

# **Some Psychodynamic Aspects of Transsexual, Homosexual and Transvestite Patients Presenting Themselves to a Psychiatric Gender Clinic \***

G. J. SARWER-FONER, M.D. \*\*

## **Introduction**

In recent years there has been an increase in the number of people who see themselves as needing sex change surgery. The fact that a diagnostic error can lead to irreversible surgical damage makes it necessary for all psychiatrists, but particularly forensic psychiatrists, to have better knowledge of such patients. This paper presents an overview of some of the significantly pertinent facts, diagnostic and psychodynamic, that one finds in many of these patients.

In the Gender Identity Clinic of the Department of Psychiatry, Ottawa General Hospital, University of Ottawa School of Medicine, I have been the senior psychiatric consultant, whose function is, as a psychoanalyst, to interview these patients independently of the psychiatric and medical service teams studying them. Two particular efforts are made in addition to the general and dynamic formulations: (1) to obtain a psychiatric history, establish a diagnosis and a psychodynamic formulation; and (2) to see if those patients, who do have profound psychiatric problems, might benefit from sex change surgery; or if, instead, they might be motivated to enter intensive psychiatric and therapeutic exploration of their problems, rather than being accepted or rejected for surgical or other procedures.

All of these patients have been interviewed in one or more psychodynamic diagnostic sessions lasting from one to several hours. Some of these patients went through other therapeutic sessions aimed at exploring their desire for, motivation for, and ability to undertake psychotherapy.

The following comments are generalizations on some unique factors seen in the different overall diagnostic grouping of such persons. Like all generalizations they are overall statements which may only more or less fit a particular case.

## **Some Aspects of Overt Male Homosexuality Pertinent to a Discussion of Transsexuality†**

Overt male homosexuality is a spectrum or range of conditions. It differs

\*From the Department of Psychiatry, The University of Ottawa School of Medicine, and the Ottawa General Hospital, Ottawa, Ontario, Canada.

\*\*Dr. Sarwer-Foner is Professor and Chairman, Department of Psychiatry, University of Ottawa School of Medicine; Director, Department of Psychiatry, Ottawa General Hospital; and President, Canadian Psychoanalytic Society. Address: 197 Cumberland Street, Ottawa, Ontario, K1N 7H4.

†See Allan (1965), Beiber (1962), Henry (1948), Marmor (1965), Livingood (1972), Socarides (1968), and Stoller (1975).

in the intensity of its presence from one person to another, and differs in many of its manifestations. Individual study of each person permits some of the differences to emerge. Overt homosexual activity in males may also differ in the nature of the attachment to overt homosexuality as a sexual expression itself — thus the sexual object may be fantasized as being completely feminine, completely masculine, or with various degrees of admixture. Thus the nature of the fantasies, the patterns of stimulation, excitement and discharge of the sexual act differ. The homosexuality may differ, in the attachment of sexual expression to the anus, for example, to the genitals as a whole, or to the male body as a whole, etc. I merely illustrate here some of the wide range of differences in people, all of whom see themselves as overtly “gay” or “homosexual.”

Despite the range of variation and differences, there are common elements in male overt homosexuals. One of these is that they “love” or “sex bond” to someone like themselves, *i.e.*, a body like “the one they know.” For some this represents a process of sexually completing their “selves” with another body that is like their own, or with a less mature or younger version, or a more mature, older version of themselves (symbol of father, brother, etc.). For example, there can in some cases be a great deal of tender lovingness for a symbolic young self, as well as aspects of symbolically degrading “father” in some of the fantasies and sexual acts.

Important here are the human relational difficulties inherent in the intrapsychic aspects of controlling, dominating, or submitting to another human being at an anal level, involving not just an anal sexual act but also the fantasies that are stimulated by any kind of anal “play” (be it heterosexual or homosexual): fantasies that are by their inherent anal nature, ambivalent and ambivalent; that become controlling and aggressive; and that are linked with the infantile memories of bowel training. (Grunberger (1959).) They emerge in all aspects of this type of relationship, along with feelings of needing to control, degrade, totally own, possess; or conversely, needing to be possessed and totally owned. These can form sado-masochistic bonds. Such are some of the factors that make the enduring (over time) of some homosexual relationships difficult, and contribute in no small measure to the impermanence of many of these relationships.

Etiologically, an absent, weak, or non-existent father is seen as important for the development of overt homosexuality in some. In some who demonstrate sadomasochistic homosexual relationships, a distant, not really present, but ambivalent, weak and often physically violent father is part of the picture. Feminine identification of a *hostile kind*, with a woman who is domineering, aggressive and rejecting of males, is often seen, and is inevitably a hostile identification (*i.e.*, such males hate the female in themselves as well as outside themselves). Here, however, the identification is with a woman and with her capacities; but “a horror” of the female body, and fear of what a female can do to a more submissive, obdurate, difficult, or hated male whose body is vulnerable, become important etiological factors in some.

The above is not meant as a complete summarization of all etiological factors in male homosexuality, but mentions a few key ones so that we can contrast them with some of the ones seen in transsexual and transvestite patients.

## Transsexualism\*

Transsexualism, by contrast to the above, can be characterized in males by a relatively unconflicted, and reasonably complete, intrapsychic identification with a female, so that the resulting person, personality, and indeed self-image is seen as being female — but in a male body. The male body is perceived and accepted as present; *i.e.*, it exists; but it is seen as something undesirable or “wrong.” It is the undesirability of this body that is attacked or rejected intrapsychically, or the adequacy of it as a body denied, in those who suffer from transsexuality. This important intrapsychic state of personal feminine identity is discordant with the physical body image of a male. This view of oneself as female is egosyntonic for these patients, is relatively conflict-free in the true transsexual (who has these factors in relatively pure culture), and offers to the patient his ego, reality-testing and social problem resolving capacities for dealing with this problem — since the intrapsychic identity is seen as female, and it is the body that is seen as non-complying and wrong. This sets up an intrapsychic split between parts of such a patient’s intrapsychic identity versus his body; he takes one series of ambivalent and negative attitudes toward his physical being, while more loving feelings are kept for the feminine identity. Since his intrapsychic identity as a female is solid, it is the male body which he sees as not conforming to his needs. He thus centers his attack on his male body and its bodily structure, rather than on the intrapsychic identity, which remains for him egosyntonic and is therefore seen as being characterologically correct, habitual and “normal.”

Etiologically, Green (1976, 1973, 1975), Stoller (1968, 1970) and others have studied the psychodynamic identificational aspects of such people, using psychoanalytic clinical techniques. A fairly typical situation consists of a mother with a male child, who in some cases did not want the child, or desired a girl child. This mother has ambivalent personal sexual identifications, or has important unresolved sexual conflicts, not so much about being female rather than male, but about the problem of being a “penisless” woman. (This is different from not wanting to be a girl.) Most of these mothers feel reasonably good about being women, but they still feel like women who are missing or lacking something by not *also* having penises *as women* (Sarwer-Foner (1963) (*i.e.*, “women should also have penises”). This feeling is a central ambivalent and unresolved conflict for them. There is in such persons a certain envy of some aspects of masculinity, but many such females are not unhappy to be women; it is merely that unconsciously they would feel more complete as persons if, as part of being a woman, they also had some kind of penis of their own for “use as a woman,” to complete whatever might otherwise be absent in them. In other words, such a woman might become “a perfect woman” by also having a penis. Her boy child is unconsciously seen as being able to complete her feminine identity by offering a potentially feminized phallus for her (Stoller (1970)).

In brief, these male patients have not been given the corrective experience by their mothers when they adopted the social role, mannerisms, and

\*See Green (1969), (1973), (1975), Koranyi (1976), Person & Oversey (1974), and Stoller (1968), (1970).

therefore bits and pieces of the personal identity of the person *opposite* to their biological sex. Male children were not sent by such mothers the corrective cues that they were boys, but rather were encouraged to identify unconsciously with Mother. When this process is long-lasting, usually also in the presence of an absent, or a present but passive, dependent, erring or inadequate father, the boy concerned often adopts the mannerisms and sexual identity of a girl. I am alluding to cases without any pseudohermaphroditism or biological intersexuality (Money (1968), Stoller (1968) – where the parents believed the patient to be of the correct bodily sex, whose social and other behavior they were encouraging). Rather, I am alluding to patients who are encouraged by mother to be like her, despite being apparently biologically normal boys. In such cases, when seen as adults or adolescents in a sex gender identity clinic, they present themselves with all the psychic identity of a girl. In the cases seen by us, a high proportion of the males were already taking female hormones, had had plastic operations (*e.g.*, silicone injections and implants for breasts, etc.), had had depilatory procedures for facial and other bodily hair, and in many cases had cross-dressed as female for one to many years. These patients showed no guilt about feelings (already described by other authors) that they were women trapped in men's bodies. Their mannerisms and social behavior were characteristic of their sexual identity.

### **Narcissism and Exhibitionalism**

As a child, the narcissist is often well loved, sometimes adored and doted on, is given a lot of attention, and, on his part, forms a real attachment to mother, and a reasonably good ego in that sense. It is important to realize that the child has a perception of himself as a very important person in his own right, one that merits a lot of attention and love centered on his needs. As adults, many of these people show self-centeredness and narcissistic immaturity, particularly as to bodily or "value of my productions" exhibitionalism. Many see themselves (for these dynamic motivations as opposed to more mature reasons) as actresses, theatrical performers – perhaps performers in strip tease or female impersonators. They are particularly aware of physical grooming and appearance. Many are, for these narcissistic reasons, hairdressers or workers in other occupations coping with their own or other people's bodily needs – where to be pretty or correct, to dress properly is valued. Many are extremely self-centered people with a limited ability to relate other than about themselves. This raises the theoretical suggestion (one I cannot prove, but one which should be looked into) that the narcissistic preoccupation of their mothers with someone "exactly" like themselves, and therefore the children's necessary preoccupation with imitating and entirely enjoying playing at being preoccupied with themselves – "I am like mother" – limits in a fixating way their capacity to develop more externalized object relationship capacity. I do not mean that they have no relationship capacities, for these patients can be seductive or outgoing, and have quite normal egos in other areas; but their intense preoccupation with their bodies and themselves, and the amount of energy that they place into this preoccupation, colours all their interpersonal relationships. To put it simply, they are more concerned with what "I am"

(meaning what they are) than with the capacity to relate to others – even when they do relate to others. Some have little ability for real intrapersonal relationships. (This becomes part of the selfcentering preoccupations with all aspects of exhibitionalism, concern with their body, its functioning and care; so often seen in such patients.)

### Valuelessness of Maleness

When the little boy plays “as mother” with mother’s things, or shows tendencies to identify with mother, no corrective signals or corrective *experiences* are sent (such as “Boys don’t do this,” etc.). Mother seems to enjoy her little boy’s playing at being mother or at being a girl, and subtly encourages it, never sending the corrective signals “You are a boy, boys are different from girls in some ways, boys don’t do this, boys do X and Y.” Rather, instead of corrective signals, there are clear indications that mother enjoys, indeed values, likes and prefers the more complete feeling of closeness and bonding to her expressed in the boy’s attempting to be like her. These approving messages are clearly sent to the young boy. Here, there is no inherent respect for the maleness, or the value of maleness, or boyhoodness, or manhood, as such. It is all subtly rejected.

By contrast, some fatherless boys, but ones who have more normal mothers, are sent messages by their mothers that *they are boys*; and thus, even in the absence of a father, it is clear that such boys become boys (because mother sends the message that maleness in its own right is important, and being a properly able man is important, is respected and is desired for him by his mother). This encouragement, even in a fatherless boy, sets up a *gestalt*, or inserts at least a dream, a fantasy or the ideal of some maleness that is desirable and necessary, a feeling that somewhere maleness can be sought and acquired. Such boys look desperately around for male identificational figures, and also adapt to mother’s images and expectations of maleness in them. These are important factors for male identity when present.

By contrast, in the transsexual male patients, such an attitude is totally absent in their mothers, the opposite being true. Here there are no signals, no attitudes, no demonstrations, conscious or unconscious, of overtly valuing maleness as such. The future transsexual boy is in close fusion with the admiration of his mother, and needs and desires the femininity and feminineness of her, and identifies with her. Thus the boy feels from the earliest times on that it is correct to feel feminine and to be female.

In such cases, any organic factors – endocrinological, somatic tendencies to intersexual states, interference with endocrine-regulating mechanisms (Money (1968), Stoller (1968)) – which may be present, even in a “frust” or subtle form, will interact with and accent the developmental problems. This statement is made here because of reports, seen as controversial by some, but nevertheless incapable of refutation by present data, of the presence of subtle, frust (*i.e.*, small or minimal) biological factors that push in the direction of endocrine, chromosomal or other organic difficulties (Koranyi (1976), Mackenzie (1978), Hoenig (1979)). A significant number of the patients seen (as many as 25%) may be affiliated with some such condition.

It should hardly surprise anyone that if organic factors operating towards

diffusion or inversion of sexual role are present, they will interact with, reinforce, and be reinforced in their turn by the above-mentioned developmental intrapsychic environmental factors.

As already stated, overt male homosexuals often have an absent father, or a weak passive one, with a strong domineering mother; or as another set, a devalued aggressive, hostile, alcoholic, or violent father who is seen as undesirable. This background sometimes also exists in transsexual patients, but in many transsexual people it is remarkable how often the father is present in the family (Sarwer-Foner (1963)), alive and active with the family, but is seen in the family as of no importance, and as passive in the child-rearing role; or as submissive; or as an "absent figure" in the sense that the father is just an auxiliary mother, or someone who leaves the care of the children totally to her, may sometimes be a passive breadwinner who comes home tired and exhausted, or is himself a weak, faintly present, dominated man. The point I am trying to make is that father is often present in the family, and later is sometimes accepting of the transsexual state of his offspring. The important point is that the father is not seen as an active, intrapsychically important individual, and he plays little role in sending corrective messages in the formative years of the boy's sexual identity. Thus the boy ends up having a rather complete identification with mother — including his sexual identity with mother in terms of passive receptivity, or of active seduction of a more passive male, symbolizing his "real" dad.

Thus, such children feel feminine. They are enormously preoccupied with (and indeed succeed in dealing with) their own appearance and the way their whole bodies look. Their femininity is egosyntonic, with gestures that are female. Feeling female and seeing themselves as physically female, they feel uncomfortable when seen as male. It is the completeness of the above-mentioned process that is clinically striking in the typical "true" transsexual who has the above-mentioned factors in full measure. The male genitalia and maleness of the male body are not valued. Indeed they are seen as repugnant, or as a burden to be borne until it can be shaken off. Such patients often complain that their maleness is "an error of nature," and that something "went wrong with my body." They do not see the problem as "something gone wrong with my mind."

When as adults, suffering from transsexual identity, they get involved in overt adult sexual experiences, or as children in sex play, they will value the relationship to a male body as a whole, but will not be particularly interested in their own male genitalia. They often make a verbal distinction between themselves as transsexuals, and overt homosexuals (in an overtly homosexual relationship). They will say, for example, of their male, adult (homosexual) partner, "He is not a homosexual, he never touches my penis, he is not interested in my genitals," the implication being that he loves their female selves and that the transsexual's male genitals are not what is valued. Such patients will use this distinction as evidence that the other person is not homosexual and that they themselves are not homosexual either — just "females in male bodies."

### **Less Suitable Surgical Candidates**

A word should be said about those patients who present themselves

because they have read or heard of sexual surgery for transsexuals, but who do not in fact fit the above-mentioned rather pure picture in important respects and are much less clear-cut candidates for sex change surgery. These are patients who initially make the same request, stating that they are “women trapped in men’s bodies” – and that they want “to change their sex.” They are of various ages. Several of our cases had been married – one of our cases had had children; another of our cases was living and having heterosexual sex with a woman who was bitterly upset by his condition, knowing that he was coming to our Clinic with the hope he could get sex change surgery. (He, in a narcissistic and self-centered way, expressed his intellectual awareness of the grief his wife was undergoing, but explained that it was important to him to attempt this change.) Many of these patients did not show the overwhelming unconscious identification with being a woman. One felt that some of these patients were diagnostically Borderline Personality Organization patients not sure of their identity, but looking for solutions (Sarwer-Foner (1977)). Others were passive-aggressive obsessional males with much female as compared to male identification, fixated largely at the anal level of functioning, both sexually and psychodynamically, particularly in terms of trying to control, or to submit themselves to someone else’s control; they were looking for socially acceptable rationalizations for their overt homosexual activities or tendencies. Several of these patients had enjoyed anal sexual activities with other males, as well as social activities as a “transsexual” with males and females, and had been doing so for years. They did not, however, see themselves as “homosexuals.” They rather preferred to see themselves as “transsexuals,” *i.e.*, to believe that nature had made a mistake – a kind of morally needed rationalization for their overt homosexual conflicts and desires, particularly of an anal kind. This was the main unconscious – and in many cases, conscious – motivation for their desire to seek surgical sexual transformation.

Inevitably we were very cautious with such patients, reserved in our recommendations, did not easily lend ourselves to recommending them *rapidly* for surgery. Rather, the conservative approach, suggested I think by all Gender Identity Clinics, was followed. The patients were asked whether they wished to go into psychotherapy, and the possibility was explored with them. Usually it was refused as not acceptable by most of these patients. These were then asked to see if they could live in a cross-dressed situation for a long time. Female hormonal treatment was tentatively suggested. Some of these patients do not stand up to the rigors of these procedures, and it is best to be really cautious in case one produces irreparable harm. Some of the consequences that can occur when this happens are recorded in the literature.

Another category of such patients is the patient with poor ego and poor body image, confusion in his psychosexual identity, often asexual; or with homosexual sexual activity, and often with very little sexuality in it. There is also the patient who is a “homosexual seducer” and feels guilty about it, and seeks surgery for relief of his guilt in this regard.

In such patients the prognosis could be guarded if they underwent sexual change operations; and the most extreme caution is indicated (along the lines already mentioned) with such cases.

It is true that some very femininely identified, overt male homosexual people (not true transsexuals), who would prefer sex change operations to justify their homosexual behavior, and who can cross-dress and live as females and be happy in the role changes, can, in some cases, make good surgical sex change subjects. The point is that they make less good surgical subjects; success with them is less certain, and many problems occur later in some of these patients. They therefore offer significant risk in what is an irreversible surgical procedure. This point is of great clinical and legal significance.

### **Pre-Psychotic Patients**

Another type of patient who sometimes presents as a candidate for surgery is a patient who is in a prepsychotic state (usually a paranoid one), sometimes with severe depressive illness, schizoaffective, or manic-depressive (bipolar) (Mackenzie (1978)) illness, but illness that is not in an overtly manifest form at the time they are seen. They often show, rather than the true transsexual identification, a compulsive desire to “get rid” of their genitalia, because their genitalia are “a burden.” Their aim is not really to change sex – they “want these damn things off,” meaning the penis and the testicles, and it is this accent, rather than a truly rather complete feminine identification, that is the clinical issue. Sometimes such patients have had previous heterosexual experiences, and occasionally, a great deal of heterosexual sex life. They come troubled by their penis and testicles, by the various symbolic meanings they have for them, and ask to be changed “into a female.” Exploration of their identifications, however, shows less of a complete intrapsychic identification with the female, than anger, ambivalence or hostility toward the “burden” put on their lives by their sexual impulses (both aggressive and libidinal) as they see them emerge through or represented by their penis and testicles. It is clinically risky to operate on such patients. They sometimes show the same kind of post-operative evolution towards paranoid states, depressive illness, and homicidal or suicidal potential as many other patients who ask that their faces be lifted, their breasts be changed, or their noses be altered, with many of the same psychodynamics, both displaced onto the face, breasts or nose in the other patients. Plastic surgeons, and occasionally psychiatrists, have become all too aware of the dangers of operating on such patients when they are not properly diagnosed.

### **Offers of Other than Sex-Change Therapy**

When one attempts in psychoanalytically-oriented interviews with such patients to explore, study and offer sympathetic psychoanalytically oriented psychotherapy, psychoanalysis, or other psychotherapeutic treatment to help them cope with or solve their intrapsychic confusion and intrapsychic identity problems – in other words, when one offers psychiatric treatment rather than surgery – it is interesting that transsexual patients are not at all interested; they want only their sex change surgery. Some of the other categories of people seen are equally distressed by their bodies and determined to seek change, but here one can usually find evidence sufficiently compelling to be able to offer such patients at least the

opportunity to look at the other problems in psychotherapy. The really determined patients, of course, refuse. One is usually able to persuade such patients to submit themselves to “the test” of living through the experience of cross-dressing, hormonal treatment, and attempting to live in the roles of the opposite sex, for a considerable period of time (up to two years) to see whether this life is possible and satisfying. In some cases this attempt is not possible, and/or does not satisfy them; and problems emerge which sometimes (rarely) then allow such patients to accept psychotherapeutic help. Many such patients, however, live ambivalent and troubled lives in the cross-dressed and hormonally-induced feminine roles, not happy, but not so desperately unhappy, either, that they cannot stand it. These are the difficult cases, often with questionable post-surgical results if one operates; but many of these patients will persist until they succeed in having surgery done by someone.

The diagnostic evaluation of patients demands good clinical judgement and the formal assessment of the risks, as well as sympathetic understanding of their suffering, and a desire to help realistically. Rarely, one can convince a patient so conflicted to become accessible to psychotherapy or to psychoanalysis. This case is the exception rather than the rule.

Psychiatrists have a serious moral obligation to help patients sort out the nature of their intrapsychic difficulties, and therefore to be able to offer reasonable therapeutic options, as compared to unreasonable therapeutic options. The need is for consenting, collaborative attempts, based on a good therapeutic alliance, to see what psychiatric, physical, and endocrinological study shows us to be the situation, and thus to be able to offer proper therapeutic information and guidance. For the selected suitable patient it may be hormones, cross-dressing, living as a person of the opposite sex, and functioning in those roles for a sufficiently long period of time, before attempting surgery.

### **Some Comments on Transvestism\***

Space precludes a major discussion of transvestism here. (Stoller (1977) succinctly classified cross-dressers in a very good and *brief* way.) Only one aspect of transvestism will, for the purposes of this paper, be mentioned here. The genuine transvestite values his penis and testicles, at least unconsciously. He may not value his male persona as such, or may feel that he “is miserable” functioning as a male, but he is aware of having and somehow wishes to retain (*i.e.*, values) his penis and testicles, even if retaining them is troublesome and he is ambivalent. He may be very anxious to be taken as a female, may dress as and look to be an attractive female. One should remember here that transvestite patients offer a spectrum of unconscious motivations for their cross-dressing – one identifying genuinely with feminine dress and feminine capacities and valuing them; another showing a very hostile and ambivalent need to caricature some aspects of femininity, etc. (Stoller (1977)). In all cases, however, the presence of the penis and testicles is unconsciously valued in their own right. Thus, psychodynamically, such patients “have a secret” – they know they have

\*See Green (1975), Stoller (1971), (1977).

the penis and testicles under their skirts. This is a very different intrapsychic set of factors from those of the characteristically complete transsexual already discussed. It is quite true that a certain proportion of transvestite patients evolve in their unhappiness and misery, particularly if they cross-dress long enough and take hormonal injections, etc., to feeling that they too want sex change procedures, and would be happier as females. Some successfully make this transition. The typical transvestite person, however, has little wish to have a surgical sex change procedure, and sees himself as living with a partial feminine identity, conflicted but unconsciously content that he also has a penis and testicles.

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