

A CASE OF CONCURRENT MULTIPLE PERSONALITY DISORDER AND TRANSSEXUALISM

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ABSTRACT

A transsexual patient suffered a coexisting multiple personality disorder that was not diagnosed until after the completion of sexual reassignment surgery. This report reviews this patient's history and experiences in psychotherapy. It is important to consider the possibility that the patient who presents with the features of a gender identity disorder may have a concomitant dissociative disorder. It is highly questionable whether a patient with both types of disorder should receive sexual reassignment surgery until the dissociative disorder has been treated to a successful resolution.

INTRODUCTION

Multiple personality disorder (MPD) is a dissociative disorder that is diagnosed when a patient fulfills two criteria: "A. The existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self). B. At least two of these personalities or personality states recurrently take full control of the person's behavior" (American Psychiatric Association, 1987, p. 272). It is not uncommon for many personalities in a given MPD patient to experience themselves as being of a gender other than that of the patient's biological gender, and to protest their lot with vehemence over a long period of time.

Transsexualism is a gender identity disorder that is diagnosed when a patient fulfills three criteria: "A. Persistent discomfort and sense of inappropriateness about one's assigned sex. B. Persistent preoccupation for at least two years with getting rid of one's primary and secondary sex characteristics and acquiring the characteristics of the other sex. C. The person has reached puberty" (American Psychiatric Association, 1987, p. 76). It is not at all difficult to conceive of how a patient with MPD who was strongly dominated by personalities of other than that patient's biological gender could present the phenomenologic picture of transsexualism.

As awareness of MPD becomes more widespread, it enters the differential diagnosis of an increasing number of mental disorders, both those for which it is mistaken, and those with

which it is found to coexist. This clinical communication will describe the circumstances of a single patient who appeared to merit both diagnoses by history and by phenomenologic criteria, in the hopes of alerting mental health professionals to the possibility that these conditions both have the potential to coexist and the potential of being mistaken for one another.

CASE HISTORY

The patient is an individual born a biological male with no known anatomical or genetic difficulties, who was thirty-two years of age when treatment was sought. Eight years prior to presenting for the current treatment, this individual underwent sexual reassignment surgery, with generally excellent cosmetic results. Because the patient still has massive areas of amnesia and cannot discuss the past without great difficulty, the history remains quite incomplete, and the events and landmarks that are known emerged very slowly and laboriously. In this report the patient will be referred to as *he* prior to this surgery, and as *she* thereafter.

The patient is the oldest of four siblings. His mother wanted him to have been a girl, and always treated him as a female. He learned from the first that "girlish" behavior was more pleasing to mother than was more masculine demeanor. He was given the responsibility of caring for his two younger brothers and one younger sister from the time of his earliest memories. He babysat for them all the time and did their washing. As they got older, it was his duty to make sure they got to school and to help them with their homework. He cooked dinner for them and made sure they went to bed on time. In every sense of the word he was a "parentified" child, socialized to fulfill a "maternal" role and serve as a mother surrogate. The patient had, and continues to have, an intermittent sexual relationship with his younger sister. The sister reports that she and all her siblings have been sexually abused by their father. Both parents are still living and the patient has daily contact with them.

The patient was sexually and emotionally abused by both parents. The sexual abuse by his mother started when he was three years old. As noted, his mother had always wanted a little girl. Consequently, she called her son by a female name, which is now the name of an alter personality, and demanded that everyone with whom the child came in contact do the same. By the time the patient entered school his feminine identification was so pronounced that he could not understand why his teachers were referring to him by a male name. He didn't know that he was a boy, and that boys used the little boys' bathroom. He became disoriented often and easily. The patient became afraid to go to the bathroom in school and periodically wet his clothes. This led to ridicule from the teacher, and made him the object

of jokes by the children in the class. His mother sexually abused him daily, just before he went to school. She drove him to school, but usually got him there late. This not only led to persistent tardiness, but also left him in a confused state during most of the morning hours. The teacher would reprimand him for being late, and not paying attention. He was chastised for daydreaming and failing to have his homework. On the rare occasions when he did arrive on time for school, he was asked to line up before entering the classroom, boys on one side and girls on the other. The patient invariably went to the girls' side, and was both teased and reprimanded for this. When he returned home with notes from the teacher, he was spanked for being bad and creating "trouble for Mommy and Daddy."

According to the patient's retrospective account, the presence and creation of alters began when the patient was about three or four years old. Some alters he simply became aware of. Others, he felt were generated: female alters were needed in order to "make Mom happy." The patient recalled feeling that his mother had always hated him for having a penis. In his fantasy, and perhaps in reality, if the mother could imagine her little boy as a little girl, she would find being close to him was much more pleasurable.

The patient states that by the time he was in second grade, all he wanted to do was get rid of his penis. He believed that it was causing all his troubles. When he expressed this thought at home, his father became very angry and, according to the patient, determined to show him how wonderful having a penis could be and how lucky and powerful he was to have one. The vehicle of this demonstration proved to be sexual abuse. The patient stated that he allowed his father to do anything he wanted in the hope that then his father would not approach his brothers and sister. He now knows that this did not work, that his father has sexually abused all four children.

When the patient became old enough to have an ejaculation, his mother, who was continuing to use him sexually, became very irate and screamed at him that he was a freak. As a result, the patient created other older female alters to cope with this new turn of events. When the patient reached the age of thirteen, both parents, who were cognizant of each other's practices, began to realize that the mother now could become pregnant by her son. The patient's father demanded that there be no more sexual contacts between his wife and her son.

The mother's first suicide attempt occurred shortly thereafter. Arriving home from school, the patient found his mother in the garage. It was locked, and her car's motor was running. During a therapy session in the course of the mother's hospitalization, the patient's mother told him that she had arranged her suicide attempt intentionally so that the patient would be the one to find her. The mother blamed him for growing up male, having a "terrible penis," and not being able to be with her anymore sexually.

The patient's father now set out to teach the child what being male really meant and how the penis should be used. He began taking the patient into the shower with him to demonstrate how to masturbate, and began having anal intercourse with him. He showed him he could insert his penis into anything he wanted. At this time, the patient created a few male alters to deal with the pain being experienced. His father would take him out for rides in the car, their "special trip time," and have sex with him.

As the patient grew older, he found that school became

more and more demanding. He lost track of more and more time. He would fail tests, and his teachers would become critical. He was sent to the school counselor more and more often. When he was in junior high school, the counselor said he needed more understanding, attention and love. The counselor continued by explaining that sex with him would change his attitude and his bad behavior. Sexual abuse by the counselor lasted throughout the patient's junior high school years. The patient was eager to graduate and progress to senior high school. He consoled himself with the hope and belief that "things would change," at least in school. However, things did not change. He was ordered to take a business math course which he knew he didn't need. He found out later that the math teacher was a friend of the junior high school counselor, and the sexual abuse started once again. The patient described creating additional alters to help deal with the disappointment, anger, and pain of these experiences.

Despite his extensive abuse experiences, the patient tried to date and be "normal." However, at the age of sixteen, he made his girlfriend pregnant. It is now clear that a male alter was trying to prove to his father that he knew what to do with his penis. This effort proved to be a disaster, however. His father became very angry and told him that he was stupid, a disgrace to the family, and irresponsible. The patient came away with the understanding that no matter what he had tried to do for his parents, his penis had always been the bad object that frustrated his efforts, and it had to be removed.

When the patient went away to college he became involved with a female. This time he married, but could not maintain the relationship. He was impotent most of the time. The relationship ended in divorce two years later. He was eventually asked to leave the college because the officials discovered he was residing in the females' dormitory rather than the males' dormitory. The patient finally finished his college years at another close-by college so he could live at home. Two more alters were created to handle the college years.

TREATMENT

At the beginning of treatment, this patient presented as a thirty-three year old post-operative female transsexual. She had a degree in a special area of education, and had done considerable graduate work. She was unmarried and unemployed.

The patient entered treatment requesting help with two areas of her life that were impeding her seeing herself as a productive adult. One was a problem finding and maintaining employment, and the other was a sense of profound difficulty with "making the right decisions." She was convinced that all of her problems were the direct result of being a transsexual. Although she was born a male, she said that she had felt like a female since the earliest years of her life. She reported two previous hospitalizations as a result of overdoses with two prescribed drugs, diazepam and a combination of barbiturates.

There was a solid resistance to remembering the experiences of her childhood. The patient was very protective of her mother but much less generous when talking about her father. She stated that her mother was loving and caring, and always took good care of her in the best way she knew how. She describes her father as a workaholic, cold, and angry most of the time. As the patient described herself and her family she showed

minimal affect. All she wanted to talk about was: how was the therapy going to get her a job, and what was the therapist going to do to "make the right decisions" for her? The patient appeared to be depressed but did not fulfill the criteria for a DSM-III-R mood disorder. At times she seemed confused as to how to answer questions. She was willing to agree to a contract concerning the treatment, but expressed dismay, stating, "No one has ever been able to help me before, so my faith that this treatment will be any different is laughable."

The patient reported having had sex with other psychiatrists, psychologists, and mental health professionals. She said, "They would have sex with me for a few months, then say 'something in (me) changed and they could no longer keep (me) in treatment.' Then they would tell me to 'get out.'" She wondered if she had a sign on her back saying "have sex with me." During many of our sessions at the beginning of treatment she verbalized the fear that I would be "no different from all the rest." In early sessions, she would test me by coming to therapy dressed scantily and by using provocative and enticing language.

With regard to the patient's MPD, her diagnosis has been confirmed independently by other clinicians with extensive familiarity with this condition. A detailed description of the personalities is not relevant to the major themes of this article, and will not be included here. The treatment of the patient has been burdened with numerous unwieldy issues: the gender differences of the alters, the persistent demanding by the patient to be told what to do, the ever-present defenses of denial, splitting, and projection, and the different sexual preferences of the alters. The gender differences of the alters, although common among patients with multiple personality disorder, are complicated by the effects of the reassignment surgery. The alters were created by a male, and then somewhere during the middle of their lives they had to learn to live in a female body. Not all had participated in this major life decision. This has created added confusion and mistrust that the alters now express through anger and hurtful acts towards each other.

Another problematic aspect has been the patient's defense of her parents. She emphatically denies that they behaved in an inappropriate manner. She defends them by saying, "All they wanted to do was help me. I was a bad child and they were just teaching me the proper way to behave." On rare occasions, the patient will allow herself to become aware that they did hurt her, but will immediately say that they were "trying to prepare me to be a responsible adult."

She incessantly asked me to tell her what to do, as her parents always did. She invariably attempted to tell me what I was thinking and how I would respond to what she said. She will come into session saying, "I have something to tell you." and then say, "Telling you doesn't matter anyway because you are going to respond this way or that way," or, "You're going to think I'm a liar."

As treatment progressed, and alters became identified and began to speak in the sessions, the existence of a few male alters came to light. When the first of these introduced himself, the change from the presenting personality, who normally presents with strongly restricted affect, was dramatic. He complained bitterly about being in a female body, which he hates. He told me freely about his feelings concerning the reassignment surgery. He described what it felt like to be on an operating table, watching, and feeling his penis being cut off while he was unable to stop the surgeons. He said that he experienced all the pain

since he was the alter that was first created to endure the father's beatings. The anesthetics had no effect on him. He says there are times, especially the time of the year that the surgery was done, that he can't control his screaming and rage. As he spoke I realized that it was likely that what had occurred was that a powerful alliance of all the female alters had presented themselves for the reassignment surgery. The few male alters were not strong enough to intercede. During a consultation, Richard P. Kluff, M.D., took an independent history of these events, and concurred with this suspicion.

This hypothesis was supported when the alters were questioned in the course of therapy. Slowly the story was clarified. All the psychiatric and psychological evaluations performed before the reassignment surgery were attended by the female alters. The patient had never spent more than six months in any therapy before this surgery. A review of the available records suggests that the pre-surgery evaluations appeared perfunctory and superficial. When I shared my impressions with the patient, the female alters finally admitted that they had gone to New York City and "bought" [sic!] a psychiatrist's evaluation stating that the patient was an appropriate candidate for reassignment surgery.

The patient has told me that in the beginning, with regard to those aspects of his dissociation over which he felt he had had some control, he made his alters, whom he called his "friends," to help with pain, both physical and emotional—but there came a time when he felt so badly about giving so much pain and hurt to his friends that he made additional counterparts to help them. In fact, the alters that are most accessible more recently are the parts that were made or created to help the overwhelmed disruptive and destructive alters, who are now contained within—in the patient's language, "downstairs." "Everything has gotten out of hand," he explained. "Life would be easier if the reassignment surgery would have been done after these others were known about." We are presently working with some of the more accessible alters on taking small amounts of the hurt and pain from the "downstairs" parts to relieve some of the fear of the disruptive power of their dysphoria.

Another issue concerns the different sexual preferences of the patient across the several alters. Such concerns frequently are raised in patients diagnosed to have multiple personality disorder. In this case, this issue is severely compounded by the fact that the patient is a post-operative transsexual. Widely different types of alters were created for particular reasons, purposes, and the management of certain situations. Some have quite different sets of responses to the same stimuli. One example: a male alter, "D," was created to be strong, to withstand pain inflicted by the father, and also to be the male who would retain and value the penis. After the reassignment surgery experience, this alter's ability to withstand pain is almost gone. He can no longer just fear castration or have castration anxiety; he has been castrated. Consequently, he has a jealous hatred of other males. When one of the female alters has sex with a man, "D" can no longer just dislike it and recede. He now feels raped. When other female alters have sex with women, he feels inadequate, ashamed, and revengeful. "D" was created as a protector, but now will express his outrage at the other alters by withholding his protection, especially of the female alters.

As treatment has progressed and all of the alters have become known, the issues surrounding the choice to become female has not proven to be a problem. The transsexual adjust-

ment is accepted by all. The child alters think of themselves as female although they have male identifying names. The main issue being addressed in treatment at present is helping the alters understand their individual behaviors and comprehend how the behaviors of each one affects the others.

DISCUSSION

It is difficult to accord primacy to either the MPD or the transsexual diagnosis in this case. The history indicates that the development of the two conditions was intertwined from the beginning, and appears to originate in the insistence by mother that her son be treated as a girl, and in the pervasive sexual abuse that has permeated the patient's life from childhood until the present. The patient appears to have developed a gender identity disorder of childhood that progressed into a fixed transsexual adaptation, and to have developed a childhood form of MPD that became a rather classic and florid adult MPD condition. It would appear that mother's efforts to give the patient a female name and dress him as a girl prevented the patient's separating from the mother at an age-appropriate time, with the result that his preferred role model did not undergo the usual male transitional patterns of changing from mother to father (Stoller, 1968, 1985).

Sexual reassignment surgery is irreversible. The choice to undertake it or not should be made in an atmosphere of free choice and informed consent, with full awareness of the possible consequences. It is doubtful that most MPD patients can

make such a decision in an unencumbered manner. Furthermore, because the alters of an MPD patient may seize control and succeed in representing themselves in a transsexual pattern, and seek sexual reassignment surgery to solidify their claim to be truly and irrevocably in power, it is crucial to rule out MPD in potential candidates for this rather drastic form of intervention. Based upon his experience consulting in situations that involve transsexuals, Kluft (personal communication, September, 1986) concludes that the definitive treatment of the MPD should precede the serious consideration of sexual reassignment surgery.

In this situation, it is fortunate that the male alters in this patient concurred with the decision to be female. One possibility that this suggests is that both a true transsexual and a true MPD condition coexisted, and that the same patient would have made the same choice even if there were no question of MPD. However, it remains within the realm of possibility that this preference is the patient's least narcissistically damaging response to an unwelcome and overwhelming fait accompli.

In conclusion, it is evident that a thorough evaluation is essential prior to a patient's being accepted for sexual reassignment surgery. This evaluation should be particularly sensitive to the possibility of concurrent MPD, or to MPD misdiagnosed as transsexualism. Working with dissociative defenses and the consequences of sexual abuse issues must not be overlooked in the required treatment preparatory to undertaking the surgical reassignment.

REFERENCES

- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (Third Edition Revised). Washington, D.D.: Author.
- Stoller, R.J. (1968). *Sex and gender*. New York: Science House.
- Stoller, R.J. (1985). *Presentations of gender*. New York: Vail Baillou Press.