When A Door Closes …

In 1972, I was a 20-year-old student at Penn State University. At that time, my gender dysphoria was becoming almost crippling. In fact, I started hormone therapy about 9 months after these papers were written. So, I used every opportunity to bury myself in the stacks of Patee Library reading every journal article and book on transvestism and transsexualism that I could lay my hands on. And since I had to write papers as part of my course requirements, why not "kill two birds with one stone?" So I wrote a

Winters at Penn State were cold, but miniskirts were *de rigueur*

number of papers on these topics as an undergraduate psychology student. As I recall, none of my classmates covered these topics.

I wrote “Transvestism: A Review of Current Literature” in the winter of 1972, as a Junior Psychology Major. It was a requirement for the PSY 412 course, which was entitled “Abnormal Psychology.” It was taught by Alan Kazdin, PhD., who was then a young new, and very progressive young professor. I had him in my Intro course, and he inspired me to pursue psychology as a major. I had the opportunity to work for him as a research assistant while in my senior year. Kazdin went on to have a stellar career at Yale University. He has authored 49 books and has served as President of the American Psychological Association. I was truly privileged to study under him.

To summarize the paper, I pointed out that as early as 1962, researchers realized that there were many reasons people dressed in the clothing typical of the opposite gender, and that crossdressing was a historical, cross-cultural phenomenon. It was an almost exclusively male phenomenon. Robert J. Stoller, who ultimately was discredited for his work on the etiology of transgender identities, said that female transvestism did not exist. “The transvestite is either autosexual, bisexual or exclusively heterosexual.” I pointed out in my paper that other than gender discomfort and a desire for gender reassignment surgery, there was no difference between transvestites and transsexuals. They existed on a continuum.

I extensively quoted Harry Benjamin. In a question of “nature vs. nurture,” I concluded that the research at that time indicated that one’s family background had little to do with the cause of transvestism. Robert Stoller divided transvestites into “phallic women” and fetishistic transvestites. Again, though Stoller was publishing frequently on sex and gender, many of his views were and continue to be controversial.

I discussed the etiology in terms of “Learning Theory” where a curiosity about one’s appearance as a woman leads to crossdressing, which leads to sexual gratification, which reinforces the act. In Freudian theory, crossdressing is a part of castration anxiety. Biological Theory was not shedding any light on causation at that time.

Treatment methods (assuming that treatment was sought out) included psychoanalysis, but I pointed out that many transvestites did not desire treatment, or merely to alleviate the associated guilt of crossdressing without a desire to stop crossdressing. I discussed aversion therapy, now discredited as “conversion therapy.” In one method, transvestites were given apomorphine, which causes nausea, while watching slides of themselves crossdressing. In time, electric shock replaced apomorphine and the results reported were “promising.” Shame aversion therapy was also tried, in which the transvestite had to dress up in front of observers who show disapproval of their behavior. I mentioned that this was likely to be quite ineffective because many transvestites had exhibitionist tendencies. Yikes!

Interestingly, Dr. Benjamin suggested estrogen therapy for crossdressers: reducing one’s libido would eliminate the drive to cross-dress. I also briefly mentioned castration, LSD, and electroshock treatment. Hypnosis was used both to discover the etiology of transvestism by regression, as well as for treatment. In the treatment of childhood transvestism, I discussed play therapy and alluded to behavior modification. I mentioned that this type of therapy needed further investigation. Again, Yikes!

In my conclusion, I mentioned the greater latitude society gave women in choosing the way they dressed (this was the 1970s, after all) and I pointed out that the problem wasn’t the crossdressing: it was society’s attitude toward crossdressing. I urged educating the public. It turns out I followed up on that pledge.

I wrote “Childhood Transvestism in Males in Spring 1972, as part of the course requirements for PSY 425, which was Child Psychology. I must admit, I never really got into the course or the subject matter. The course was taught by Dr. David S. Palermo. At that time, he was doing pioneering research in psycholinguistics, specifically in child cognitive development and language acquisition. He would go on to write several books and over a hundred journal articles.

I noted in this article that even then, we knew that children of age 3 were aware of gender differences and gender expression, and gender identity is established by age 4. Fifty years of research since then has supported that finding. Crossdressing in boys also starts early: at about that age 2 to 4. I also pointed out that transvestism, rather than being a separate entity (in the 1970s, a separate **pathological** entity) could be a symptom of cross gender identification, transsexuality, or homosexuality.

In discussing parental influences, I cited John Money, who thought that gender role is learned, and not influenced by chromosomes, gonads, or sex hormones. We know now in retrospect that Money was completely wrong. To pile on some more misguided research, I cited Robert Stoller who said that crossdressing was caused by moms seeking to feminize their sons, sometimes unwittingly aided and abetted by the father, sometimes even forcing the child to cross-dress as punishment. Sheesh.

Other folks that I cited rolled out the usual arguments: mothers who wanted a daughter but got a son, rejection by fathers, over-domineering fathers and protective mothers, the boy’s over-identification with his mother, aggressive mothers, submissive fathers, parental rejection, confusion over sexual identity, imprinting, adverse conditioning, castration anxiety, unresolved Oedipal complex, narcissism, and even fetishism. But the best explanation at the time was an “inherent factor” in the hypothalamic center of the brain. I did mention Virginia Prince and *Transvestia* magazine, who also thought the etiology was likely neuroendocrine.

Since in the 1970s childhood crossdressing required “treatment” and I was, after all, writing a psychology paper, I discussed the current types of therapy: Play therapy, family therapy, and behavior modification (conditioning). But I closed by saying that transvestism is generally resistant to treatment. In the long run, perhaps we realized that it isn’t a pathology and therefore doesn’t need treatment.

It wasn’t a particularly well written paper and my grade reflected that. But I managed to earn a B in the course.

The other paper is “The Treatment of Transsexualism,” which I wrote for PSY 482, which was Clinical Psychology, another course that I also took in Spring 1972. In my paper I open with Harry Benjamin describing transsexuals as “emotionally immature, unreliable, self-centered and irresponsible, with occasional paranoid tendencies.” Some of those traits pretty much describe me and a lot of the trans folks I’ve met as well. Also, at that time, it seemed that the ratio of trans women to trans men was 3 to 1, but since then, that ratio has largely evened out.

I wrote about the possibility of treating transsexual children with intensive individual and family therapy with the goal of a reversal of the child’s gender orientation. But if treatment is not successful by adolescence, the orientation could not be changed. I cited Ira Pauly’s research that psychoanalysis is useless as gender identity is fixed early in life. Transsexuals were also resistant to aversion therapy, again because gender identity is already fixed. Librium and Stelazine didn’t help either, but where they failed, estrogen succeeded in trans women.

I felt the role of the psychologist was more to support the transsexual and their family in the transition process, as well as postoperative support. I cited research that showed that in 1969, most psychiatrists and surgeons, and a good percentage of general practitioners opposed gender reassignment surgery, even if the individual were suicidal. I pointed out the old argument that ultimately doomed the Johns Hopkins Gender Clinic, that transsexualism is a mental illness, and mental illnesses aren't treated by surgery.

My conclusion was that given the successful postoperative outcomes of transsexuals, surgery is a legitimate therapy, and "in this way, medicine and psychology can combine to bring help to transsexual individuals, where they have failed to do so separately." I kind of like that. I guess my professor did as well: I got an A in the course.

By the time I graduated in March 1973, the effects of six months of estrogen were starting to show. I threw the dice and applied to two graduate schools that had a BS to PhD in Clinical Psychology track. I was not accepted into either program, which was a hard thing to accept. Instead, I chose to focus on my gender transition first, and then eventually revisit education. So I suppose when that door closed, a window opened.

Graduation Day!