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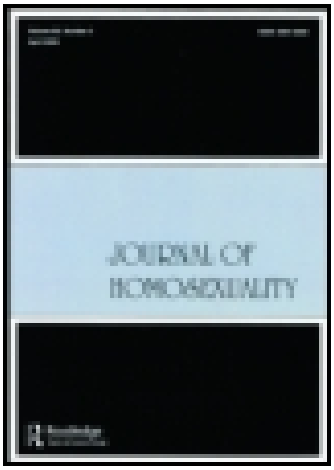

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Blanchard's Autogynephilia Theory: A Critique

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Over the last 20 years, Ray Blanchard, Ph.D., with a variety of coauthors and collaborators, has proposed a theory that links the sexual orientation of male-to-female transsexuals with the presence or absence of autogynephilia (erotic arousal by the thought or image of "himself" as a woman). Blanchard's Autogynephilia Theory suggests that the association between sexual orientation and autogynephilia among male-to-female transsexuals is clinically important and the association is always (or almost always) present. Although the theory has been criticized by clinicians, researchers, and transsexuals themselves, it has not been critiqued in a peer-reviewed article previously. This article will attempt to fill that gap. Key studies on which the theory is based will be analyzed and alternative interpretations of the data presented. I conclude that although autogynephilia exists, the theory is flawed.

KEYWORDS autogynephilia, gender dysphoria, gender identity disorder, transsexuality

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How individuals develop their specific sexual interests is a basic and unanswered question in sexology. A related question, also basic and unanswered, is how individuals develop their gender identity (i.e., their inner sense of being male or female). For more than 20 years, Ray Blanchard (with others) has articulated a theory that unifies these two questions: Proponents of Blanchard's Autogynephilia Theory (BAT) suggest that male-to-female transsexuals (MTFs) who are *not* primarily sexually attracted to men also manifest a specific sexual interest (i.e., autogynephilia, or arousal by the thought or image of "himself" as a woman). Conversely, in those MTFs

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who are primarily sexually attracted to men, autogynephilia is absent. Thus, autogynephilia, sexual orientation, and gender identity are interrelated and interdependent in MTFs.

Autogynephilia is mentioned in the text of the *Diagnostic and Statistical Manual* (*DSM-IV-TR*) published by the American Psychiatric Association (APA, 2000). Bailey (2003) believes that autogynephilia should be added formally to the Gender Identity Disorder diagnostic criteria, which, if that were to happen, it would signify that autogynephilia is a psychopathological symptom and not just an attribute that some MTFs have. By connecting both gender identity and sexual orientation, BAT connects two distinct concepts in sexology usually thought of as independent and has significance beyond just defining a characteristic of MTFs. Although some professionals, researchers, and transsexuals have been very critical of this theory (see Bockting, 2005), it has not been critiqued formally in a peer-reviewed article.

Blanchard defined autogynephilia as "a male's propensity to be sexually aroused by the thought of himself as a female" (Blanchard, 1989a, p. 616). He derived the term from its Greek roots, love of oneself as a woman (Blanchard, 1991, 2005), and later, expanded the term to denote "a male's paraphilic tendency to be sexually aroused by the thought or image of himself as a woman . . . [and refers] . . . to the full gamut of erotically arousing cross-gender behaviors and fantasies" (1991, p. 235). Note that the definition is not limited to MTFs. Autogynephilia does exist in non-transsexuals (e.g., some individuals with transvestic fetishism or transgendered natal males who do not identify as female consistently).

Blanchard (1988) argues that MTFs can be classified by their sexual orientation into two basic types, "homosexual" (predominantly sexually attracted to men) and "nonhomosexual" (*not* predominantly sexually attracted to men). Blanchard employs these terms in relation to natal sex, not self-definition or presentation. He adopted the term "nonhomosexual" as individuals in this group report sexual interest in women, both men and women, or neither men nor women, but not primarily in men (Blanchard, 1988). This article will use Blanchard's terms for consistency, but the terms will be critiqued later in the article.

In his review of the development of autogynephilia, Blanchard (2005) appropriately distinguishes between autogynephilia and theories involving autogynephilia. No one disputes that autogynephilia exists or that it can explain the motivation of *some* MTFs; many MTFs readily admit that this construct describes their sexual interest and motivation. Nevertheless, it is not clear how accurately the BAT predicts the behavior, history, and motivation of MTFs in general.

BAT has evolved over the years, so it is difficult to ascertain clearly the current manifestation of the theory. This article will focus on those statements that are central to the theory and that have been cited repeatedly. The theory has been instrumental in our understanding of both MTFs and autogynephilia (at least by demonstrating its existence, stimulating

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discussion of its importance, and identifying its different presentations); as well as suggesting links and interactions between gender identity and sexual orientation.

The criticisms of BAT by professionals and MTFs themselves are based on numerous implications of the theory. These implications include: Autogynephilia is always present in non-homosexual MTFs and always absent in homosexual MTFs; those non-homosexual MTFs who deny autogynephilia and those homosexual MTFs who report autogynephilia are mistaken or in denial; autogynephilia is a paraphilia; autogynephilia is an orientation; autogynephilia is *the* motivation of non-homosexual MTFs to seek sex reassignment surgery (SRS); autogynephilia is clinically important; and non-homosexual MTFs have difficulty with pair bonding due to their autogynephilic interests.

The BAT model always seemed contrary to my extensive experience as both a psychotherapist and a physician working with individuals undergoing gender transition. Separately, I have been critical of the concept that paraphilias are mental disorders as defined in the *DSM-IV-TR* (APA, 2000; see Moser, 2001, 2002, 2009a; Moser and Kleinplatz, 2002, 2005a, 2005b). Despite this criticism, other paraphilias and paraphilia-related disorders have been suggested for inclusion in the next edition of the *DSM* (see Blanchard, Lykins, et al., 2009; Mick & Hollander, 2006; Stein, 2008). The contention that autogynephilia is also a paraphilia, that it should be included in the diagnostic criteria in the next edition of the *DSM*, and my professional experiences led to the analysis presented here.

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PROBLEMS WITH LANGUAGE

Blanchard's articles lack clear operational definitions for many of the terms used (e.g., paraphilia and fetishism) and whether they imply pathology and normal variation. Clearer definitions and more precise operational definitions will be needed if future research is to settle any of the questions the theory raises.

Prior to coining the term autogynephilia, Blanchard (1985a) used the term "heterosexual-fetishistic transsexual" to describe an individual with a continuous self-image as female and who, "has been sexually aroused by the idea of being a female" (p. 229). He contrasted this with the "homosexual-nonfetishistic transsexual," who also had a continuous self-image as female, but was "never sexually aroused by the idea of being a female" (p. 229). (Note the use of the terms "has been" and "never" in early development of the concept. This aspect of the classification will be discussed later.)

Homosexual MTFs often self-identify as heterosexual females, thus, the use of the term homosexual can appear inaccurate and disrespectful (contradicting their self-identity). Similarly, non-homosexual MTFs may

self-identify as lesbians; and again, the term can appear inaccurate and disrespectful. It may be more accurate and sensitive to define the sexual interests of MTFs as androphilic, gynephilic, bi-philic, or trans-philic (those who prefer other transsexual partners). MTFs, who do not choose to have partnered sexual interactions, usually will have a preference for specific types of partners and can still be classified in one of these categories.

Although possibly descriptive, the notion of autogynephilia has particularly negative connotations within segments of the transsexual community. In the same way that it may be accurate to state that men, on average, have more upper body strength than women, it is inappropriate and inflammatory to say that women are the weaker sex. It is also inappropriate to say that MTFs, who have struggled to be considered women, are just generic *men* with an unusual sexual interest.

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CATEGORIZATION ISSUES

Blanchard (1985a) created the Cross-Gender Fetishism Scale as a way of distinguishing autogynephilia, although that term had not been coined yet, from other types of cross-gender interests. A sample item is, "Have you ever felt sexually aroused when putting on women's underwear, stockings or a nightgown?" (p. 243). All the items in this scale use the term "ever," emphasizing that even one episode in the distant past factored into the score on this scale.

The consistent use of "ever" in these scales is analogous to classifying someone as homosexual on the basis of a few episodes of arousal from same sex contact during a brief period, despite years of satisfying heterosexual experience, interest, and denial of subsequent homosexual experience or interest. Although some MTFs acknowledge ongoing autogynephilic arousal, many others deny this (Lawrence, 2004, 2005). Blanchard (1985b; Blanchard, Clemmensen, & Steiner, 1985) and Lawrence (2004, 2005, 2006) dismiss their denials and insist that they are still autogynephilic.

Non-homosexual MTFs who report never or infrequently experiencing autogynephilic arousal are not rare. Prior to SRS, almost 35% of non-homosexual MTFs reported a history of 12 or fewer lifetime episodes of autogynephilic arousal (Lawrence, 2005). Lumping individuals with minor, often time-limited, histories of autogynephilic arousal with individuals who have extensive histories for most of their adult lives appears problematic. It would seem more appropriate to consider consistently versus rarely autogynephilic groups separately.

Blanchard (1989a) demonstrates that there is a statistically significant correlation between reported autogynephilic interests and a non-homosexual sexual orientation, suggesting that one can distinguish homosexual from non-homosexual MTFs on this basis. This approach is

equivalent to distinguishing men from women by finding a statistically significant correlation between the presence of a Y chromosome and gynephilia (erotic attraction to women), which obscures the very real existence of gay men and lesbians.

HOW DO NON-HOMOSEXUAL (AUTOGYNEPHILIC) AND HOMOSEXUAL MTFS DIFFER?

Blanchard (1989b, 1993a) suggests that the non-homosexual (autogynephilic) and homosexual transsexuals differ on a variety of attributes and that these are important clinical distinctions. He states, "autogynephilia is clinically significant because it interferes with normal interpersonal sexual attraction and because it is associated with gender dysphoria" (1993a, p. 301). There are no data to suggest that autogynephilia actually interferes with interpersonal sexual attraction or that homosexual MTFs do not experience problems with interpersonal sexual attraction or gender dysphoria (i.e., "discontent with one's biological sex, the desire to possess the body of the opposite sex and to be regarded by others as a member of the opposite sex" [Blanchard, Clemmensen, & Steiner, 1987, pp.139–140]). Most MTFs, autogynephilic or not, report both interpersonal attraction toward the partners of their choice and gender dysphoria.

After an extensive review of literature, I could not find reports of any substantial differences between the gender dysphoria of homosexual and non-homosexual (autogynephilic) transsexuals, a difference between the response to anti-androgens by homosexual and non-homosexual MTFs (contradicting the implication that sexual motivation is present in one and absent in the other), or the clinical utility of distinguishing MTFs with and without autogynephilia if the concept were to be added to the *DSM* diagnostic criteria. There are some contradictory data suggesting non-homosexual MTFs are more likely to regret SRS than homosexual MTFs, but even if true, regret is still quite rare for both groups (see Lawrence, 2003; Olsson & Möller, 2006).

IS AUTOGYNEPHILIA EXCLUSIVELY A TRAIT OF NON-HOMOSEXUAL MTFS?

The statement, "All gender-dysphoric biological males who are not homosexual . . . are instead autogynephilic . . ." (Blanchard, 2005, p. 445; see also Blanchard, 1989b; Blanchard et al., 1987) is contrary to Blanchard's own data and the data of others. It is important to note that he does recognize that the absolute aspect of the categorization "is an empirical question that can be resolved only by further research" (Blanchard, 2005, p. 445).

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Erotic cross-dressing is not necessarily equivalent to autogynephilia, but "90% of autogynephilic men . . . have also been aroused by the act or thought of wearing women's clothes" (Blanchard, 1993b, p. 249; see also Blanchard, 1985b, 1991). Blanchard (1985b) found approximately 15% of his homosexual MTFs reported a history of cross-gender fetishism. Bentler (1976) found 23% of his sample of homosexual transsexuals admitted sexual arousal by cross-dressing. Leavitt and Berger (1990) reported almost 36% of their androphilic transsexuals had a history of sexual arousal by cross-dressing (using an item from Blanchard's [1985b] inventory to measure this cross-dressing fetishism). It is hard to dismiss all these studies as systematic distortions and misrepresentations.

Lawrence (2005, 2006) argues that many self-identified homosexual MTFs with histories of autogynephilia identified themselves incorrectly; many of these MTFs reported a history of heterosexual marriage or a significant number of female partners, but female sex partners and history of marriage are not uncommon among non-transsexual male homosexuals. Approximately 20% of "white homosexual men" had a history of marriage to women, 14% had heterosexual coitus in the last year, and 52% of those who self-defined as exclusively homosexual had a history of heterosexual coitus (Bell & Weinberg, 1978).

There are non-homosexual MTFs who do not report any history of autogynephilic arousal. Lawrence (2005) found approximately 10% of her non-homosexual MTF sample reported that they never experienced autogynephilic arousal prior to SRS. Blanchard (1985b) reported that almost 27% of his sample of non-homosexual transsexuals did not acknowledge a history of sexual arousal while cross-dressing. Blanchard et al. (1987) classified 82.2% of their heterosexual male transsexuals to be fetishistic (autogynephilic), suggesting that 17.8% were not. Bentler (1976) noted only 18% of his "Asexual" MTF group and 50% of his "Heterosexual" MTF group indicated that cross-dressing was sexually arousing presurgery, suggesting a majority did not find it sexually arousing. Again, it is difficult to dismiss all these findings as systematic distortion and misrepresentation.

It appears that substantial minorities of homosexual MTFs are autogynephilic and non-homosexual MTFs are not. It is possible that all these individuals were mistaken or purposely misleading the researchers, but that would imply all the self-report data upon which BAT is based are similarly suspect. The actual percentage of non-homosexual MTFs who are not autogynephilic will change when those with minimal or only adolescent histories of sexual arousal at the thought or image of themselves as women are excluded.

"DENIAL" OF AUTOGYNEPHILIA

Blanchard suggests that non-homosexual MTFs who deny autogynephilia are seeking to present themselves as "socially desirable," that they want

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to emphasize the traits and behaviors that will win them a favorable SRS recommendation, and that some admit to falsifying their presurgical evaluation (Blanchard, Clemmensen, & Steiner, 1985). He also cites another study, which demonstrates erotic arousal to cross-dressing (autogynephilic) stimuli in individuals who deny they are aroused (Blanchard, Racansky, & Steiner, 1986). That study will be analyzed in detail in the next section of this article. Blanchard et al. (Blanchard, Clemmensen, & Steiner, 1985; Blanchard, Racansky, & Steiner, 1986) are cited repeatedly by BAT proponents to demonstrate that non-homosexual MTFs who deny autogynephilic interests are actually autogynephilic (see Blanchard, 1994; Lawrence, 2004, 2006).

Blanchard, Clemmensen, and Steiner (1985) studied "adult male gender patients," not all of whom were MTFs. They found a correlation between a tendency of the heterosexual sample to describe themselves in terms of moral excellence or admirable personal qualities (as measured by the Social Desirability Scale; Crowne & Marlowe, 1964) and the denial of autogynephilic interests; this correlation was not found in the homosexual sample. The authors argue that those most motivated to create a favorable impression are those most anxious for SRS and that these individuals emulate the presentation of classic (homosexual) transsexuals, who also usually deny a history of autogynephilic interests. Considering that Blanchard's clinic did not discriminate against autogynephilic MTFs and heterosexual MTFs were an accepted transsexual subtype in the *DSM-III* (APA, 1980), it is not clear why these individuals would choose to falsify their history. Therefore, the motivation hypothesized by Blanchard, Clemmensen, and Steiner (1985) may not have been present.

In most studies, some individuals misrepresent some answers. It would be surprising if at least some gender dysphoria patients have not done this, but there is no indication that non-homosexual MTFs are falsifying their responses in one particular manner. Although conjectural, the opposite misrepresentation also may have occurred: Non-homosexual MTFs desirous of surgery and noting that individuals with transvestism (who by definition are heterosexual) could evolve into an MTF (APA, 1980), may have admitted falsely to autogynephilia that was not present to obtain a favorable evaluation for SRS.

The study by Blanchard. Clemmensen, and Steiner (1985) has methodological problems. The study did *not* compare homosexual and heterosexual MTFs, but homosexual MTFs to a mix of heterosexual MTFs and other types of male gender patients with less consistent cross-gender feelings. Only 69% of the heterosexual sample felt like women all the time for at least one year, which was the authors' definition of a transsexual, versus 96% of the homosexual sample (Blanchard, Clemmensen, & Steiner, 1985). In the discussion, the authors suggested one explanation for their findings was "that heterosexual patients are genuinely more variable in their behavior and in their feelings . . ." (p. 514). Grouping transsexuals with non-transsexuals

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seems likely to produce more variability in their behavior and feelings, in comparison to the more homogeneous homosexual MTF group.

The authors reported that for both heterosexual and homosexual samples, the greater proportion of time they felt like a woman was significantly associated with higher social desirability scores and that these individuals would be most motivated for surgery (Blanchard, Clemmensen, & Steiner, 1985). They found that homosexual MTFs are highly motivated for SRS and deny autogynephilia; they also found that heterosexual MTFs are highly motivated for SRS and also deny autogynephilia (Blanchard, Clemmensen, & Steiner, 1985). This suggests that non-transsexual male gender patients (transvestites or other non-transsexuals) have lower social desirability scores, are less motivated for SRS, and are more likely to admit to autogynephilia. The correlation between social desirability scores and denial of autogynephilia may *not* be significant when only heterosexual and homosexual MTFs (those who have felt like women for one year or more) are compared.

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THE PHYSIOLOGICAL DATA

BAT is primarily based on inferences from self-reports of MTFs. A study of the physiological responses of MTFs could be a powerful confirmation of his theory. The use of phallometry is controversial (APA, 2000; Marshall & Fernandez, 2000); however, a critique of this technique is beyond the scope of the present paper. Nevertheless, we will assume the method is accurate for the purposes of the present article.

Blanchard, Racansky, & Steiner (1986) attempted to show that heterosexual cross-dressers who did not report sexual arousal from cross-dressing were actually sexually aroused by cross-dressing narrative audio tapes. This would suggest that their denial (either intentional misrepresentation or their own misperception) of sexual arousal from cross-dressing stimuli was erroneous.

The subjects were more than merely heterosexual cross-dressers in that, "they felt like women at least when cross-dressed" (Blanchard, Racansky, & Steiner, 1986, p. 456), but it is not clear that they were transsexuals. On the basis of self-report, the cross-dressers were divided into four groups (i.e., always, usually, usually not, and never sexually aroused by cross-dressing in the past year). They were compared to a control group of 10 heterosexual male community college students.

The responses showed that cross-dressers who in the last year had, "never felt sexually aroused when putting on female underwear and clothing" (Blanchard, Racansky, & Steiner, 1986, p. 456), *did* respond significantly more on phallometric testing to the cross-dressing tape than to the neutral tape (described as a depicting a solitary and nonsexual activity) as predicted

by the BAT. It also showed that this same group responded significantly more to the tape of sex as a female with a male partner than either the neutral tape or the cross-dressing tape. The same pattern was true for the group of cross-dressers who were "usually not" aroused by cross-dressing. The cross-dressers "usually" aroused by cross-dressing were significantly more aroused by all the sexual stimuli tapes than the neutral tape. Again, the sex as a female with a male partner tape was the most arousing to this group. The group who reported that they were "always" aroused by cross-dressing, found the cross-dressing tape significantly more arousing than they found the other tapes.

Despite being "heterosexual," the subjects did not respond most to sex as a male with a female partner. Of interest, there was no tape of sex as a female with a female partner, which would be the expected fantasy of cross-dressers (who by definition feel female when cross-dressed and desire sex with women) and could possibly outweigh the other responses. The statistical analysis was based upon maximal arousal, which is important because the heterosexual control group was presented with their ideal fantasy. If the cross-dresser subjects had had more robust erections in response to other stimuli, the minimal changes observed with the cross-dressing tapes may not have been significant. This is a significant flaw in the study's design, which limits its conclusions.

Blanchard, Racansky, and Steiner (1986) conclude on the basis of the physiological arousal to the cross-dressing tape that "fetishism" is present in cross-dressers. In the discussion, the authors admit it is plausible, "some [heterosexual male cross dressers] HCDs are actually unaware of erotic arousal accompanying cross-dressing" (Blanchard, Racansky, & Steiner, 1986, p. 460); the level of arousal, while physiologically present may not have been apparent to the subjects. Nevertheless, they suggest the subjects were either, "consciously attempting to mislead the examiner . . ." (p. 460), that their attention was directed " away from mild and transient penile tumescence" (p. 461), or that the " erotic response to their usual cross-dressing activities has been extinguished through repeated exposure . . ." (p. 461).

Contrary to their conclusion, there was no discrepancy between, "verbal self-reports and their more directly observed physiological responses" (Blanchard, Racansky, & Steiner, 1986, p. 460). The phallometric data and the self-report data were consistent; the response to the cross-dressing tape was directly related to the subjects' stated report of arousal by cross-dressing. Those who denied arousal by cross-dressing experienced minimal response to the cross-dressing tape, of which the authors admit they even might not have been aware. Although the response to the cross-dressing tape may represent a statistically significant increase from the neutral tape, there was significantly less response than to a tape of sex as a woman with a man. As the stated arousal by cross-dressing increased, the response to the cross-dressing tape increased. This suggests the subjects were truthfully and

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accurately reporting their responses. There is no indication that the subjects were trying to conform to a stereotype.

Finding a physiological response in a group does not mean that everyone in the group responded. There is no indication in the article that all individuals had a physiologically significant response. It is possible that some did not. Even if all the subjects had a significant response, the never-aroused group consisted of only nine individuals. It is possible that a larger sample would find a subset of individuals who did not respond.

If the subjects had a minimal phallometric response to a cross-dressing tape and a vigorous response to other stimuli, it does not imply any misrepresentation of their response to the cross-dressing tape. If a man denies erotic interest in other men, has a minimal phallometric response to a "homosexual" tape of which he may not even be aware and a robust response to a "heterosexual" tape, it seems inappropriate to conclude that the subject was misrepresenting his sexual interest in men. Blanchard, Lykins, et al. (2009) seem to agree; they used maximal phallometric responses and ignored minimal responses when classifying individuals as pedophiles, hebephiles, and teleiophiles (i.e., individuals with erotic preference for adults).

Some BAT proponents might suggest that the subjects' response to sex as a female with a male partner tape demonstrates their autogynephilia, but these individuals were not asked if they were autogynephilic or if they thought the female with a male partner scenario would be sexually arousing to them. Arousal to the sex as a female with a male partner tape may be most arousing because they felt like women when cross-dressed. Sex as a male with a female partner could be incongruous with their gender identity and, therefore, not as arousing.

IS AUTOGYNEPHILIA A "PARAPHILIA"?

Paraphilias are defined as mental disorders in the *DSM-IV-TR* (APA, 2000) and are usually thought of as unusual sexual interests, which might include autogynephilia. There is no apparent rationale why unusual sexual interests per se are mental disorders (Moser, 2009a; also see Silverstein, 2009). If we assume that the term paraphilia *just* describes, without any implication of psychopathology, "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors . . ." (APA, 2000, p. 566), then both autogynephilia and heterosexuality could fit this definition (see Moser & Kleinplatz, 2005b). Nevertheless, there is reason to conclude that autogynephilia is not a paraphilia when compared to other sexual interests usually classified as paraphilias.

If the impetus for gender transition is a paraphilia (autogynephilia), then reduction of the sex interest should decrease the desire for the transition. Low testosterone, either due to anti-androgens or other causes, is associated

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with decreased sexual interest in individuals with or without a paraphilia. Estrogen acts to decrease testosterone levels, but most transsexuals are prescribed anti-androgens to reduce further their testosterone level, often to the undetectable range. The result is often decreased sexual interest, as expected, but this rarely causes any discomfort or regret. Most MTFs report their drive for gender transition is unabated; Blanchard (1991) also observed this same phenomenon.

If autogynephilia were a paraphilia, we would expect that MTFs would want estrogens to feminize themselves, but decline anti-androgens or report that they disliked the effect. This is contrary to the observation that MTFs request and like the effects of anti-androgens. Lawrence (2004) attempts to explain this paradox by hypothesizing that the anti-androgens may treat "ego-dystonic paraphilic arousal" (p. 78), but this entity is not commonly seen in individuals diagnosed with other paraphilias. The consensus opinion is, "many individuals with these [paraphilic] disorders assert that the behavior causes them no distress" (APA, 2000, p. 567), "These individuals are rarely self-referred" (p. 566) for treatment, and the paraphilias "are rarely diagnosed in general clinical facilities" (p. 568). This suggests that ego-dystonic paraphilic arousal is not a common problem motivating individuals with traditional paraphilias to seek professional help (whether psychotherapy or anti-androgens). In my clinical experience, there are individuals with autogynephilia (e.g., transvestites) who request estrogens for feminization, but decline anti-androgens.

Support groups comprised of individuals with similar sexual interests appear effective at reducing ego-dystonic arousal to unusual sexual interests (see Kleinplatz & Moser, 2004; Moser, 1988). Many, if not most MTFs, participate in these support groups either online or in person. It seems "ego-dystonic paraphilic arousal" is rare among individuals who are diagnosed with traditional, noncriminal, paraphilias and there is no evidence that "ego-dystonic paraphilic arousal" is more than temporary phase for most transsexuals.

Even if Lawrence (2004) is correct and anti-androgens treat their "ego-dystonic paraphilic arousal," then it is still not clear why autogynephilic transsexuals pursue gender transition. They are not doing so to treat their ego-dystonic arousal and they are not doing so because of their autogynephilia, both of which have been "treated" (significantly diminished) by the anti-androgens. Many individuals diagnosed with a paraphilia and treated with anti-androgens report a significant decrease in their desire to act on their paraphilic interests (see Guay, 2009); this is not seen with MTFs. Some individuals with a paraphilia may choose to use an anti-androgen to avoid societal penalties for their sexual behavior or as a requirement of parole or probation, but in my clinical experience it is rare for them to like the effect. This is another way individuals with autogynephilia differ from individuals diagnosed with other paraphilias; they like the effects of anti-androgens.

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Also, as stated earlier, there is no reported difference in the response of homosexual and non-homosexual MTFs to anti-androgens, which argues against a sexual motivation in one type of MTF and not the other.

There are also MTFs for whom estrogens are medically contraindicated (e.g., individuals with a deep vein thrombosis), who have found that anti-androgens relieved their gender dysphoria without the use of additional feminizing hormones. They found demasculination without feminization helpful. This would suggest that MTFs are motivated to block their masculine characteristics ("autoandrophobia"), rather than just enhance feminine characteristics. The desire to block other sexual interests is not characteristic of individuals with a paraphilia, (see Langevin, Lang, & Curnoe, 1998).

Strong, persistent sexual interests (whether conventional or unusual) are not generally amenable to extinction by repetition or satiation. The *DSM-IV-TR* definition of a paraphilia specifies that the sexual arousal is "intense" (APA, 2000, p. 566) and "[paraphilic] disorders tend to be chronic and lifelong" (p. 568). All sexual urges tend to diminish with advancing age, but MTFs often report other sexual interests long after their autogynephilic interests diminish. Lawrence (2005) indicated 24% of her sample reported 1–12 episodes of autogynephilic arousal prior to SRS, suggesting it was not enduring (and probably not intense) for many MTFs. If autogynephilia is not intense and not enduring, then it is also unlike other paraphilias. A sexual interest that is not intense, not present at time of diagnosis, and not causing current distress or disability does not meet the *DSM-IV-TR* definition of a paraphilia or a mental disorder (APA, 2000, see p. xxxi); gender dysphoria may be a better criterion than autogynephilia when diagnosing individuals with Gender Identity Disorder (see Moser, 2008).

Blanchard (2005) states "Autogynephilia does not occur in women . . ." (p. 445), though he admits it "is an empirical question that can be resolved only by further research" (p. 445). If autogynephilia is a paraphilia and traditional paraphilias are rare in women (APA, 2000), finding autogynephilia in a substantial number of women would suggest either that it is not a paraphilia or that paraphilias in women are more common than previously assumed. Using different instruments, two independent studies, both employing similar but not identical items to Blanchard's (see 1985a, 1989a) instruments, found significant numbers of women scored as autogynephilic (Moser, 2009b; Veale, Clarke, & Lomax, 2008). Moser (2009b) found 28% of his sample reported frequent arousal to multiple items on his Autogynephilia Scale for Women. Lawrence and Bailey (2009) calculated mean scores for non-homosexual (autogynephilic) MTFs from Blanchard's (1989a) data; they found the Core Autogynephilia scale mean was 6.1 (range 0 to 9) and the Autogynephilia Interpersonal Fantasy scale was 2.7 (range 0 to 4); higher scores imply more autogynephilia. On Veale et al.'s (2008) versions of these scales, 52% of their biological female sample scored 6 or greater on the Core Autogynephilia scale *and* 3 or greater on the Autogynephilia Interpersonal

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Fantasy scale (J.F. Veale, personal communication, July 7, 2009). It seems that a significant number of biological females endorse items similar to those used to categorize MTFs as autogynephilic. It appears that a substantial number of natal women are autogynephilic or manifest a sexual interest similar to autogynephilia.

IS AUTOGYNEPHILIA AN ORIENTATION?

Blanchard (1993a) alternatively suggests, "autogynephilia might be better characterized as an orientation than as a paraphilia" (p. 306). He defines orientation as including, "courtship, love, and cohabitation with a partner of the preferred sex; for autogynephilic men, it includes the desire to achieve, with clothing, hormones, or surgery, an appearance like the preferred self-image of their erotic fantasies" (Blanchard, 1993a, p. 306). From this description, MTFs do not differ from natal women, who also employ clothing, cosmetics, and surgery to achieve a desired self-image and to attract a partner of the preferred sex for courtship, love, and cohabitation.

Blanchard (1993a) does not present any data to demonstrate that the autogynephilic MTFs' interest in transitioning overshadows their desire for "courtship, love, and cohabitation with a partner of the preferred sex . . ." (p. 306). Most MTFs do pursue courtship, love, and cohabitation with a partner of the preferred sex, most report having a stable partnered relationship after SRS (Lawrence, 2005), and non-homosexual MTFs often have intact marriages to women when they present for treatment (Blanchard, 1993b).

MTFS AND PAIR-BOND FORMATION

Blanchard (1991) states "autogynephilia . . . is the main correlate of transsexual tendencies and also of diminished capacities for heterosexual relations and pair-bond formation" (p.249); no data are presented to suggest that most heterosexual or bisexual MTFs have diminished capacities for or any problem with pair-bond formation or heterosexual relations. If autogynephilia is correlated with a diminished capacity for pair-bond formation, then homosexual MTFs should report more stable partnered relationships; the opposite is seen. In a subset of her sample, Lawrence (2005) found that 83% of MTFs interested in female partners both before and after SRS (autogynephilic MTFs) were in a stable partnered relationship *at the time* of her survey in comparison to 36% of the MTFs interested in males before and after SRS (homosexual MTFs). MTFs with predominantly female partners before SRS and male partners after SRS (also classified as autogynephilic), were intermediate between the other two groups (43%). She also found no significant

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difference among the groups, for stable partnered relationships *at any time* after SRS, though the data trend suggested that MTFs oriented toward female partners before and after SRS, were most likely to report a stable partnered relationship. It appears that autogynephilic MTFs have the same or less problems with pair-bond formation than homosexual MTFs.

Lawrence (2005) compared her sample to the National Health and Social Life Survey data (Laumann, Gagnon, Michael, & Michaels, 1994) and concluded "many MtF transsexuals have difficulty finding regular partners after SRS" (p. 163). The comparison of Lawrence's convenience sample (age range 19 to 72) to a national probability sample (Laumann, Gagnon, et al., 1994; age range 18 to 59) is problematic statistically. The median age bracket in Laumann, Gagnon, et al. (1994) was 35–39; Lawrence's mean age at the time of the survey was 47 years old, with a standard deviation of ±9 years. Lawrence's sample appears older and the percent of individuals with no sexual partners in the last 12 months increases with increasing age (Laumann, Gagnon, et al., 1994). In another study by Laumann, Glasser, Neves, Moreira, & the GSSAB Investigators' Group (2009) specifically studying at 40–80 year olds, 20.6% of the men and 30.7% of the women reported no sexual partners in the preceding year, similar to Lawrence results. Therefore the comparison of Lawrence (2005) to Laumann, Gagnon, et al. (1994) may be misleading.

Nevertheless, almost 50% of the sample had two or more partners after SRS, 45% were in a stable partnered relationship at the time of the survey, and 62% had had a stable partnered relationship since undergoing SRS (Lawrence, 2005). The lengthy recovery period after SRS, becoming comfortable with one's "new" anatomy, learning how to maintain relationships as women, overcoming discrimination by prospective partners against MTFs, and occasional poor functional results (see Lawrence, 2003), all combine to inhibit the development of stable partnered relationships or finding regular partners. Considering that about half of all marriages between nontranssexuals end in divorce (National Center for Health Statistics, 2005) and sexual dysfunctions are common among "normal" heterosexuals (Laumann, Paik, & Rosen, 1999), one similarly could conclude that "normal" heterosexuals also have a diminished capacity for heterosexual relations and pair-bond formation.

The difficulty in finding partners is germane only when the individual wishes to find a partner. There is a group of MTFs who report a lack of interest in partnered sex or intimate relationships with men or women. These individuals are classified as asexual or analloerotic (Blanchard, 1989a). Lawrence (2005) found that pre-SRS, 13 subjects reported no male, female, or other transsexual partners (the asexual or analloerotic group); post-SRS, 52 subjects reported no partners. Assuming the anallerotic group still is not interested in finding a partner post-SRS, only 39 subjects (17%) who might want to find a partner did not. It appears that post-SRS, the ability of most MTFs to find partners is surprisingly good.

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There is no suggestion that individuals in the anallerotic group are distressed by the lack of partnered relationships, that they desire the situation to change, or that it affects other types of relationships. Considering the level of disdain and rejection MTFs often encounter and the internal turmoil that gender transition engenders, it is not surprising that some individuals choose to avoid these painful situations, but it does not reflect necessarily on their capacity to pair bond. In my clinical experience, many of these individuals report close friendships, appear to have strong family relationships, and deny problems with work relationships. I am unaware of any data to the contrary.

Blanchard (1989a, 1991) suggests the male partner of a non-homosexual MTF "is usually a vague, anonymous figure rather than a real person and probably has little excitatory function beyond that of completing the fantasy of vaginal intercourse in the female role" (p. 237). Lawrence (2004) echoes that sentiment suggesting that the androphilic interests of "non-homosexual" MTFs are focused upon an imagined partner who, " is faceless or quite abstract, and seems to be present primarily to validate the femininity of the person having the fantasy, rather than as a desirable partner in his own right" (pp. 79–80). Stable partnered relationships would appear contrary to those assertions. The BAT would imply that non-homosexual MTFs attracted to men would have multiple male partners and no stable male partnered relationships. This expectation does not seem to be supported by the available data. Of the MTFs who had exclusively female partners before SRS and exclusively male partners after SRS, 71% reported at least one stable partnered relationship post-SRS in comparison to the 64% of MTFs who had exclusively male partners before and after SRS (Lawrence, 2005). The MTFs with female partners before and male partners after SRS reported a mean of 2.8 male partners after SRS, in comparison to the 8.4 male partners for MTFs with exclusively male partners before and after SRS (Lawrence, 2005). A partner who confirms one's status or sexual attractiveness is also relatively common among non-transsexual men and women (e.g., trophy wives, society wives, rich husbands, star of the football team).

Blanchard (2005) states that for some autogynephilic males, SRS "represents a form of bonding to the love-object and is analogous to the desire of heterosexual men to marry . . . [and] autogynephilia is a misdirected type of heterosexual impulse, which arises in association with normal heterosexuality but also competes with it" (p. 445), but presents no data to support these statements. Considering that MTFs search for stable partners, develop relationships, and do marry (when the option is available to them), these individuals seem interested in bonding to love-objects other than their female persona. It seems plausible to conclude that in many cases the desires for SRS and marriage (or a similar committed relationship) are not competing. It is not clear how autogynephilia competes with

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"normal" heterosexuality when autogynephilic transsexuals self-identify with all possible "normal" sexual orientations both before and after SRS.

THE MOTIVE FOR SEX REASSIGNMENT SURGERY

Bailey (2003) explains, "Succinctly put, homosexual male-to-female transsexuals are extremely feminine gay men" (p. 146). Lawrence (2004) suggests that homosexual MTFs transition because it "seem[s] obvious" (p. 70) and for "greater social and romantic satisfaction and success . . ." (Lawrence, 2006, p. 272); she presents no data to support these statements. Amputation of one's genitals is neither an obvious nor usual strategy for most effeminate homosexual men to achieve social and romantic success. One could argue that homosexual MTFs are sexually attracted to "heterosexual," rather than "homosexual," men, but that reasoning is eerily similar to the explanation that autogynephilic MTFs develop an attraction to men to confirm their status as women (Blanchard, 1991; Lawrence, 2004).

Lawrence (2004) suggests that sexual motivation (autogynephilia) explains why successful men in masculine professions choose to become women. SRS is major surgery, expensive, usually not covered by government health programs or private insurance, usually requires extensive psychotherapy prior to the surgery, and has a long recovery period; it is not entered into lightly. Sexual motivation for SRS seems more unlikely as men age (many "autogynephilic" MTFs are older when they transition; see Blanchard, 1994; Lawrence, 2003, 2005). In general, older non-transsexual men often accept diminished libido or functioning. Men with erectile dysfunction often do not seek sex therapy or medical evaluation (Mirone et al., 2002). Even those who pursue treatment often do not refill medications that were effective in restoring their sexual functioning (Rosen et al., 2004). Interest in paraphilias also reportedly decreases with age (APA, 2000; see Blanchard & Barbaree, 2005). Yet, older, often autogynephilic, MTFs continue to pursue SRS.

DISCUSSION

The arguments presented in this article are, for the most part, reinterpretations of the data collected by BAT proponents and used by them to support the theory. Contrary to the conclusions of BAT proponents, many of the tenets of the theory are not supported by the existing data, or both supporting and contradictory data exist. The rejection of the data contrary to BAT by its proponents raises questions about the validity of the other data on which BAT is based.

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There are several significant reasons to question the use of autogynephilia as a pathognomonic clinical sign for non-homosexual MTFs and its inclusion in forthcoming editions of the *DSM*:

1) The purported clinical significance (Blanchard, 1993a) of BAT is not clear. The focus on autogynephilia may have led to other factors being ignored or not investigated. It has created a new stereotype to which prospective SRS patients must now adhere.
2) Some proponents of the BAT have asserted that non-homosexual MTFs who do not report autogynephilia are "autogynephiles in denial" and that homosexual MTFs who report autogynephilia are mistaken. Invalidating the experiences of those MTFs on the basis of our current level of knowledge is inappropriate, disrespectful, and possibly detrimental to individual.
3) BAT implies that sexual orientation and gender identity are not independent concepts. The ramification of that finding has profound implications. Are all gender manifestations secondary to sexual orientation? Are all gay men somewhat feminine and all lesbians somewhat masculine? Are all feminine heterosexual men and masculine heterosexual women denying their homosexuality? Will we resurrect the concept of "latent homosexuality"? BAT proponents are not suggesting any of these propositions, but the questions do flow out of the theory.

I am *not* suggesting that acknowledging a history of some autogynephilia is not correlated with a non-homosexual sexual orientation among MTFs, but correlation does not imply causation. If BAT proponents admit that there may be some cases of homosexual MTFs with autogynephilia and non-homosexual MTFs without autogynephilia, then autogynephilia just becomes another trait that some MTFs have, rather than the pathognomonic marker.

This article questions the following tenets and predictions of BAT. Reviewing the same data as the BAT proponents, it is not clear that autogynephilia is always present in non-homosexual MTFs and always absent in homosexual MTFs; the practice of discounting statements by non-homosexual MTFs "denying" and homosexual MTFs reporting autogynephilia appears flawed; autogynephilia seems to differ from other paraphilias in significant ways; natal women score as autogynephilic on similar inventories used to categorize MTFs as autogynephilic; according to Blanchard's (1993a) definition of orientation, autogynephilia does not seem to be an orientation overshadowing other traditional orientations; there is little reason to suggest that autogynephilia is *the* motivation of non-homosexual MTFs to SRS; and there are no data to suggest that non-homosexual MTFs have difficulty with pair bonding. Further empirical studies are needed to confirm any of these assertions.

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This article should not be interpreted as supporting any alternative theory or hypothesis of the origins or nature of transsexuality. There may be more than one cause of transsexuality; Blanchard et al. (2009) similarly accepts that there can be more than one cause of a paraphilia.

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