties after surgery. For example, it was pointed out that the HS-TS group in particular has had physical problems since the operation and was dissatisfied with postoperative counseling, and that about two-thirds of the AS-TS group reported feeling that medical science did not do all it should for them. A similar indication of a potential problem was noted in the two-thirds of subjects who indicated that they have sex primarily for partner's pleasure; however, it is possible that subjects interpret such an attitude as consistent with the feminine role, and consequently they may not be dissatisfied. Related considerations are summarized in Table V. Data presented there are also suggestive of a relatively higher level of strain for the HS-TS and AS-TS groups, a strain that might be predictive of future longterm adjustment problems.

Close to one-third of the HS-TS group report that life as a woman was not up to expectations. Whether this attitude represents a failure of appropriate pre- and postsurgery counseling, or of the more specific sex-related motivation for surgery observed in these groups, cannot be ascertained. While about two-thirds of all subjects continue to see old friends and acquaintances after surgery, the HT-TS subjects in particular report a greater distance and coolness on the part of previous male friends and somewhat the same pattern for female friends, an observation shared by AS-TSs as well. Two-thirds of the AS-TS subjects re-

Table V. Postoperative Attitudes as Stress Sources

	Homosexual (%)	Asexual (%)	Heterosexual (%)
Life as a woman: better than expected	33	50	64
not up to expectations	27	0	0
Continue to see old friends and acquaintances	73	75	62
Male friends are cooler and more distant now	27	30	50
Female friends are more cool and distant now	14	33	30
Tell no new friends about previous life	57	69	46
See parents (if alive) as regularly as before	46	67	89
"Most people who seek sex reassignment . . . should be helped to get it . . ."	38	40	69
"Of 100 males who come to a doctor saying that they are transsexuals . . . how many . . . would be properly qualified . . . to have the operation"	39	25	50

port not telling any new friends about their previous life, while only about half of the other subjects indicate this. Finally, it is the HS-TS subjects in particular who report seeing their parents less frequently than other subjects. Thus there appears to be a pattern in which at least one-third of subjects report difficulties maintaining relationships, and no doubt feel a certain lack of personal closeness for that reason, but it appears to be the HS-TS and AS-TS groups in particular who have the greatest degree of change in social interaction, and who consequently may experience life-change stress. It is quite likely, for example, that the sharing of intimate details about one's personal life is an important human need, one that is unlikely to be satisfied in a good proportion of these individuals.

The implication that the HS-TS and the AS-TS groups experience a relatively greater degree of strain in their current adjustment can also be made from the attitudes of the subjects toward other individuals who might be seeking sex-reassignment surgery. As can be seen in the last two lines of Table V, subjects in these groups appear to believe that only a small percentage of people should receive the operation—perhaps representing an attitude of exclusiveness, indicative of how unique they are, but alternatively representing a possible hint of regret about their own situation.

THEORETICAL STATEMENT

These data have demonstrated certain differences among the three identified subgroups of transsexuals, as well as many commonalities. An understanding of transsexualism, however, requires understanding not only of the interrelationships among different subgroups of transsexuals but also of the relation-

ship of the entire category of transsexuals with closely related conditions, such as effeminate homosexuality and transvestism. It is well known that only a very small percentage of applicants actually receive sex-reassignment surgery. For every one operated on, there are perhaps another nine who desire the operation. It is most likely that these individuals also distribute themselves among the three classes of transsexuals described. However, one would expect that many of these individuals show no convincing evidence of gender dysphoria. Many such applicants no doubt fall into categories of effeminate homosexuality and transvestism *per se*, and there is little question that by far the largest proportion of feminine homosexuals and transvestites never come to the attention of gender identity clinics. Yet these groups are sufficiently similar to the transsexuals that a theory of transsexualism should account for this similarity—as well as being able to explain the differences.

Table VI presents the essence of a fairly complex developmental theory designed to explain feminine identification. I have chosen to be extremely specific in my statements, and quite comprehensive. I believe that this specificity represents a major advance over previous theories, for example, in comparison to those reviewed by Ehrhardt (1974) or Green (1974), because I have identified numerous processes involved in gender-role development that are typically left unspecified. This specificity is also a major fault, because many of my suggestions will no doubt turn out to be false. From my vantage point, however, it seems important to provide a very detailed theoretical statement that can be falsified by evidence, in contrast to one that is so vague as never to be testable, or that gives a gross oversimplification of the phenomenon. In my view, previous theories of the development of these conditions have been tremendously oversimplified, and bear little relationship to the complexity of the individuals I have encountered.

In Table VI are listed 32 specific processes that I hypothesize to be related to inappropriate gender role development. A small “x” has been written if the particular process is hypothesized to occur in a particular condition, such as effeminate homosexuality. A quick scanning of the entire table will indicate that there are some hypothesized processes that may occur in all three conditions, while there are others that only occur in one or two of the conditions. It is the existence of a particular process in the three types of individuals that makes for an observed commonality of symptoms, behaviors, and attitudes among subjects from the three groups, and that is likely to lead to the development of transsexuals with either homosexual or heterosexual transvestic orientations. Of course, not every individual is assumed to experience each of these processes, even where an “x” is indicated. The differential experience of different individuals within a particular category would yield behavior and symptom patterns that are different among individuals within the same category. The greater the number of processes that are shared among individuals, however, the more homogeneous the behavior and action patterns are assumed to be.

Table VI. Development of Feminine Sex Role in Males: A Theory

Possible developmental basis of:	Homo- sexuality	Trans- sexualism	Trans- vestism
1. Prenatal feminization of the brain	x	x	
2. Low activity and energy level		x	
3. Inborn temperament to fussiness and unresponsiveness	x	x	x
4. Nonoptimal stimulation during infancy		x	x
5. Rigid identification with anatomical correlates of sex roles (body type, hair)		x	
6. Presence of a weak and nonnurturant father	x	x	x
7. Training in impulse control, harm avoidance, and behavioral inhibition		x	x
8. Learning of negative attitudes toward sexual organs		x	
9. Reinforcement of feminine role behaviors and attitudes by a significant other or peer	x	x	x
10. Absence of consistent, effective rewards for sex-role stereotyped behaviors and interests	x	x	x
11. Emphasis on independence, with absence of same-sex affiliative behavior	x	x	x
12. Unresolved oedipal complex	x	x	
13. Becoming unresponsive to social influence by same-sex peers and parents	x	x	x
14. Development of a self-concept as different from other boys	x	x	x
15. Lack of disclosure of self-concept to significant others	x	x	x
16. Homosexual sex play	x		
17. Emphasis on intellectual success			x
18. Rejection by boy and girl playmates	x	x	x
19. Rejection of sex-role stereotyped attitudes with acceptance of the behaviors		x	x
20. Learning not to look at females as sex objects	x	x	x
21. Development of rewarding masturbation patterns	x		x
22. Anxiety reduction associated with orgasm while cross-dressing			x
23. Orgasm with fantasies focusing on homosexual behavior	x		
24. Perceived difficulties in dealing with heterosexual dating patterns	x	x	x
25. Rejection of homosexual self-concept and experiences			x
26. Elaboration of feminine self in fantasy and behavior	x	x	x
27. Perceived difficulties with masculine work roles		x	
28. Use of marriage to bolster the masculine sense of self			x
29. Elaboration of homosexual self-concept and behavior	x		
30. Finding marriage stressful and unsuccessful in eliminating feminine gender behavior			x
31. Greater enjoyment of masturbation than heterosexual sex			x
32. Elaboration of feminine self-concept	x	x	x

A few comments about each of the hypothesized processes may be in order. It will be obvious that there is an extensive literature regarding many of these propositions, but because of space limitations I will limit my comments primarily to observations based on my own research and clinical work.

The effects that prenatal feminization of the brain has on later anatomical, physiological, and behavioral consequences have been studied extensively in animals (Money and Ehrhardt, 1973). Although there is little evidence at the moment for this process existing in homosexuals and transsexuals, it seems to me that the possibility needs to be left open. I do suggest that transvestites either have this feminization to a much lesser degree, perhaps occurring later in fetal development, or do not have it at all. The possibility that the low achievement and drive level of transsexuals (relative to other groups) have a biological disposition must be entertained. Closely related is the observation of Zuger (1970) that many parents of effeminate boys report that their child was different since birth, and that no matter how hard they tried as parents to modify their child's behavior they were unsuccessful. Thus the next two processes must be given consideration. Bates *et al.* (1973) observed that feminine boys tended to exhibit a pattern called "behavior disturbance," marked by irritability, bossiness, and tantrumlike behavior that may relate to inborn temperamental variables and may make sex-role socialization relatively difficult. Although the role of nonoptimal stimulation during infancy is typically considered with respect to intellectual development, it is possible that early handling or gentling plays an important role in attachment and socialization. One way to account for the relative rigidity of transsexual and transvestic behavior and desires is a possible rigidity in behavior once found positive, a type of rigidity that might be consistent with a "hormonostat" interpretation of adjustive adrenal responsivity following early manipulation, in accord with the hypothesis of Levine and Mullins (1968).

Studies of normal children have clarified some of the processes involved in early sex-role identification. It has been found, for example, that young children judge normal and transsexual dolls primarily by their hair style and body type, not by their sexual organs (Thompson and Bentler, 1971), suggesting that one early precursor of transsexualism may be particularly strong identification with these anatomical correlates of sex roles. Social learning theory has been quite explicit in pointing out that individuals who are warm and powerful are imitated more than those who are weak and cold (Mischel, 1970), and, consequently, a father's behavior pattern can have a strong impact on the child's identification with him. The suggestion that training in impulse control and inhibition occurs primarily in transsexuals and transvestites comes from the repeated observations of certain obsessive-compulsive trends (e.g., Bentler and Prince, 1969; Bentler *et al.*, 1970). Certainly observations of effeminate boys' childhood play patterns (Bates and Bentler, 1973) demonstrate that they appear to be hindered in their normal exploratory behaviors such as those that might be involved in games that

may involve possible harm. Inhibition and negative attitudes directed toward one's own sexual organs are quite likely learned through parental punishment of early sexual exploration, and can represent one explanation for the striking negativity observed toward the penis by the AS-TS group in this study.

There are, of course, well-known sex-role stereotypes and attitudes in adults (Ellis and Bentler, 1973), and these no doubt translate into expectations and reinforcement patterns in children. Very positive responses toward observed feminine behavior and attitudes in children by significant others or peers will serve to build feminine patterns. For example, a boy's playing only with girl playmates represents a frequent clinical pattern. Some of the specific patterns of behavior that feminine boys show have been quantified by Bates *et al.* (1973) and Green (1973, 1974, 1976; Green *et al.*, 1972).

Of course, it is not only the reinforcement of feminine behavior but also the absence of consistent and effective rewards for sex-role stereotyped behavior that builds sex-role deviancy. Thus it is becoming clear that feminine boys not only hang onto feminine behaviors that may have been acquired earlier but also fail to learn new activities that boys typically learn as they grow older (Bates and Bentler, 1973; Bates *et al.*, 1973). An emphasis on independence, with the rejection of affiliative behavior with same-sex peers—a pattern of rejecting any type of peer influence—is a likely possibility in all three groups.

The unresolved oedipal complex represents a standard theoretical statement regarding sexual misidentification, and theoretically, at least, it is distinct from other processes above. In contrast to the more typically normal pattern of pre-adolescent peer interaction, in which same-sex peers can exert more power than parents, effeminate boys start actively rejecting social influence attempts of this sort. One consequence of the previous processes is the development of a self-concept as being different from other boys. This self-concept is no doubt built through a process of observation and social comparison, in which the boy begins building a self-image consistent with what he observes about himself; namely, that he does not like doing and does not engage in the kinds of things that boys his age typically do. He will notice that his behavior and play patterns differ from those of other boys, as described by Green (1974). It also seems that as a consequence of recognizing that he is different, as he gets to be 8 or 9 years old the feminine boy stops disclosing his inner, private thoughts to others because of his fear of rejection and punishment. Therefore, anxieties, anger, ambivalences, and other emotionally charged events maintain their affective significance unnecessarily long. As a consequence, unrealistic stereotypes and beliefs cannot be modified through the typical process of give and take that characterizes the sharing of intimate secrets.

Although many boys experience episodes of sexual behavior with other boys, homosexual sex play occurs earlier or gains exaggerated significance particularly for the effeminate homosexual group. In contrast, the transvestites appear

to be particularly reinforced for intellectual success. A frequent, sad occurrence among feminine boys is the rejection not only by boys but also by girl playmates. As he grows older, the boy who wants to be the mother while playing "house" becomes unacceptable even to girls. Such a rejection appears often to be associated with continued lack of disclosure of the self-concept and other processes mentioned above. As pointed out previously, with increasing age a feminine boy starts complying overtly to the perceived norms (a process well known as "forced compliance" in the social psychology literature); for example, he may take up a masculine sport. However, the boy's attitudes and private feelings are quite divergent with his overt behaviors. He feels misunderstood, and his true feelings go underground and become more difficult, if not impossible, to modify.

I do not believe that adolescent and adult sexual behaviors follow directly from the general influences typically described, or even from the above-mentioned specific influences. It seems to me there is also a further, specific process involved in learning not to look at females as sex objects. An effeminate boy will not have developed the "in-group" and "out-group" attitudes typical of boys and girls regarding the opposite sex, and parental attitudes may have made it difficult for the boy to express possessive or teasing attitudes toward girls. Thus as he progresses into adolescence and erotic feelings start appearing, he cannot direct his thoughts and attitudes toward the appropriate sex objects. Of course, the transvestites are less subjected to this process than the others. In addition, while most boys normally learn to masturbate, either because of prior learning, anxiety, low sex drive, or fear of punishment, I hypothesize that the asexual transsexual barely develops such patterns. As a consequence, such a boy will not develop cross-dressing habits which result from anxiety reduction associated with orgasm, or the focused homosexual fantasies of the effeminate homosexual (Bentler, 1968c). It is also well known that males typically progress through a series of progressive behavior patterns that culminate in sexual intercourse (Bentler, 1968a). For most boys, the behaviors in this sequence, when first encountered, are anxiety provoking and conflict ridden. The feminine boy experiences even greater conflict, and, not having learned to continue exhibiting masculine behaviors in spite of fear of failure, he will more easily give up. Dates will not be called, girlfriends will be avoided, and he will question his masculinity still more. For the transvestite, there continues a period of active rejection of homosexuality in the light of such failures, but all three groups continue elaborating their feminine self in fantasy and behavior. The previous sexual experience, of course, directs the fantasy. The elaboration takes on anatomical and sexual characteristics for the homosexual, anatomical characteristics for the transsexual, and social-role characteristics for the transvestite.

As the adolescent approaches adulthood, work roles are established. In view of the data indicating the relatively low economic achievement of trans-

sexuals, it would seem that these individuals would perceive greater work adaptation difficulties than the other groups, verifying their feminine identification. The transvestites, more than the others, use marriage as a means of bolstering their masculine sense of self, but find over the long run that marriage is stressful and unsuccessful in eliminating their compulsive feminine gender behaviors. Finally, finding heterosexual behavior stressful because of potential rejections and the difficulty of maintaining feminine sexual fantasies while acting as a male, the transvestite reverts to his more easily available "internal marriage" (Buckner, 1970) and masturbates in the presence of his developing private feminine personality. In contrast, the effeminate homosexual begins experiencing more mature homosexual interpersonal encounters and elaborates his homosexual sense of self. The final process reported in Table VI refers to the well-known continuing elaboration of the feminine self-concept in response to continued sex-role behavior and gender identity successes and failures in life.

CONCLUSION

The theory of gender identity development proposed above is offered in the spirit of directing research toward developmental processes potentially relevant to understanding male transsexualism, transvestism, and effeminate homosexuality. While I have no illusion that the theory is "true" or "correct," I would expect confirmation in some aspects and disconfirmation in others. It is often stated that one crucial function of a theory is to direct research—whether or not the research is specifically confirmatory of the theory. In contrast to alternative formulations, the theoretical statements of Table VI can at least be put to test and, it is to be hoped, definitively rejected if wrong. If they cannot be rejected after careful investigation with appropriate methodologies, the propositions will gain credence.

The proposed gender identity theory is consistent with the primary classification criteria used in the empirical study reported above. This should not be surprising since the theory grew out of the observations, in part. The data, however, cannot be used as specific tests of the theory because the questionnaire used in the study was not constructed to evaluate it. No questions had been specifically devised to assess the propositions; future research with transsexual, transvestite, and homosexual populations could take such an approach. Of course, alternative types of studies, such as longitudinal studies of untreated preadolescent boys showing feminine behavior patterns and long-term follow-ups of surgically treated transsexuals, must also be used to evaluate the power of the theory.

One important feature of the theory lies in its suggestion that there may exist developmental processes experienced by all boys showing feminine be-

haviors and identity. These include such processes as reinforcement of feminine role behavior, lack of disclosure of feminine self-concept, and the perception of difficulties in heterosexual dating patterns. A consequence of such developmental uniformities would be similar expressions of feminine role behavior as adults. Casual observation, however, suggests that wide individual differences also exist. These differences may be understood as resulting from variations in the physical, social, and psychological environments that children are exposed to. Consequently, it would not be surprising to find many variations in individual expression of femininity among boys. In addition, however, the theory proposes that experiences are not purely random but that they also group themselves to generate effeminacy associated with asexuality, homosexuality, and heterosexuality. For example, it is proposed that learning of negative attitudes toward one's sexual organs occurs primarily among the asexuals, that homosexual sex play occurs primarily among the homosexuals, and that anxiety reduction associated with orgasm while cross-dressing occurs primarily among the transvestites. The extent and strength of such experiential groupings will determine whether the proposed typology is a viable one. If the experiential groupings do not occur regularly, feminine gender identity and behavior in males would distribute themselves across the proposed typology, and many in-between or hard-to-classify cases would exist; this problem was not observed in the current study. Of course, it must be acknowledged that the ultimate value of any typology of transsexualism depends on its consistency with the etiological, observational, and prognostic facts of the syndrome. Since several investigators have been converging upon a classification similar in part to the current one, I am reasonably confident that the tripartite division of transsexuals into component types is empirically warranted. In contrast, it seems to me that current empirical data are not sufficiently detailed to enable one to accept or reject the idea that differential etiologies and prognoses are associated with the behavioral observations. It is to be hoped that future data can clarify this issue.

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