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Increasingly Ruth: Toward Understanding Sex Reassignment

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Both the clinician and the patient present accounts of a 44-year-old male's search for a comfortable gender identity. The juxtaposition of these two perspectives illustrates many of the dilemmas inherent in the therapy of gender dysphoria. Ruth underwent sex reassignment surgery in 1976—one year after the assumption of a full-time female gender role. Six months after surgery, she made a serious suicide attempt. At age 50, she has now consolidated her feminine gender identity and has become a thoughtful, unusually honest, articulate person. The physician's "objective" and the patient's retrospective perspectives provide evidence of the psychodynamic nature of transsexualism and the limitations of evaluation criteria for sex reassignment surgery.

KEY WORDS: transsexualism; sex reassignment; sexual identity; gender identity.

INTRODUCTION

Psychiatric knowledge about individuals who request sex reassignment surgery (SRS) is largely derived from two sources—brief clinical and psychometric evaluations of large numbers of applicants to gender identity clinics (Meyer, 1974; Levine, 1980) and psychotherapy with small numbers of patients (Lothstein and Levine, 1981). Although guidelines for the management of surgical candidates have emerged from such work (Founding Committee, 1981), the relationship between psychiatric evaluations and the patient's ultimate clinical course is uncertain.

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It is useful to remember that clinicians and their patients share the same goal — attainment of a sexual identity that no longer interferes with the patient's capacity to live a full life. The problem lies in the "simple" fact that their perspectives on goal attainment are divergent.

Many patients are so single-minded in their quest for surgery that they are unable to consider their other options. While surgical candidates are often decidedly articulate about their mental suffering, they are conspicuously unable to reveal much more about their inner lives. This inability is often rooted in a developmental background that has not encouraged reflection; sometimes, however, their prior decision to undergo gender transition and SRS is a more important explanation. Constriction of the patient's capacities for self-awareness is probably required in order to accomplish this dramatic life change. Once gender transition and surgery have been accomplished, some patients evidence new interest in their internal processes, motivations, conflicts, and developmental histories (Lothstein, 1978, 1980). Unfortunately, few of them are articulate enough to portray their inner experiences.

The clinician's perspective, though more objective, is not always helpful or accurate. Many clinicians totally reject the possibility of surgery, and establish conditions that encourage the patient to leave. For others, the usual psychiatric skills often seem insufficient to conceptualize and resolve the gender problem. The enormity of the clinical decision, combined with the patient's intense pain and the frequent manipulative interactions, often stimulate strong countertransference forces that subtly undermine objectivity. Whatever a clinician decides about surgery, there is a vested interest in perceiving that decision as wise and humane.

This paper presents several perspectives on one person's quest for a comfortable gender identity. The clinician's initial "objective" view of the patient is presented first. Then Ruth, an unusually honest and articulate postsurgery patient, presents her view of the experience. Finally, I offer a retrospective view of the patient's clinical course and a caveat about premature evaluation of the efficacy of SRS.

THE CLINICIAN'S PERSPECTIVE

In June 1974, a stooped, balding, conservatively-dressed, gentle, masculine, 44-year-old man came to me after being frightened by a surgeon's willingness to proceed with sex reassignment. He was surprisingly articulate and revealed many fascinating things about his mental life. He felt increasingly unable to suppress his lifelong sense of femininity. His chronic depression was worsening, and he was certain that he could not

survive much longer as a male. He was willing to give up his executive position to become a secretary earning one quarter of his salary.

Five months earlier, the patient had found the courage to seek professional help from the book *Conundrum* (Morris, 1974), which he read shortly after holding a loaded revolver in his mouth. He knew that sex reassignment surgery was his only solution, even though it meant divorcing his wife and moving away from his three children. He did not feel this would be a great loss for them, since his preoccupation made him emotionally unavailable, anyway. Although the role of husband was unbearable, he was quite attached to his devoted wife of 20 years. Their children had been adopted because of his psychological inability to have coitus. When love-making did occur, it was accompanied by his fantasy of reversing bodies—i.e., her breasts became his, etc. He preferred masturbation, however, because nothing interfered with his fantasizing of himself as a woman being made love to by a man. He hated his penis—"that thing"—and longed for its removal.

His descriptions and behavior revealed a number of character traits. He had always been a loner who rebuffed all attempts at friendship. He was a hard-working, very well organized, scrupulously honest man of enormous drive and resolve. These traits had earned him a leadership position. His first major career as an ordained minister ended after 6 years because he found the masculine burdens of the role excessive. He then obtained a second master's degree in a field he felt demanded less masculinity. During his years as a minister, he had built his own home.

The patient was born in a rural community to high-school-dropout parents. His father, usually drunk and unemployed, drifted in and out of his early life. He was raised by three women—his mother, his grandmother, and his aunt. From latency on, he cross-dressed in secret. There was no homosexual behavior. His long-standing adolescent crush on an older boy was sometimes associated with fantasies of being a woman. He dropped out of high school to become a factory worker. Within a year, a religious conversion enabled him to stop his secret cross-dressing, finish high school, attend college, and become a minister.

From a psychiatric and psychometric viewpoint, the patient seemed clearly schizoid and obsessive-compulsive; there was no evidence of psychosis. He shunned all human contact that was not absolutely necessary, constantly retreating into fantasy. His capacity for work was impressive. His numerous accomplishments resulted from his preoccupation with detail, organizational skills, and perseverance. These accomplishments provided him with an escape from his defective gender sense. He was a severely crippled heterosexual, handicapped by intense anxiety about phallic expressions. His retreat into feminine identifications seemed to

provide only a brief and incomplete escape from anxiety and left him chronically depressed.

But was he a transsexual, as he insisted? Was he an aging transvestite trying to avoid a repetition of his father's death from heart disease at 54? Fetishistic responses to clothing were not apparent, although he thought they might have been present during his adolescence, 25 years earlier. Was his depression worsening because he envied his daughter's pubescence? Did it worsen because of the increasing demands of his new job? He denied both possibilities. He had just received widespread acclaim for an enormous political victory. Was his drive for surgery a form of masochistic self-punishment for his recent success? Was it his need for a new organizing focus for his life?

I planned to explore such questions with him during our weekly psychotherapy. But my interest in the answers was overridden, dismissed, and skillfully diffused by his convincing single-mindedness. A number of factors explain why I went along with this subversion. I believed that if anyone could actually accomplish gender change, he could. I told myself that more conventional ambitions begin as fantasies; to some extent, all people create their realities from fantasies. I was very much interested in transsexual phenomena and at that point, 1974, I knew I needed to know more. I doubted my ability to help him with psychotherapy alone. The most persuasive factor, however, was the fact that as he progressed in gender transition, his depression lifted dramatically. He was more social, more energetic, and less tortured than I had ever imagined possible. Although he appeared to be ecstatic most of the time, he was able to continue working effectively in his executive position—before and after his gender transition. He maintained financial support of his family and continued to show concern for their well-being.

Three years after his initial visit—one year after his public gender transition—the patient underwent SRS. The immediate postoperative course was uneventful, except for a brief delirium. Ruth was pleased because her stability between operations refuted my often-stated concerns about the lack of preoperative anxiety being a denial of any attachment to maleness. She began addressing me by my first name after surgery. It was clear that she was no longer interested in patient status, and avoided seeing me at regular intervals.

The reappearance of depression dramatically occurred after all the surgery had been completed. Three months later, after two lesser suicide attempts, Ruth slashed at her jugular vein with a butcher knife. After a prolonged psychiatric hospitalization and surgery to remove a kidney stone, she gradually improved. She has reintegrated in an impressive manner and has successfully maintained her life as a woman.

THE PATIENT'S PERSPECTIVE: FOUR YEARS AFTER SEX REASSIGNMENT SURGERY

My feminine identity has evolved from a personal mythology and has resulted in a more than satisfactory psychosocial adjustment. I would regard as myopic any attempt to reduce this mythology to mere fantasy, for it had a truth and reality of its own. I use the word *myth* in reference to that unverifiable part of me, my feeling of being female, the origin of which I cannot document. The existence of my feminine self was there at the beginning of perception, a given, all-pervasive feeling that something about me was wrong. For reasons I do not understand, I believed that I was a victim of a sexual mistake—that I should have been a girl rather than a boy. These feelings presented a conflict which I resolved, in so far as I could, by accepting the mythological solution that I was, in fact, female. That this mythological identity was neither known nor accepted in the context of my family and acquaintances only served to make the myth more personal and intensely secretive.

Unlike other childhood flights into fantasy, this myth had results that were permanent and useful in coping with the events of my life. By events, I mean the day-to-day happenings in my childhood development and adulthood. My chief coping mechanism was the rationalization that these events would have been less threatening to me if I could only have been a girl. When I felt the pain of loneliness, rejection, and disapproval—and there were many such pains—I soothed it with a reminder that if I were a girl others would find me more acceptable and provide me with the love I was not receiving. I did not find it necessary to reason that little girls might not always be loved and accepted. In fact, all this was less a reasoning process than a reflexive handling of adverse reality. It was simply more pleasant to contemplate being a girl, and to imagine some distant, magical solution that would one day allow this metamorphosis; then I would feel better forever.

In time it became important to nurture and protect this mythology, for I believed that I could not endure the real world without it. It was the very promise of the myth—my eventual metamorphosis—that gave meaning to reality. Because I imagined that this mistake in identity could be corrected, I could endure an existence I did not like. Unfortunately, the myth did not support my feeling of self-esteem, for admittedly the strange creature I perceived myself to be was less than a whole person. In the real world, I thought of myself as a freak. In contrast to such unacceptable reality, I had a good thing going internally; I was determined to preserve my mythological existence. In addition to my conscious support, the myth seemed to have a power of its own, a sustaining force exceeding that of any other rationaliza-

tion I experienced. The persistence and momentum of the myth hint at some deeper level of origin – a mystery that eludes and intrigues me.

I sense the power of this myth in the persistent appearance of its imagery in my fantasies, which seemed to come as metaphorical messages. The image of a house was uncommonly present in daydreams and nocturnal dreams all during my childhood, and continues to the present moment in the latter. In daydreams, it was my favorite device, like an elaboration of the child's game of playing house; I made a game of "playing Ruth." My imagined house was an essential and secret structure, a place of refuge where I could be me. I remember, at a very early age, enjoying variations on the theme of the secret cottage. In my cottage there lived a large cat, to whom I attributed anthropomorphic character. He was the "man" of the house, and I was his cherished little girl housekeeper. This was an outrageous bit of fantasy and immensely good fun, continuing, as I remember it, for several years in my preadolescent period. In later variations, a human benefactor replaced my feline Prince Charming. Interestingly, the "men" of my daydreams always appeared as adult males. This was especially true when my daydreams evolved into sexual fantasies.

I am not certain at what point some of my daydreams took on the character of sexual fantasies. I do remember that a transition appeared necessary, for it seemed that I had to correct something in my body in order to resolve sexual excitement. My sexual awakening made me painfully aware that I did not have a vagina. What was happening to young women in my peer group was not happening for me. I was very envious of their outward appearances; but, most of all, it was the vagina which symbolized the lack in my own body. The emerging sexual fantasies brought this conflict into rather sharp focus. Since I could not resolve this conflict in the real world, my personal mythology provided me with compensatory fantasies. In my early sexual fantasies, I became a captive of an adult female who forced me to live with her as a servant girl. In exchange for sexual favors, she promised to change my genitals magically into a vagina. By having her will imposed on mine, I removed my guilt and responsibility for these imagined sexual acts. My magical vagina allowed me to imagine sexual contact with males. Orgasm was contingent on achieving the most authentic feeling of femaleness that I could force from my fantasies. When the fantasy failed, guilt blocked the orgasm. Following orgasm, guilt returned to mock my real genitals.

I suspect that I desired my father sexually. I prefer not to pursue this idea very far, for I find it less than acceptable. In my dreams, however, I sometimes find myself crawling into his arms for comfort. This gives me a sense of well-being, not unlike what I feel sexually about men in general. The privation of his love and affection was a fact, and a great disappoint-

ment to me. Possibly, the woman in my sexual fantasy who held me in captivity was my mother. If that is true, then the fantasy may also have been a device for making myself acceptable to my father—to have him as she had him. The metaphorical image of the house may then take on the significance that I was trying to supplant and replace her completely. In any event, the men to whom I now respond sexually do indeed resemble my father.

In my adolescence there was much conflict between my personal mythology and reality. I believe there were many times when it was very difficult for me to keep contact with the real world. I was a loner, an alien. I had a sense of not belonging to the world in which other people lived. A disturbed family life, including alcoholism and physical abuse, probably contributed to this feeling of aloneness, but does not explain it away. I believe that my personal mythology distorted my view of reality. This alienation may have been the result of my need to conceal my secret identity. If other people penetrated very far into my personal space, I usually saw them as a threat. If what they did or said hurt me, I simply closed my eyes and became Ruth.

Alienation characterized my life, as I lived in tension between my personal mythology and reality. As an adult, I arranged a sort of truce between my metamorphic dreams and the demands of the real world. Although I had learned of its possibility, sex reassignment surgery was not an immediate option. I chose to continue in the male identity as a reluctant participant in life. It became a sort of defiant posture, in which I was determined to achieve, take, and manipulate reality to my own ends wherever possible. At the same time, I chose not to give much of myself as a person to anyone.

Perhaps I can best describe my life as an adult male in terms of a constricted personal territory. By *territory* I mean the emotional lifestyle which I allowed myself, squeezed in between the imperatives of my personal mythology and the limitations of reality. Since I could be true to neither demand, I declined to make the emotional commitments that are part of living in the real world. Both negative and positive emotions were kept in tight control. It was as though I constricted my personal territory to the narrowest limits possible—perhaps because I wished to squeeze myself into nonexistence.

I was pragmatic about the real world. I traveled into reality on a temporary visa to conduct the necessary commerce of maintaining the person who fronted for the real me. My loyalties were to another realm. Yet I knew very well that the meaning of life could only be found in some accommodation with reality. As middle age approached, I was panicked by the idea that my constricted personal territory was all I would ever have. It was as though life had become a party to which I had not been invited; so I

created a lonely party of my own in the secret world of Ruth. In the end, the myth became stronger than reality—and I chose its offer of freedom. I had a fierce determination to find the magician who could make me a woman, whom I had named Ruth longer ago than I could remember. The choice was to be mentally healthy, as me.

"Where did you go?" the therapist sighs.

"Where do you go when you close your eyes?"

I go where I can cry.

I was ready for the magician, but the magician was not quite ready for me. For several months in the summer of 1974, I played hide-and-seek with a nebulous gender program. Only Kafka could have designed such a torment of uncertainty. The difficulty of obtaining appointments, unexplained interviews with various professionals, and taking tests with no knowledge of their application—all served to intensify the anxiety I experienced in my drivenness toward sex reassignment surgery.

Now I smile as I remember my first exposure to the rather casual use of the term *gender dysphoria.* In that light, passing a kidney stone would be a discomfort. I have suffered with both sicknesses through the long night, and can testify to their pain. I was hurting in my search for therapy. My sexual identity conflict was like a colic, in which I endured spasm after spasm, straining to turn myself inside out.

I regarded every delay in entering a gender program as an added dimension of suffering. I recorded it in my log as if it were a Kierkegaardian sickness-unto-death:

> Today was a downer . . . the weeks ahead will be a certain test of my strength. Sex reassignment seems so far away on days like these. . . . All around my life comes crumbling down . . . no meaningful past. . . pain in the present. . . uncertainty in the future. The possibility of an emotional breakdown is imminent. Yet I must handle all of this and keep my mind intact.

I waited in vain for telephone calls that never came; I called for wizards who were unavailable because they were in conferences. Every particle of me seemed to strain in a polarization between hope for life as Ruth and despair that it would never happen. I imagined the worst and drove myself onward as though to escape the pain of my very imagination. When I occasionally reached someone in my telephone efforts, I wrote of it in rather extravagant terms:

> I called Miss ____ today [the social worker who was my contact person in the gender program]. She assured me that I was not forgotten. An appointment *will* be set up soon . . . she *will* call me. On God! Is it really coming true? The wishes of a thousand nights! The end of ceaseless pain! That beautiful morning when never again will I have to dress and act as a man! That day when the deformity is removed from between my legs! Please, dear God, let it come true!

It was the longest summer of my life. Each day was an eternity. My quest for surgery was my losing race against the calendar. My log served as a daily lamentation, a liturgical whip to drive me onward:

> If only I would hear from Miss ____! I am so weary of being a man. The male identity wears on me like an iron suit. I don't see how I can go on this way . . . no relief from the pain . . . I am down, way down. Nothing is happening. Nothing comes.

When I met the doctor who became my therapist, I described the meeting as a "most encouraging interview." A few weeks later, following a therapy session with him, I wrote:

> The bottom fell out just like I was afraid it would. My visit with Dr. L. leaves me depressed . . . typically a psychiatrist . . . we got no place. I know now why Jan went to Casa Blanca. If I get thwarted I shall do the same. That operation means more to me than life itself. If I am denied the operation for whatever reason I will put a bullet through my head, so help me God! I am so down.

I was practicing brinkmanship with depression right up to the thinnest edge I could manage, which was familiar territory to me. This was an authentic expression of how desperately I was hurting, but it also had an element of blackmail. I was blackmailing myself into not wavering from my objective. This was an old tactic that I had used many times before to whip myself on to some difficult achievement. Since this usually involved a radical tearing down and rebuilding, I used psychic pain for motivation.

What I regret today is that this state of mind distracted me from a realistic assessment of my upcoming psychosocial adjustment. I was so obsessed with surgery that I willed other concerns to lesser priority.

Living the way I was, I felt lonely, hurt, and angry for most of my life. My therapist gave me the opportunity to come out of my autistic existence and talk about my unhappiness for the first time; this provided some release from psychic pain. When he prescribed estrogen, my morale improved considerably. I was fortunate to have had a therapist who was sensitive to my despair. Had he been otherwise, especially in those early months, I believe I would have destroyed myself. In spite of his special skills, I did not establish a complete trust relationship with him. I had lived as an alien from society for too long. There was always an undercurrent of suspicion that my therapist was part of a medical conspiracy to prevent me from having the operation.

My determination to complete my program gathered momentum in the following months. I settled an array of personal matters, including the sale of my rural estate, relocation of my family, divorce, name change, and cosmetic adjustments such as electrolysis. I applied all the driving force I had learned in my work toward these objectives. At that time, I was the fiscal officer in charge of a $10 million budget for a large public institution.

During part of this period, I also served as the acting director of the institution and managed a levy campaign to fund its operating budget. When I felt it was time to begin living as Ruth, I solicited and secured the support of my board of trustees. With no little aplomb, I left work Friday as a man, and returned on Monday in a dress. I faced the news media with courage, and rallied an uncommon support from other people, including public officials. In spite of the logistics, all of this took place with surprising ease. Family, friends, and co-workers supported me in a splendid manner, contributing to my confidence. Thus fortified, I established a convincing female identity.

It was not all hurrah. Inside I was fragile. I realize now, although I did not at the time, that there was a significant ambivalence in my feelings about myself. Even if I had understood this, I am sure I would not have admitted it to my therapist—and I most certainly did not deal with it myself. I know now that I was losing ground in the matter of self-esteem. It was as though I was being carried on the laurels of the man whose identity I was negating. In spite of my unhappiness as a male, that identity gave me a protective surface, a veneer of self-esteem, shielding me from attack. As Ruth I was experiencing a new emotion—fear.

I do not believe I had ever experienced fear before I assumed a female role. There was no rationale for this fear; my personal safety as a male was of no consequence to me. Although I had previously had opportunities for fear, I would not have acknowledged them. On a dare, I had once laid lengthwise on the Baltimore and Ohio railroad track and tried to stop the Capitol Limited Express train as it tore down the Sand Patch Grade. There was no way I would admit that I was now afraid of employees whom I could previously have withered with a glance.

I believe I now understand what was happening to me in the preoperative period, and why I dealt with it more effectively following surgery. My concept of being a woman had developed within the necessary limitations of my personal mythology. I had no understanding of the day-to-day realities of such a role. I did not know how to handle the new emotions I was allowing myself to have as I emerged from my constricted personal territory. Ruth-of-the-myth always provided herself with a benefactor—some knight-in-armor with a protective house in never-never land. Being vulnerable was an inherent part of my very being. The woman of my early daydreams was a fair maiden awaiting rescue.

This may be an oversimplification. While Ruth was waiting for rescue, the other side of my identity was fiercely determined to have an operation. I believe that determination was motivated by a powerful anger that had been lurking in the background of my emotional constraint. Not only did I feel hurt, but I also restrained my anger at the world that contributed to my captivity by its moral attitudes. In late 1974, I wrote

> My birthright is lost forever! Society has locked my door and keeps me in a cell. What horrible fear is there that prevents me from walking through that door and demanding my birthright? Curse you, society! You are a god without mercy!

I was damn mad at anything or anybody who might have contributed to my existence. It was only a matter of time before I identified myself as one of those contributors. I was both a fair maiden awaiting rescue and the knight-in-armor raging to break out of my dungeon to rescue the fair maiden within myself.

Although I do not believe we could have done anything in the preoperative period, my therapist and I should have ascertained the existence of this monstrous anger and prepared to deal with it almost immediately after surgery. Ironically, once the object of my anger was removed, the knight-in-armor within me tried to destroy the fair maiden. My postoperative depression and attempted suicide were, in my judgment, inevitable outcomes of a lifetime of intrapsychic conflict and unexpressed anger. The symbolic objects of my anger were my genitals; as long as I could hate them, I had a safety valve. Sex reassignment surgery was not a cosmetic matter, but an essential step toward correcting my psychic disorder.

I chose to correct the symbolic problem—i.e., my genitals—before dealing with my intrapsychic conflicts. The authenticity of my female identity was contingent on having a vagina. The fact that, in reality, "a vagina does not a woman make" is beside the point. I was trying to objectify an idea that had never existed in reality. As a student of philosophy, I knew intellectually that my use of this symbolism was incorrect. But my feelings were unalterably obsessive, and no process of intellect could have changed my mind to fit my body. In short, no therapy could have established my mental health before surgery because I would not have permitted it—no matter how long the preoperative trial period. I was not even interested in an analytic self-appraisal until many months after the operation. The complications of my gender disorder were far greater than I had ever imagined in my metamorphic dreams.

Nevertheless, my dreams came true. I had the final stage of sex reassignment surgery in November 1976. I consider the result satisfactory in every way. Having a vagina is an existential necessity; I now feel whole, in a way that eluded me before. Sexually, I was vaginally oriented from the moment of my pubertal awakening. I now have orgasms that are more intense and of longer duration than those I experienced before. Simply stated, my vagina allows me to feel good about myself. I ask nothing more of the surgeon.

I should have asked more of my therapist, however. I made no commitment to him for postoperative therapy, and we developed no

strategies. If we had been able to minimize my anxiety, I believe the trust relationship might have been improved—especially if surgery had not always hung in the balance. I might then have accepted—and fulfilled—an agreement for protracted postoperative therapy.

I now believe my physical and mental health should have been monitored closely until there was reasonable assurance that I was out of danger—probably for about two years. After surgery, I experienced an emotional upheaval that fractured my coping mechanisms. I felt as though some taut cable in my life had been cut, leaving me umprepared for the release of tension. My lifelong reason for survival, i.e., to change my sex, had ceased. I went from euphoria to fear and depression in a very short period of time. Although I had practiced brinkmanship with depression for many years, I could no longer keep my balance. In short, I lost my courage to exist. In March 1977, I attempted professional and physical suicide. No longer employed, and a danger to myself, I was hospitalized and treated for clinical depression.

My recovery from depression was complicated by chronic urinary infections and a kidney stone, which later required major surgery. Many months passed before I regained my energies. Subsequently, I returned to one of my previous professions as a reference librarian. This has been a fortunate choice because I am constantly meeting people, most of whom I do not know. This type of disciplined activity has produced a continual feedback that reinforces my identity. In a way, others have given me my female identity—which is not unlike the way in which I was given my male identity. This interaction has been therapeutic in helping to minimize my fears.

Today my momentum has returned. I have taken responsibility for myself in a lifestyle that pleases me; I have objectified my sex role in reality. Four years after sex reassignment surgery, I feel very good about the result. My previous life was a lonely, painful trip. I would not have chosen any alternative other than to fulfill my myth-given destiny. The solution has been a success for the person to whom it really matters—me.

I do not claim to be outrageously happy, just moderately delighted with myself. I no longer await rescue, but have learned to bring about things I want for myself. I do not feel, nor do I want to feel, vulnerable in this sex role. I enjoy being a multidimensional person in my own right. In fact, I am experiencing a rather wide range of controllable emotions: It is OK to cry, and I have thundered through a few rages, weathered some unreasonable pouting, engaged and withdrawn within acceptable social limits, and, I hope, laughed at myself and others with grace.

My alien status has given way to some sort of membership in the human race, if not by birthright then by an adoption which I have willed for

myself out of necessity; I can no longer return to the land of myth—it is gone. The "war" is over; I have declared peace. While I may never understand much of the conflict, the struggle has resulted in my freedom. I am increasingly Ruth in a variety of roles: I am Ruth who is a talented librarian; who enjoys a rather domestic lifestyle; who has discovered running marathons; who is a member of a Bible class; who is a daughter and an aunt; who enjoys a little yellow sports car; who is learning how to flirt.

The list could go on, and that is the fun of it. Perhaps none of this finds definition in a sex role, or may be limited by traditional stereotypes; but being comfortable in a sex role has allowed me to rediscover such definitions. The internal conflict between my perception of my identity and that of others with whom I interact has ceased. My freedom has enabled me to minimize my neurotic claims on life, experience self-acceptance, and progress toward self-realization as Eliot (1963) described:

> We shall not cease from exploration
> And the end of all our exploring
> Will be to arrive where we started
> And know the place for the first time.

DISCUSSION

Ruth was one of several patients who helped the Case Western Reserve Gender Identity Clinic to clarify its policy about granting relatively rapid SRS. She was neither the first nor the last person to urge us to "make an exception and move more rapidly toward surgery—for humanitarian reasons." She was, however, the most persuasive. Were Ruth to enroll in the clinic today, her drive for surgery would be interpreted as a sign of faltering defenses. A more forceful attempt—in a psychiatric hospital if necessary—would be made to help her cope with deepening depression by exploring her inner life and development. Such psychotherapy might have helped Ruth to attain a more comfortable transvestic adaptation; subsequent patients have been helped with this approach.

If Ruth were to present today, her gender diagnosis would be considered a secondary gender dysphoria syndrome, not transsexualism. The division of SRS applicants into primary and secondary categories, based on their previous function in the male gender, is a useful distinction (Person and Ovesey, 1974a, 1974b). Primary patients—i.e., those who have never been able to study, relate, or work comfortably as males—respond best to psychiatric interventions aimed at dealing with mental health issues other than gender. Their cross-gender living does not seem to be a matter of

choice (Stoller, 1975). Secondary patients are those who have previously been able to function in their gender-appropriate roles. Those who are still ambivalent about their decision to have SRS may be "cured" with intensive psychotherapy. While such "cures" do not produce aproblematic heterosexuals, they are evidence that a gender dysphoria syndrome can be resolved without surgery.

On the other hand, diagnostic distinctions based on behavior alone can be misleading. Some patients do not fit neatly into either primary or secondary categories. It is important to realize that almost all gender dysphoric males have always had strong, secret feminine identifications. They are sincere in their declarations of lifelong femininity, even though they may only have been living as females for a short time. The life changes and mental processes that precede the decision to change gender roles are of great interest. Men with secondary gender dysphoria often decide to change sex in an attempt to preserve life or avoid mental decompensation (Lothstein, 1979; Wise and Meyer, 1980)—i.e., they have exhausted their coping capacities. Ruth's emergence from suicidal depression into seeming good health is not atypical. Many such patients experience a euphoria and new tranquility when they abandon the male gender role. The durability of this new "mental health" is a crucial issue in determining surgical eligibility; it is also the rationale behind a two-year minimum preoperative waiting period.

It is indeed rare to find so much honesty and insight in an autobiographical account of a postoperative patient. These traits appeared after Ruth failed miserably in her initial postsurgical adaptation as a female. Since her suicidal depression, Ruth has been able to use introspection to facilitate her personal growth and adjustment. Ruth articulates several important ideas for professionals who work with postsurgical patients: The immediate postsurgical period may be associated with the sudden loss of organizing purpose. The previously comforting fantasy must be transformed into reality—i.e., the patient must begin to generate a history as a female. For Ruth and others I have seen, this was a period of vulnerability and need. It may also be a period of genuine interest in psychotherapy. The advisability of stopping all regular contact with patients after surgery is, therefore, debatable.

This report also has important implications for studies of postoperative transsexuals. At 6 months post-surgery, there was no doubt that the decision to operate had been a disastrous error. The patient was better after a year, but was still not well. Three years after surgery, the patient seems well by objective standards. Despite her near suicide, she believes the operation saved her life. She has no regrets about having surgery and no longer has the frenetic quality that characterized her pre-

operative emotional health. She now earns less money, but is more comfortable and experiences a wide range of affects, including anger and sadness—which she found intolerable as a man. She has lost some of her schizoid features and can no longer be described as depressed. As the clinician, I am no longer certain that Ruth would have been better off without surgery.

Clinicians must carefully consider the criteria used to evaluate the usefulness of SRS. Even with the best of intentions, both patients and researchers can subtly distort observed phenomena. Both perspectives must be considered, even though unresolved conflicts result in continuing ambiguity; ambiguity is superior to a firmly held but erroneous "fact."

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