The Treatment of Transsexualism

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PSY 482

Spring 1972

Mesics

Transsexuals are persons who feel that they are inwardly members of the opposite genetic sex. They claim to feel like a person of the opposite sex, but think that their bodies have somehow, by a freak of nature, developed abnormally and not according to their true nature. Physically, these people are normal, as contrasted with the hermaphrodite, who actually possesses physical characteristics of both sexes. They seek medical treatment-if necessary, surgery - to have their bodies changed into what they feel to be their real sex. In fact, the wish to change their sex becomes so dominant that they pursue this goal relentlessly - in spite of great difficulties. This often leads to maladjustment in their social, psychological, and economic lives. In some cases, transsexuals live their lives as total misfits, and may even commit suicide.

In recent years, much information has become available on the transsexual phenomenon. However, these studies are more directly aimed at the problems of diagnosing transsexualism, as well as post-operative studies of the transsexuals' adjustment. Very few studies in the literature focus on the psychological aspect of therapy for transsexuals.

Harry Benjamin, an expert in this field, pointed out that the clinical management of the transsexual is a difficult problem, because transsexuals are often emotionally immature, unreliable, self-centered, and irresponsible, with occasional paranoid tendencies. (Benjamin, 1964) They are obsessed with the desire to change their sex, no matter what the cost.

The problems of diagnosing the transsexual will not be dealt with in detail here. Suffice it to say, that before a transsexual is to undergo psychological and/or surgical treatment for a change of sex, the therapist must be sure that the diagnosis is correct. Often, there is some difficulty in distinguishing the transsexual from the transvestite or the homosexual. Since the prognosis of a sex change for these later two groups is poor and surgical change

is irreversible, the diagnosis must be sound. *

It should be mentioned here that this paper will deal with male transsexualism; that is, when a genetic male desires to be changed into a female. Most studies of this phenomenon reveal a ratio of three male transsexuals to every female transsexual. (Hoenig & Kenna, 1970) Since this condition exists more for males, most studies have focused on the problem for the male. However, most of the conclusions reached in this paper are also applicable for females.

Treatment

There exists a better prognosis in the case of childhood transsexualism than there is for adults. Newman (1970) has found that if the condition of transsexualism is discovered early in life, by age 5 or 6, and intensive individual therapy for the child and family counselling is begun on a regular basis, a reversal of the child's gender orientation is possible. With feminine boys the treatment is based on interfering with the child's feminine fantasties, reassuring him that he will not grow up to be a girl, and helping him to see that being a male also has its rewards. This therapy requires the constant participation of the parents. Also, Newman points out that the therapist must be a person of the same sex of the child, so that identification with the therapist can be encouraged.

In the case of childhood cross-gender identification, Green (1968) points out that play therapy is sometimes useful, for it permits the boy to express his masculine and feminine behavior, with the hope of understanding the latter and reinforcing the former.

Green further points out that therapy with the child's parents should focus on their disparate roles in the child's upbringing, with an emphasis in improving the way they relate to the child.

If, however, the child's transsexual wishes are not treated by the time he reaches adolescence, the hope for him to reverse

his gender orientation is poor. Newman says that beyond childhood, psychotherapy and psychoanalysis are no longer effective in dealing with the problem.

Concerning psychotherapy for the adult transsexual, Pauly (1968) points out that "psychotherapy has not proved helpful in allowing the transsexual to accept the gender identity which is consistent with his genital anatomy." In fact, Pauly points out that transsexuals have been pushed into psychosis at the point where the therapist felt they were beginning to cure the patient of his gender misidentification. Pauly feels that this resistance to psychotherapy is due to the fact that gender identity is established early in life, and by adulthood is extremely resistant to change.

The usefulness of psychotherapy is best summed up by Baker (1968). "I have been unable to find a single report that documents successful psychological treatment of an adult or adolescent transsexual."

Behavior modification methods have also been used in an attempt to cure transsexuals. In a study by Marks, et. al. (1970), seven transsexuals were treated in a hospital for 2 to 3 weeks, receiving aversion treatment twice daily. This was dome by administering electric shocks to the man's forearm at an intensity that was unpleasant, but not painful, to the subjects. Shocks were given while the patient carried out or fantasized his sexual deviation. Transvestites, fetishists, and sadomasochists were also treated in this manner.

The results were that aversion therapy was followed by a lasting reduction of deviant behavior in most of the transvestites, fetishists, and sadomasochists, but not in the transsexuals. All seven transsexuals had cross-dressed before treatment, and every one continued to do so in the period up to the final follow-up study (2 years later). At the end of the follow-up, there was no overall improvement in the conditions of the transsexuals.

Marks et. al. explained their findings by saying that transsexualism is a case of extreme transvestism, and the poor

response of transsexuals to aversion therapy reflects the intensity of the condition. Also, they felt that transsexualism may indicate an earlier disturbance of gender identity formation in childhood. Therefore aversion therapy did not succeed because experiences learned early in childhood are hard to modify in the adult. These two explanations may occur separately or together.

Other therapists have employed psychopharmalogical methods to deal with transsexuals. However, two of the most widely used drugs, Librium and Stelazine, had no effect on the patient (Green, 1970). Benjamin (1964) found that efforts at psychotherapy were aided a great deal by administering hormone medication to the patient. The hormone estrogen has a calming effect on male transsexuals, which helps to take the edge off the psychological guidance by reducing libido. Also, the feminizing effects on the male patient's secondary sex characteristics may provide secondary gain for the transsexual.

In all reality, the psychologist will be of most use to the transsexual in aiding him during the sex change procedure, rather than trying to reverse his sex identification. The therapist, after concluding that the reversal is not possible, no longer should refuse the patient's wish to live as a member of the opposite sex.(Newman, 1970) As Newman further points out, the therapist should encourage the patient to live as a member of the opposite sex for at least one year before possible surgery. Along with this role switch, family councelling sessions should be initiated. A good way to begin these sessions is by having the transsexual share his feelings about the new role with his family and therapist. The therapist must educate the family about the nature of the patient's condition and provide counselling to the family members. After emotional preparation of the patient and family has been completed, the trial period in the new sex role can begin. If the trial in this new role is successful for a year, and the patient has no doubts or second thoughts, Newman (1970) recommends that surgery be undertaken.

Hoenig, et. al. (1970) notes that the psychologist can be of great help in the management of the patient's affairs after surgery. He can do this by counselling patients as they live in their new role and by providing practical help for the patient in attaining legal status as a member of the opposite sex. Hoenig feels that the sex change operation provides the patient with a greater tranquility, which in itself is a good psychological cure.

Wolf et. al. (1968) found that for the postoperative transsexual, frequent visits of the psychiatrist were helpful in furnishing support during the crises periods that may arise, while the transsexual is adjusting to his (her) new body. Also, it furnishes an opportunity to gather information on these little studied individuals. It has been found; however, that postoperative (male) transsexuals report clinical sexual data similiar to normal women. (Baker, 1969)

why however

One major problem for transsexuals is the resistance of the medical profession to perform the sex reassignment surgery. In a survey by Baker (1969), 55% of the psychiatrists, 63% of surgeons, and 40% of general practitioners would oppose such an operation. If the patient made a threat of suicide, 54% of psychiatrists would still oppose the surgery. Similiar findings have been reported by Green & Stoller (1966). Baker concludes that psychiatrists would rather see the patient dead than grant their request.

Many psychologists are of the opinion that a transsexual is a mentally ill person, and his mental illness should not be treated surgically for it does not attack the cause of his disturbance. (Sacarides, 1969)

It seems, however, that in light of the successful postoperative adjustments made by these people, surgery is a legitimate means of therapy. In this way, medicine and psychology can combine to bring help to transsexual individuals, where they have failed to do so separately.

what is the rate in terms of successful outcome adjustment after surgery. A-

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