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Transsexuals in the Military: Flight Into Hypermasculinity

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A sample of 11 male gender-dysphoric patients meeting DSM-III criteria for transsexualism was seen over a 3-year period by a military psychiatrist. Eight patients had extensive military experience, including combat duty in some cases. At the time of evaluation three were on active duty, one was a Department of Defense employee, and four were veterans. Evidence is presented for a hypermasculine phase of development that coincides with the age of enlistment in nearly all cases. The psychodynamic underpinnings of the choice to enlist in transsexual males are discussed. Outcome of military service was premature discharge in over 60%. The military's management of gender-dysphoric servicemen is described. Current military policies, in association with the proposed hypermasculine phase of transsexual development, may actually result in a higher prevalence of transsexualism in the military than in the civilian population.

KEY WORDS: hypermasculine; military; gender identity development; gender dysphoria; transsexualism.

> To be a boy is to be macho, to have weapons, to be a fighter, and to kill, at first in play, then maybe later in a war. (Money, 1980)

INTRODUCTION

The concept of hypermasculinity, described in part by Money in the quote above, has been variably described throughout this century as "make-believe masculinity" (Fenichel, 1945), "masculine protest" (Adler, 1923/1955)

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"macho personality" (Chodoff, 1982), and "Man's Man" or "Ladies' Man" (Glass, 1984). Hypermasculinity has multiple facets with sexual and gender implications and inventories have been developed to assess its features (Mosher and Sirkin, 1984). Characteristics include foolhardiness, overcompetitiveness, bellicosity, fragile hardiness, and equations of "violence as manly" and "danger as excitement" (Glass, 1984; Mosher and Sirkin, 1984).

Cultural factors are important in a consideration of hypermasculinity, as the term may have inappropriate, judgmental connotations depending on its usage. Masculinity itself is not a unitary construct; the line separating mature masculinity from hypermasculinity can be drawn in different places on a continuum of male gender roles depending on cultural context. Role behavior that is deemed hypermasculine in middle-class, Caucasian, American culture may be considered mature masculinity in a Hispanic society (Goldwert, 1985). This clinical investigation accepts the general definitions of hypermasculinity as indicated by the previously cited authors as they apply to the cultural contexts of the patients in the group to be described.

Three major theoretical constructs have been applied to the induction of a hypermasculine adaptation in males: repudiation of feminine aspects of the self, defense against homosexual anxiety, and early/middle childhood parental influences (Glass, 1984; Ovesey, 1969; Mosher and Sirkin, 1984). Most relevant to a consideration of gender-dysphoric males is the first of these constructs. Stoller and Herdt (1982), in their cross-cultural contribution to the study of masculinity, noted that the repudiation of feminine aspects of the self in a sexually dichotomized society can become a "frantic preoccupation". It is clear that the transsexual drive for sex reassignment surgery and hormones qualifies as "frantic preoccupation" and, had we seen these very same patients while they transverse their rocky hypermasculine terrain, one can readily speculate the same would have applied.

As an active duty military psychiatrist at a major medical center I have had the special opportunity of studying such patients in the midst of their "rocky hypermasculine terrain." The Air Force base is situated in the midwestern United States in a community of about 300,000 military members, dependents, retirees, and civilians; all individuals who have, or have had, a connection to any branch of the U. S. military service are entitled to psychiatric care at this facility.

Intuitively, one would assume that the prevalence of severe gender dysphoria and, specifically transsexualism, would be low in the military—certainly lower than in the civilian population. Surely, a male who is gender dysphoric and engages in cross-gender activities and possibly sexual activity with other males would not voluntarily submit himself to a system known for its staunch intolerance of deviancy in any form, whether it be homosexuality, long hair, or wrinkled uniforms. Furthermore, given an incidence of

transsexualism of between 1:37,000 and 1:100,000 males (Roberto, 1983), the likelihood of seeing *any* transsexual patients in the general adult outpatient clinic or the 30-bed inpatient unit at this medical center over a 3-year time span is low. It seems especially unlikely in the absence of any specialty clinics dealing with sexual or identity problems or any interest in studying problems believed by many not to exist in this system.

During the past 3 years I have evaluated 11 biologic males with severe gender dysphoria, all of whom meet DSM-III (American Psychiatric Association, 1980) criteria for a diagnosis of transsexualism. Three had had no military experience. Eight had had extensive active duty military experience; only one was drafted, then chose to enlist. The other seven joined voluntarily at a time when no draft existed or other options were readily available to them. All branches of service were represented; three were on active duty at the time of evaluation, one was a Department of Defense employee, and four were veterans. Ages ranged from 20 to 44 years. Three were officers. All were Caucasian and six had been married. All were requesting cross-gender hormones and/or sex reassignment surgery.

Of the three civilian patients evaluated, one had received written and verbal recommendations from his internist to "join the Army, go to boot camp, and learn how to run over trees with a tank" as treatment for his transsexualism. This advice was rejected.

A striking similarity was noted in the histories of nearly all of the military gender dysphorics: They joined the service, in their words, "to become a real man." Representative quotes from taped interviews include:

> I tried to do things to make me feel more masculine, like joining the Navy and getting married.
>
> I joined the Navy hoping maybe the problem would go away. It did for a while, but it's still here.
>
> I joined the Air Force as a cover. In uniform, my masculinity would not be questioned—I was above reproach.

The following two cases are representative of the group.

CASE A

L. B., a 37-year-old, single, Caucasian, biological male, was abandoned by his natural mother at birth and adopted by a middle-income childless couple at 2 weeks of age. He showed an interest in cross-gender activities throughout childhood, including doll play and extensive nonfetishistic cross-dressing beginning at age 6. He was the object of ridicule by boys his age, especially when he wore unisex clothes to school. Adolescence was particularly tumultuous and after graduating from high school, he enlisted in the

Air Force. He believed basic training and military discipline "would make a man out of me" and "make my [adoptive] father proud of me." After successfully completing basic training, he became a laboratory technician at a base in Germany and lived in the male barracks. The only period of his life he did not cross-dress was during the first half of his tour of duty. Concurrently, he took up avocations that involved significant personal risk: mountain climbing in the Alps and high-speed race car driving. He masturbated for the first time at age 19 and began dating women. During the peak of hostilities in Southeast Asia, he applied for combat helicopter training. He completed his 4-year tour of duty without incident and went to college, during which he experienced increasing gender dysphoria (which had reemerged before his discharge from the military), substance abuse, and depressive symptomatology. These symptoms prompted multiple requests for hormones and surgery and an evaluation at a Gender Identity Clinic 9 years ago. At the time of the current evaluation, he had been taking prescribed female hormones and living successfully in the cross-gender role for over a year as a female nursing student. He has not participated in dangerous sports for many years and dates exclusively heterosexual men. He has no medical or surgical problems and no personality disorder.

CASE B

L. N., a 26-year-old single, Caucasian, biological male, was the youngest of three sons born to a farming family from the Midwest. His father retired after serving 20 years in the Air Force, and was described as emotionally distant and physically absent during L. N.'s entire childhood. He cross-dressed privately beginning at age 7 and would pray nightly, asking God to let him wake up the next morning as a girl. He was quiet, withdrawn, and socially awkward as an adolescent. After graduation from high school, he went to college where he joined a fraternity, lived in a male dormitory, cut his hair short, and began dating women. He discontinued all cross-gender activities and enrolled in an Air Force program as an officer candidate. After 2 years, he became disillusioned with the military and questioned his original motives for joining ("I thought it would make a man out of me"). He intentionally failed a college course in order to be dismissed from the Air Force. He resumed his cross-gender activities and went on to work in the male role at a major Air Force base as a Department of Defense employee handling sensitive information requiring a security clearance. He had been taking female hormones, binding his genitals, and growing his hair long for 8 months prior to evaluation and he cross-dresses in all environments outside of work. He has no medical or surgical problems and, although he displays schizoid and avoidant traits, no personality disorder is diagnosable.

FLIGHT INTO HYPERMASCULINITY

The transsexual "flight into femininity" is well-described by Steiner *et al.* (1978) as a possible phase observed in middle adulthood applicants for sex reassignment surgery. It is clear that in the cases above, and in others I am aware of anecdotally (e.g., 6 transsexual fighter pilots; Lothstein, personal communication, 1986), a diametrically opposed phenomenon may be occurring: a "flight into hypermasculinity." For some, the mere act of enlisting was not enough. In the first case described above the patient deliberately chose the path of greatest danger while in the service: He elected to leave the relative safety of his laboratory technician job and apply for combat helicopter pilot training at the peak of the Viet Nam war, when this was an extremely high-mortality position. Another patient in this sample graduated second in his class at Officer's Candidate School. He volunteered for Special Warfare School, became a Green Beret, and saw extensive combat in Viet Nam and Thailand, completing 4 years of active duty in the Army. In addition to these cases, the military experiences of several well-known transsexual individuals are well-documented in their autobiographies (Cowell, 1954; Jorgensen, 1967; Morris, 1974; Richards, 1983).

Gershman (1986) has stated that the development of identity is an example of a continuum within an individual and evolution is continuous around a central core. Although core gender identity is believed to be largely established by 18 months, other maturational levels of development are operational throughout childhood and adolescence, with attainment of a mature gender identity/role in early adulthood in many individuals (Gershman, 1968).

Levine *et al.* (1975) described a "role transformation" in the 12 male transsexuals they studied. Military history was not specified. The succession of roles they observed was as follows: role ambivalence, transsexual homosexuality, "drag queen," adult transsexual. The 8 patients in this military population seem to have undergone a succession of identities and roles as well, although my observations fit more closely with the evolution delineated in Fig. 1.

The gender-disordered child has, at most, an awareness of the self as different from the societal dictates of his anatomy. He does not know what a transsexual is and feels confused about his identity/role. According to Stoller (1974; 1975), a lack of symbiosis anxiety as a protective shield against femininity may contribute to early overidentification with an engulfing mother, unimpeded by the proverbial absent, unreliable, and inconsistent father. Whether or not this theory is widely applicable, the pre-transsexual adolescent does not possess the ego strength to withstand the social ostracization and ridicule of adopting the cross-gender role. Furthermore, he cannot tolerate

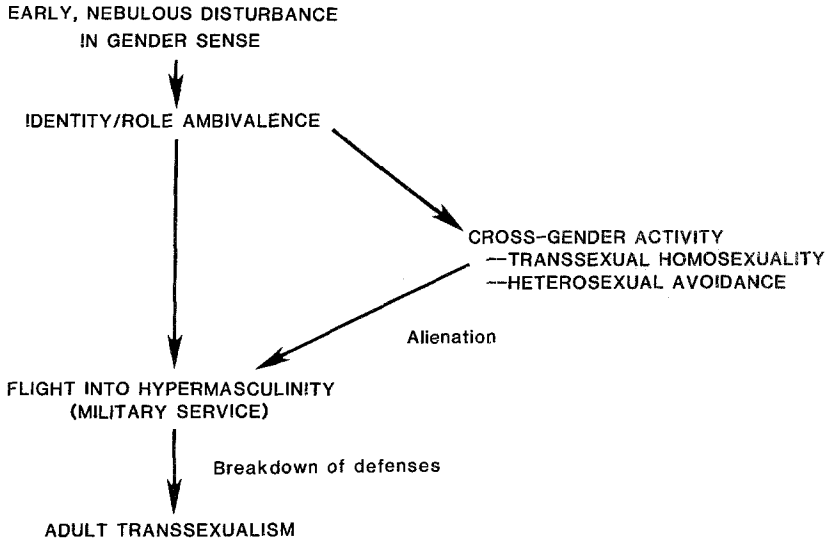

Fig. 1. Transsexual role transformation.

his growing awareness of the mismatch between his anatomy and sense of self. In the prevailing adolescent atmosphere of individualized conformity, "fitting in" is the means of securing psychological supplies and bolstering a flagging self-esteem. Even non-gender-dysphoric adolescents are readily rejected by their peers for minor aberrations in behavior and appearance. The "solution" (adaptation) to this dilemma may be withdrawal into schizoid isolation and fantasy, a well-known clinical variant among applicants for sex reassignment (Meyer, 1974). Alternatively, he may attempt to "force a fit" by the unconscious and conscious "selection" of a hypermasculine adaptation. Inadequate, faulty object relations and a high prevalence of borderline personality organization (Levine and Lothstein, 1981) obviate a consideration of a more moderate, androgynous approach. Androgyny or integration are not *rejected*, they merely do not exist as choices for the untreated transsexual.

For the hypermasculine phase gender-dysphoric male in late adolescence, "the first order of business of being a man is: don't be a woman" (Stoller and Herdt, 1982). Benefits theoretically accrued from such a hypermasculine flight include: (i) Panacea for a variety of anxieties, e.g., homosexual anxiety, anxiety over loss of love of family and friends. (ii) Recoup of lost of love and respect from significant others, especially parents (de-alienation). (iii) Trial identifications with hypermasculine figures interpreted as more socially acceptable and readily available in the mass media. (iv) Seemingly safe haven away from

intense cross-gender feelings: More masculinity is seen as less femininity and less problematic (requires purge of all aspects of the femme self).

This hypermasculine flight coincides chronologically with the age most men enter military service, either voluntarily or via the draft. The military places a high premium on virility, stoicism, machismo, assertiveness, and all that is, by definition, hypermasculine. It seems that active duty is a natural choice for the gender-dysphoric male in the hypermasculine phase who is attempting to make a last ditch effort to take the path of least resistance vis-à-vis society and family. He sees a chance to maximize his ambivalently present masculine self while de-integrating and purging his feminine self, all in the service of adaptation and accommodation. In an all-volunteer force (the situation that has pertained since 1973), the prevalence of gender-dysphoric, initially hypermasculine males could very well be much higher than in the civilian population as a result of this mechanism, which clearly relies heavily on reaction formation for its unconscious components.

OUTCOME

What is the outcome of the gender-dysphoric soldier? An answer to this question can be, at best, educated speculation given the size of this sample and the general selection for more severely disturbed individuals. Literature is almost entirely lacking on the subject, with the exception of a single paper detailing the military's management of five cases of gender dysphoria and one case of physical intersex in a soldier's spouse (Jones *et al.*, 1984). A consideration of the eight patients in the present sample and the five reported by Jones and co-workers indicates four possible outcomes:

1. Early (less than 1 year) breakdown in hypermasculine defenses with premature discharge;
2. Later (after 1 year) breakdown with premature discharge from service;
3. Completion of tour(s) of duty subsequent to breakdown in hypermasculine defenses;
4. Completion of tour(s) of duty with hypermasculine defenses intact; self-referral later in life as veteran.

Half of the patients in this sample evidenced the first outcome; one each for outcomes 2 and 3; two for outcome 4. The five cases described by Jones *et al.* assorted one case to outcomes 1, 3, and 4 and two cases to outcome 2. Completion of all tours of duty or a 20-year career subsequent to a breakdown in hypermasculine defenses accompanied by adoption of a cross-gender identity/role is the least likely outcome of the 13 cases listed, while early discharge at less than 1 year of service is the most likely outcome, initiated

by the individual or by the military system. This is not surprising given that hypermasculinity is itself a form of gender disorder, specifically a disorder of gender role in response to a primary disorder of core gender identity. These component disorders conflict with each other, creating a self-imposed mismatch between core gender identity and gender role. The resolution of this conflict necessitates abolition of the hypermasculine role and defensive structure and evolution towards the adult transsexual phase with its concomitant quest for hormones and surgery.

MILITARY POLICY

Current military policy regarding gender-dysphoric service members is sketchy and appears to be applied on a case-by-case basis. The military's formal position as applied to transsexuals who are self- or service-identified is often the same as in cases of homosexuality and bisexuality as defined in Department of Defense memorandum 1332.14, dated 28 January 1982: Homosexuality and bisexuality are incompatible with military service and their presence "adversely affects the ability of the Armed Services to maintain discipline, good order, and morale" (Jones *et al.*, 1984). Transsexuals can be considered as homosexual or bisexual by military definition if they engage in, or desire to engage in, bodily contact for the purposes of sexual gratification with a person of the same anatomic sex. This results in prohibition from enlistment or separation from service through administrative (nonmedical) channels, usually with an Honorable Discharge.

Heterosexual transsexuals, as defined by a desire for sexual contact with the anatomically other sex (DSM-III; American Psychiatric Association, 1980), pose a more difficult problem. Their gender disorder cannot be ignored or relegated to irrelevancy in this unusual situation. Policy is still evolving in this area.

For those who receive sex reassignment, irrespective of sexual orientation, medical arguments have been used successfully to support both prohibition from enlistment and separation from service (*Doe v. Alexander,* 1981). A more recent legal opinion prepared for the U. S. Air Force supports the use of medical arguments (i.e., the probable need for specialized medical, surgical, and psychiatric care is incompatible with worldwide deployment) over the vague, general grounds for discharge as applied to homosexuals in Air Force regulations AFM 39-12 and AFR 36-2 (OpJaGAF 1982/24, 1984).

The above considerations are usually circumvented entirely by the medical authorities, possibly due to these vagaries, and patients are diagnosed with personality disorders (usually Borderline) and administratively discharged as "unadaptable to military service" on that basis. The matter is far from

resolved and largely untested. The legal opinion cited previously summarizes the military's precarious position:

> The short of the matter seems to be that if we propose to base the policy of discharging members who undergo sex change operations on promotion of good order, discipline, morale, or other similar virtues, we must prepare for a challenge on the ground that there is no empirical evidence that transsexuals have an adverse impact on those values. (OpJAGAF 1982/24, 1984).

Given that gender dysphoria is an all-pervasive disorder and not an "off-duty" idiosyncracy or alternative life-style, it seems that the adaptability of some cross-gendered servicemen is predicated upon intact hypermasculine defenses. Without a significant breakdown in these defenses, they do not come to the attention of the system and are not identified as "deviant." For the majority, whose hypermasculine flight falls far short of a complete tour of duty, military life itself becomes yet another mismatch. The difficulties they experience in nearly all facets of military life (*after* evolving beyond this phase) leads first to their identification as deviant and, second, to mandatory evaluation for confirmation of that suspicion. At this point, both the patient and military system are happy to part and go their separate ways. On the other hand, it is conceivable that a significant number of higher functioning transsexuals without severe character pathology could traverse the military system undetected, as did four of the veterans in this sample.

CONCLUSION

A phase of hypermasculinity seems to be experienced by the gender-dysphoric males in this sample, usually during middle to late adolescence and variably sustained into young or middle adulthood. As a caricature of mature masculinity, the hypermasculinity adaptation in these males necessitates a way of being that is staunchly nonfeminine; risk-taking behaviors, machismo, and a facade of power are prized. While some patients choose hypermasculine pursuits limited to contact sports, race car driving, or mountain climbing, an unknown number choose military service as the quintessential hypermasculine environment in which to purge their cross-gender identifications.

The prevalence of transsexualism in the armed forces may actually be much higher than in the civilian population. This potentially increased loading of transsexuals in uniform may be due to the hypermasculine phase adaptation described and possibly to existing military policies. For example, it has been previously hypothesized that the number of homosexuals in the military is actually increased by military policies that exclude women from the draft and concentrate on late adolescent males (Harry, 1984). This theory is predi-

cated on the finding that the homosexual men who enlisted or were drafted at age 17 or 18 did not yet "know" they were gay, as the median age of "coming out" (i.e., assuming a homosexual role) is 19 or 20 years (Dank, 1971; Harry and DeVall, 1978). As military policies, formal and informal, serve to reaffirm values of masculinity and heterosexuality, they also serve as an enticement for the hypermasculine phase gender-dysphoric male who is frequently in this very age group.

There are numerous other motivations, overt and covert, underlying the decision to enlist in the military service. Many of these may have little or nothing to do with hypermasculinity, e.g., patriotism, desire to be in close quarters with other males, economic pragmatism in a difficult job market, method of escape from a malignant home environment. It is unclear what role these factors may play in the gender-dysphoric male population, in addition to the proposed hypermasculine defensive structure.

More study is warranted on the prevalence of gender disorders in the military environment. Awareness of these problems, especially in the active duty force, is essential for the provision of optimal mental health care in the context of the mission of the Department of Defense. While information on the natural history of male gender dysphorics in the military is sparse, data on the prevalence of gender disorders in women who choose military careers is entirely lacking. This, too, could be a fruitful avenue of inquiry in future studies of gender dysphoria in the military.

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REFERENCES

Adler, A. (1955). *The Practice and Theory of Individual Psychology,* translated by P. Rabin (original work published 1923). Routledge and Kegan Paul, London.

American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.), APA, Washington, DC.

Chodoff, P. (1982). Hysteria and women. *Am. J. Psychiat.* 139: 545-551.

Cowell, R. (1954). *Roberta Cowell's Story,* William Heinermann Ltd., London.

Dank, B. (1971). Coming out in the gay world. *Psychiatry* 34: 180-197.

Doe v. Alexander (1981). 510 F. Supp 900, D. Minn.

Fenichel, O. (1945). *The Psychoanalytic Theory of Neurosis,* Norton, New York.

Gershman, H. (1968). The evolution of gender identity. *Am. J. Psychoanal.* 28: 80-90.

Glass, L. L. (1984). Man's man/ladies' man: motifs of hypermasculinity. *Psychiatry* 47: 260-278.

Goldwert, M. (1985). Mexican machismo: the flight from femininity. *Psychoanal. Rev.* 72: 161-169.

Harry, J. (1984). Homosexual men and women who served their country. *J. Homosex.* 10: 117-125.
Harry, J., and DeVall, W. (1978). *The Social Organization of Gay Males,* Praeger, New York.
Jones, F. D., Deeken, M. G., and Eshelman, S. D. (1984). Sexual reassignment surgery and the military: Case reports. *Milit. Med.* 149: 271-275.
Jorgensen, C. (1967). *A Personal Autobiography,* Paul S. Erikson, New York.
Levine, E. M., Shaiova, C. H., and Mihailovic, M. (1975). Male to female: The role transformation of transsexuals. *Arch. Sex. Behav.* 4: 173-185.
Levine, S. B., and Lothstein, L. M. (1981). Transsexualism or the gender dysphoria syndromes. *J. Sex. Marit. Ther.* 7: 85-113.
Meyer, J. K. (1974). Clinical variants among applicants for sex reassignment. *Arch. Sex. Behav.* 3: 527-558.
Money, J. (1980). *Love and Love Sickness,* Johns Hopkins University Press, Baltimore.
Morris, J. (1974). *Conundrum,* Harcourt Brace Jovanovich, New York.
Mosher, D. L., and Sirkin, M. (1984). Measuring a macho personality constellation, *J. Res. Pers.* 18: 150-163.
OpJAGAF 1982/24 (1984). *Med. Services Dig.* 35: 2.
Ovesey, L. (1969). *Homosexuality and Pseudohomosexuality,* Science House, New York.
Richards, R. (1983). *The Renee Richards Story: Second Serve,* Stein and Day, New York.
Roberto, L. G. (1983). Issues in diagnosis and treatment of transsexualism. *Arch. Sex. Behav.* 12: 445-473.
Steiner, B. W., Satterberg, J. A., and Muir, C. F. (1978). Flight into femininity: the male menopause? *Can. Psychiat. Assoc. J.* 23: 405-410.
Stoller, R. J. (1974). Symbiosis anxiety and the development of masculinity. *Arch. Gen. Psychiat.* 30: 164-172.
Stoller, R. J. (1975). *Perversion: The Erotic Form of Hatred,* Pantheon, New York.
Stoller, R. J., and Herdt, G. H. (1982). The development of masculinity: A cross-cultural contribution. *J. Am. Psychoanal. Assoc.* 30: 29-61.