

BEHAVIOR THERAPY FOR TRANSEXUALISM

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Transsexualism is a rare disorder, and there is little literature available on its treatment. A case is presented of transsexualism with homosexual orientation in a 24 year old male. Since the disorder appeared to have behavioral antecedents, it was treated with a behavior therapy package comprising relaxation, aversion therapy with aversion relief, modelling, hypnosis, orgasmic reconditioning, behavioral counselling and sex education. Therapy resulted in normalization of gender identity, but the homosexual orientation persisted.

Key words: *transsexualism, gender identity disorder, behavior therapy.*

INTRODUCTION

Although transsexualism has been recognized as a diagnostic entity since 1853, there are no satisfactory theories as yet regarding its etiology, nor are effective therapeutic strategies available (Stoller, 1985). Today, literature on treatment for transsexualism remains confined to isolated case reports. We herein present a case of transsexualism, treated with behavior therapy.

CASE REPORT

R, a 24 year old unmarried male graduate from a middle socioeconomic background, presented with the conviction that he was a female trapped in a male's body. The symptom was insidious in onset, dating back to childhood. For as long as he could remember, R had been treated as a girl by his parents, relatives and teachers. In childhood, he was often told that he was small, delicate, fair and attractive, was often hugged and kissed, and was frequently dressed in feminine clothing and paraded. He was discouraged from playing masculine games such as hockey and football and was encouraged to take up embroidery, knitting, doll-making, cosmetic preparation etc. Thus, all through childhood he adopted a feminine role and was accepted as such by peers and elders alike. At no time did he feel the incongruence of his behavior.

During his teenage years, social disapproval of his femininity became manifest and progressively increased; his habits and hobbies however remained unchanged. His first sexual experience was at the age of 13 when he was fondled by an older male. R reacted to the incident with mixed pleasure and guilt. Subsequently, he had many homosexual (but no heterosexual) contacts, usually in the passive role and usually confined to petting. The thought of anal intercourse always remained repulsive to him.

From, the age of 17, his distress with his biological sex grew intense. He began to long for breasts and female genitalia. He would act out his fantasy to menstruate by using sanitary napkins. He even contemplated sex change surgery in his longing to bear a child. His inner "real" femininity contrasting with his biological masculinity occasioned in him sufficient distress to impair social and occupational functioning, and generated depression of suicidal intensity.

R had been referred for psychiatric treatment by a physician whose help he had sought to effect a change in biological gender for the purpose of conceiving. R was shattered to learn that sex change surgery could never confer upon him the ability to bear a child. In consequence, R agreed to undertake therapy directed towards altering his belief in his feminine gender.

Physical examination was unremarkable, revealing unequivocally male genitalia of normal proportions. R qualified for a diagnosis of transsexualism (with homosexual orientation) on DSM-III-R.

Medically, a diagnosis of complex partial seizures of two to three years duration had been made; frequency of seizures was, on average, once in two to three months; the clinical features were sudden onset of masticatory movements associated with confused, automatic behaviors lasting for a minute or two and followed by tiredness. The EEG revealed a left anterior temporal focus. Hemogram, urinalysis, skull X-ray, chromosomal analysis and semen analysis all proved normal.

R's epilepsy was independently treated by a neurologist. Phenobarbitone (30mg at night) and carbamazepine (200 mg twice a day) led to the control of seizures. Behavior therapy (BT) for transsexualism was begun about three months after the medical management was successful. The program sought to reverse (a) the female role indoctrination, acceptance and practice (dating back

to childhood) and (b) the male sexual preference. The BT package developed for the case was chosen based upon R's case history as well as upon components of BT described in successful BT of transsexualism (Barlow et al, 1973 & 1979). The techniques have been detailed by Brownell and Barlow (1980).

Treatment was conducted on an inpatient basis for two reasons: Firstly, it was expected that therapy would generate considerable anxiety and frustration; as an inpatient, R would be easily accessible for timely resolution of distress. Secondly, R had no social supports in the city, and he could not afford to make private arrangements for boarding and lodging; he therefore opted to stay as an inpatient, receiving free treatment. Since daily sessions were planned, this arrangement was most convenient to all concerned.

As many of the components of the BT program were likely to induce anxiety, treatment commenced with 20 once-daily sessions of (Jacobsen's) progressive muscular relaxation. This phase of therapy helped R to reduce his overall anxiety level. Relaxation was subsequently continued with later components of the program.

Twenty sessions of aversion therapy followed: an electric shock accompanied slides of attractive males while relief from shock accompanied slides of attractive females. The procedure sought to inhibit pleasurable responses to male cues and to facilitate such response to female cues. Aversion therapy with aversion relief, like relaxation, was continued during the subsequent program. The remainder of therapy, spanning about 40 sessions, comprised modelling, hypnosis, orgasmic reconditioning, behavioral counselling and sex education.

Modelling involved correction of his feminine style of walking, talking, emoting, relating, dressing and non-verbal communication. Three sessions of hypnosis attempted to reinforce the masculinity engendered by the aversion and modelling sessions. Orgasmic reconditioning, practiced alone, involved introduction of female cues when masturbatory orgasm was imminent, thus putatively reducing the arousal threshold for female cues. Behavioral counselling involving reorganization of hobbies, restructuring of interpersonal relationships, and adoption of problem solving techniques, sought to foster masculine behavior and responses and diminish femininity.

Sex education on coital and reproductive physiology and processes, filled in the gaps in his knowledge and clarified existing doubts and misconceptions. The inpatient therapy spanned about three months of daily sessions, each of about 1 to 1.5 hour's duration. After R's discharge, weekly one hour sessions were conducted for three more months. These sessions in essence continued the inpatient program. This intensive behavior package progressively reduced the fixity of R's belief in his feminine gender. At the end of six months, he achieved the I-male stance.

The I-male stance was maintained over two years with booster sessions. These booster sessions were conducted at roughly three month intervals and involved one or more one hour (once daily) sessions per occasion. During booster sessions, behavior during the period of follow up was reviewed and specific issues, as may have cropped up during the interval period, were dealt with. Regular practice (during the intervals between follow up sessions) of relaxation, orgasmic reconditioning, and of issues handled earlier (e.g. during modelling and behavioral counselling) was confirmed. Essentially, techniques employed previously (modelling, behavioral counselling etc.) were reutilized.

As R's perception of his gender was unequivocally male, he no longer was a transsexual. However, his sexual arousal to female cues was weak, while that to male cues remained powerful. Thus, his homosexual inclinations persisted.

DISCUSSION

The etiology of transsexualism has been well reviewed by Hoenig (1982). We do not propose to argue an organic basis to our case. Certainly, temporal lobe abnormalities have been etiologically implicated in transsexualism but, as Hoenig shows, the argument is nebulous and weak. While it is theoretically possible that control of epileptic discharges from the temporal lobe may have led to time dependent changes in sexual orientation, in our case progressive change in gender identity conviction seemed, rather, to accompany the ingredients of the BT programs.

Prominent in R's early history was the consistent reinforcement of cross gender behavior by all significant members in the psychosocial environment (why this should have occurred was unknown to R; since no family member was available, no clarification could be sought). Hypothetically, this could

explain the confused gender identity. BT could therefore be considered as the logical therapeutic modality.

The therapeutic implications are that BT may be the treatment of choice in cases in which the environment has played an important role in the genesis of the condition. Unfortunately, literature on therapy of transsexualism does not differentiate between transsexuals of different etiology. This may be because, as discussed earlier, etiology is difficult to establish, and because the area is riddled with controversy. Had this not been the case, it may have been easier to establish why BT was effective in the few case reports of successfully treated transsexuals - those of Barlow et al (1973, 1979) - where a BT package similar to the one used in this case had been utilized. To our knowledge, there are no other reports of transsexualism successfully treated with BT. Indeed, there are few reports of any form of therapy being successful for transsexualism. Hoenig (1982) has listed the successes of conventional and eclectic psychotherapies in transsexuals.

It is hard to explain why BT effectively changed R's gender identity but not his homosexual inclinations. Possibly, the inescapable biological masculinity nonspecifically assisted therapy directed towards gender identity change while the learning of years associated with continued social acceptance and reinforcement from prospective male homosexual partners impaired the effectiveness of

therapy directed towards altering patterns of sexual arousal. Environmental factors did not permit an intensive focus on R's homosexuality once the gender identity symptom had been resolved. Had the situation been favorable, further therapy specifically directed at the homosexual inclinations could have been undertaken.

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