THE MALE TO FEMALE TRANSSEXUAL: A CASE STUDY

by

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ABSTRACT

This study was undertaken to examine the development and ongoing adjustment of a male-to-female transsexual. Relying primarily on interviews with the case subject, selected friends and family members, the research attempted to uncover incidents which were critical in this person's post operative psychological and social adjustment. The interviews were conducted in accordance with guidelines set down by Flanagan (1954). The incidents were classified in accordance with the eco-systemic framework put forth by Conger (1981). This theoretical framework emphasized the context within which the incidents occurred. Psychological and social adjustment were assessed by three standardized instruments: The Minnesota Multiphasic Personality Inventory (Hathaway & McKinley, 1967); The Social Support Questionnaire (Sarason, Levine & Basham, 1983); and The Family Assessment Measure (Skinner, Steinhauer, & Santa-Barbara, 1984).

During the course of the interviews a total of 30 "critical incidents" were revealed. Of the 30 incidents, 22 of them were classified at the "community" level of analysis. This result underscored the importance of various community level systems or groups, at both the pre- and post operative stages. Once classified, the incidents were rated, by both the case subject and case investigator, in terms of relative importance to the individual's post operative adjustment. These incidents were then discussed in terms of three primary themes: acceptance versus rejection, competency versus incompetency, and isolation versus belonging.

In addition to the critical incidents, a series of ongoing situational influences were revealed during the interview process. These influences were also classified in terms of Conger's (1981) eco-systemic classification system. The situational influences were discussed in terms of two primary themes: personal style and interpersonal relationships.

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CHAPTER I

INTRODUCTION

Transsexualism is the conviction in a biologically normal person of being a member of the opposite sex. This belief is sometimes accompanied by a request for surgical and endocrinological procedures that change anatomical appearance to that of the opposite sex (Stoller, 1968). The DSM III (1980) defines the phenomenon as "a heterogeneous disorder of gender identity (the sense of knowing to which sex one belongs)." The primary features are "a persistent sense of discomfort and inappropriateness about one's anatomic sex and a persistent wish to be rid of one's genitals and to live as a member of the other sex." (p. 261-262)

The issue of classification and diagnosis has been one of ongoing debate: a debate which continues today. Parallel with efforts to diagnose, there has been a concerted attempt to discover the cause(s) of this seemingly aberrant perception of gender identity. The results of this stream of research remain equivocal. Some writers are now suggesting that the majority of the evidence points to a 'social learning' basis for the development of the syndrome (Hoult, 1983/84), while others take a more interactive stance between biological and psychological theories of etiology (Hoenig, 1985). Ethical, legal and medical implications of sex-reassignment have been argued as well. Results of outcome studies now suggest that for an appropriately diagnosed group, surgical sex-reassignment does appear as the best option (Hunt and Hampson, 1980; Abramowitz, 1986).

Though many of these issues are common to the study of both male and female transsexuals, this study focuses primarily on the phenomenon of the male (i.e. biologically male) transsexual. An exploratory, single case design was selected to study an individual male-to-female post operative transsexual who has lived in

the community for a significant length of time (fourteen years) in an apparently successful manner. The analysis attempts to apply an ecological systems classification to the 'critical incidents' gleaned from interviews with the case subject and significant others in her life. The purpose of this analysis is to illuminate the range of influences which have affected her post operative adjustment and to increase the empirical data base on male-to-female post operative transsexuals.

Nature of the problem

Examples of what we now term as transsexualism have been recorded throughout history (Steiner, 1981), although scientific study of the phenomenon has been primarily limited to the last forty years. The term was coined by Caldwell in 1947. In the 1950's, the case of Christine Jorgenson was reported widely in the popular press (Ball, 1981). For the first time, the condition of transsexualism and the intervention of sex-reassignment surgery began to enter the public consciousness. Accompanying this increase in public awareness was a corresponding increase in demand for the surgery (Ball, 1981). As a consequence, the psychiatric community was faced with an increasingly heterogeneous population requesting sex-reassignment (Ball, 1981).

Due to this heterogeneity in the patient/client population, issues of diagnosis and classification became increasingly complex. Research into this area was fraught with disagreement. Though a variety of schemas were introduced, the issue remains contentious to this day.

As scientific interest increased, etiological issues became a primary focus of study. Again, results were conflicting; some authors suggested that the majority of the evidence supports a 'social learning' model of etiology (Hoult, 1983/84) while other authors supported the view that psychological factors may come into effect

only if a biological predisposition is first in place (Hoenig, 1985; Money, Hampson and Hampson, 1957).

Studies of treatment outcome suggest that sex-reassignment surgery is the preferred mode of treatment in a select group of appropriately diagnosed individuals (Hunt and Hampson, 1980). Research also indicates that surgery does not preclude the use of psychotherapy in dealing with both pre- and post operative issues (Lothstein, 1983). In addition it appears that in the majority of cases, post operative adjustment is significantly affected (positively) by psychotherapy in conjunction with medical treatment (Lothstein, 1980). Some authors have recently suggested, however, that the frequency of classification as 'surgically appropriate' transsexuals has been too great and that in certain cases, non-surgical interventions (i.e. psychotherapy) would be more successful (Lothstein, 1983).

Purpose of the Study

Though interest as well as disagreement in areas of etiology, treatment, and classification is ongoing within the scientific community, we are still faced with individuals displaying symptoms which meet various criteria for diagnosis as transsexual. In addition, medical intervention in the form of sex-reassignment surgery (SRS) is performed in various countries, including Canada. It appears that we are not in a position where pre-operative issues may be studied exhaustively before beginning the study of post operative ones.

Accepting that at present psychotherapeutic intervention is useful in conjunction with SRS for the most positive post operative prognosis, the goal of this study was to explore the form this intervention (i.e. psychotherapy) might optimally take, and the general issues on which it might focus. Though differences between individuals surely exist, empirical research in areas such as psychiatry, clinical psychology, and counselling psychology has provided theory and statements

of principle. Such information guides therapists in their work with individuals. Statements of principle and theory appear to have been lacking for the persons described as transsexual.

The purpose of this study has been to reveal the development and ongoing adjustment of an individual within the context of her life circumstances. This focus differs from that of most of the published research (e.g. Randell, 1969; Skapec and Mackenzie, 1981), which appears largely to have ignored the impact of the family, the medical, psychiatric, and legal professions, and other groups which surround the individual and comprise the context within which life is lived. The exception to this situation are certain studies cited which focus on the etiology of the transsexual syndrome.

Bronfenbrenner (1977) proposed an ecological systems model for research which views the reciprocal interaction of a series of "nested systems." Using Conger's (1981) adaptation of this model as the basis for the analysis of an individual case, the present research examined how such 'systems' as the family, peer group, medical and educational agencies have influenced the post operative adjustment of the individual.

This study does not provide definitive answers, it does however enrich the existing knowledge base in the area of transsexualism. Perhaps more importantly, by taking the case study approach, and examining what factors are perceived as significant in this person's post operative adjustment, and how they have interacted to affect this individual, the study provides an alternative focus to much of the published research in this area.

This project contributes to the development of an ecological, systemic understanding of post operative transsexual adjustment from which clinicians may draw when called upon to intervene with this population.

The Ecological-Systems Model

Central to systems theory is the belief that the various elements or parts of a bounded unit (i.e. a system) are interdependent. As each element acts and reacts, it cannot help but have an effect, either directly or indirectly, upon other elements which in turn react and have an effect on the original unit at some later moment in time (Conger, 1981). Historically, systems theorists have defined this 'bounded unit' as being the family (Haley, 1963). The result of this definition was a focus on the 'family system' and the various subsystems which comprise it.

Bronfenbrenner (1977, 1979) proposed an expansion of this model for the study of child development. Emphasizing the notion of 'reciprocity' (interacting and mutually affecting elements), he proposed that the family be viewed as one of a series of micro-systems which affect the developing child. In his descriptions of the different levels of systems, he gave examples which applied to adults as well as to children. This suggests that he viewed the individual as a dynamic system developing throughout the life cycle. Coupled with his notion of 'ecological transition' (where the individual's position is changed in the environment as a result of change in role, setting, or both [1979, p. 26]), it would seem that the ecological systems model is an appropriate model for studying the entire life cycle, and is not limited to a study of childhood.

Conger (1981), building on the work of Bronfenbrenner proposes his own model for behavioral assessment of families. "Following Bronfenbrenner (1979), we are concerned with the reciprocal influences that individual characteristics, family dynamics, and transactions with the outside community have on one another." (p. 202) The focus is on the creation of a framework which stresses the interaction of three primary levels of analysis. The levels of analysis and illustrative measures proposed by Conger are summarized in Table 1.1.

TABLE 1.1

THE ECOLOGICAL SYSTEMS FRAMEWORK

Level of Analysis	Illustrative Measures
1. The individual family member	a. Social background (parents) b. Experiences in family of origin c. Mood: depression d. Intellectual functioning e. Excessive, deficient, or inappropriate behavioral characteristics
2. The family system	a.Structure (1)number of adults (2)number of children (3)ages of parents and children (4)living conditions b. perceptions and attributions by family members to one another c. patterns of interaction
3. The community	a. Social position: (1)economic status (2)educational success (3)geographic location (4)desirability of employment b. Contacts with social agencies (1) voluntary as desired (2) coercive - economically necessary or instigated by others c. Social relationships (1) friendship networks (2) extended family (p. 202)

This table is based on a systemic conceptualization involving circular and reciprocally interacting relationships. Conger views the individual as embedded within the family and the family within the community. This schema emphasizes the series of "nested systems" which form a dynamic and interacting context within which assessment can take place at any or all of the levels of analysis.

Research Questions

What are the significant factors in the post operative adjustment of a male-to-female transsexual? What are the consequences of these factors, and why are they seen as significant in the subject's post operative adjustment? Among factors identified as significant, what is their order of significance?

Definitions

Transsexual

O'Gourman (1982, p.23) defines transsexualism as " . . . a disturbance of sexual identity in which the patient's morphological sex is incongruent with psychological sex. The patient persistently seeks to live as a member of the other sex." For the purpose of this study, the individual under investigation had experienced the process of diagnosis, screening, and medical intervention (sex-reassignment surgery) and had lived post operatively as a woman for some fourteen years prior to the study.

Adjustment

In this study, 'adjustment' focused on the individual's level of both psychological and social functioning as measured by self-report instruments. Areas assessed included:

-family functioning,

-interpersonal relationships and social support,

-self image, and

-psychological functioning

Pre-operative Transsexual

A transsexual person before sex-reassignment surgery.

Post Operative Transsexual

A transsexual person after sex-reassignment surgery.

Significant Factors

A significant factor may be an individual event (e.g. disclosure to the family of the subject's desire for sex-reassignment surgery) or a situation or set of circumstances over some discrete period of time (e.g. economic difficulties).

Data were generated by using several methods: self-report; reports of significant others, including family, friends, involved professionals; and data from past medical/psychological records of the individual, (including standardized assessment instruments). In addition, factors gleaned from the research literature were investigated for applicability to the case subject.

The factors were elicited through an interview process, and their significance was assessed qualitatively using statements of the case subject, family and friends.

CHAPTER II
REVIEW OF THE LITERATURE

This review of the of the current research literature on transsexualism and gender dysphoria focuses primarily on the three major topics of diagnosis/classification, etiology, and treatment (including studies of treatment outcome). They are surveyed here not only for their prevalence in the research literature, but also for this writer's supposition that they cannot truly be separated from each other (i.e. opinions about one topic cannot help but influence opinions on the others). It is also this writer's supposition that the treatment community's opinions and beliefs about these topics will strongly affect the experience of the transsexual person seeking sex-reassignment surgery.

Research on Classification and Diagnosis

O'Gourman (1982, p. 23) defined transsexualism as " . . . a disturbance of sexual identity in which the patient's morphological sex is incongruent with psychological sex. The patient persistently seeks to live as a member of the other sex." Jan Morris, a post operative (male) transsexual, defined it as " . . . its classic form is as distinct from transvestism as it is from homosexuality . . . . Transsexualism is something different in kind. It is not a sexual mode or preference. It is not an act of sex at all. It is a passionate, lifelong, ineradicable conviction . . . " (1974, p. 8).

For the past forty years, research has attempted to classify this state of psychological and morphological incongruence, termed as "transsexualism" (Caldwell, 1947). Though specific terms have varied, efforts have been directed at classification and distinction of 'primary' transsexualism from 'secondary'

transsexualism (transvestites or homosexuals requesting sex-reassignment surgery [SRS]) (Ball, 1981; Roth and Ball, 1964).

Benjamin (1966) developed a seven-category "Sex Orientation Scale," describing what he saw as a continuum of gender orientation. The first category was in part described as " . . . any person of normal sex and gender orientation for whom ideas of cross-dressing or sex change are completely foreign and definitely unpleasant, whether the person is hetero, bi- or homosexual" (in Oles, 1977, p. 68). The remaining categories followed from this extreme along the continuum and were represented as: Pseudo Transvestite, Fetishistic Transvestite, True Transvestite, Non-Surgical Transsexual, True Transsexual--Moderate Intensity and True Transsexual--High Intensity. The latter six categories all shared the outward behavior of cross-dressing but with varying degrees of identification with the cross-gender as well as frequency of the behavior.

The use of the more recent term 'gender dysphoria syndrome' reflects this notion of a continuum and range of behaviors, motivations and attitudes which are presented by individuals requesting sex-reassignment (Oles, 1977). Gender dysphoria as a category subsumes not only that of transsexual but the entire range of individuals who may at some time have cross-gender desires. This group will include select transvestites and some effeminate homosexuals and masculine lesbians (Steiner, 1985). Transsexualism may be viewed as an extreme of the gender dysphoria syndrome. Though the transsexual may have certain characteristics in common with other gender dysphoric individuals, other members of this classification will be distinguishable due to their inconsistency of cross-gender desire and associated negative affect (i.e. anxiety and reactive depression) (Steiner, 1985).

A more recent classification system now in use at the Clarke Institute of Psychiatry focuses on the variations of gender dysphoria presented. These are:

transvestite, heterosexual transsexual, asexual transsexual and homosexual transsexual (Steiner, 1981). All four categories have in common the behavior of cross-dressing. The transvestite individual is defined as a heterosexual male who achieves fetishistic arousal by wearing various items of feminine attire. Though at times the transvestite may experience gender dysphoric feelings, these are usually of a transitory nature and consequently the individual is not considered to be either transsexual or a good candidate for SRS. However, there are recorded cases of diagnosed transvestites who in middle age develop into transsexuals (at which time the diagnosis changes). The latter three categories all experience ongoing gender dysphoria: they differ in sexual orientation (object choice) and not in the overall classification of transsexual. From this standpoint they are all considered potential candidates for SRS (Steiner, 1985).

Attempts to classify in terms of either of these and other schema have taken a variety of forms. These have included screening processes stressing multidisciplinary interview techniques, including social, psychological, psychiatric and neuroendocrinological assessments (Lothstein 1980; Weatherhead, Powers, Rodgers, Schumacher, Ballard, and Hartwell, 1978). In both of these studies cited, the process was multi-purpose, including: diagnosis, acceptance to the program of SRS, and follow-up on post-surgical adjustment. Lothstein (1980) specifically addressed the need for psychotherapy from the time of diagnosis through surgery (and after), so as to facilitate improved adjustment to the new role.

Weatherhead et al. (1978) reported that counselling was a requirement of their program at the Cleveland Clinic. It was carried out by a psychiatric social worker for a minimum of six months pre-operatively, and post operatively, for an undescribed period of time. They stated that counselling served several purposes: (1) to support patients in adjusting to the social environment as they begin the process of full time cross-living; (2) to develop a counselling environment of total

acceptance where the patient feels free to explore all areas of self doubt (whether or not they are related to transsexualism); (3) to monitor the continued motivation of the patient; (4) to allow for an ongoing intensive evaluation and assessment of the patient. During this process the team psychologist would administer the Thematic Apperception Test. Data generated from this test would be supplied to the therapist for further exploration (if not already covered) during therapy. Once at the point where the therapist was prepared to commit the patient to the stage of SRS, they (the therapist) would refer the patient back to the team psychiatrist for another assessment (which included a rewriting of the original test battery). If the psychiatrist was in agreement, the case was then put forth to the treatment team as a whole. If the entire team agreed, the patient/client was recommended for surgery.

Questions could be raised regarding how therapists at the Cleveland Clinic were able to provide therapeutic environments of "total acceptance" when they were simultaneously conducting assessments which would contribute to a recommendation for or against surgery. Weatherhead et al. (1978) did not discuss this concern, and how it was dealt with in their program.

Shumaker, in chronicling her experiences as a pre- and then post operative male-to-female transsexual (Levine and Shumaker, 1983), addressed directly this issue of the theraputic relationship. In describing her pre-operative therapy (with Levine, her later co-author) she stated that she consciously limited the therapeutic experience, being always slightly suspicious of her therapist, whom she knew to hold much power over her ability to attain the SRS. It is Shumaker's contention that had pre-operative therapy been effective at a deeper level, it might have helped to prepare her for the post operative realities (and difficulties) which she would later face.

Psychotherapy, while difficult and at times controversial, has been central in both issues of diagnosis and adjustment. Keller, Althof and Lothstein (1980) conducted a four year study of the efficacy of group therapy with proclaimed male and female transsexuals (all pre-operative). As a screening device, the modality of long term group therapy was seen as being highly effective. Over the period of study, 43% of the participants opted out of the program and, in effect, out of surgery. The authors classified these as instances of transvestism. It is interesting to note that the group that dropped out tended to be older (mean age 35) white males. What ultimately became of the program dropouts and whether follow-up was done with them was not explained by the authors.

Morgan (1978) presented his efforts in an ongoing process of classification, which included an initial diagnosis, followed by further refinement so as to differentiate those individuals appropriate for SRS, from those whom he judged would benefit from psychological forms of intervention. Morgan states that, in his opinion, "core gender identity" (as defined by Stoller, 1968) is a continuum on which we all reside. Experience, he reports, has shown him that the hypothetical and classic case of the anatomical male who views his penis as some type of growth capable of giving him no pleasure, who has always thought of himself as a woman, who presents convincingly to the world as such, is a very straight-forward but extremely rare case (p. 274). The majority of patients who present as transsexuals (self-diagnosed) do not fall at this extreme of the continuum, but rather somewhere closer to the centre. As a result, classification and diagnosis is a process which requires an intense evaluation over an extended period of time. Morgan says that the clinician, when engaging these individuals in this ongoing process of evaluation and treatment, must be prepared to deal with what he has termed "the transsexual imperative" (the determined, unrelenting, and sometimes hystrionic pursuit of SRS). He estimates that as an outcome of the classification/diagnosis process, 15% of

transsexual candidates will be found to be suffering from a major mental illness, 30% will be classed as 'homophobic homosexuals' attempting to escape a sexual orientation they find abhorrent, and 20%-25% are sexually ambiguous individuals who are given the diagnosis of "inadequate personality." This latter group, Morgan suggests, are correct in their assessment that they must make some profound changes if they are to achieve any sense of satisfaction and happiness from life; they are incorrect, however, in labeling it as an issue solvable by surgical gender transformation. In discussing why 65%-70% of individuals presenting as transsexual are actually suffering from other difficulties, Morgan returns to his concept of "the transsexual imperative." He points out that diagnoses such as schizophrenia, inadequate personality and homosexuality carry clear negative connotations. Transsexualism, he asserts:

> . . . has somehow escaped the severe censure of these other three, perhaps because it is a diagnosis like 'acute appendicitis.' After surgery the diagnosis goes away. After the surgery the transsexual is a 'woman,' a considerable improvement over being 'crazy,' 'inept,' or 'queer,' in the minds of most. The imperative of the transsexual candidate is an echo of the societal imperative to be 'normal,' 'regular,' and 'straight,' as this society defines these terms. (p. 281)

Descriptions of behavior, congruent with Morgan's concept of the transsexual imperative, can be found in the writings of a number of other authors (e.g. Ball, 1981).

Following Morgan (1978), Meyer (1983) clearly stated that in his opinion, appropriate diagnosis takes place within the framework of ongoing (and relatively long term) psychotherapy. Meyer, in describing his program, said that if the prospective patient was accepted into the program, he or she was then immediately

referred to either group or individual therapy (as a prerequisite to any further progress toward SRS, including the administration of appropriate hormones). It should be noted that individuals accepted into this program were given no guarantees of SRS as a final outcome. Meyer said that diagnosis of the 'true transsexual' took place over the course of the weekly therapy sessions. Considered in this diagnosis was how well a sense of feminine identity was integrated (in the case of a biological male) as well as the individual's ability to deal with frustration, and to 'bide time.' Meyer stated that the candidate with the best prognosis was one with a real understanding of the difficulties to be faced once this transformation was complete. He went on to suggest that this understanding, combined with a personal maturity, may possibly have been correlated with the stability of the cross gender identity.

In this program (Meyer, 1983) only 5% to 10% of candidates actually opted for the completion of SRS. Other reported results included: permanent passing without surgery, or passing while waiting for improved surgical techniques; living (at different times) as both sexes, and settling on neither; resolution of the dysphoria and permanent return to the original gender.

Efforts at the creation of a common psychological profile through the use of such standardized measures as the Minnesota Multiphasic Personality Inventory, California Personality Inventory and Thematic Apperception Test, have yielded no consistent results (Weatherhead, et al., 1978). Other efforts at seeking common characteristics across subjects suggest that the most outstanding characteristic of people diagnosed as transsexual is a narcissistic withdrawal to a condition which is "dominated by submission and pseudo-femininity" (Sorenson and Hertoft, 1982, p.142). This was observed in conjunction with a suppression of aggressive and sexual feelings (Sorenson and Hertoft, 1982). In addition to this, the other common

finding is that of lower self esteem scores compared with both heterosexual and homosexual groups (Ball, 1981; Skapec and Mackenzie, 1981).

Walinder, Lundstrom, and Thuwe (1978) studied a mixed group (biological females and biological males) of fourteen post operative cases. Five of these individuals stated that they regretted having had the surgery, and therefore were considered as failures. Walinder et al. hypothesized a series of factors, which if present would act as contraindicators to surgery, and would therefore tend to be present in the background of the five subjects who stated regret at having been sex-reassigned. The twelve factors hypothesized were: psychosis, mental retardation, unstable personality, alcoholism/drug addiction, criminality, inadequacy of self-support, inadequate support from family, excessive geographical distance between patient and therapist, inappropriate physical characteristics to new gender role, completion of military service, heterosexual experience and strong sexual interest (p. 17-18). A review of the backgrounds of the five individuals stating regret showed an average of 7.8 of the hypothesized items (median score: 7.0). The group of nine cases who reported being pleased at having had SRS showed an average of 2.8 of these factors (median score: 2.0). This difference was statistically significant ($p < .02$). Reasons for this difference were highly speculative. The authors reported however, that with the exception of psychosis and mental retardation, the presence of these factors may have resulted in some ambivalence toward the reassignment and hence caused lower levels of satisfaction with the outcome. Though not originally hypothesized, Walinder et al. also stated that the dissatisfied group was significantly older at the time of request than was the satisfied group. In spite of the results being based on a small (and mixed) sample, the authors suggested that the greater the number of these factors present (including age), the greater the likelihood of dissatisfaction after surgery, and hence cause for restraint in embarking upon a course of sex-reassignment.

As can be seen from the preceding discussion, the issue of classification and diagnosis is still problematic. Ball (1981), in describing his experience of working with transsexuals over the past thirty years, suggested that it appears that this issue has become more complicated rather than less so. In his original work in the mid 1950's, the majority of people requesting sex-reassignment appeared relatively homogeneous as compared with the presenting population today. He characterized them as being of above average intelligence, extremely determined to complete the process, and with "high personal aspirations which were thwarted by their personal difficulties" (p. 40). Using the Terman Miles 'Attitude Interest Scale' the subjects scored higher on feminine interest scales than did a matched group of women. In his article, Ball pointed out that at that time, very little of the work in this area had been published by the popular press, with the exceptions of the Jorgenson and Cowell cases, which had just recently been reported. He described this initial group as being largely self-selecting. As the study of transsexualism and SRS has increased in the public consciousness, the patient profile requesting surgery has become more heterogeneous rather than homogeneous.

Research on Etiology

The issue of classification is intrinsically linked with efforts to establish cause/etiology of the syndrome (as well as with treatment outcome). Reported incidence of what would appear to be transsexualism has been recorded throughout history (Steiner 1981). Early theorists hypothesized that the cause of the phenomenon lay in some form of pathogenic relationship between mother and son. Modern research has not supported this hypothesis (Buhrich and McConaghy, 1978). These early theories focused on biological males, due to the belief that they were the great majority, if not the total phenomenon. Statistics now show that the disparity between males and females diagnosed as transsexual is shrinking (Oles,

1977). A common finding, currently in the research, relates not so much to the role of the mother but rather, to the absence, inability or disinterest of the father to function adequately within the paternal role (Bernstein, et. al., 1981; Burich and McConaghy, 1978; Sipora and Brzeck, 1983; Stoller, 1979).

In addition to investigations which have studied psychological dynamics which could conceivably result in the development of the transsexual syndrome, investigations have also addressed possible biological factors in the etiology of this syndrome. Stoller (1964) suggested that some hidden constitutional (i.e. biological) factor must be present for the syndrome to unfold. This factor may operate in conjunction with psychosocial factors present, but in Stoller's estimation, the latter (the psychosocial factors), in and of themselves, will not produce the syndrome. This concept was the result of his study of cross-gender identity, presented in a small number of intersexes (hermaphrodites and pseudo-hermaphrodites). Hoenig (1985), in his review of the research into biological antecedents pointed out that Stoller's notions of the importance of the biological factor were supported by Money, Hampson and Hampson (1957). Hoenig, in his explication of their research, stated that it supported the position of a 'neutrality' of gender identity at birth. Money, Hampson and Hampson (1957) argued that the development of gender identity took place through the process of imprinting. Since imprinting, unlike conditioning, is genetically fixed and species-specific, the formation of gender identity is then an issue of a genetically inherited predisposition which is released or triggered by certain psychosocial events which occur in the presence of the individual.

Hoenig (1985) showed that there is anecdotal evidence suggesting that epilepsy with accompanying temporal lobe lesions occurs more frequently in the transsexuals than in other sub-groups of the population. Hoenig acknowledged that such reports were highly tentative and their significance was (and remains)

unclear. Hoenig and Kenna (1979), studying the EEG patterns of a group of 56 transsexuals (35 male and 11 female), did conclude that there were abnormal patterns in a disproportionately large segment of the subjects (48% showed clear abnormalities while 24% were borderline). In approximately 50% of these cases the abnormality was in either the left or right temporal area. Hoenig acknowledged that this finding was not necessarily consistent with other research (when EEG abnormalities have been reported, they have not always centered in the temporal lobe area). Explanations for the inconsistency of these findings as well as for their significance to the etiology of the syndrome are not forthcoming as yet. As Hoenig pointed out, despite the inconsistency in incidence of EEG abnormality, elevated levels of abnormality have now been reported across a variety of studies (e.g. Walinder, 1965; Blumer, 1969; Randell, 1970; Kockott and Nusselt, 1976; Hoenig and Kenna,1979). This is an issue, Hoenig says, which will have to be accounted for in future theoretical formulations.

Attention has been focused on other areas of the brain as well, in an effort to discover abnormalities which could explain the development of transsexualism. These include studies of hormonal imbalances resulting in maldevelopment in the hypothalmic region (Neumann, 1970). Another stream of research has focused on an androgen deficiency during the second and third trimester of fetal development, resulting in what is described as a "feminized" brain. This theory states that given certain environmental triggers in conjunction with this sex-differentiated brain, the result is the development of transsexualism (Dorner, Rohde, Seidel, Haas, and Schott, 1976). Hoenig (1985), in his review of these two studies, pointed out that both theories were based on results extrapolated from animal studies, which leave them open to some question. Commenting on the latter of the two studies, he stated that the existence of a sex-differentiated brain in

humans has never been demonstrated to exist. Overall he expressed grave doubts that gender identity could be understood by observing behavioral traits in animals.

Hoenig (1985) goes into some detail on the research of Engel, Pfafflin, and Wiedeking (1980) on the frequency of H-Y antigen abnormalities in both male and female transsexuals. Engel et al. (1980) have reported the occurrence of H-Y antigen abnormalities in a significant number of transsexuals studied. H-Y antigen has been shown to be significant in the establishment of sex. As yet however, these researchers are not able to offer any documented rationale for the role of H-Y antigen in the development of gender identity.

As this brief review of some of the representative studies in this area shows, there exist some interesting early findings, but as yet no conclusive statements of biological, psychological or interactive pathways of etiology may be made.

Research on Treatment Outcome

Lothstein (1980) studied 21 biological male transsexuals who had completed sex-reassignment surgery. Group I completed the surgery prior to the organization of the Case Western Reserve University (CWRU) Gender Identity Clinic, and Group II had surgery after the creation of the clinic. The services of the clinic were two-fold: to provide an intense interdisciplinary evaluation of each patient and to provide ongoing psychotheraputic support prior to, during and after surgery. In the two year follow-up after SRS, 57% of Group I who had been employed prior to surgery, were unemployed in the follow-up period. There was also a common theme of social isolation, and at best only marginal relationships with people. The follow-up procedures for Group II were more detailed and consequently not all of the results were directly comparable to Group I; nonetheless, Group II showed a 65% improvement in work adjustment, 29% no

change and 7% showed a negative change. In terms of relationships there was no evidence of significant positive improvement in social relationships. As with the first group, they tended to be socially isolated. Despite reports of subjective satisfaction, patients in Group II exhibited multiple fears surrounding their new identities and the adequacy of their genitals. A full 50% of patients reported incidents of recurrent images of 'phantom penises' up to two years following surgery (the duration of the study). There were also reports of ejaculatory sensations despite the physiological evidence (the removal of male tissue) of the impossibility of this. Among this group, there were also reports of episodic depression and thoughts of suicide (though no actual suicides occurred during the time of the study). Lothstein reported that there were no changes in character structure or psychiatric diagnosis in either post-surgery group. Behaviorally, he reported that in the post operative period less stereotypical recreation and social activities were engaged in.

Though the lack of a control group limited the generalizability of the results from Group II, Lothstein (1980) suggested that in this study there was an overall improvement rate of approximately 65%. He pointed out that it was difficult to separate the effects of SRS from the effects of psychotherapy in revealing which factors had resulted in the improvement rate. He also acknowledged that this was a self-selecting group who would submit to the requirements of a gender identity program, and may have been significantly different from those individuals who would have chosen to go through a private practitioner who would not place the same requirements on them.

Though Lothstein's (1980) results demonstrated improvement on specific dimensions, the findings remained somewhat mixed when contrasted with the subjective ratings of post operative satisfaction by those individuals involved, all of whom reported being extremely satisfied. Noting this, Lothstein cited previous

findings demonstrating an 80% social-psychological improvement following surgery (Benjamin, 1966; Randall, 1969). Lack of standardization in rating procedures appeared to be one of the factors in these conflicting results.

Hunt and Hampson (1980), in a study of post operative patients (mean of 8.2 years), could demonstrate no significant changes in levels of psychopathology and only modest gains in terms of economic functioning and interpersonal relationships. More striking changes (positive) occurred in sexual satisfaction and family acceptance. The inclusion of subjects demonstrating psychopathology in this study strongly limits its comparability with the previously cited work, yet one may suggest that the existence or non-existence of psychopathological symptoms prior to surgery is not significantly affected by SRS.

Fleming, Cohen, Salt, Jones, and Jenkins (1981) found a significantly higher level of psychological functioning (MMPI scores) in post operative subjects, compared with testing in pre-operative periods. The authors did not suggest from this result that SRS is capable of curing symptoms of mental illness, but rather, may have a positive effect on non-psychopathological functioning.

Attempts have been made to introduce a standardized rating system to investigate pre- and post-surgical adjustment (Hunt and Hampson 1980). In spite of the already mentioned issue of the inclusion of subjects exhibiting psychopathological symptoms, their dimensions for rating (economic, interpersonal relationships, psychopathology, sexual adjustment, additional surgeries and procedures, and current family reactions) begin to address the need for commonness in rating and follow-up. This broader focus in rating success/failure, is also important in terms of a move away from the narrow focus of solely medical and/or psychological assessments for intervention, treatment and evaluation.

Hastings and Markland (1978), tracked twenty-five male-to-female transsexuals as part of a ten year study, They also offered a scheme for assessing

post-surgical success. Rating on four dimensions: social, emotional, sexual and economic, each dimension was scored as excellent, good, fair or poor. Reporting at the mid-point of the study (five years post operatively), they found that consistent with other findings, the subject population unanimously agreed that they were pleased at having completed the process of SRS. Immediate post operative results included a sense of relief at "finally being a woman," surprise at the degree of post-surgical pain, and interest in mammaplasty and cartilage shaving of the adams apple. No post operative delirium, psychotic reactions or occurrences of 'phantom penises' were witnessed in this group. Unfortunately, the longer-term results were not reported, other than to say that subjects who rated an overall poor to fair rating were characterized as having "high sociopathic loading of personality structures prior to surgery" (p. 33). Hastings and Markland stated that in their sample the area of romance proved to be the most difficult and problematic to post operative adjustment (whether overall high or low ratings). This may be consistent with a previously cited study (Lothstein, 1980) which stressed the characteristic of social isolation. Some studies showing improved social adjustment (Weatherhead, Dixon, et al., 1978) were found to be vague in their definition of 'improved social adjustment.'

The single most influential and controversial research project of the 1970's has come to be known as "The Hopkins Report" (Meyer and Reter, 1979). The "Johns Hopkins Gender Identity Clinic and Committee" was established in 1965, having dealt with transsexual patients for the previous five years. Meyer and Reter (1979) began the study in 1971 in an attempt to " . . . step back from the normalization of sex-reassignment procedures in order to look objectively at the long-range effects of surgery" (p. 1010).

Beginning with 34 operated and 66 unoperated patients the researchers set out to assess (using primarily interviews) the functioning of operated subjects

before and after surgery. Though not a strict 'control group,' the unoperated sample offered some basis for comparison. During the data collection period (three years) a third group emerged: subjects who were operated on during the course of the study. Ultimately, 52 interviews were completed, across the three groups. Follow-up scores were calculated (based on concrete behaviors) on each of four dimensions: legal, economic, marriage/cohabitation and psychiatric. From these dimension scores, an overall change score for each subject, and mean change scores for each group were calculated.

The results showed that there was a positive shift overall for each of the three groups, accompanied by a narrowing of standard deviations. The change scores, between groups, were not significant. Change scores for operated patients (those originally tagged as operated as opposed to those who subsequently became 'operated') were not significant ($p<1.0$). Unoperated patients did achieve significant change scores ($p<.001$). The subsequently operated group fared the worst of the three in overall change (mean, -0.4). The authors concluded that SRS resulted in no objective advantage in terms of social rehabilitation, as measured by the four dimensions used. The passage of time would affect improvement in the social functioning of these individuals where the intervention of SRS would not.

Abramowitz (1986), in reviewing the last two decades of empirical work in the area of outcome of sex-reassignment surgery, devoted a section of his review to the Hopkins Report and the criticisms of it. Citing Fleming, Steinman, and Bockneck (1980), he questioned the arbitrariness of the outcome categories. For example, living alone was considered less adjusted than living with someone. It is also worth noting that the marital/cohabitation dimension judged appropriateness of the partner's (spouse's) gender. For example, for a post operative male-to-female transsexual to be judged as successful on this dimension, the partner would be male. The couple were then viewed as living in an 'appropriate' heterosexual

relationship. The post operative individual living with a woman, in a lesbian relationship, appears to have been judged as having a 'gender inappropriate' relationship. Fleming et al. (1980) went on to note that each dimension had a different number of response categories and different possible score ranges, therefore causing different components to have unequal ratings. Basing their deductions on possible score ranges and actual reported means, Fleming et al. made a convincing case that certain negative events figured cumulatively but that the duration of events were ignored. Examples of the ramifications of this were supplied by the authors: two arrests were worse than one (disregarding the severity of the charges); two hospitalizations were worse than one whatever the durations of the hospitalizations might have been.

Abramowitz (1986) stated that if Fleming et al. (1980) were correct in their deductions, the confound of different lengths of time for follow-up (an average of 5 years in the operated group and 2 years for the unoperated group) was significant. If the negative events were weighted cumulatively, then the longer the follow-up period, the more opportunity to amass negative points, so to speak. He went on to express amazement that such an elementary psychometric error could have escaped both the authors and the original reviewers. He concluded however, that it did appear that the calculations of the Hopkins Report were biased against the primary surgical group and therefore the findings were misleading.

Abramowitz (1986) did not save his methodological criticisms exclusively for the Hopkins Report. Resulting from his review of this body of literature, he stated that departures from the usual scientific procedures were all too frequent. As an example he noted that control groups were an innovation introduced only in the previous five years. Without the use of rigorous control groups, attributing either success or deterioration to the intervention of sex-reassignment surgery is scientifically indefensible. Though frustrated, he also expressed sympathy with the

difficulty and sometimes impossibility of creating these control groups. He expressed less sympathy with other practices discovered in the literature.

> We are typically left in the dark about such obviously critical subject variables as psychiatric status and diagnosis, extent of gender reorientation, and previous early-stage sex-change procedures. Subjects included in subsequent reports by the same investigator sometimes appear to overlap with samples from earlier series. Incredibly, subjects who committed suicide are occasionally not included in computation of the improvement rate because they were not available for follow-up . . . . The research is rife with violations of generally acceptable assessment practices. (p. 184)

Abramowitz divided the research into two methodological groups: pre-quantitative and quantitative. Outcome reports in the pre-quantitative studies (10 studies reviewed) showed that 60% to 85% of patients were rated as improved or satisfied. A total of 14 serious complications (defined as a reversal request, a psychotic episode, hospitalization, or suicide) were reported in the ten studies (6.4% of the total subjects). The strongest positive results were on dimensions of cosmetic satisfaction, interpersonal relationships and psychological well-being. Less pronounced improvement was reported in areas of work, economics, legal and sexual relationships.

In reviewing these studies, Abramowitz (1986) cautioned the reader that this body of research did not incorporate psychometric instruments, and universally, the authors had significant personal investments in the outcomes. On a positive note, he added that the results were strengthened by "well articulated outcome variables and potential patient mediators" (p. 185). Without control groups, we are

unable to draw causal relationships between baseline and outcome data and the effect of SRS.

The quantitative studies incorporated psychometric inventories and standardized rating scales. A total of fourteen studies were reviewed in this section. The average follow-up period was four years. Results of the studies employing longitudinal follow-up without the use of a control group supported the earlier pre-quantitative research and showed an average improvement rate of approximately two-thirds (a range from 50% to 85%). Of the three quasi-experimental studies reported (Fleming, et al., 1981; Fleming, MacGowan, Robinson Spitz & Salt, 1982; Meyer and Reter, 1979) two of the three reported significant improvements in the surgical group (the third study was the previously discussed Meyer and Reter, 1979). A single study based on quantified Rorshach responses showed equivocal results (Fleming, Jones & Simons, 1982).

Taken as a group, the quantitative studies reported the greatest gains in the areas of sexual satisfactions and relationships (though a minority of studies, previously cited, could demonstrate no significant improvement in relationships). Less improvement was made in socioeconomic areas and in cosmetic results. The lack of gains in cosmetic results conflicts with the earlier (pre-quantitative) research and is confusing in light of surgical advances of this time period. Abramowitz suggested that this result may be due less to the cosmetic results themselves, and more to the lack of standardization in measuring it.

In discussing the variables which may mediate outcome, this more recent group of studies (quantitative), clearly supported the earlier finding (pre-quantitative), that character pathology is a negative factor in post operative prognosis. Walinder et al. (1978), as mentioned before, demonstrated evidence for other negative factors, including: inadequate family support, criminal records, older patients, inappropriate physique, and inadequate self support.

Abramowitz (1986) closed his review of the last two decades of outcome research by saying:

> Research is merely human behavior, no more and no less, and every bit as subject to personal whims and commitments. One can even look on the failure to incorporate proper controls as motivated forgetting, in the service of retaining personal control over the ultimate interpretation of the results. Perhaps the absence of control groups need not be viewed so harshly. After all, they are impractical (and sometimes unethical) in addition to being inconvenient. The failure to follow reasonable assessment practices, which are relatively simple to ascertain, seems less easily understood without invoking the notion of ego involvement.
>
> After three decades of case historical, prequantitative, and quantitative research on the outcome of sex-reassignment surgery, we have yet to see either the replicative use of standardized assessment devices to facilitate cross-study comparison or the development of a multidimensional inventory to tap the various sub-domains of postsurgical rehabilitation . . . . This collective reluctance to bring state-of-the-art methods to bear on the difficult treatment decision becomes less perplexing, however, when we have recourse to scientist-as-person variables in our model of the development of a research literature. (p.188-189)

In this review of the literature on transsexualism, what has emerged is a series of empirical studies which have attempted to focus primarily on three areas: classification, etiology and treatment outcome. The results of work in the areas of etiology and treatment appear to be frequently inconsistent and conflicting. The

classification schemas are yet to be truly standard although there does appear to be a general goal of establishing a working definition of a 'primary' or 'true' transsexual. The studies of post-surgical follow-up to determine outcome have lacked consistency of method and approach (Lothstein 1980, Abramowitz, 1986). It would appear that these issues are highly interrelated. Lack of agreement in areas of 'cause' and classification will tend to foster inconsistency in treatment (psychological/psychosocial, medical or both) and consequently lead to inconsistency of focus in follow-up.

Oles (1977) presented a discussion of what she views as general psychotherapeutic issues pertaining to work with gender dysphoric individuals. This paper resulted from her clinical experience at the "Gender Identity Program" in San Francisco. While presenting an overview of such landmark research as Caldwell (1947), she focused primarily on various aspects of life which impact on the individual. Working from the assumption of gender identity residing on a continuum, and that surgery in some cases is the best option, Oles discussed the impact of family, community, employer, and other factors, on the people she has treated in therapy. At a more specific level, she spoke of the impact of being 'read' on the street (recognized as a transsexual) being arrested, cross-dressing at work, as well as various responses from family, friends and therapists.

Yardley (1976), in reviewing his work with transsexuals, hypothesized that acceptance by the therapist of the pre-operative transsexual's desire for SRS may be significant in successful post operative adaptation.

Both Yardley (1976) and Oles (1977) have addressed what can be termed as 'contextual' issues. Yardley, with his hypothesis regarding acceptance by the therapist, and Oles in her discussion of the impact of the employer, the family and the general public, have both acknowledged that the individual does not live in a vacuum, but rather, must exist and interact with a variety of individuals and

groups who all -to varying degrees- affect the individual. To a somewhat lesser extent this was also acknowledged by Walinder et al. (1978) who, in their focus on contraindicators, listed (among others): lack of family support, geographic distance between the therapist and patient, and lack of personal support. Shumaker (Levine and Shumaker, 1978) recalled her frustrated attempts to get appointments with the gender identity clinic staff. When appointments were secured, she reported that they frequently involved being interviewed by unknown, and (to her), anonymous professionals. At other times the appointments consisted of writing test batteries, the purposes of which were not explained. She finished her description of these experiences by saying: "Only Kafka could have designed such a torment of uncertainty" (p. 254).

Mason (1980), a post operative female-to-male transsexual, told of the gradual realization of his transsexualism and his eventual efforts to become sex-reassigned. He described how, beginning at puberty, he had less and less in common with other girls yet because of his position as a biological female, was unable to make friendship ties with boys; loneliness and isolation became primary themes. Mason then related his experiences in seeking professional help during the 1960's. These included meeting with: a church social worker who advised him to pray; a psychiatrist who believed he was delusional; an endocrinologist who said that notions of sex-reassignment were absurd and that he should get a job; and finally, a psychiatrist and gender identity team who diagnosed him as transsexual and actively supported his efforts to habilitate into the new gender. He reported that the treatment team's use of the male pronoun when referring to him, and their referring to SRS as "corrective surgery," all helped him in his efforts to achieve what he terms "self respect." Though this is a highly subjective account, the issues raised are important ones. For example, the difficulties of pre-operative cross-living, disclosing to friends and colleagues, accidental meetings with past

acquaintances, and the sharing of accommodation when travelling, are all examples of what could be termed contextual issues.

Empirical work of this type (i.e. that which focuses on mediating factors which exist within the environment, as well as intrapsychically, and affect the process of adaptation) appears to be lacking in the published literature. This project has attempted to address this by viewing the individual not as an isolated phenomenon, but rather, as one embedded within a context. The "Ecological-Systems Model" which was chosen as a guide for the classification of these factors, emphasized the interaction of the individual and surrounding systems. It provided a system of classification which clearly highlights the environmental influences acting upon the individual.

Extending the work of Yardley (1976), Oles (1977), Mason (1980), Levine and Shumaker (1978), the study focused on the specific incidents, events, attitudes, etc., occurring both pre- and post operatively, which affected the individual's post operative role adjustment. The case study approach allowed for a comprehensive study of an individual, hypotheses generation for testing with others in the population, and a starting point to construct and enrich theory. Ultimately it is this theory which will guide clinicians in their attempts to impact most positively on the lives of transsexual people.

CHAPTER III
METHODOLOGY

The nature of this study has required the use of qualitative and case study methods. The data collection has focused heavily on semi-structured interviews (with both retrospective and current foci) in conjunction with standardized instruments: The Minnesota Multiphasic Personality Inventory (Hathaway and McKinley, 1967), the Family Assessment Measure (Skinner, Steinhauer & Santa-Barbara, 1984), and the Social Support Questionnaire (Sarason, Levine, Basham & Sarason, 1983). The data analysis, utilizing the critical incident technique, has resulted in a classification system based on an ecological model of interacting systems. The classification system was then subjected to further analysis so as to establish a distribution displaying the critical incidents according to their perceived levels of significance.

The Case Study

Allport (1962), citing Graurmann, states: "shall our units of analysis in the study of personality be derived from general psychological concepts or from lives as actually lived?" (p. 409). Allport goes on to describe traditional methods as "horizontal" (across people). He uses the term "morphogenic" or "vertical" to describe those methods which focus on the individual and the understanding of one person rather than many. He challenges researchers to ask the question: "Do the horizontal dimensions (psychological laws) have true significance to the individual?" As an example, he uses the hypothetical 'Bill:' " . . . if so, how are they patterned together to comprise the 'Billian' quality of Bill. Ideally research should explore both horizontal and vertical dimensions" (p. 410).

Bogden (1974) echoes similar concerns about overemphasis on the results of horizontal methods of research in his defense of the use of autobiography as a research tool:

> That is, the autobiography adds to theory construction and diagnoses another view point which provides professionals with an opportunity to examine the possibility that they are not doing what they profess to be doing or that they are misrepresenting those whom they claim to be telling us about. This reality confrontation cannot help but be productive. (p. 4)

Bogden (1974) has raised two issues which underlie this study. The first issue questions the applicability to the individual of general psychological laws obtained by "horizontal" methods of study. The second issue raised is that of 'theory construction.' Yin (1984), in his book *Case Study Research* states that:

> Survey research relies on 'statistical' generalization, whereas case studies (as with experiments) rely on 'analytical' generalization.
>
> In analytical generalization, the investigator is striving to generalize a particular set of results to some broader theory. (p. 39)

The choice of the case study as the preferred research design for this investigation was based on the two above mentioned issues. As the review of the literature revealed, there is currently little empirical data and even less theory in the area of post operative transsexual adjustment. In addition to this, the existing research demonstrates what could be interpreted as an overemphasis on horizontal methods of study in the area. For these reasons, more research focusing on post operative adjustment is needed. The case study method, with its 'morphogenic' focus is an appropriate and productive method with which to conduct this

research. From the results of this preliminary work, we can begin the process of theory construction which will have practical significance to clinicians working with this population.

The Case Subject

The case subject is currently 39 years old. She works part time as a hair stylist and has lived for the past year with her common-law husband and his three year old son. When not working, much of her time is taken up with parenting the child and managing the household.

The subject was born in a rural community in Saskatchewan. She was the younger of two sons (her brother is 4 years older). She was born with a bilateral cleft palate and bilateral cleft lip, which were repaired at the age of 8 months and then operated on again at the age of 12.

The case subject described being cross-gender identified from her earliest memories. She reported that as a child, she always felt more comfortable playing the games of little girls rather than those of boys. It was during this period (prior to puberty) that she taught herself to sew.

She began cross-dressing at an early age and continued to do so (though in secret) into her teenage years. As a teenager she was ridiculed by her peers, and also by her grade 9 teacher for her feminine behavior. At this time she resolved to leave high school and attend trade school in Toronto. Though her parents were initially resistant, they eventually supported this decision.

During this same period, the subject saw a television interview with Christine Jorgenson, a post operative male transsexual. Realizing that sex-reassignment was possible, she approached her family physician about the procedure. He recommended that she contact the Johns Hopkins Clinic where sex-

reassignment was carried out. Logistical and financial considerations eventually precluded entry into the Johns Hopkins program.

Approximately three years later, having completed trade school and successfully launched her career, the subject approached the plastic surgeon who had originally operated on her cleft palate and cleft lip. He referred her to the Clarke Institute of Psychiatry in Toronto. Appointments at the Clarke Institute were secured in the fall of 1971. By this time the subject had disclosed her desire for sex-reassignment to her family. She also had begun cross-living exclusively during this period. Two years later she was surgically reassigned.

Immediately after surgery the subject moved to Vancouver where she began working in a large salon. Since then she has lived in Vancouver, with the exception of a three month period (in the first year) in which she moved to Regina and lived with her mother. This was after the break-up of a relationship.

In Vancouver her career has progressed. She has both managed and owned salons. Between 1979 and 1982, however, she suffered several periods of depression. There was also one suicide attempt during this time. The instances of depression have not recurred in the last five years. The basis of the depression is somewhat speculative at this time, but appears at least partially related to work pressures combined with relationship difficulties.

The subject reports being stable and happy in her present situation. She enjoys warm relations with all members of her immediate family who express approval and acceptance of her. She maintains a network of meaningful and supportive friendships. It appears that the subject has successfully integrated into the post operative role.

The Case Study Investigator

A common factor in all case studies is that the quality of the study ultimately rests on the expertise of the case study investigator in collecting the data:

> This is because the data collection procedures are not routinized. In laboratory experiments or in surveys, for instance, the data collection phase of a research project can be largely, if not wholly, conducted by a research assistant.
>
> The assistant's goal is to carry out the data collection activities with a minimum of discretionary behavior, and in this sense the activity is routinized--and boring. There is no such parallel in conducting case studies (Yin 1984; p. 56).

Yin goes on to suggest a list of skills required by the case study investigator:

> A person should be able to ask good questions--and to interpret the answers.
>
> A person should be a good "listener" and not be trapped by his or her own ideologies or preconceptions.
>
> A person should be adaptive and flexible, so that newly encountered situations can be seen as opportunities, not threats.
>
> A person must have a firm grasp of the issues being studied, whether this is a theoretical or policy orientation, even in an exploratory mode. Such a grasp reduces the relevant events and information to be sought to manageable proportions.
>
> A person should be unbiased by preconceived notions, including those derived from theory.
>
> Thus, a person should be sensitive and responsive to contradictory evidence. (p. 56-57).

The case study investigator for this project has received graduate level training in counselling psychology. As a result of this training, he has an acceptable level of competency at the skills of listening and questioning which Yin (1984) highlights as important. In addition, he has studied extensively in the area of transsexualism and gender dysphoric behavior and has been able to demonstrate his knowledge of the area with colleagues, supervisors and practitioners in the field.

The Semi-Structured Interview

The semi-structured interview attempted to draw from both the unstructured and structured forms of the research interview. Rather than using strict protocol as in the structured interview, the interviewer used a more general 'guide.' The guide contained a series of questions which served as a general plan for the interviewer (as opposed to a rigid list of questions which were to be read verbatim).

In common with unstructured interviews, skills such as reflection of content and emotion, probing, and open and closed questions were used by the interviewer in the interview process. In addition, the interviewer was prepared to (and did) generate new questions which resulted from the information put forth by the case subject during the course of the interviews.

The use of a variety of sources of data collection served to increase the validity of the results. By interviewing not only the case subject but also her family and selected friends, the interviewer was accessing information which may have been forgotten or repressed by the subject. Caunel and Kahn (1968) identified three reasons for data being inaccessible through the interview process:

1. the material is forgotten,

2. the material is repressed

3. the respondent lacks the cognitive structure to respond to the question posed (i.e. does not code the experience with the frame of reference from which the interviewer presents the question) (p. 532).

The third area of data inaccessibility was approached in this investigation through eliciting of a 'story' followed by non-directive probing and reflection, aimed at discovering the effects of events within the stories related.

Data Collection

In this study, data were collected primarily through the interview method (see Table 3.1). Interviews were conducted with the case subject, with members of her family, with three of her friends, and with her common-law husband. In conjunction with the interview data, standardized psychological measures (the *Minnesota Multiphasic Personality Inventory*, the *Family Assessment Measure* and the *Social Support Questionnaire*) were administered to assess the case subject's current psychosocial functioning.

The study began by obtaining "human subject approval" (a process which included, the subject's consent in writing, to participate in the study). Data collection began with an initial interview with the case subject (see appendices C and D for interview guides). This interview focused on basic demographic information. In conjunction with demographic-type information (e.g. age, place of birth, schools attended etc.) a general life story was elicited from the individual. The purpose of this initial interview was to provide a framework and basis for the following interviews.

Following this, the case investigator visited the Clarke Institute of Psychiatry (Toronto, Ontario) where the case subject had originally been assessed and later surgically reassigned. An attempt was made to interview the Chief

Psychiatrist who had dealt personally with the case subject both pre- and post operatively. Unfortunately this was not possible; however, the case investigator met with and interviewed the coordinator of the Gender Identity Programme. The information resulting from this meeting was useful in obtaining an understanding of general clinical trends in working with gender dysphoric individuals. It also suggested issues to be explored in later interviews with the case subject.

With the written consent of the case subject, The Clarke Institute released two *MMPI* profiles (one administered two years pre-operatively [1971] and one administered two years post operatively [1975]) and a brief case summary. The Clarke Institute of Psychiatry was not prepared to release the entire file on the case subject. The *MMPI* profiles, combined with the current profile, allowed for a comparison of scores over a period of approximately sixteen years. The case summary suggested areas to be explored in the interviews with the case subject.

The second interview with the case subject focused on the time from the decision to seek treatment to the time of surgery. Information regarding her perceptions of the assessment and treatment process was solicited. In addition, her memories regarding her reactions and the reactions of significant persons in her life was requested.

The third interview with the subject centered on perceptions of family life. Though including information from earliest recollections forward, special focus was placed on how the family helped and/or hindered --or if they had an effect-- on adjustment to the new gender role.

The following interviews were with the mother and brother. Questions were focused in the areas of: family relationships, social relationships, work and school functioning, from the past, up to the present. Both the mother and the brother (and at later time, the father) were interviewed individually. They were encouraged to give expression to their own experience of being a witness to this

process as well as their observations of its effect on the subject and the people around her.

The fourth interview with the case subject focused on 'romantic' life. Data in this area were elicited for both pre-operative and post operative time periods. In addition, questions focused on both heterosexual and homosexual experiences. Consistent with the research findings in the literature, the majority of romantic experiences had occurred post operatively. This topic was given special attention (approximately three and one-half hours of interview time) because prior research suggested that romance is an area of ongoing difficulty for many post operative individuals (Hastings, 1978) and hence it was thought, merited as much data collection as possible. As in other interviews, the individual's subjective experience in this area was focused upon (through the eliciting of 'stories') in conjunction with concrete events.

The fifth interview with the subject focused on perceptions of friends and peer group. This included reactions to disclosure, duration and number of friendships, feelings of belonging versus isolation, changes in the perceptions of friends over time, such as acceptance, rejection, etc..

Interviews with three friends of long standing and the case subject's now common-law husband (co-habitation began during the data collection period) were done throughout the interview period, as times could be arranged. These interviews served to corroborate information from the case subject as well as providing new information to be noted and explored. In addition, these individuals were asked for their perceptions of how the subject in question has adjusted to the new role (e.g. socially, sexually, in relation to family etc.).

The sixth interview with the case subject focused on the time from SRS to the present. Though summarizing some information already obtained, it focused on issues of role adaptation and satisfaction post operatively. The seventh

interview was used as a general summary and discussion of the impact of this process (the data collection) on the case subject.

FIGURE 3.1

SCHEDULE OF DATA COLLECTION

Source	Type of Data	Time Focus	Target Information
1. Case Subject (interview #1)	Interview data	past-present	-factual data -general life story -medical history -employment history -educational history
2. Visit to Clarke Institute of Psychiatry	Case records interview data (specific to subject and general background) past MMPI Profile	past	-demographic information. -clinical information -background information regarding transsexualism
3. Case subject (interview #2)	Interview data	past	-events from time of seeking treatment to surgery -reaction of family, friends and professional community -emotional state during this time -helping/hindering factors
4. Interview with Mother	Interview data	past-present	-reaction to disclosure -reaction of other members of family -reactions to cross-dressing -current acceptance/ rejection of gender reassignment -assessment of gender reassignment -helping/hindering factors in post operative adjustment
5. Interview with Brother	Interview data	past-present	-reaction to disclosure -reaction of other family members -reaction to cross dressing -current acceptance/rejection of gender reassignment -assessment of gender reassignment success/failure -helping/hindering factors in post operative adaptation
6. Case Subject (interview #3)	Interview data	past-present	-family life from childhood to adult family relations -role of family members in facilitating/ hindering adjustment -effect of SRS on relationships with family members
7. MMPI,SSQ and FAM (case subject)	Test data	present	-psychological functioning -social support measurement -family functioning
8. FAM (family members)	Test data	present	-family functioning
9. Case subject (interview #4)	Interview data	past-present	-romantic life -sexual relationships/experience -sexual satisfaction pre and post operatively -effect of transsexualism on romantic relationships

FIGURE 3.1 SCHEDULE OF DATA COLLECTION (continued)

Source	Type of Data	Time Focus	Target Information
10. Interview with Father	Interview data	past-present	-helping/hindering factors -reaction to disclosure -reaction of other family members -reaction to subject's cross-dressing -current acceptance rejection of gender reassignment -assessment of success/failure of gender re-assignment
11. Case Subject (interview #5)	Interview data	past-present	-role of friendships -reaction of friends pre-and post operatively to disclosure of transsexualism -perceived degree of acceptance/rejection by friends -perceived sense of belonging versus isolation
12. Peer group	Interview data	past-present	-perception of adjustment to female role -perceived hindering/facilitating factors -acceptance/rejection of subject's transsexualism -assessment of subject's integration/ isolation in terms of social network
13. Case Subject (interview #6	Interview data	past-present	-assessment of surgical success -issues regarding assimilation into community as a woman
14. Case subject (interview #7)	Interview data	past-present	-summary of interview process -concluding remarks

What emerged from the interviews was a series of subjective accounts of the process of this person's life. From each interviewee, a 'story' was elicited, focusing on environmental events and the case subject's reaction to and impact on that environment. Statements of behavior, of feeling, and of thought were probed for throughout these accounts. Interview data, coming from other than the subject herself served not only to corroborate her statements but also to generate further questions and arenas to be explored.

Data Analysis

Once complete, the interview data were reduced to a series of incidents which were then classified into Conger's three levels of analysis. The primary criterion for an incident to be considered as 'significant' was that the occurrence of this incident led to an observable change or result. In effect, this required that all incidents had to have resulted in a behavioral outcome (or at least to have had an outcome which had a behavioral component to it). Though cognitive and affective effects of incidents were noted, a conscious decision was made to restrict the 'incidents' to having a minimum behavioral requirement. This was done so as to avoid the 'hypothesizing' by the interviewee, (which Flanagan [1954] warns against in conducting a "Critical Incident" study).

The classification level, labeled "Community" was the most disparate of the three levels, in terms of the motivating sources of incidents. It also contained the greatest number of incidents. To add clarity to this level, it was further divided into sub-categories reflecting the community systems (as outlined by Conger, 1981) involved with the incidents (see Table 3.1).

TABLE 3.1

AN EXAMPLE OF THE COMMUNITY CLASSIFICATION

COMMUNITY	Incident	Result
-medical system	-	-
	-	-
	-	-
-educational system	-	-
	-	-
	-	-
-friends	-	-
	-	-

The nature of the sub-categories came out of the data itself rather than any *a priori* system (i.e. incidents involving teachers were grouped into a sub-category entitled "Educational", incidents involving work experiences formed the sub-category "Vocational", etc.).

The use of the standardized instruments, each reflecting one of the levels of data analysis (i.e. individual, family or community) yielded information about how the subject currently functions. These results served to complement the interview data and provided an opportunity to examine the convergence and divergence of information generated from the different sources.

The pre- and post SRS, *Minnesota Multiphasic Personality Inventory* profiles demonstrated what personality changes have taken place over time (individual level of analysis).

From the historical and retrospective data, case records, test scores and interviews, the study attempted to show the manner in which the case subject, prior to and at the time of SRS, was functioning. The data collection, focusing on current information, obtained from test scores and interviews, demonstrated how the subject functions today.

The analysis of the critical incidents and their results, obtained by the use of the "Critical Incident Technique" attempted to answer the initial question of 'what' factors have been significant. From responses within the interviews, we attempted to answer 'why' these factors were seen as significant by the individuals interviewed. In addition, a classification analysis of the 'critical incidents' was undertaken in which the case subject ordered the incidents on a six point scale varying from 'most significant' to 'least significant'. The same process was undertaken independently by the case investigator. The correlation between the two independent rankings was then calculated so as to ascertain the level of agreement between investigator and subject on the question of relative importance of the incidents.

The Critical Incident Technique

Woolsey (1985) argues that a schism exists between researchers and practitioners in counselling psychology. She suggests that this is at least in part the result of the disuse of research methodologies which would have relevance to, and use the skills of the practitioners (as well as of the researchers). She goes on to state:

> Thus, it seems imperative to explore new methodologies in research, not only to better address the research question, but to resolve the value-incongruence between counselling theories and research paradigms, so that counsellors will be enabled to fully develop their research potential. . . . Hence, it is important that innovative methods be value-congruent as well as practice effective.
>
> Counsellor training in the skills of interviewing, empathic listening, participant observation, vivid qualitative description and the analysis of intra-personal and inter-personal patterns are all relevant to qualitative, naturalistic, phenomenological and ecological research strategies. (p. 2 - 3)

Woolsey (1985) presents the critical incident technique as an example of a method of research well suited to be used by counsellors. It meets the requirements of acceptable validity and reliability while remaining congruent with humanistic values. In addition, the skills required to execute the technique complement the training and experience of most counsellors. It is a technique appropriate to exploratory research (Woolsey, 1985).

Flanagan (1954) identified five steps in concluding a critical incident study: (1) determining the overall aim of the activity under study (in this case, the overall aim was to study the process of adaptation to the gender reassigned role); (2) formulating plans and specifications for collecting information about the

activity studied (in this study family, friends and the individual herself, were given instructions to report on behaviors, thoughts and feelings which have had an observable effect on the case subject's process of post operative role adaptation); (3) collection of the information by the process of interview and case record analysis; (4) analysis of the data; (5) interpretation and reporting of the data.

Andersson and Nilsson (1964) in their study of reliability and validity of the technique, concluded that it adequately assessed the content domain and that other methods of assessment when applied, did not add new information. In addition they found that different interviewers only marginally affected the number and distribution of the critical incidents. They concluded that the method allowed for the collection of data which was both reliable and valid.

The Critical Incident Scale

Following Flanagan's (1954) guidelines for conducting a critical incident study, interviews were carried out with the case subject, selected members of her family, and specific friends of long standing. It was during these interviews that the critical incidents were revealed. All incidents described by other than the case subject were discussed with her during later interviews. It was a requirement, for the incident to be considered critical, that she agree with the description of the facts of the incident and of its result.

A scale was developed so as to allow for a rater(s), in this case the case subject and the case investigator, to differentiate levels of significance between the 30 incidents. The six-level scale was designed so as to force a "normal distribution" of incidents. To accomplish this each level was only allowed a specified number of incidents (Level One, one incident; Level Two, four incidents; Level Three, 10 incidents; Level Four, 10 incidents; Level Five, four incidents; Level Six, one incident).

For any incident to be considered 'critical' it had to have had some type of observable result. This defined the minimal requirement of Level One: that the incident resulted in a single consequence or behavior. The second level specified a series or group of consequences/behaviors as a result of the incident. Level Three added the dimension of attitudinal change to the basic behavioral requirements and Level Four extended the behavioral and attitudinal components over a greater period of time (greater than three months). Level Five incorporated observable consequences in others as a result of the changes for the case subject. Level Six marked the single most significant incident as defined by its long term or permanent ramifications on behavior and attitude change for the case subject and others involved in her life.

Standardized Instruments

Three standardized instruments were used in this study: the *Minnesota Multiphasic Personality Inventory*, the *Family Assessment Measure* and the *Social Support Questionnaire*. The *Minnesota Multiphasic Personality Inventory* was chosen primarily because it allowed the researcher to compare the current profile with past profiles of the same instrument. This resulted in being able to measure change in psychological adjustment (as measured by the *MMPI*) over some sixteen years. The *Family Assessment Measure* attempts to integrate both systemic and nonsystemic theories of psychological adjustment within the family. It also focuses on the process of family interaction rather than on family structure (which was of doubtful appropriateness in view of the ages of the children, and of their separate domiciles). The *Family Assessment Measure* was chosen for these reasons. The *Social Support Questionnaire* tested the subject's perception of the adequacy of her social support. A number of instruments in this topic area were reviewed,

however, the *Social Support Questionnaire* was chosen here for the types of support it measures, as well as for its reported validity and reliability.

Minnesota Multiphasic Personality Inventory

The *Minnesota Multiphasic Personality Inventory* (Hathaway and McKinley, 1967) first appeared in 1940 and since that time has become the most extensively researched paper-and-pencil index of psychological adjustment in existence (Hopkins and Stanley, 1981). The *MMPI* consists of ten "clinical scales" and three "validity scales." The ten clinical scales are as follows:

1. Hs: Hypochondriasis
2. D: Depression
3. Hy: Hysteria
4. Pd: Psychopathic deviate
5. Mf: Masculinity-femininity
6. Pa: Paranoia
7. Pt: Psychasthenia
8. Sc: Schizophrenia
9. Ma: Hypomania
0. Si: Social Introversion

The three validity scales consist of:

(L) Lie Score: Calculated from a group of items which would appear to put the examinee in a favourable light but in reality are unlikely to be answered in the scored direction if the examinee is answering truthfully.

(F) Validity Score: Calculated from a set of items which though describing undesirable behavior are not frequently answered in the scored direction by any standardization group. As a set they adhere to no pattern of abnormality or psychopathology. A high F score may indicate scoring errors, carelessness in the examinee's responses or deliberate malingering (faking bad).

(K) Correction Score: The K score is a measure of test taking attitude. A high K score may indicate defensiveness and/or an attempt to appear in a favourable light. A low K score may be indicative of excessive self criticism or malingering (Anastasi, 1982).

The *MMPI* consists of 550 statements to which the subject responds with "true" "false" or "cannot say". Used primarily for the process of differential diagnosis, reports of test scores on this instrument are not uncommon in the research on transsexualism. Though there is considerable evidence to suggest that elevation on the clinical scales is indicative of psychological disturbance (Anastasi, 1982), research in the area of transsexualism has not demonstrated a consistent or typical transsexual profile (Weatherhead, et al., 1978). The instrument has also not proved to be reliable in terms of its ability to predict post operative adjustment (L. Clemmenson, personal communication, February, 1986).

The *MMPI* was used in this project as a measure of both psychological adjustment and of change in adjustment over time. Test scores from 1971 (pre-operative) 1975 (post operative) and 1987 (post operative) were interpreted. This allowed for direct comparison of functioning, as measured by this instrument.

The individual form of the *MMPI* was used on all three tests. The test was administered and scored in 1971 and 1975 by the staff of the Clarke Institute of Psychiatry and by the case study investigator for the 1987 administration. An outside psychologist, (Dr. Tom Tombaugh, Carleton University) expert in the area of *MMPI* interpretation, was enlisted for the task of interpreting all three of the profiles for this project. His discussion of the profiles was audio taped for later review. The primary reference for interpretation, used by Dr. Tombaugh, was: *The MMPI: Clinical Assessment and Automated Interpretation.* (1974).

The Family Assessment Measure

The *Family Assessment Measure* (Skinner, Steinhauer & Santa-Barbara, 1984) developed at the Addiction Research Foundation (Toronto, Ontario) is a self-report instrument which attempts to measure elements of family strength and weakness. The basic dimensions assessed by the *FAM* are: task accomplishment, role performance, communication, affective expression, involvement, control, values and norms. The assessment of these dimensions is accomplished through three separate scales: the General Scale, Dyadic Relationship Scale and Self Rating Scale. Each scale allows for a different perspective of family functioning (Skinner, Steinhauer & Santa-Barbara, 1983). The *FAM* is based on a "Process Model" which emphasizes the dynamic interactions of major aspects of family functioning as well as the interplay between the individual and the group: the intrapsychic and the interpersonal. The focus is one of process rather than structure. (Steinhauer, Santa-Barbara & Skinner, 1984).

The standardizing groups (475 families in the Toronto area) are described in Skinner et al., 1983. Demographic information, including age, sex, length of cohabitation, number of children, education level, income, etc., demonstrates that a heterogeneous population served as the norming group. Reliability estimates for the overall scales for adults range from .89 to .93 and for children, from .86 to .94. Reliability ratings for each of the subscales are also given for both adults and children. The range for adults is from a low of .39 (Self Rating: Control) to a high of .87 (General Scale: Social Desirability). The range for subscale reliability for children is .27 (Self Rating: Role Performance) to .77 (Communication: Dyadic Relationships). Reliability is affected by the number of items, and the decrease in subscale reliability, to a degree, is to be expected on these briefer subscales (Skinner, et al. 1984). The primary scale reliabilities can be considered quite robust. A multivariate comparison of problem and nonproblem families is also

reported. The results supported the *FAM* General Scale's ability to discriminate between 'problem' and 'nonproblem' families (Skinner, et al. 1984).

The development of the constructs (i.e. of the Process Model) upon which the *FAM* is based are detailed in Steinhauer et al. (1984). At present it is reported that research into external validation of the constructs is ongoing. In addition further research examining its concurrent validity (correlation with other family instruments) is noted, as is research into its clinical and predictive validity (Skinner et al. 1983).

The *FAM* is a self-administered instrument. Directions for completion of the scales are on the front cover of the corresponding question booklet. With the case subject, the investigator reviewed the purpose of the *FAM* and general guidelines for completion. He remained present while the case subject completed the questionnaires. The other family members (who do not live in the same cities as each other or as the case investigator) were contacted by telephone (permission had been granted for this at a prior meeting). During this conversation, the investigator reviewed the purpose of the test and guidelines for completion. The booklets and question/answer sheets, with an attached letter reiterating instructions and rationale, were then mailed to each of the family members, who completed the tests and mailed them back to the case investigator.

Each scale consists of either 42 or 50 statements to which the test-taker answers with "strongly agree," "agree," "disagree," or "strongly disagree." As the examinee marks the answer sheet, the marks are transferred (carbon copy) to attached scorer's sheets. From this the scorer can calculate raw scores, and then transform the raw scores to standard scores (tables provided). Profiles are provided for graphic display and comparison, as are guidelines for interpretation of the scores.

The *FAM* was chosen for this project not only for its reported reliability, validity and ease of administration, but also for its focus on process rather than structure and its attempt to integrate systems theory with individual psychopathology. The emphasis it places on the "interface between the individual subsystems and the family system" (Steinhauer, et al.,1984, p. 78) was thought to be extremely appropriate to this case study.

The case subject was asked to complete all of the questionnaires from the point of view of how the family currently functions (keeping in mind their separate domiciles). The subject completed three Dyadic Relationship Scales (i.e. relating to her mother, her father and her brother). The other family members were each asked to complete a General Scale and a Dyadic Scale (considering their relationship with the case subject). This allowed for the comparison of three different views (note: the father declined to participate in this section of data collection) of the family functioning, as well as different views on the dyadic relationships of the case subject with other family members.

Social Support Questionnaire

The *Social Support Questionnaire* (Sarason, Levine, Basham and Sarason, 1983) was used as a measure of adequacy of social support. In discussing issues in the measurement of social support, Sarason et al. state that:

> Regardless of how it is conceptualized, social support would seem to have two basic elements: (a) the perception that there is a sufficient number of available others to whom one can turn in times of need and (b) a degree of satisfaction with the available support (p. 128-129).

In presenting his view of the conceptual issues involved in the area of social support measurement, Tardy (1985) suggests that there are five basic dimensions in defining the construct. He represents these dimensions as: (a) Direction, (b) Disposition, (c) Description/Evaluation, (d) Content, (e) Network.

Direction he sees as being the direction of the support: either given or received. The issue is not which direction is studied but rather that the direction is overtly delineated.

Disposition, like Direction is seen as comprising two complimentary components: availability (quantity and/or quality) and utilization.

Description/Evaluation refers again to two related facets of social support. Description refers only to the existence of supports, while evaluation refers to the individual's level of satisfaction with the support available. Research is reported which looks at these facets individually and together.

Content of social support is conceptualized by citing House (1981), who distinguished among four types of support content: emotional, instrumental, informational and appraisal.

The term Network describes the existence of a support network without implying a direction for the support (Tardy, 1985, p. 188-190).

Having reviewed a variety of the instruments in this area, the *Social Support Questionnaire* (*SSQ*) was chosen for this study for a number of reasons. Inspection of the *SSQ* reveals that it too meets Tardy's basic criteria (1985) for covering the range of basic elements of social support. The *SSQ* clearly states that the Direction of the support being discussed is coming 'to' the individual in question and not from the individual. In terms of Disposition, the instrument focuses on availability rather than on enactment. Description and Evaluation are both overtly measured by the instrument. Content tends to refer primarily (though

not exclusively) to emotional support and finally, a Network of support is measured by the SSQ.

In reporting a series of projects investigating the *SSQ*, (Sarason, Levine, Basham, and Sarason, 1983) a study of 602 undergraduate university students found that N scores (number of persons available) had an internal reliability coefficient (between items) of .97 and the correlation of items with the total score ranged from .51 to .79. The S scores (satisfaction) had an alpha coefficient of .94 while the correlation of individual items with the total score ranged from .48 to .72. The test-retest reliability (for 105 students to whom the test was re-administered) was .90 (N scores) and .83 (S scores) over a 4-week interval. A further study reported significant negative correlations with depression. Other studies in this series correlate the measure with lack of satisfaction in social support and the occurrence of negative life events as well significant positive correlations (in female subjects) between N scores and extroversion, and negative correlations (in female subjects also) between neuroticism scores and S scores. The authors note that on the latter two studies the results for men were in the same direction as for women but were not as strong.

The combination of construct and concurrent validity, and internal reliability, outweigh the disadvantage of the instrument not having an extensive norming population. The authors report a range of N scores from 2.92 to 5.46 with a mean of 4.25 and a range of S scores from 5.12 to 5.57 with a mean of 5.38. These ranges and means are reported on the sample of 602 undergraduate university students.

Like the *FAM*, the *SSQ* is largely self-administered. The researcher reviewed the rationale and guidelines for completing the questionnaire with the case subject, and then remained present in the room while she completed it. The test consisted of 27 items to which the subject was required to: (a) list the person(s)

(by initials and relationship) to whom she could turn for support in the manner described by the question, (b) circle the satisfaction level with the overall support available for each of the areas questioned (i.e. on a scale of "1-very dissatisfied" to "6-very satisfied").

The overall N and S scores were calculated by taking the sum of each section (N and S) and dividing by the number of items (27).

CHAPTER IV
RESULTS

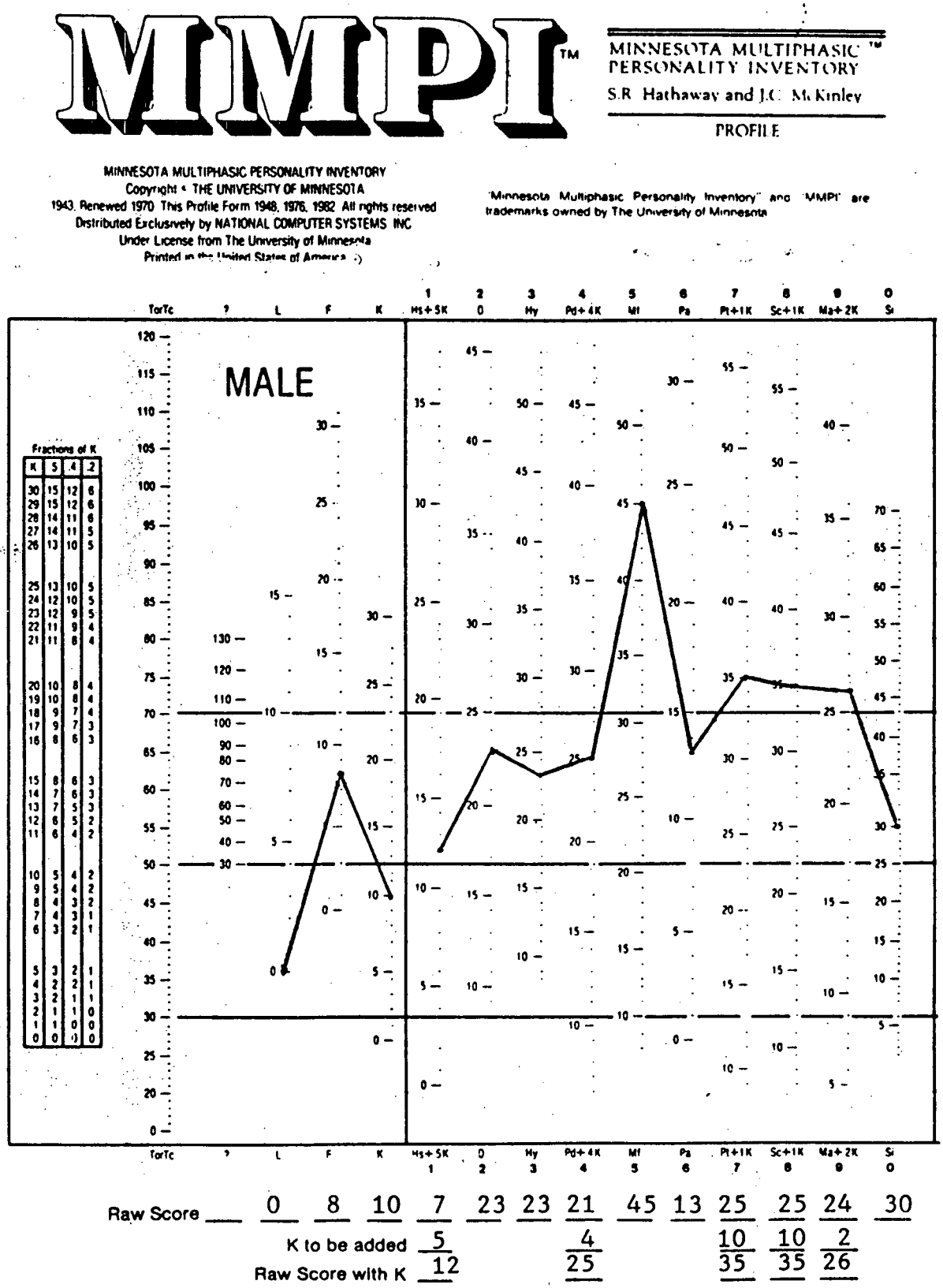
Introduction

The use of the three standardized measures allowed for an assessment of the case subject's functioning in three different domains. The instruments were chosen in part for their approximate correspondence to Conger's levels of assessment (individual, family and community). In addition, as was noted in Chapter III, the Minnesota Multiphasic Personality Inventory had been used on two prior occasions to assess the psychological functioning of the case subject. The comparison of these three MMPI profiles (two historic and one current) allowed for an assessment of change in scores over a sixteen year time period, from the first to the current profile (see figure 4.1).

MMPI Profile Interpretations

The 1971 profile showed significant elevations (defined as a T score of 70 or greater) on scales 7, 8 and 9. More moderate elevations (T score of greater than 60) were evident on scales 2, 3 and 4. This profile was interpreted as belonging to a person who was extremely careful, perhaps to the point of being obsessive (L scale = 0). The scores showed evidence of worrying, self preoccupation and schizoid tendencies (pattern of 7, 8, 9, elevations). Though the scores showed both obsessive-compulsive and schizoid tendencies, there was no evidence of actual delusions or psychotic reactions. The depression scale (2) was elevated to suggest some ongoing depression and an overall lack of pleasure in life. Other qualities suggested in the interpretation were: high energy (scale 9) and perhaps at times a sense of confusion about a world in which the subject somehow felt that he did not belong (scales 6 & 8). There was also some evidence of interpersonal panic (pattern of scales 7, 8, & 9).

Figure 4.1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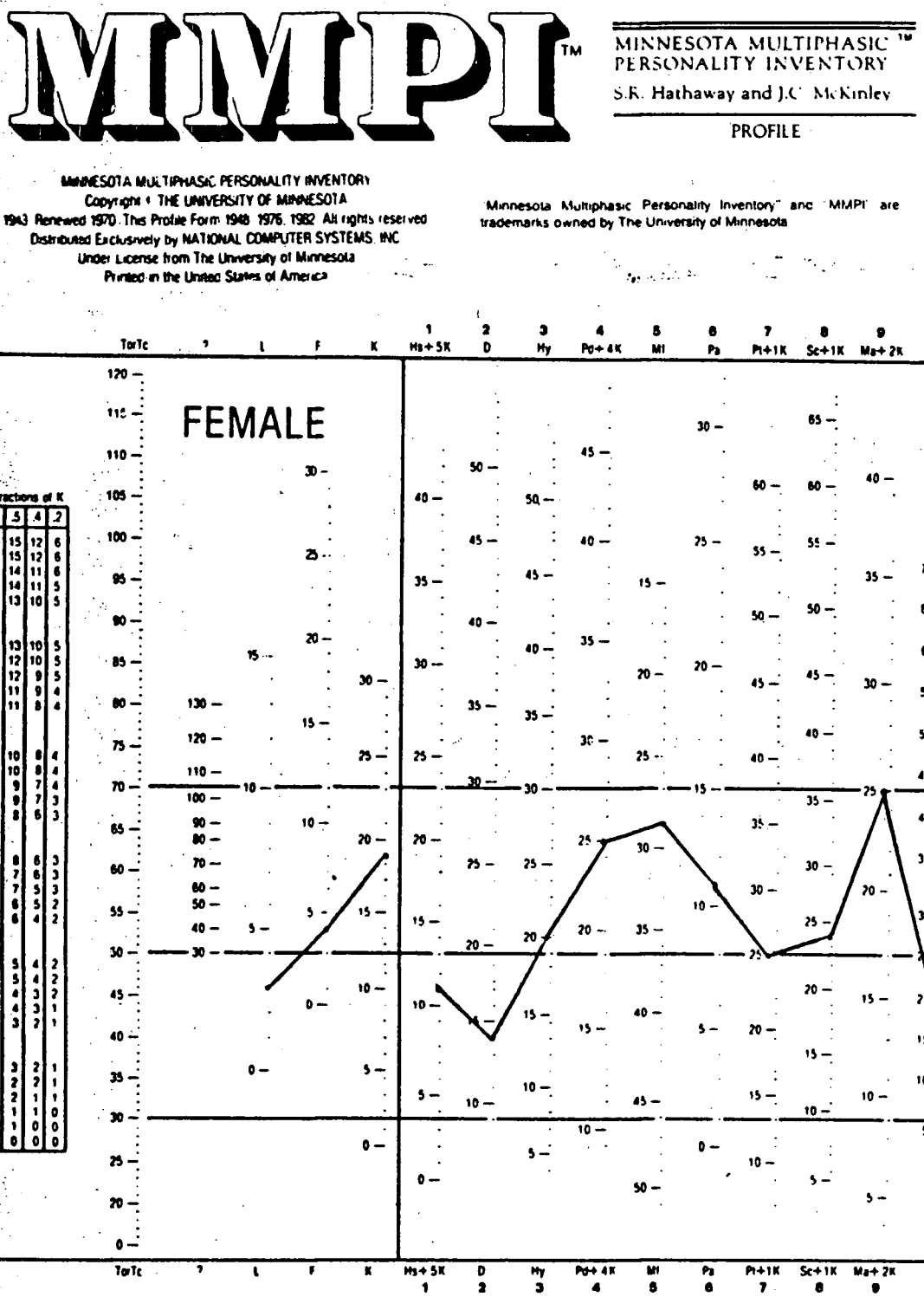
MALE
TorTc ? L F K Hs+.5K 1 0 2 Hy 3 Pd+.4K 4 Mf 5 Pa 6 Pt+1K 7 Sc+1K 8 Ma+.2K 9 Si 0
Fractions of K
K .5 .4 .2
Raw Score 0 8 10 7 23 23 21 45 13 25 25 24 30
K to be added 5 4 10 10 2
Raw Score with K 12 25 35 35 26

Figure 4.2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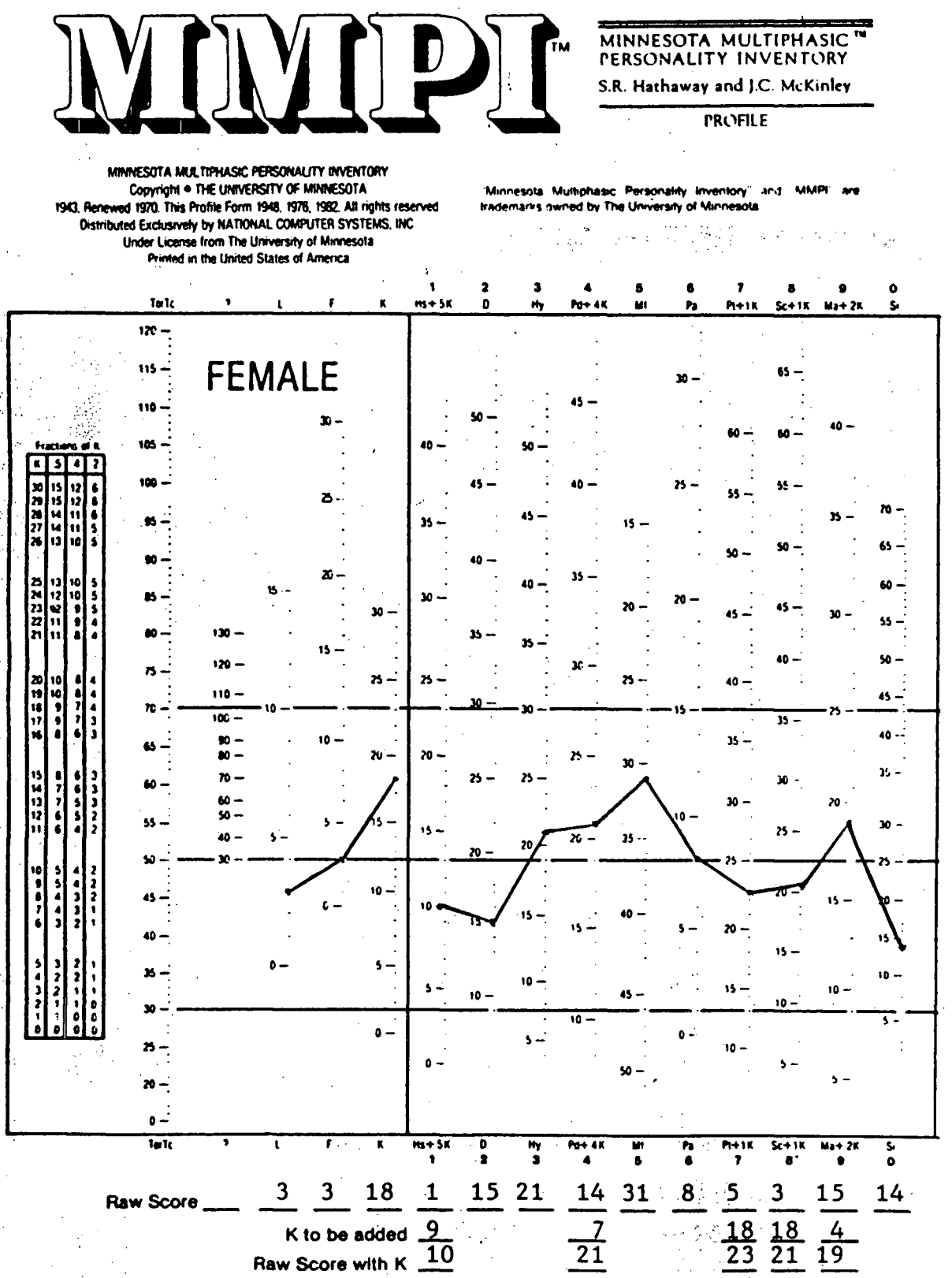
FEMALE
Fractions of K
TorTc ? L F K
1 Hs+.5K
2 D
3 Hy
4 Pd+.4K
5 Mf
6 Pa
7 Pt+1K
8 Sc+1K
9 Ma+.2K
0 Si
Raw Score 3 4 19 1 14 20 17 31 11 6 5 21 16
K to be added 10 8 19 19 4
Raw Score with K 11 25 25 24 25

Figure 4.3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FEMALE
TorTc ? L F K Hs+.5K D Hy Pd+.4K Mf Pa Pt+1K Sc+1K Ma+.2K Si
1 2 3 4 5 6 7 8 9 0
Fractions of K
Raw Score 3 3 18 1 15 21 14 31 8 5 3 15 14
K to be added 9 7 18 18 4
Raw Score with K 10 21 23 21 19

Inspection of the 1975 profile (two years after surgery) showed several significant changes. The K scale had risen from a T=41 in the 1971 profile to a T=61 in 1975. This level of elevation on the K scale, in conjunction with a low L score (T=52) raised some questions. The pattern of a high K and low L scores may have reflected a lack of validity in the profile, or it may have signified an increase in ego strength (i.e. the individual was not 'faking good' but rather felt good about herself). This pattern also tends to occur after an individual has participated in psychotherapy. After review and comparison with the other profiles, this profile was accepted as valid (the hypothesis of increased ego strength was accepted). Other changes from 1971 included the decrease in elevation of scale 2 (depression). It was interpreted that post operatively, the case subject was expressing less anadonia and more pleasure in life. Elevations on scale 4 (T=64) and scale 9 (T=71) were interpreted as evidence of a high-energy person who holds a certain sense of anger and who as a result has the potential to 'act out' in some negative way. This high energy and inner anger was also evident in the 1971 profile. It should be noted that the non-clinical scale 5 had by this time, dropped to 31 (T=70) from 45 (T=97).

Taken in its entirety, the 1975 profile was interpreted as reflecting a psychologically 'healthier' person than did the 1971 profile. The drop of scales 7 and 8 were evaluated as signifying acceptance, rather than rejection of self, and the drop of scale 2 demonstrated that the subject was attaining more pleasure in life.

The 1987 profile showed only scale 5 (a non clinical scale) as being elevated beyond one standard deviation (T=64). Scoring on the "Female" profile (since both 75 and 87 are post operative profiles) the elevated MF score was interpreted as showing the case subject as more assertive and aggressive than the mean of the reference population. This was thought, however, to be quite appropriate and

consistent with the role expectations of the working woman in our present day society. Evidence of depression as well as of obsessional thinking was no longer present. All clinical scales on this (1987) profile fell within the normal range.

Scale 9 (hypomania) on this current profile dropped to within one standard deviation of the mean. From this, it can be suggested that the 'energy' evident in the previous profiles was probably anxiety driven rather than physiologically based. The evidence of anger (scale 4) present in the 1971 and 1975 profiles was noticeably decreased in the 1987 profile.

The current profile was seen as belonging to a psychologically 'healthy' individual. Overall, these three profiles indicated an individual who, over a sixteen year period, had become less rigid and more flexible, less stereotyped in terms of sex role behavior, significantly more relaxed, less anxious and more accepting of herself and capable of deriving more pleasure from life.

Family Assessment Measure

All three forms of the *Family Assessment Measure* (*FAM*) were administered to the case subject: The General Scale, The Individual Scale and The Dyadic Relationship Scale. The case subject's mother and brother also completed the General scale and the Dyadic Relationship Scale (focusing on their relationship with the case subject). The case subject's father agreed to be interviewed but declined to complete the FAM questionnaires. This section of data collection has allowed for the comparison of different perceptions of family functioning and of dyadic relationships between the subject and her mother, and the subject and her brother. Though information from the father would have been useful for added comparison, the relationship with him is described, but only from the point of view of the case subject.

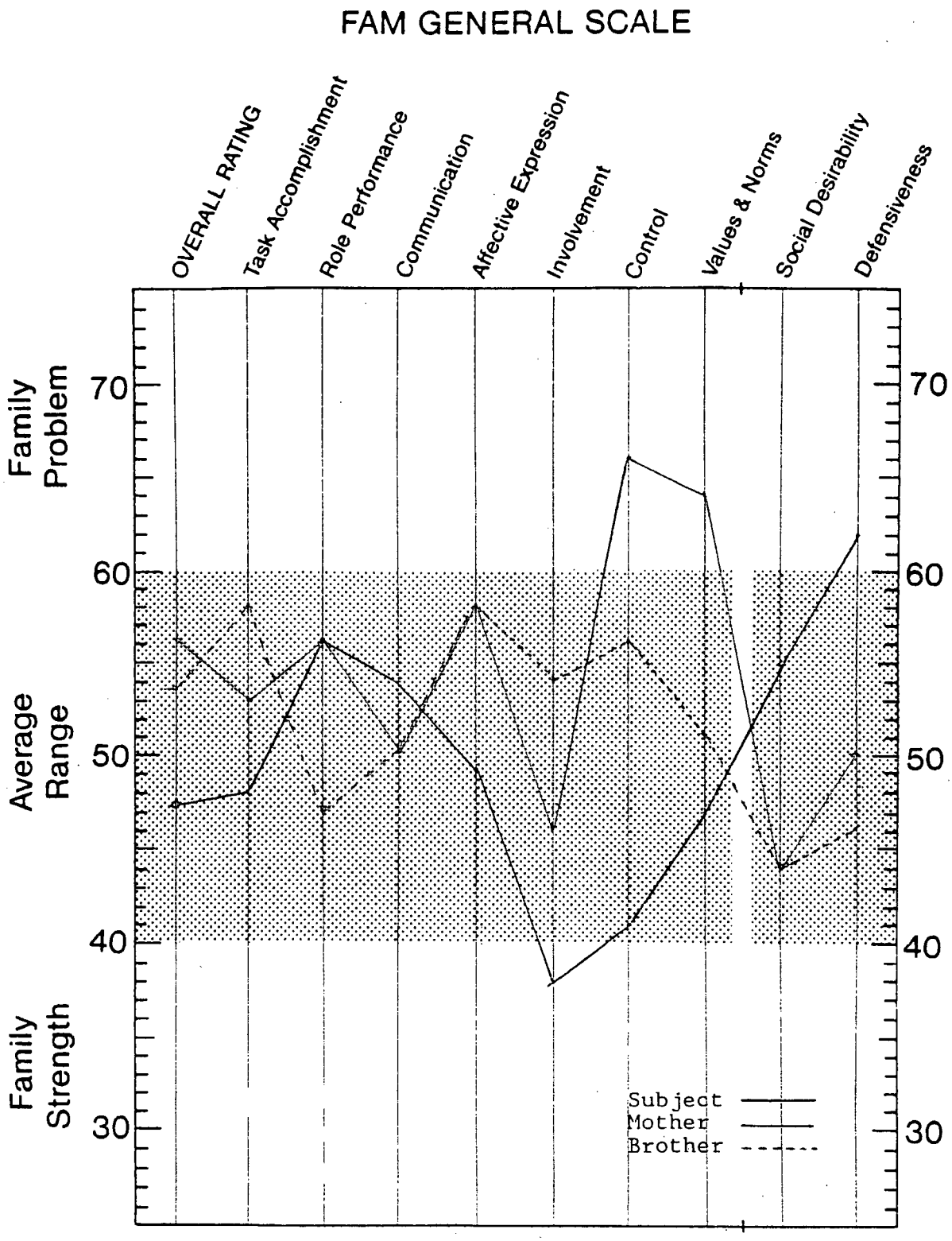
Identical instructions were given to each of the individuals completing the questionnaires. The one modification made to the standard *FAM* manual instructions was necessitated by the separate living situations of all family members. Each person was instructed to answer the questions to the best of their ability, from the perspective of how the family functions currently. Question #2 ("Family duties are fairly shared") was used as an example of a question which might be confusing because of their separate living situations. It was suggested to each family member that the term 'duties' could still apply, but not in the same sense (e.g. household duties) that it would have when they were all living together. After discussion with each of the individuals, it appeared that there were no difficulties in understanding and relating the questions to their current situation.

Once the questionnaires were completed, responses were scored and then transformed into standard scores as per directions in the interpretation guide. The mean for standard scores is 50 and the standard deviation is 10. Interpretation of the profiles was completed by the case investigator. For the General, Dyadic Relationship, and Self Rating Profiles, see Figures 4.4, 4.5, 4.6, and 4.7.

Interpretation

On scales rating Social Desirability and Defensiveness, the case subject attained standard scores of 55 and 62 respectively. The Defensiveness score, being greater than one standard deviation above the mean, signified the possibility of some degree of defensiveness or 'faking good' in the overall profile. This score was kept in mind in the interpretation of the profile. By comparing the scores of the case subject with those of the mother and brother, an assessment of the risk of the profile being invalid was made. In the opinion of the case investigator, the profile of the case subject was a valid one, based on a comparison of her scores with those of the other family members.

Figure 4.4


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Subject
Mother
Brother

The case subject's Overall Rating for the family (calculated by finding the mean score for the seven clinical subscales) was a standard score of 48, well within the normal range. With the exception of the aforementioned Defensiveness scale, the only score to fall out of the normal range (i.e. greater than one standard deviation from the mean) was that of the Affective Involvement. The subject's score of 38 suggested high levels of empathic involvement between family members, mutual concern and a nurturing and supportive involvement with each other. Both the mother's score (47) and brother's score (54) suggested somewhat less positive views of this dimension, however both scores fell within the normal range for nonproblematic families in the norming group.

The subscales measuring Control, and Values and Norms, showed the greatest disparity of scores. The case subject attained a standard score of 41 on the control subscale. This would suggest that she views the manner in which control and power is wielded within the group as being a family strength. The *FAM* interpretation guide suggested that extreme low scores (defined as less than 40) indicate patterns of predictability yet flexibility in the meeting of changing demands, and that control and attempts at control are largely constructive, educational and nurturing.

The subject's score on this subscale was in significant contrast to her mother's score, which at 65, was greater than 2 standard deviations away. A score of this magnitude would suggest that the mother views the issue of control as being problematic within the family. The *FAM Administration and Interpretation Guide* suggested that scores above 60 may signify any of the following:

> "patterns of influence not allowing the family to master the routines of ongoing family life; the failure to perceive and adjust to changing life demands; a lack of spontaneity or its opposite, chaos, in issues of power and control; a style which is too rigid or too laissez-faire; control attempts which

are destructive or shaming and family patterns which are characterized by overt or covert power struggles" (p. 19).

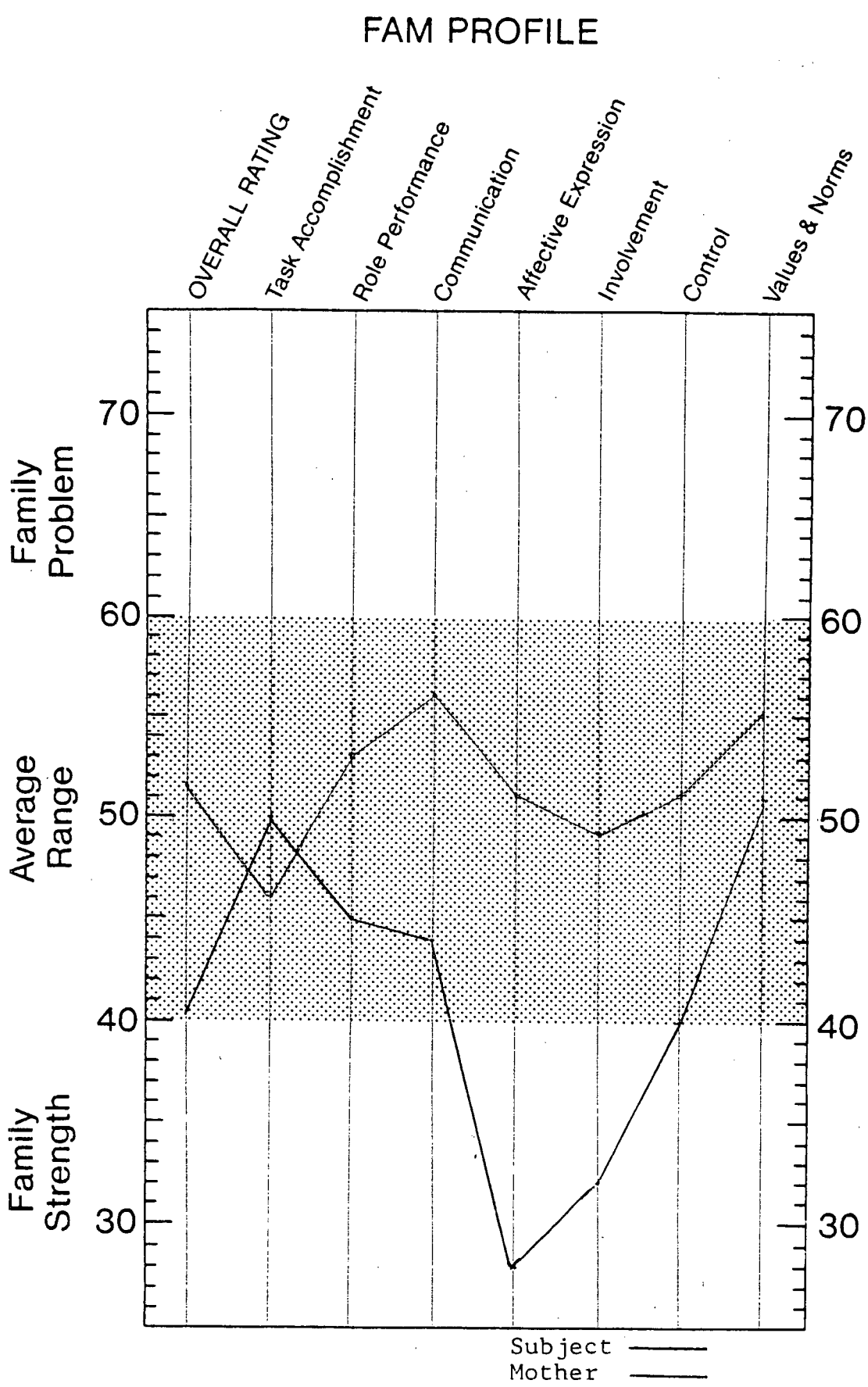
As a contrast to both of these extreme scores, the brother scored 55 on this subscale. A number of possible explanations were evident for this disparity in scores. The father and mother have been divorced for a number of years and perhaps the mother's score related more to the past marital dyad (and hence memories of past marital conflict) than to the family as a whole. Another possibility was that control was an issue on which the three family members reacted to uniquely; what was problematic for the mother was an area of satisfaction for the case subject, and of little concern for the brother. Considering the defensiveness score of the case subject, there was some suppression of negative aspects of this content area in her scores. On the subscale Values and Norms the mother again scored beyond the 'normal' range. Her score of 64 would suggest that she perceived this also, as being a problematic dimension for the family. The case subject and her brother, however, both scored near the mean, with scores of 47 and 51 respectively. Inspection of this subscale revealed that it shares certain characteristics with the Control subscale. Values and Norms includes concepts such as family rules, societal norms and rules, and the identification of the congruence or incongruence between the family's values and those of the society at large. Where the Values and Norms subscale identified rules, norms and values, the Control subscale is complimentary in that it looks at the enforcement of such. It is therefore not surprising that problematic scores on one subscale foreshadow problematic scores in the other. Considering the sibling agreement on the Values and Norms subscale (in a nonproblematic direction) it could be argued that the hypothesis regarding the disparity of scores on the "control" subscale, being due at least in part to remnants of marital discord, was strengthened.

The case subject and her mother showed the same score on the subscale of Role performance (56) while the brother at a score of 48 appears to have perceived this as an area of somewhat greater strength. Though there is some disparity in scores here, it was not considered significant since all of the scores fell within the normal range and also fell within one standard deviation of each other. The other three clinical subscales (Task Accomplishment, Role Performance and Communication) all fell within the normal range and the scores of the three family members fell within one standard deviation of each other.

The mean Overall Ratings (for all three test takers) fell within the normal range. In spite of significant differences on specific subscales (Involvement, Control and Values and Norms) the Overall Ratings fell relatively close (within one standard deviation) to each other.

It should be noted that the norming population for the *FAM* does not include families with adult children no longer living in the same domicile as the parents. The case investigator was assured by the Research Coordinator of the "FAM Research Project" that this instrument has been found to be valid for families at this stage, however, the relationship of this family's scores to the scores of problematic and nonproblematic families used as the reference population should be interpreted with some caution.

Figure 4.5

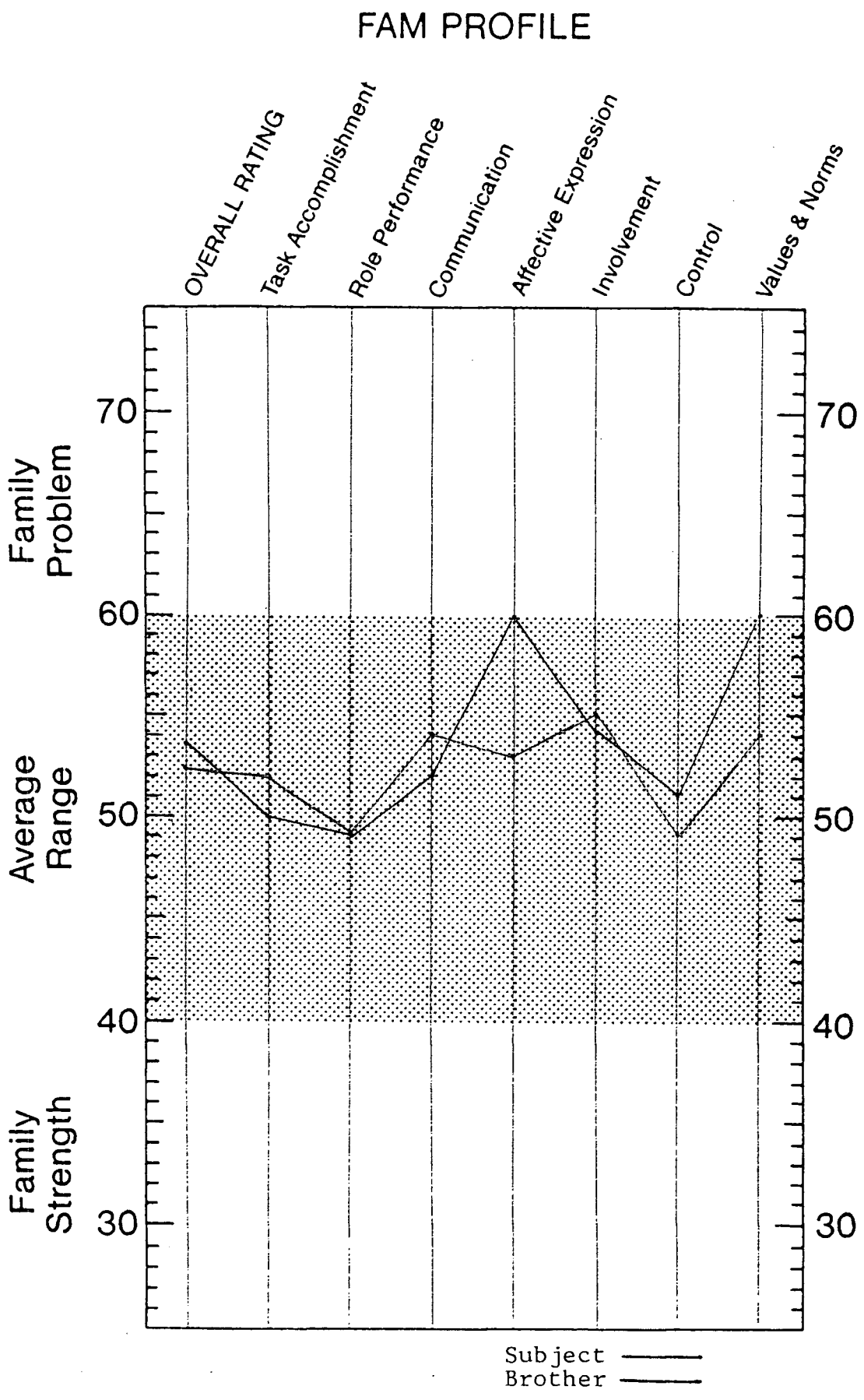

FAM PROFILE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Family Problem
Average Range
Family Strength
70
60
50
40
30
Subject
Mother

Interpretation

In rating her relationship with her mother, the case subject scored an Overall Rating of 51.5. This was the average of the seven clinical subscales (all of which fell within .5 standard deviations of the mean). The most extreme score in a positive direction was on the subscale of Task Accomplishment (46). The most extreme scores in a negative direction were for the subscales of Communication (55) and of Values and Norms (55). Inspection of the graphic representation of the profile (figure 4.3) shows that these scores fell within the 'normal' range. This was in contrast, however, to the mother's rating of this same relationship. At an Overall Rating of 40, the case subject's mother appeared to perceive the relationship as generally being characterized by extreme adaptiveness.

Inspection of the subscales in the mother's profile revealed a number of scores significantly divergent from the those of the case subject. On all subscales except Task Accomplishment, the mother scored the relationship in the direction of 'greater strength' than did the case subject. This was most evident on the subscales of: Affective Expression (28), Involvement (32), and Control (40). Since the focus of this study did not include an intensive clinical assessment of the mother's perception of her relationship with the case subject, this outstanding result could not be conclusively explained. Based on the results of this questionnaire and on one interview with the mother, it was the case investigator impression that the mother perceives her relationship with her daughter as being characterized by openness, empathy and caring.

Figure 4.6

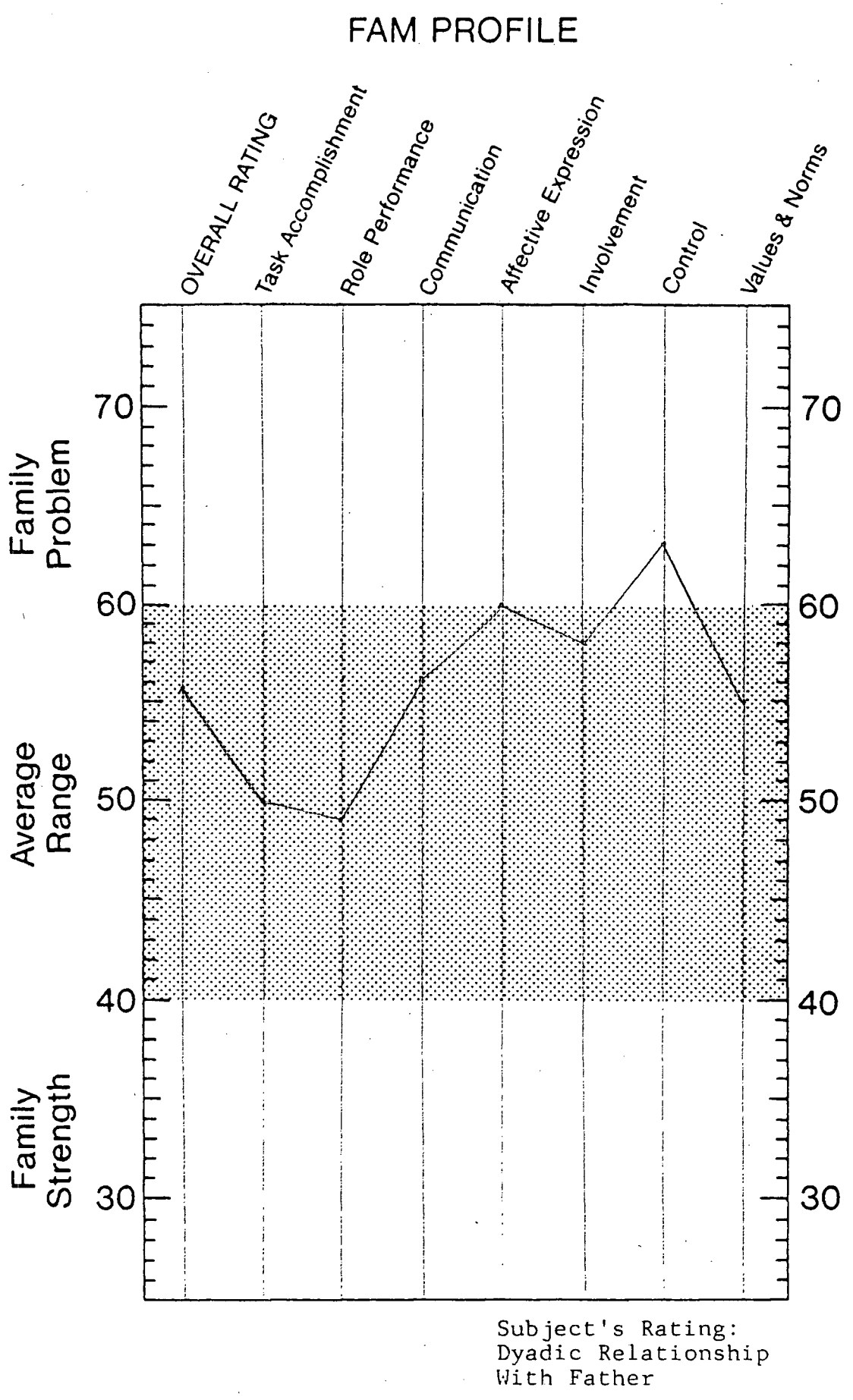

FAM PROFILE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Family Problem
Average Range
Family Strength
70
60
50
40
30
Subject
Brother

Interpretation

The case subject's rating of her relationship with her brother showed a somewhat greater range in scores than did his rating of his relationship with her. The Overall Rating, for the case subject, was shown at 54 with a range of scores from 49 (Role Performance) to 60 (Affective Expression and Values and Norms). The Affective Expression score suggested that communication between the two, in the case subject's opinion, has an inappropriate emotional quality to it relative to the situation (either extremely lacking or laden with emotionality). Her score for the Values and Norms subscale signified that she sees her values and those of her brother as being somewhat opposed.

With the exception of these two subscale scores, there was very close agreement between the siblings on their relationship (all other subscale scores were within two points of each other). On the subscales of Affective Involvement and Values and Norms the brother scored 53 and 54 respectively. These latter two subscales represented the greatest disparity in scores with the case subject, yet still fell within one standard deviation. The brother's Overall Rating was 52.25, approximately one point less than the case subject's rating.

Figure 4.7

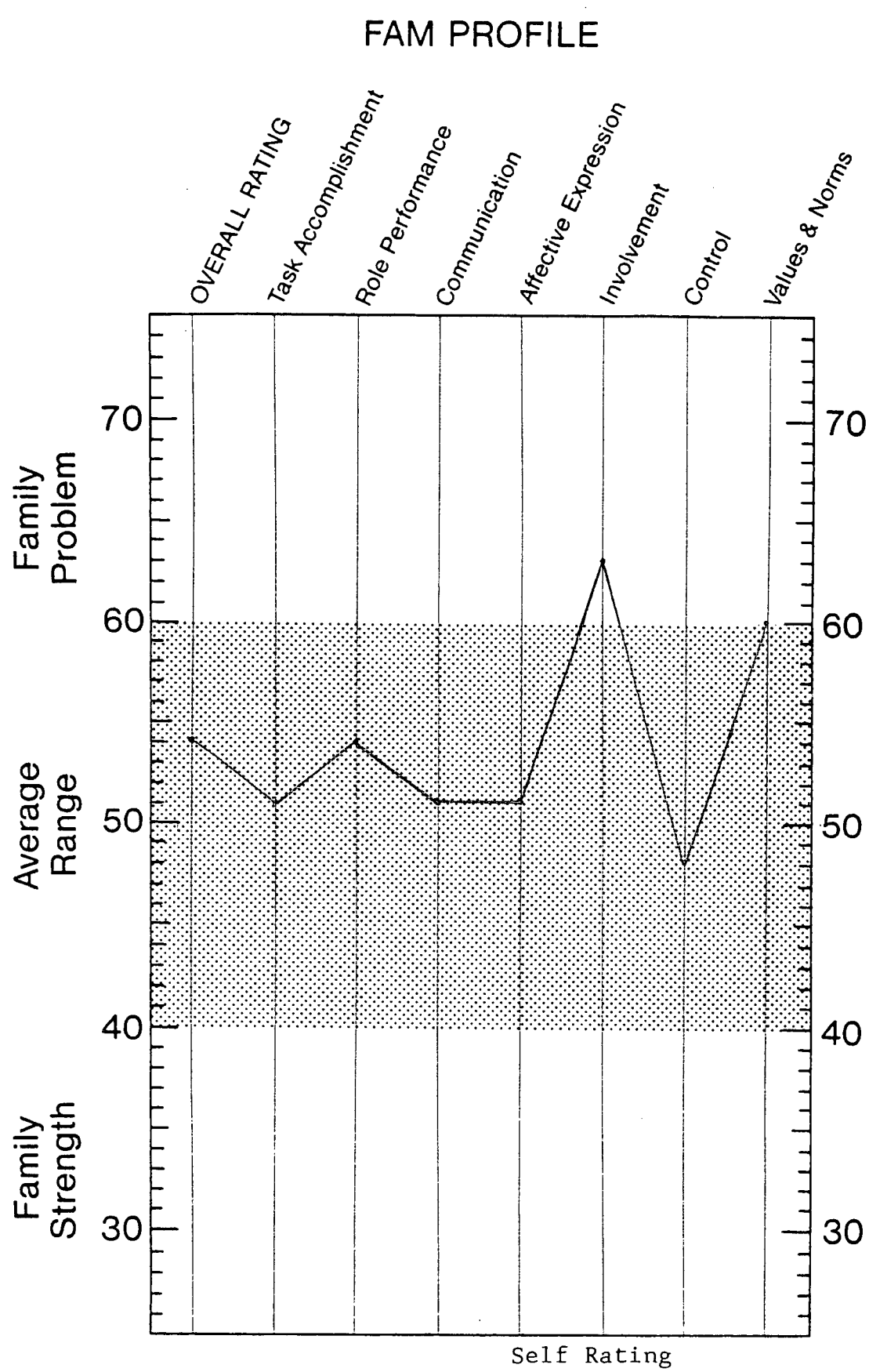

FAM PROFILE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Family Problem
Average Range
Family Strength
70
60
50
40
30
Subject's Rating:
Dyadic Relationship
With Father

Interpretation

The case subject's rating of her relationship with her father suggested that on some dimensions this was viewed as a somewhat more problematic relationship. The Overall Rating for the profile, at 55.85, was within the normal range. The range of scores was from 49 (Role Performance) to 63 (Control). A comparison of this profile and the case subject's dyadic profile with her brother showed some strong similarities, though this was a profile of more extreme scores. The most extreme score (negative) was on the subscale Control (which was also the point of greatest divergence from the profile with the brother). This score suggested problems centering on issues such as: failure to perceive and adjust to change, inappropriate attempts at control, and ongoing power struggles.

The next highest score was in the area of Affective Expression (60) followed by a score of 58 on Affective Involvement. The Affective Expression score was identical to the score on the dyadic profile with the brother and suggested problems in the area of affective communication. The Affective Involvement score was within the high normal range. It suggested possible difficulty in the area of affective/emotional involvement (either too close or too detached).

Figure 4.8


FAM PROFILE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Family Problem
Average Range
Family Strength
70
60
50
40
30
Self Rating

Interpretation

On the Self Rating scale, the case subject attained an Overall Rating of 51.7. Six of the seven scales fell between 47 and 54. The one outstanding score was for the subscale, Values and Norms. The score of 60 on this subscale, suggested some disturbance centered on perceived dissonance between the case subject's values and those of the family generally. This score may also have been showing conflict in the area of family rules, specifically between overt and covert rules. These scores will be discussed further in the context of the overall data collection in Chapter V.

Social Support Questionnaire

The results for the *Social Support Questionnaire* (*SSQ*) indicated that the case subject's perceived level of social support, across the situations presented, ranged in number (N score) from 4 to 8 people (mean = 5.7). The authors reported, that in their research with college students the N scores ranged from 2.92 to 5.46 with an overall mean of 4.25. The case subject's S score (satisfaction level with the support available) was 6 (very satisfied, the highest possible score) for all of the situations rated. The range of S scores that the authors report was 5.12 to 5.57 with an overall mean of 5.38.

The case subject's results on this instrument, suggested that she has a greater level of social support and is more satisfied with the quality of support available, than the reference group supplied by the instrument's authors. However, this comparison may not have been a valid one, since the reference group used is a sample of college students. There may be significant differences in the area of social support between this reference sample and other populations which have more in common with the case subject.

Inspection of the individual test items revealed that the case subject had listed a minimum of four sets of initials for each of the situations posed. The relationships listed appeared to represent both family and friends. Though the combinations of people changed across situations, the answers demonstrated that there were a number of people who recurred across a variety of situations. These people included: family of origin members (i.e. mother, father and brother) friends and common-law husband. The overall picture appears to be one of a circle of close friends and family, who the case subject believes can be relied upon to be supportive across a variety of life situations.

The consistent scoring of satisfaction level at '6', raised the question of whether or not this was a valid reflection of the actual level of satisfaction or if this was some form of 'response set.' This question could not be definitively answered, however, the interview data suggested that there was a long history of close and supportive friendships.

The Critical Incidents

In his description of the Critical Incident Technique, Flanagan (1954) defined an 'incident' as " . . . any observable human activity that is sufficiently complete in itself to permit inferences and predictions about the person performing the act" (p. 327). The incident was seen as "critical" if it " . . . occurs in a situation where the purpose or intent of the act seems fairly clear to the observer and where its consequences are sufficiently defined to leave little doubt concerning its effects" (p. 327). In this study, the definitions were modified slightly. A 'critical incident' was defined as an event which occurred within the awareness of the case subject and resulted in an observable consequence to, or behavior by the case subject, which lasted over some period of time. Though it was acknowledged that a result or consequence may be of an affective or cognitive nature and hence not

be observable, for the purposes of this study, the event was required to have some observable component (though other nonobservable components, if acknowledged, were reported as well). The classification of the critical incidents is shown in Table 4.1.

TABLE 4.1

ECO-SYSTEMIC CLASSIFICATION OF CRITICAL INCIDENTS

Incident	Perceived Result
Individual	
#1-Suicide attempt age 15	-Teacher becomes less abusive
#2-First crossdressing in public	-Never dresses as a male again
#3-Change of surname	-Less concern with hiding the past, greater honesty
#4-Suicide attempt age 31	-Change in relationships
Family	
#5-Mother discovers that subject has not attended Air Cadets	-No further pressure at home regarding activities
#6-discovery of letters re. SRS	-open discussions about SRS
#7-telling father and brother about efforts to attain SRS	-open communication with father and brother
#8-first post SRS Christmas Card	-feelings of acceptance
Community	
(Educational)	
#9-Ridiculed by Grade 9 teacher	-less interest in school
#10-Attending Trade School	-becomes qualified hair stylist
(Medical)	
#11-Psychiatrist makes transsexual diagnosis	-Subject writes J.Hopkins Clinic
#12-First response from John Hopkins	-Subject continues to write
#13-Plastic surgeon supports SRS	-referral to Clarke Institute
#14-being calmed by surgeon	-relief and confidence post surgery

TABLE 4.1 (continued)
ECO-SYSTEMIC CLASSIFICATION OF CRITICAL INCIDENTS

(Vocational)	
#15-Subject begins to charge for hairstyling	-extra money allows for expansion of the business
#16-buys first salon in Oxbow	-is successful financially
#17-organizes community hair and fashion show.	-receives positive public attention
#18-wins provincial hair competition	-moves to Regina
#19-fired from job in Toronto	-boss offers a job in Regina
#20-Ex-boss asks Subject to return to Regina	-returns to Regina
#21-buys salon in Regina	-trapped by debts, unable to sell
#22-Regina salon burns down	-moves to Vancouver
(social/friends)	
#23-Going to Air Cadets	-feels humiliated does not return
#24-family friend speaks to son and his friends 'about Henry'	-the boys cease ridiculing subject
#25-moves to Vancouver to live with boyfriend	-returns to Regina
#26-joins West End Players	-change in social life
#27-moving in with common-law	-change in life circumstances
(community at large)	
#28-sees Christine Jorgenson on T.V.	-seeks information about transsexualism
#29-man on plane comments on attractiveness	-stops crying
#30-going to bar with cousin in Toronto	-increased confidence and continued socializing

Situational Influences

As a result of the interview process, it was discovered that there were a range of influences and situations which could not be clearly classified as incidents (due to their lack of obvious beginning and end points) yet appeared to be significant to the psychological and social adjustment of the case subject. They are presented in Table 4.2, employing the same classification system as for the Critical Incidents.

TABLE 4.2

ECO-SYSTEMIC CLASSIFICATION OF SITUATIONAL INFLUENCES

Influence	Perceived Result
Individual	
#1-unathletic as a child	-spent a lot of time alone, sewing
#2-learning to sew and cut hair	-during teens these provide the subject with a service to offer peers and as an adult these become viable vocational skills
#3-realizing that it made her feel better to be honest with people she cared about	-Immediate family all knew about subject's desire for SRS by 1971 (prior to cross-living in Toronto)
#4-always felt relaxed as a woman	-didn't feel that she had to work at 'passing'
#5-one year spent cross-dressing in Toronto	-confident when dressed as a woman
#6-ongoing depression 1980-1984	-vocational instability and excessive use of alcohol and drugs
Family	
#7-no rejecting responses from family members (re. SRS)	-always felt supported and taken seriously
Community	
#8-being introduced to the Gay community in Regina	-developing empathic friendships
#9-ongoing interviews with psychiatrist at the Clarke Institute	-positive therapeutic alliance which increased determination and faith in ability to succeed
#10-befriending a woman subject saw as self destructive	-motivation to change behavior patterns of 1980-1984
#11-occasionally feel 'read' due to voice	-has attempted to modify but unsuccessfully

TABLE 4.3

A COMPARISON OF THE CASE SUBJECT'S AND CASE INVESTIGATOR'S SIGNIFICANCE RATINGS OF THE CRITICAL INCIDENTS

Number of Incidents												
10					28*	29**	29*	28**				
9					20*	18**	18*	20**				
8					12*	17**	17*	10**				
7					10*	13**	13*	09**				
6					06*	01**	30*	30**				
5					23*	23**	26*	26**				
4			23*	14**	22*	22**	24*	24**	14*	06**		
3			01*	12**	21*	21**	11*	11**	27*	27**		
2			15*	15**	19*	19**	04*	04**	08*	08**		
1	09*	23**	05*	05**	16*	16**	03*	03**	07*	07**	2*	2**
	1		2		3		4		5		6	

Levels of Importance

Column * Case Subject's ratings
Column ** Case Investigator's ratings

The Product Moment correlation between the Case Subject's significance ratings and the Case Investigator's significance ratings: r = .55

Table 4.3 displays the results of the case subject's and case investigator's ratings of the critical incidents, using the scale developed for that purpose (and described in Chapter III). Pearson's Product Moment Correlation was calculated between the two sets of ratings (r = .55). As can be seen by inspection of Table 4.3, there was substantial disagreement between the case investigator and case subject in rating the relative importance of the Critical Incidents. This result will be discussed further in Chapter V.

CHAPTER V
SUMMARY AND DISCUSSION

This project was based on the premise that the post operative adjustment of transsexual individuals can be positively affected by counselling, prior to, and post surgical sex-reassignment. The primary purpose of this study was to examine the development and ongoing adjustment of a single individual. By focusing on the current psychological and social adjustment of this individual, and then attempting to discover what factors had been significant to this person's adjustment, the researcher was able to emphasize the significance of the context within which the individual has lived and to show the importance of the various groups or systems which she has come into contact with over the years. This has enriched the knowledge base in the area of transsexualism and has allowed for a shift in research focus (which, historically, has largely ignored the effect of the people and groups which surround the individual).

An ecological model for assessment guided the classification of the critical incidents revealed during the interview process. The model, which emphasized the interaction of the individual with a variety of groups within the environment, served to highlight the effect of interpersonal variables. The use of the three standardized instruments allowed for an assessment of the individual's current psychosocial functioning. The historical *MMPI* profiles allowed a portrayal of change in psychological functioning over the time span of the tests.

The comparison of the three *MMPI* profiles (administered over a sixteen year time period) offered an opportunity to understand how this individual has developed and changed on the dimensions which this instrument measures. The results of this study suggest a number of issues which appear to have significantly influenced the post operative adjustment of this person.

The Test Results

As reported in Chapter IV, the results of the *SSQ* showed the number of support persons (N score) listed across the situations presented, ranged from 4 to 8 people, with a mean score of 5.7. The authors reported a mean N score of 4.25 in their research with a sample of 602 college students. With reference to this comparison group, all that can be said is that the case subject's mean N score is greater than the mean of the author's sample. Looking more closely at the subject's responses to specific questions, one sees a certain repetition of people listed. This suggests that, in the case subject's opinion, there is a group of people whom she feels comfortable turning to, and also whom she feels may be relied upon across a variety of situations. This information is consistent with information gleaned from interviews with the friends and family of the case subject.

One of the persons interviewed described the experience of first meeting the case subject and being "checked out" by the circle of friends of that time. It was reported that there was a sense of having to prove oneself, not to the subject, but to her friends. Other persons interviewed also noted the role of friendships and how the subject had always had a circle of close, and at times protective, friends around her. The *MMPI* profiles, from the earliest administration onward, support the finding that the subject did not view herself as being socially isolated, in spite of whatever other difficulties she may have had.

During the process of the interviews, the subject's own descriptions frequently returned to the theme of relationships. In her description of 1971, the year spent cross-living in Toronto, the isolation and lack of close friendships appeared to play a crucial role in what she described as possibly the most difficult year of her life. The importance of work and of being near people while at work, was discussed and appears to have been a mechanism for coping during this period.

In conjunction with this, relatives in the Toronto area were reported to have provided some emotional support and contact during this period of time.

These different sources of data collection are all consistent with the results of the SSQ, showing an individual who enjoys a close and supportive network of relationships. This appears to be true not only in the present context, but also, to have been consistent through the majority of her adult history.

The *Family Assessment Measure* provided data on a variety of dimensions of family functioning, not only from the case subject's point of view but from those of the mother and the brother as well.

In rating the family as a whole, the case subject scores the dimensions of Control and Affective Involvement as areas of greatest strength. The score for Affective Involvement suggests that the subject thinks that within the family there is a sense of empathy and emotional involvement. The subscale Control is also interpreted as a dimension of adaptiveness for the subject. It is interesting to note that the scores for Affective Expression and Communication are identical (50) and though hardly problematic, are still not scored at a comparable level of strength, which the Affective Involvement and Control subscales are. A close inspection of these subscales suggests that, in the case subject's opinion, this family is more effective in action based dimensions than in verbally based ones.

The dyadic profiles reveal certain consistencies across the three relationships (when rated by the case subject). In all three relationships (mother, brother and father) the Communication subscale is rated at approximately .5 standard deviation above the mean. The direction of these three scores suggests that the subject feels that communication between herself and individual family members may not be as effective as it could be.

Values and Norms is not rated by the case subject as problematic when she is focusing on the overall family. It is interesting that when she is responding to

questions regarding the component dyadic relationships, she rates this dimension from scores of 55 (relationship with her mother) to 60 (relationships with father and with brother). This subscale, on the subject's self rating profile, is scored at 60. These consistent elevations in dyadic scores, coupled with the case subject's self rating score, would suggest that she views components of her value system to be in conflict with those of her family. In apparent opposition to this, when rating the family overall she does not rate this subscale as problematic. A possible explanation is that she rates the family as being relatively congruent on this dimension, yet sees herself as somehow different from them. This incongruence does not then become evident until the dyadic relationships are examined. This hypothesis is highly speculative and must be viewed with caution; however, it may possibly relate to an underlying theme of 'isolation versus belonging' to be discussed later in this chapter.

The Self Rating profile shows the subject as rating 6 of the 7 subscales within 4 points of the mean. Overall, it would appear that she views her ability to function within the family structure (as it currently exists) as being relatively problem free, with the exception of the aforementioned subscale of Values and Norms.

The current *Minnesota Multiphasic Personality Inventory* shows no significant elevations on clinical scales. This is a dramatic change when compared with the 1971 profile, which showed elevations of greater than one standard deviation on Scales 2 & 3 and greater than two standard deviations on Scales 7, 8 & 9. It is interesting to note that the 1971 profile supports the interview data, which stated that the high level of social support being measured currently by the SSQ was relatively consistent historically. In spite of an elevated Scale 8 (suggesting schizoidal tendencies) the social introversion scale shows a score slightly above the mean. This suggests that though the subject may have been spending time alone

ruminating, and may have felt unaccepted by the world (and probably unaccepted by herself as well) she did not perceive herself as being socially isolated.

The 1987 profile shows a lower score (raw score = 16) on the social introversion scale; however the schizoidal tendencies are no longer in evidence. The scale 5 (masculinity/femininity), being elevated slightly beyond one standard deviation, suggests that the subject is not answering the questions of this subscale in a stereotypical feminine fashion. This does not necessarily call the subject's integration into the feminine role into question; it does show that the role integration is not based on traditional stereotypes. Considering the content of this scale, a score in the 'feminine' direction would be of questionable adaptability at this time in our society. This too is a dramatic change from the 1971 profile which showed the subject scoring at the 97th percentile of this scale.

In summary, the standardized tests have portrayed the case subject as a person who is: (1) socially integrated; (2) feels affection and empathy with her family of origin, though she may have difficulty expressing it; (3) feels somewhat apart from her family on issues of certain basic values; (4) demonstrates no evidence of mental illness; (5) appears to derive pleasure from life; (6) is neither excessively sex-role stereotyped nor excessively counter-stereotyped.

The Critical Incidents

In reviewing the critical incidents, what is most striking is that of the 30 incidents reported, 22 of them fall under the classification, "Community." This confirms an underlying assumption of this research project: that the individual exists and interacts with a variety of individuals and groups, all of which, to varying degrees, exert an influence upon the individual.

The incidents can be interpreted on several levels. When classified on the basis of the sub-systems involved, the reader is able to see the impact of separate

groups, all of which were significant to the case subject at different times in her life. This emphasis is an important one because it highlights the significance of the context within which the individual exists. The subject's transsexualism created a specific set of needs or wishes. An example of this was the wish for sex-reassignment. As a result of this wish/need, certain sub-systems became extremely important. Representatives of the medical community, with their power to support or not support the individual's goal of sex-reassignment, came to have considerable significance. Inspection of the incidents in this category reveal that the case subject was largely supported by the physicians whom she came into contact with prior to surgery. What seems important is that none of the medical professionals appear to have questioned the seriousness of her request. Though the process was a long and frustrating one, it was not filled with the diagnoses of delusional states, ridicule or indifference, which at times have been reported in the literature. (e.g., Bogden, 1974; Mason, 1980)

The effect of the case subject's pre-operative characteristics (i.e. feminine characteristics) on other people, and as a result, their reciprocal effect on her, are clearly shown in the incident with the grade 9 teacher (incident #9, table 4.1). Though school had always engendered certain difficulties, such as periodic teasing from classmates, until grade 9 it had been a bearable, if not pleasant experience (according to retrospective descriptions). No academic problems were evident prior to this time. Beginning in this year, and continuing in the two years that followed, the subject's difficulties in school escalated, as did her desire to leave and attend trade school. Ridicule from the grade 9 teacher, and then again in grade 10 (the same teacher taught both years) appears to have been pivotal, in terms of attitudes toward school. Ridicule from classmates also peaked during this period. This appears to have subsided however, after incident #24 (see table 4.1) in which a family friend spoke to a number of neighborhood children about the case subject

'being different.' It was not until a suicide attempt at age fifteen, and the resulting visits to the school psychologist, that the teacher's behavior was modified. By this time the subject would not be swayed from her decision to stop her secondary education and commence attending trade school in Toronto.

It was also toward the end of this period (1963) that the then fifteen year-old case subject saw Christine Jorgenson (a post operative male-to-female transsexual) on television, and began to seek information about the procedure of sex-reassignment. These two goals, formed by about age fifteen became primary, and remained constant until the successful completion of each.

Attending trade school to study hairstyling formalized and gave sanction to an activity the case subject had done (and been paid for) since her early teens. Incidents #15 through #22 are focused in the area of vocation. Incident #15 occurs at about age fourteen, when the subject first began to be paid for cutting hair. This effectively was the beginning of her career. By age twenty, the subject had bought her own salon in the town where she grew up. During the interviews this was described as a time of some social isolation, yet, a time of vocational and financial success. It was also during this period that the subject organized an historical hair and fashion show which was received favorably by the press and the public. The young man who years before had been refused a request to take sewing in school had staged a successful fashion show (sewing the clothes himself) in the community which had previously censored him for his atypical behavior.

The subject then entered a provincial hair styling competition. He entered in three categories, winning in two and placing third in one. With this came recognition within his trade and offers of work in more urban centers. This resulted in a decision to move to Regina and the forging of professional and personal connections which remain intact to this day.

During the interviews the case subject said that as a teenager her ability to cut hair and to sew gave her a way to build relationships with peers. One incident (#24), in which the adult family friend spoke to her own son and his friends about the teasing of the case subject, supports this to an extent. It was after this incident, that the boys are reported to have ceased teasing. The subject explained that once the teasing stopped, she became friendly with this group and began sewing for them and cutting their hair. Even if this interpretation (that the foundation of those relationships was at least partially based in the service which the subject provided) is incorrect, it is important that she still perceives that her offering of these skills served as a springboard for the development of these friendships.

Beginning at trade school in Toronto, friendships of a somewhat different nature are reported. During this time, the relationships appear based on a mutual interest in hairstyling as well as other activities such as music, going to cafes, etc. rather than in the offering of skills or services. The case subject reported that it was in Toronto where she first felt that she did not stand out and was free to act as she pleased. Later, in Regina, while socializing in the gay community, she reported this same sense of not standing out, and of meeting people who understood about "being different." This initial involvement with the gay community was pre-operative, and occurred prior to the subject's commencement of cross-living. She stated that though the individual relationships were empathic ones, she did not consider herself to be homosexual. This is consistent with reports expressed in the research that though the sexual orientation may be homosexual or heterosexual, it is the gender orientation which is primary in the individual's definition of self (e.g. Steiner, 1985).

During the time of this research project, the subject and her boyfriend made the decision to live 'common-law.' For the subject, this involved not only a

commitment to the relationship, but also to the responsibilities of being a parent: the partner brought to the relationship a three-year old son from his previous marriage. Though he had custody of the child at the time of the decision to co-habitate, a custody dispute with the biological mother ensued.

For the case subject, this involved her transsexualism effectively being 'held up to public scrutiny,' as her fitness to be a parent (as well as that of the boy's father) was argued by representatives of the family court system. It was the decision of the court to award temporary custody to the subject and boy's father, and to review the case again in one year. It is noteworthy that in the report to the court (compiled by the social worker who had studied both home environments), it was stated that the subject was perceived to be able to provide stability for the child, and demonstrated a clear ability to parent. Her transsexualism was seen by the social worker, and ultimately by the court, not to be a barrier to fulfilling the maternal role.

The Situational Influences

Table 4.3 consists of 11 ongoing influences or issues uncovered during the interview process. They have been classified using the same eco-systemic classification scheme used with the critical incidents. What differentiates these 'influences' from the critical 'incidents' is their lack of obvious beginning and end points.

Of the 11 influences cited, 6 (55%) of them are classified at the "Individual" level. Although these influences appear diverse and varied, it is noteworthy that this large a proportion of them are at this level of classification, whereas only 4 of 30 'incidents' were classified at this level. These influences appear to relate to a style, or way of being. Influence #1 (the lack of athletic skills and resulting time spent alone) and influence #2 (learning to sew and later to cut hair) resulted in

the development of skills which in turn appear to have later facilitated teenage relationships (or so the case subject believes). The realization that openness and honesty, with significant others, could have positive results (influence #3), lead to disclosures (pre-operatively) of the desire for sex-reassignment (and resulting from that disclosure, family support for the process, [influence #7]).

From the data available we cannot tell if influence #6 is truly an influence or a result (i.e. did the depression result in vocational instability and alcohol and drug abuse, or vice-versa?). We also are not able to assess the degree of the depressive symptomology.

The "Community" level influences are focused on various types of relationships. The forging of friendships within the context of the gay community of Regina (influence #8) allowed for the development of empathic friendships and feelings of belonging, yet also of being apart. Although the subject reported that she thought that her friends understood her feelings of 'being different,' it was clear to her that she was not homosexual and as a result would never feel completely a part of this community.

Transsexuals and homosexuals, although sharing the characteristic of being sexual minorities, are clearly not the same phenomenon. This common factor of minority status may serve to facilitate acceptance of each other, yet it would not (and did not, for the case subject), result in the eradication of their differences.

Influences #9 and #10 represent relationships which the case subject acknowledges as having had a great enough impact to result in a change of behavior. This is consistent with other data gathered which highlight the importance of having meaningful relationships. In a less obvious manner, influence #11 could also be related to this issue of relationships. The feeling of being 'read' due to the quality of her voice, could conceivably cause either the

subject or the person whom she felt 'read' by to withdraw, thereby negatively affecting the formation of that (probably transitory) relationship.

In summary, the influences cited here appear to revolve around two primary issues. Those influences classified at the Individual level relate strongly to the subject's individual style or way of being in the world. Those classified at the Family and Community levels relate to the formation and maintenance of different types of interpersonal relationships.

Underlying Themes

As stated at the outset, the eco-systemic classification scheme served to highlight the importance of the context in which the individual lives. When looking at the incidents collectively though, it appears that there are several more general themes underlying the classification scheme. These themes centre on issues of: acceptance versus rejection, isolation versus belonging, and competency versus incompetency. Acceptance as a woman, by society and its individual representatives; affirmation of the individual's competency, whether that be vocationally, or in roles, such as that of 'mother;' and the need to belong, not always to be apart and different from others, are themes which permeate the incidents and influences cited.

The choice to live common-law and to take on the role of parent, and then the ensuing custody dispute, may be seen as involving all of these individual themes. In the sixth interview, which was focused on the area of 'romance,' the investigator questioned the subject about the meaning of, and reasons for, taking on the roles of wife and mother. Though a number of issues relating to feelings of love and caring were discussed, the subject said also that it was the fulfillment of and old dream: the dream of becoming wife and mother.

The theme of 'belonging' is intrinsically tied to this dream of becoming a wife and mother. Fulfilling the roles of wife and mother within a nuclear family can be interpreted as having a place (i.e. the family) where one belongs. The custody dispute can be seen as a challenge to the subject's legitimacy in these roles. Ultimately, it is the court report and custody disposition which demonstrates society's acceptance of this individual as a woman, and its statement of her competence as a mother.

For a complete classification of the critical incidents according to these themes, please see Appendix E.

Research Questions: Conclusions

What are the significant factors in the post operative adjustment of a male-to-female transsexual?

A total of 30 critical incidents were revealed during the data collection process. The Classification Table of Critical Incidents (Table 4.1) shows that the "Individual" and "Family" levels contain 4 incidents each. The remaining 22 incidents are classified in one of the sub-sections of the "Community" level. While not negating the importance of any one of these sources, the significance of sub-systems at the community level is emphasized by the number of incidents which fall into this category. Within the Community level, 8 incidents (40% of the total number) are seen in the sub-section entitled "Vocational." Having the ability to be self supporting, as well as being recognized as skilled, appears to relate to an ongoing theme of competency. In conclusion, this initial research question is answered by inspection of the individual critical incidents. It seems important though, to discuss this question with attention not only to the specific incidents but also to the pattern which they form.

What are the consequences of these factors, and why are they seen as significant in the subject's post operative adjustment?

The consequences of these factors (incidents) are listed under the "Result" section of Table 4.1. They were classified as significant as a result of meeting two primary criteria: they were considered to be significant by the case subject, and they resulted in an observable change of some type (a behavior, an event, etc.) which could be related to the case investigator. These two points of view (i.e. the case subject's perception of significant events in her own life, and the researcher's desire to anchor the incidents in observable and verifiable phenomena) were not always in agreement. The requirement that 'significance' be agreed upon, and meet the criteria of both the investigator and the subject, ultimately allowed for the generation of a series of incidents which satisfied both.

Among factors identified as significant, what is their order of significance?

The exploration of this final question proved to be an interesting exercise. The correlation of the two sets of ratings showed that the level of agreement was not particularly strong ($r = .55$). The statistic used measured only the level of agreement/disagreement between the case investigator and case subject and did not account for the degree or magnitude of the discrepancy. For example, of the ten incidents rated at level 4, the subject and investigator rated six of them the same. The remaining four of the incidents rated at this level by the case subject can be found rated by the investigator at level 3. Of the remaining four incidents rated by the investigator at level 4, three of them can be found in the case subject's rating of level 3. As one looks at these ratings, the level of disagreement appears somewhat less. It does not, however, change the result of this section of data analysis; there is considerable disagreement between subject and investigator about which factors were most significant. When looking at the level 3 and level 4 discrepancies, an argument can be made that perhaps the distinction between these

levels was not clear. It is doubtful, however, that this explanation can be used to explain all differences between ratings. With the data available, conclusive explanations of this result remain elusive. It is a possibility though, that much of the disagreement resides within different perceptions of what constitutes the 'significance' of an incident (i.e. the investigator's need for a tangible result and the subject's subjective understanding of the intangible results of incidents).

The Results Within The Context Of Other Research

It is interesting and important to look at this project within the context of past studies. The intensive case study method used here has generated a mass of data, which is broader in scope than the research questions have required. This section of the study therefore looks at the relationship of this project with past empirical work by focusing not only on the research questions, but on the data base as a whole.

Evidence of increased levels of self esteem (post operatively) found in the *MMPI* profiles is in keeping with the findings of Ball (1981) and Skapec and Mackenzie (1981). The overall improvement in pre- and post operative *MMPI* profiles supports the work of Fleming et al., (1981) who showed significant improvements following sex-reassignment in the profile generated by this instrument. What this study went on to suggest is that the improvement may continue over a long period of time, as evidenced by the change from 1975 and 1987 profiles. Since no studies were found in the literature that studied the *MMPI* dimensions (post operatively) over a comparable length of time, it cannot be stated with certainty whether this is a significant trend or a result peculiar to this individual. Meyer and Reter (1979) did show that in all three of the groups they studied (operated, unoperated and subsequently operated), there was general trend to psychological and social improvement, which is similar to the present result.

The lack of data to resolve this question definitively points out the need for ongoing follow-up and the tracking of these individuals, post operatively, over years (rather than months, which is the more common case).

The loneliness and isolation of adolescence reported in the interviews is echoed in the writings of the female-to-male transsexual, Mason (1980). The later frustration experienced by the case subject in seeking sex-reassignment closely parallels the experiences of Shumaker (Levine and Shumaker, 1983).

Unlike the finding of Lothstien (1980), all evidence suggests that for this individual there is a consistent history of meaningful and supportive relationships. This current finding is also at odds with other studies, which show social isolation pre-operatively, followed by a lessening of such post operatively (Fleming et al., 1981; Fleming, MacGowan, Robinson, Spitz & Salt, 1982). The relative consistency of the case subject's social integration is an unusual finding.

As stated in the review of the research literature, relatively few studies have focused on the contextual and interpersonal variables which affect post operative adjustment. Hastings and Markland (1978) found that the area of 'romance' tended to be an area of ongoing difficulty for many post operative individuals. The data gathered here suggested a history of at least two severely troubled relationships, one of which appears to have predicated a suicide attempt (incident #4).

Notwithstanding periodic romantic difficulties, the case subject would now rate as 'successful' on any of the outcome scales known to this researcher (e.g. Hastings and Markland, 1978; Hunt and Hampson, 1980). As might be predicted from the results of Walinder, Lundstrom and Thuwe's research (1978), none of the contraindicators they found were present in the pre-operative history of the case subject. The one exception to this was the geographic distance between therapist and patient, which the case subject resolved by moving to Toronto.

This project follows in the tradition of a small number of studies which have highlighted and posed questions about the effect of the environment on the individual. This group of studies would include Levine and Shumaker (1983), Mason (1980), Oles (1977), and Yardley (1976).

Oles (1977), in her discussion of psychotheraputic issues, states that the area of employment is an important and often difficult one for transsexual people. As an example, she points to the dilemma of whether or not the individuals should disclose their transsexualism to employers. In her opinion, if the person discloses, they risk being fired (which happened to the case subject in Toronto). If they do not disclose, they may find themselves living in fear of being discovered (an experience also related by the case subject).

Yardley (1976) hypothesizes that acceptance by the therapist of the cross-gender desire of the patient, is a positive prognostic indicator. Yardley does not elaborate further on this hypothesis. In the data collection for this study, the subject did report a belief that the relationship between herself and her psychiatrist at the Clarke Institute had a significant positive impact while she was in the stage of cross-living. The subject described this impact as a feeling of being "challenged to succeed." Without more elaboration of Yardley's hypothesis it is difficult to know if this belief (of the case subject) is in support of it.

Results of this study appear to be consistent with the description of Mason (1980), who stated that the client's feelings of being accepted by the therapist and/or clinical team leads to increased feelings of self esteem. In retrospective descriptions, the case subject described how any response from representatives of the medical community, which acknowledged her diagnosis as transsexual (even if the response itself was not positive) encouraged her to continue to seek SRS. From the data available we cannot say positively that these retrospective descriptions demonstrate increases in self esteem. It does appear however, that feelings of

being encouraged and affirmed are being described and that these may be related in some way to increases in self esteem.

There was no suggestion here that the case subject placed similar constraints and limits on the theraputic relationship (due to the ability of the psychiatrist to recommend for or against SRS) as was described by Levine and Shumaker (1983).

Limitations of the Study

This study has described the experience of an individual. The data cannot be generalized. It has provided a portrayal of the psychological and social adjustment of one transsexual.

Unlike forms of research which attempt to generate information which can be generalized to a population, this mode of research provides in-depth knowledge of one person. This methodology has succeeded in providing details about one case, and generating questions to ask across a larger sample of transsexual people.

The use of a number of sources of data collection (historical records and test scores, interviews with family and friends, case subject interviews and current test scores) increases confidence in the validity and in the reliability of the results. Conclusions regarding the subject's historical functioning would have been strengthened had more detailed case recordings from the Clarke Institute been made available. Unfortunately, this was not possible.

This study is a foundation upon which, by the process of answering the questions it raises, and confirming or disputing its findings, a significant body of knowledge in the area of post operative transsexualism may be constructed. Viewed in isolation, the results are highly limited. Viewed as a source of data, of hypotheses, and of questions for future research projects, the usefulness of the project becomes clear.

Implications and Suggestions For Future Research

The number of critical incidents which were found at the "Community" level of the classification scheme suggests that research needs to address the impact of negative and positive responses from these specific groups (e.g. medical community, friends, etc.) on psychosocial functioning at the pre-operative, as well as post operative stages. The hypotheses put forth by Yardley (1976) regarding the effect on outcome, of acceptance by the therapist of the transsexual's desire for sex-reassignment, remains untested. In this study, what appears to have been a positive therapeutic alliance between the case subject and her psychiatrist was, in the case subject's opinion, beneficial in terms of self confidence and determination to overcome obstacles. The effect of different therapist/client relationships on habilitation and outcome in the post operative gender role, remains an important but uncharted area of study with this population.

Outcome studies, in their attempts to measure the degree of post operative success or failure, usually include some rating of employment functioning. This project has suggested that the meaning of employment transcends --and is much more complex-- than an ability to be self-supporting. For the person studied here, career success appears to have increased feelings of confidence and self worth (after a childhood marked by episodes of ridicule and pervasive feelings of being 'different' and 'odd'). The effect of employability and career success/failure on such dimensions as self image (both pre- and post operatively) is another area of possible study. This also would suggest that research in the area of vocational counselling, and into what the specific needs of this population may be, would seem a valuable area of study.

Improved social and familial integration and acceptance, post operatively, is a common but not universal finding in the literature. The struggle for an ongoing sense of 'belonging' appears to be a primary theme with this person. When one

considers the experience, related by many transsexuals, of feeling as if they are born into the wrong body, this theme has intuitive validity. Pre-operatively, the transsexual person not only feels different and isolated from others, but also feels incongruent with, and in a fashion isolated from, his or her own body. Research which attempts to ascertain if this sense of isolation is truly common in the transsexual population (both at the interpersonal and intrapsychic levels) and if so, then in what ways it may be decreased, seems an area of paramount importance to counsellors dealing with this these people.

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APPENDIX A

Letters of Introduction

APPENDIX B

Consent Forms

SUBJECT'S CONSENT FORM

I agree to participate in a research project, investigating post operative transsexualism. I understand that participation in this study is voluntary and that I am free to withdraw at any time or refuse to answer any question.

I understand that I will be interviewed as well as be required to complete a series of three questionnaires. This process will take a maximum of twenty-one hours, spread over five to seven interviews. I do this with the understanding that the information will be kept confidential, used for research purposes only, and destroyed at the end of its usefulness.

_____

PARTICIPANT'S CONSENT FORM

I agree to participate in a research project on post operative transsexualism. I understand that participation in this study is voluntary and that I am free to withdraw at any time, or refuse to answer any question.

I understand that I will be interviewed and that this process will take approximately two hours of my time. I do this with the understanding that the information will be kept confidential, used for research purposes only, and will be destroyed at the end of its usefulness.

_____

APPENDIX C

A Detailed Interview Guide

A Detailed Interview Guide.

Interview #2 with the Case Subject

Time focus: From early understanding of transsexualism to the time of surgery.

1. Please focus on when you first heard about transsexual people.
   A) You saw Christine Jorgenson on T.V. How old were you?
   B) What effect did this have on you? Did it alter your thoughts or your feelings or your behavior in any way?
   C) Did anything happen as a direct result of this?
2. When did you decide that you might be a transsexual?
   A) Can you remember anything which helped to bring this about?
   B) What were the effects of this realization? Did it change the way you thought, behaved or felt?
   C) Was it a gradual or sudden realization?
3. You told me, that beginning in Grade 9, you began seeing the school psychologist.
   A) How did this come about? What triggered it?
   B) Who's decision was it that you begin counselling?
   C) What did you and the psychologist talk about?
   D) Could you tell me about the effect (if any) of these sessions on you? On the people around you?

4. When did you decide to inquire about sex-reassignment?

   A) Having made this decision what did you then do?

   B) Do you think that making the decision had any noticeable effects on how you behaved?

   C) Was there anything(s) that helped you in making the decision? Delayed it?

5. In terms of your awakening realization of transsexual feelings . . .

   A) Whom did you tell first, second, third, etc.?

   B) What did you tell them? Did you say the same information to each person?

   C) What were their reactions?

   D) Can you remember a specific incident(s) that made you feel that you were doing the right thing? The wrong thing?

6. What was your first step i starting the process?

   A) Did people take you seriously? Who?

   B) What were their reactions? What did they say?

   C) Did people try and talk you out of it? What did they say?

   D) Tell me your fondest memories from this period.

   E) Tell me your worst memories from this period.

7. What prompted you to change your name?

   A) Did this have an effect on you? Did it have an effect on others around you?

   B) What were the reactions of people around you? Does any one person's reaction stand out?

8 Think back to at age 21, when you began to live the majority of your life as a woman.

A) As you began to present yourself to the world as a woman, how were life different? Can you give me some examples of this, which seem important?

B) Were there any incidents/events, which strike you as particularly helpful/hurtful during this time?

9. Think back to 1971, you were fired after having disclosed your boss that you were cross-living.

A) What did you do think about this?

B) How did you feel in the time after it happened?

C) What did you do after this happened?

D) Did this change or influence your behavior as a consequence of this happening?

10. You told me in our first interview, that at age 22 after one your of cross-living, you were tired and ready to give up. Please think back to that time.

A) Can you remember a specific day or time when you felt like giving up? Tell me about that.

B) Can you remember when you decided not to give up?

C) Do you know what made you change your mind?

11. Did you ever feel like you were making the wrong decision?

A) Did something happen to make you feel this way?

B) What happened to keep you from reverting back to life as a man?

C) Was there any time where you did revert to living as a man?

12. Were you going to school or working during this time?

    A) Was this an added stress, or did it help? In what way?

    B) Did people at school/work know that you were going through this process? If so, what were their reactions?

13. Tell me about how you made the initial disclosure about wanting SRS, to Dr. Slazik.

    A) What was his reaction?

    B) What did he do?

    C) Was he helpful? Not helpful?

    D) Did this have an effect on you? Can you tell me that?

14. How were you emotionally during this time?

    A) Were you ever depressed? suicidal? happy?

    B) Who do you remember as being emotionally supportive? What did they do to be supportive?

    C) Who was nonsupportive, or perhaps destructive? What did they do?

    D) Can you give further examples of events/incidents which were helpful?

15. What was your relationship with your family like during this period?

    A) Did it evolve or change as the time of surgery approached?

    B) What incidents stand out for you?

16. Tell me about your friendships during this time?

A) Are there friends which seem important during this period? What did they do to make them special for you? What makes them seem important?

17. Tell me about going to the Clarke Institute.

A) How did you contact them?

B) Whom did you see first?

C) Did you feel that you were treated fairly?

D) What incidents stand out as being helpful to you?

E) Were there incidents which you feel were hindering in any way?

APPENDIX D

The 'General' Interview Guides.

Interview #1 with the Case Subject (Demographic Information)

Introduction:

"I would like to begin these interviews by asking you some basic information about your life from birth through to the present. This will give me a basic framework to better understand the information we will discuss in the coming interviews."

Questions and Topics to be covered:

1. Family Constellation (Genogram)
2. Place of birth
3. Residences lived in to the present
4. Educational history (schools, trade school, etc.)
5. Employment history
6. Medical history
7. Transsexual history

    -first thoughts of feeling as a woman

    first hearing about transsexualism and sex-reassignment

    -first experience cross dressing

    -point of living as a woman

The purpose of this initial interview was to establish a chronological framework and to gather basic information. It attempted to accomplish a general life overview rather than an intensive study of events such as the following interviews did.

Interview with Subject's mother and father

(to be interviewed separately)

1. Please think back to the time when Terry was a child, say before the age of ten. Did she have many friends? Were they boys? Girls? Both?
2. Are there any issues or problems relating to social life which stand out from this time?
3. How did Terry do at school? (e.g. academically, socially, getting along with her teachers).
4. Are there any events from these first few school years which stand out for you?
5. Once Terry reach her teenage years did you ever suspect that something was not right or was troubling her?
6. Was it Terry who first told you about her suspected transsexualism? When did this happen? How did she go about telling you? What was your reaction?
7. After the initial disclosure, did you continue to discuss it? What were those discussions like? What stands out (if anything) from those discussions?
8. What was the reaction of your spouse? Your son? Other relatives? Friends?
9. Was Terry aware of these reactions?
10. Remember back to the first time you saw Terry dressed as a woman. What was your reaction? What did you think? How did you behave?

11. What was your relationship like during this period?
12. What was the reaction of your spouse to this change in Terry? What was the reaction of your son? Other relatives? Family friends?
13. Did people discuss the situation openly?
14. Was Terry aware of the reactions of people (i.e. family, friends) to her during this period?
15. What is your current relationship with Terry like?
16. Do you feel that Terry is doing well today?
17. Do you feel that Terry still faces difficulties as a result of being a transsexual? Could you give some examples?
18. Do you think that Terry is better off for the sex-reassignment process? Why?
19. Do you think of Terry as a woman?

Interview with the Case Subject's brother

1. Think back to when Terry was a small child, say before the age of ten. Did she have many friends? Boys? Girls?
2. Are there any particular social problems or successes which stand out for your from this time?
3. Were you and she close during this time? If so, what kinds of activities did you do together?
4. Remember Terry in elementary school. How did she get along? (e.g. academically, with teachers, etc.). How about in high school?

5. Are there things from the school age period which stand out for you?
6. When Terry was a teenager (or before) did you ever think that something was not right, or perhaps was bothering her?
7. How did you find out that Terry was transsexual? Did you understand what that meant?
8. What was your reaction to this information?
9. Did you say anything to Terry? To your mother? Your father?
10. What was your mom's reaction? Your dad's reaction? Other friends or relatives of the family?
11. Was Terry aware of these reactions?
12. When did you first see Terry as a woman?
13. What was your reaction? What did you say? Think? Feel?
14. What was your relationship like with Terry during this period when she first began to live as a woman? Was it different than before? How?
15. What about her relationships with other family members? Can you remember specific incidents?
16. Did you and your family talk about what was happening with Terry at this time? Can you tell me about those conversations?
17. What is your current relationship with Terry like? How does it compare with your relationship during other periods in your lives?

18. Do you think that Terry is doing well? In what way(s)?
19. What/who has helped her most?
20. What/who has hindered or hurt her?
21. Do you think that Terry is better off for the sex-reassignment surgery? Why?
22. Do you think of Terry as a woman?

Interview #3 with the Case Subject. The topic is 'family life' and the time focus, is from the earliest recollections, to the present.

1. Think back to the time before you entered school. Were those happy times? Can you tell me some of the events or memories which make you remember them the way you do?
2. What was your relationship with your mother like during that time? With your father?
3. What was your relationship with your brother like? Were you and he close? In what way?
4. Did you do things as a family? Can you give some examples?
5. What stands out for you from this period? What seems important?
6. You've told me that you were taken to see a doctor because you wouldn't play with "boy's toys". How old were you when this occurred? Do you remember it? If so, what did you understand about it, at the time?
7. Did you feel loved and approved of by your mother during this period of time? By your father?

8. As you grew older, did these feelings (relating to love and approval) remain stable or did they change in some way? If so, can you explain how they changed?
9. Did you ever feel pressure to conform in any way? (For example: as a male, socially, academically, in choosing a profession, etc.).
10. What was homelife like when you were a teenager?
11. What events stand out for you from this time?
12. When you disclosed that you thought you were a transsexual, what happened? What were the reactions of the people you disclosed to? Whom did you tell first, second, etc..
13. When did you leave home? What were your reasons for leaving home and your feelings surrounding the move?
14. Did you continue to see your parents? How was your relationship different? How was it the same?
15. Did you feel more or less accepted by your parents after you moved out, or did your feelings of acceptance remain the same? What were the type of things your parents did to make you feel this way?
16. Having disclosed your transsexualism to your parents did you ever feel rejected as a result of it? Did you ever regret telling them?
17. Did they try and learn about transsexualism and about the process you were going through?

18. When did they begin to refer to you as their daughter? What was that like? Do you remember the first time they did that?
19. Do you feel accepted as a woman, and as an individual, by your parents currently?

Interview #4 with Case Subject. The topic is pre- and post operative romance, sexual relationships and sexual functioning.

1. Did you date as a teenager? Were your dates, with females, or males, or both?
2. Think back to those times. Was dating an enjoyable experience? Do any of them standout? Tell me about some of your dates?
3. Tell me about some of your early sexual experiences. Who were they with? Were they enjoyable?
4. What do you consider your first serious relationship? Tell me about what that relationship was like?
5. When you began to cross-dress frequently, did you date as a woman? Can you remember some of these experiences?
6. In dating situations, have your partners been aware that you have had sex-reassignment?
7. What have been some of their reactions upon finding out?
8. Your brother told me that you had told him about an experience once, where someone became violent with you. Can you tell me about that?

9. Have you had relationships which terminated after your partner found out the you were transsexual?
10. Do you consider your transsexualism an impediment or an advantage. Please elaborate and explain in what ways.
11. Do you think that men respond to you as they would respond to a woman who has not had sex-reassignment?
12. What would be the ideal relationship for you?
13. Do you feel that this is realistic and achievable? Please explain.
14. In what ways is your current relationship similar to past relationships? In what ways is it different?
15. What are this relationships strengths? What are its weaknesses?
16. Are you happy with the state of your romantic life? What pleases you about it? What would you change?
17. Sexually, how do you compare your satisfaction now, with when you were a man?
18. Are you orgasmic? Is the sensation of orgasm different, than when you were a man? If so, in what way?
19. Are you satisfied with the surgical construction of your genitals? Have you ever been dissatisfied?

Interview #5 with Case Subject. The topic is 'friendships' (both pre- and post operatively).

1. As a teenager, did you have close friends? Did you have acquaintances? What kinds of activities did you do with them?

2. Did you often feel lonely or isolated? Can you remember specific times when you felt like lonely and/or isolated? Please tell me about these.
3. Who was the first friend you told about your feelings of being the wrong gender? What was their reaction? Did it encourage or discourage you from telling others? Did it change your relationship with that person?
4. As you began to live as a woman, did you have close friends?
5. Tell me about these friends. Were they accepting? Supportive? Rejecting?
6. Did you have friends who were also transsexual? Can you tell me about those relationships?
7. Did you have friends who stayed constant throughout the process of sex-reassignment?
8. As you were going through that process, did you feel that you could confide in your friends? Did you feel understood by them? What made you feel that way?
9. Do you feel that you can confide in your present friends. Do you feel that they are 'deep friendships'? Can you tell me about these relationships?
10. Is what you want from friendships now, different than before SRS? In what ways? Are you getting what you want from your current friendships. Is there any area in which you are dissatisfied?

11. Do you feel that you can count on your friends when you need them?
12. Do you feel accepted by your friends? What do they do to make you feel accepted or to make you feel not accepted?
13. Do you have a feeling of 'belonging' with your friends, or do you feel somewhat apart? Explain.
14. Do you ever feel 'judged' by your friends? In what way, and around what issues?
15. Do you do activities or see your friends on a regular basis? Tell me about some of these activities?
16. Do you discuss thoughts/feelings/problems etc., related to being transsexual, with your friends?
17. What defines your closest friends, as such? What is it that sets them apart from people less close to you?

Interview with Subject's friends and peer group.

1. How long have you known Terry?
2. Tell me about how you met Terry?
3. Did you know that Terry was transsexual when you met her? How did you find out? What did you understand this to mean?
4. Tell me about your relationship with Terry. Do you feel that you are 'close' to her? In what way? Do you see her often? Do you see her as much now as you did in the past? More? What kinds of activities do the two of you do together?

5. Does Terry have other close friends? Do you know those people?
6. Does Terry seem lonely to you? What makes you think that she is (isn't) lonely?
7. Do you ever talk about issues relating to transsexualism? If so, could you tell me about some of these discussions?
8. Did you know Terry as a man? Do you think of her as a woman now?
9. Does Terry's transsexualism affect your relationship? If so, can you think of incidents or examples which have happened which seem to you to show your relationship, being affected by it?
10. Do you see Terry as basically happy? Sad? Both? Please explain.
11. What kinds of problems do you think that Terry faces being a post operative transsexual? Could you give examples of these problems, and if possible how you have seen Terry deal with them (or not deal with them)?
12. Do you have to deal with problems that arise as a result of being a friend to Terry? Explain.
13. Have you ever seen instances where Terry was ridiculed, singled out, or in some way isolated for being a transsexual?
14. Is it common knowledge among her friends and acquaintances which you know, that Terry is a transsexual?

15. Having known Terry pre-operatively, have you seen her change and grow into the female role post operatively (note: only to be asked of people who knew her pre-operatively)
16. Do you ever see things in Terry that remind you that she was once a man?
17. Have you seen incidents or people doing things which seem to help Terry get along, or perhaps which, have hurt her or stood in her way? Explain.

Interview #6 with the Case Subject. The topic, is post operative life experience.

1. Think back to being in the hospital, waking up from the anesthetic. Do you recall any of your thoughts and feelings? Can you tell me about those?
2. In those first days after surgery, were you pleased with the results?
3. After leaving the hospital, do you remember consciously 'working' at being feminine?
4. Were you worried about 'passing'?
5. Were there times when you felt stared at, singled out, etc.? Can you give some examples of these times?
6. Did you ever try and hide your past as a man? When? Why?
7. Did you ever try and shock people with your past? Can you remember specific instances?

8. Do you feel that there was a point of 'stabilizing' in the new role? When was it? What makes it a point of stabilizing?
9. Are you pleased with your physical appearance now?
10. Do you ever feel 'read' as a transsexual now? How does that make you feel? Can you give some examples of when that happened which stand out for you?
11. Do you still think at times, that you have to 'work' or struggle to get along, in ways that people born into their genders do not?
12. Do you feel that you 'blend in' or do you sometimes feel that you stand out? Can you give examples of either, or both?
13. Do you feel that what you've gone through has been worth it? Why? Is it a success?
14. If a nineteen year old male came to you now, and said that he wanted to begin the process of sex-reassignment, what advice would you give him?
15. Looking back, what could you have done differently to make it easier?
16. If you could go back in time, who would you 'hug' and who would you 'tell off'? Explain.

Interview #7 with the Case Subject

This final interview with the case subject, had no guide formulated in advance; instead, it consisted of a series of questions which attempted to clarify some of

information elicited in the previous interviews. It also included an informal discussion of the experience and impact of the interview process itself.

APPENDIX E

A Thematic Classification

A Thematic Classification

Unlike the initial classification of the critical incidents, this classification is not meant to consist of mutually exclusive categories, nor is it meant to be seen as the primary classification scheme for the project. It is presented here in an attempt to clarify, for the interested reader, the relationship which the case investigator has drawn between specific 'incidents' and what he sees as underlying themes. The investigator does not claim that this is the only thematic interpretation and resulting classification scheme possible, nor even perhaps the definitive one; it is however, one which has a validity for the case investigator in his experience both as researcher and as clinician.

Incidents Relating to the Theme of Acceptance (8) versus Rejection (2):

#3-Change of surname (R)
#5-Mother discovers that subject has not attended air cadets (A)
#6-Mother discovers of letters regarding SRS (A)
#7-Telling father and brother about efforts to attain SRS (A)
#14-Being calmed by surgeon (A)
#13-Surgeon supports SRS (A)
#19-Fired from job in Toronto (R)
#20-Former employer asks Subject to return to Regina (A)
#24-Family friend speaks to her son and his friends 'about Henry' (A)
#26-Joins West End Players (A)

Incidents Relating to the Theme of Competency (4) versus Incompetency (1):

#15-Subject begins to charge for hairstyling (C)
#16-Buys first salon in Oxbow (C)
#18-Wins provincial hair styling competition (C)
#21-Buys salon in Regina (C)
#23-Going to Air Cadets (I)

Incidents Relating to the theme of Isolation (3) versus Belonging (2):

#1-Suicide attempt at age 15 (Is)
#4-Suicide attempt age 31 (Is)
#22-Regina salon burns down (Is)
#27-Moving in with D. D. (B)
#28-Sees Christine Jorgenson on T.V. (B)

Incidents Involving Themes of both Competency versus incompetency (7) and Acceptance versus Rejection (1):

#2-First cross-dressing in public (C,A)
#9-Ridiculed by Grade 9 teacher (I,R)
#10-Attending trade school (C,A)
#11-Psychiatrist makes transsexual diagnosis (C,A)
#12-First response from John Hopkins (C,A)
#17-Organizes community hair and fashion show (C,A)
#29-Man on plane comments on subject's attractiveness C,A)
#30-Going to first bar cross-dressed in Toronto (C,A)

Incidents Involving Themes of both Acceptance versus Rejection (1) and Isolation versus Belonging (1):

#8-First post SRS Christmas card (A,B)
#25-Moves to Vancouver to live with A. (R,Is)