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The Treatment of Transvestism and Transsexualism

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There is no adequate treatment for either transvestism or transsexualism; what follows will only emphasize this opinion.

Our discussion will be confused unless transvestism and transsexualism are defined. Not all conditions in which there is dressing up in the clothes of the opposite sex—cross dressing—are transvestism. Momentary transvestic tendencies are seen in many children; some homosexuals cross-dress on occasion; and if one judges by the frequency of transvestic references nowadays, in books, plays, movies, and jokes, many adults who do not need to cross-dress are nonetheless interested in its manifestations. However, transvestism is different from the above. The transvestite wishes to be accepted in society as a woman at the same time as he wishes to remain a male.* He starts (except in children, who will be discussed later) as a fetishist, with a single garment producing excitement, gradually progressing until an equally impelling need develops —the desire to appear, when dressed, so much like a woman that he can pass undetected for one. That part of transvestism which is fetishistic serves, as do all perversions, as a preserver of sexual gratification, (potency), without which, either in practice or when used in fantasy, the man's sexual capacities are severely crippled. The fact that the transvestite's sexual response is so restricted by this unusual practice contributes to the fierceness of the need and the intensity of the pleasure, making treatment—since it aims at removing this pleasure—so difficult. However, in addition to the fetishism, with its sexual excitement, is the nonsexually exciting need to take on the role, especially the femininity, of a woman. This is a matter of having identified with women (not merely imitating them) and can lead the transvestite to run the great

*The word "woman" will be used to imply an identity, a gender, and a role—psychological qualities; "female" implies only biological attributes of sex; likewise

risks of social humiliation or arrest if he is caught trying to pass as a woman. In addition to passing, almost every transvestite also lives part of each day undisguisedly as a man. There is great satisfaction for him in telling himself he is able to be *both* a man and a woman. Crucial is his constant awareness, whether sexually excited or not, that he has a penis and thus is a "woman with a penis."

The above description excludes all other types of people who cross-dress, even the transsexual. The transsexual is different in that he does not wish to alternate between being a man and woman but rather wants to be changed by any devices known to medicine to be both a woman and a female.* He gets no sexual excitement from clothes and will gladly sacrifice his genitals to live a woman's role.

Therapy

In the first place, the transvestite does not wish to stop being a transvestite. He would like society to change so that he would be safe; this not having happened, he will occasionally seek out a psychiatrist to learn how to avoid the fear, shame, and guilt produced by society's attitudes. Although he may ask the psychiatrist to cure him of the transvestism, what he is really asking is to be cured of his pain. He generally does not consider his transvestism to be painful. Quite the opposite, it is most enjoyable; what it stirs up in others is what leads to the pain.† So when the transvestite discovers that the doctor's goal is the removal of the syndrome, the patient leaves.

There are variations in the above discussion of ego syntonicity. In adolescence the transvestite will feel evil and a freak, but the pleasure is too intense to be stopped. Later on, the man may have fits of remorse and disgust after orgasm, throw away the clothes and, if he has been caught at it, come to the psychiatrist filled with strong motivation to change. This almost always passes off after one or two visits. Rarely, a patient will continue in treatment for months or years, but the reports in the literature of extended treatment end with such a statement as: "The patient was improved but moved before treatment ended."

I would consider a transvestite to be cured of transvestism if, without

*Note that the transvestite wants to be a male and a woman but not, as the transsexual wishes, a female and a woman.

†I have been unable to determine, either from the literature or from patients evaluated or seen in research-treatment, to what extent their guilt is an inherent part of the complex psychodynamics at the heart of the condition and to what extent it is the effect of society's fear of and indignation at cross-gender impulses. Practically speaking, the amount of guilt felt by the transvestite is insufficient to [illegible] how to deal with society.

the need for conscious control—inhibition, suppression, denial, avoidance, or courage—he no longer cared to cross-dress, had not substituted barely disguised but similar forms of sexual or gender role behavior, and was now potently and pleasurably using a woman with whom he had an affectionate relationship for his sexual gratification. (This would be asking a lot of most men, not just transvestites.) In other words, his character structure would have so changed that he now wished to maintain the differences between men and women, no longer needing to merge with women now that his excessive identification with them had withered.

Certainly such changes do not seem impossible. To a lesser degree they may occur in the normal development of children and adolescents and in the treatment of some effeminate men, whether practicing homosexuals or not. Oddly enough, there is no case reported in which one can feel this has occurred with a transvestite.* The few psychoanalytic wrtings on the subject reveal that the treatment has illuminated the psychodynamics, but in no case in which the descriptive material is that of a real transvestite is it clear that the patient lost his perversion—either the sexual (fetishist) aspect or the gender (the desire to pass as a woman).[2-9] This holds true for the rest of the psychiatric literature except for a very few recent papers to be discussed.†

The only recently reported treatment for which more than one author shows enthusiasm is that called aversion therapy, conditioning, negative conditioning, or behavior therapy. These reports show a resurgence of interest in the use of repeated applications of pain or vomiting that were in vogue 50 years ago and sporadically since (e.g., in the treatment of alcoholics). While the theory has become more sophisticated, the techniques have retained their simplicity: painful electric shock to the edge of agony or monumental bouts of vomiting, these administered while the patient dresses in his favorite garments, looks at photographs, or listens to tapes of himself describing himself as a transvestite, etc.[16-29]

I am prejudiced against these techniques‡ and worried that learning

*Although one report, suggesting personality change, is optimistic, the follow-up is superficial.[1]

†Because this is a biased statement, I should note there are sporadic reports[5,6,10-15] of patients who are described as better, relieved, improved, etc., but it is not really clear what was done in treatment, why the patient changed and what were the manifestations of the change or in some cases even if the patients were transvestites or more simply fetishists.

‡So are others.[30-34] ". . . I submit that electric shocks [faradic aversion treatment] are in the same category as the flogging, ducking, and corpse-fring of the

theory is being prostituted into a device for flailing at psychoanalytic theory and data, and fearful that such forms of treatment might become facile techniques for cruelty in unscrupulous hands. Still one must be cautious about claiming the only true faith. There are many treatments in medicine which may be brutal for patients but when properly used are the best that we as yet have to offer (e.g., EST in the psychotic depressions). If the goal of the treatment of the transvestite is set as being the removal of cross-dressing, if nothing else has been of use, and if aversion treatment removes the activity, then it should be used—if. The next series of "if's" takes us into an even soggier swamp, the whole issue of who defines what is antisocial behavior and the extent to which this behavior endangers society or its individuals. How much pain should be inflicted on a patient to make him conform? For the homicidal individual, a great deal. How much for the transvestite? To what extent does society's lenient attitude cause deviant behavior to increase? Does deviant sexual and gender behavior weaken a society? What does "weaken a society" mean? How do we discuss transvestism and its treatment if we haven't the answers to these kinds of questions?

The recent optimistic reports of the aversionists leave a therapist hungry with hope and a skeptic skeptical. If the treatment works and there are patients who want it, the misery should be worth suffering; we must not discard a treatment that is of use simply because it is not the kind we prefer for theoretical, moral, or idiosyncratic personal reasons. Thus far, however, the number of successes is very small, the follow-ups too short, and the method of checking if the treatment has worked either skimpily reported or skimpily applied. ("Are you better?" "Yes." Good—the patient is better.)

Let me report briefly a "cure" that I observed but played no significant part in, and as one picks holes in the argument he can experience the kind of skepticism some of us feel regarding any cures of transvestism ascribed to *any* method of treatment.

I had been seeing this man, a typical transvestite, for about a year. He would not consider himself a patient but rather a research subject, though I was aware that his occasional visits were motivated by more than his willingness to assist in the research. As distinct from most transvestites, he had a clear though mild paranoid quality, which put him into closer contact with some of his psychodynamics than the typical transvestite. Sometime before his first visit, he had gotten from some reading the idea that transvestism and homosexuality were connected. To determine if this were true for himself, over a period of several months [illegible] visited "gay" bars and read increasingly

about homosexuality. (I take this to be evidence of homosexual desires, still forbidden, nonetheless moving toward conscious gratification.) Along with this interest, he coerced his wife into sexual games in which homosexual qualities were increasingly manifest. This was accompanied by a crescendo of anxiety, irritability, suspiciousness, depressive fits, and hyperactivity, culminating in a paranoid psychosis precipitated by his having his wife, dressed like a prostitute, attach to herself an artificial penis he had made, with which she then performed anal intercourse upon him. Following this finally quite conscious gratification of his homosexual desires, he became suicidal and homicidal. As we talked throughout the several hours of this emergency, he vividly expressed his opinion, derived possibly in part from his readings but mainly from his own psychotic thoughts, that his transvestism had been an attempt to keep himself from sensing his homosexual desires. As he absorbed what he was saying, he became calmer. He also stopped his transvestism. Since that moment, a year ago, he has not practiced it again.

A psychodynamic remission. He now has insight, the product of his psychosis and the cause of his remission. Where formerly a potential psychosis was held in check by the complex character structure we have called transvestism, the psychosis is now contained by insight. But is that the answer? Is there proof this is so? Would a recurrence of the psychosis prove the thesis wrong?

The patient now says that he no longer has any desire to dress. He has given away the clothes, makeup, wigs, transvestite magazines and books, and the clothes catalogs. When he sees a woman wearing articles of clothes the sight of which would formerly excite him, he feels no lust (nor disgust either). His wife corroborates all this, although, since she cannot climb into his mind and know all he thinks, she still fears it might start up again. (To what extent do her fears that he might indulge press him toward doing just that?)

Yet it is with as inadequate data as the above that we must judge the results of treatment reported in the literature. In this case, the time of remission has been too short to say that his "self-cure" has worked. Many transvestites are known to have periods of disgust or fear in which they swear off their perversion and get rid of their paraphernalia. Under sufficient provocation—and a terrifying psychosis may be as effective as a course of apomorphine, electric shock, or a jail sentence—transvestites can refrain from months to years.

The point is this: It is too early to be enthusiastic about results of aversion treatment. If it turns out that its users can effect long remissions in many cases, without a high price in substitute symptom formation or

overlying crippling inhibitions, then this painful therapy will be valuable. Until then it cannot be reported that it is the proper treatment for transvestism.*

Another form of treatment that might be considered is castration. Legislation permitting this under certain circumstances for managing "sexual psychopaths" has been enacted in California and Scandinavia. The loss of testosterone would undoubtedly drastically reduce the number of orgasms the transvestite enjoys from the fetishistic aspect of his perversion; it probably would not effect his desire to pass as a woman. Transvestites who have lived into their 60's and 70's note a decrease in sexual desire but none in the desire to cross-dress.

Since transvestites do not endanger other people, there is no rationale for forcing them to be castrated.

For the sake of completeness, we can note reports on two other types of treatment. The first[35,36] is that of a borderline patient who was a transvestite and gave up his transvestism under nialamid, meprobamate, and chlorpromazine; after maintenance dosage for four years he is reported in "good mental health." It is not clear how extensive the follow-up evaluation has been. At any rate, this method has not yet produced a wave of former transvestites successfully treated with phrenotropic drugs.

The second report is that EST made two transvestites feel better.[37]

So far, this discussion has concerned only men. What about women? While women cross-dress, they do not fulfill the other criteria for a diagnosis of transvestism. Our society permits normal women to wear mannish clothes or even men's clothes. In addition, cross-dressing is seen in some homosexual women. However, this is not fetishistic, and they are not trying to pass as men. On the contrary, it is a preoccupation with them to let the world know that they scorn men and feel them unnecessary.

There are, however, a very small number of women who wish they were men and who pass as men. They are not transvestites but transsexuals and do whatever they can to obtain sex transformation operations.

In other words, although there are many *transvestic* women, I doubt if there are any *transvestite* women.[38]

Transsexualism

It is impossible to discuss the treatment of transsexuals without becoming involved in moral issues. The transsexual, unlike the transvestite, does not wish to remain a male† but wishes to have his body changed so that

*See also Coates[31] for a reasoned display of skepticism.

†For simplicity I shall discuss this primarily in terms of males.

he becomes as completely female as medical techniques can contrive. In addition possibly to threatening the masculinity of the physicians to whom the transsexual makes his request, the patient treads on ancient feelings in society regarding the preservation of fertility. Then too, of a more practical nature, the surgery is extensive and not without danger; being of a completely elective nature—the indications are purely psychological—one hesitates to embark on cosmetic procedures that are so much more intricate and hazardous than fixing a nose.

The most troubling aspect is that the easier it is to have such procedures done, the more patients request them. As the word gets around, as it has in the last decade or so, more and more effeminate men request to be changed. Lumping them all together in one category leads to the implication that anyone making such a request is a transsexual.[39,40] If it is a surgeon who oversimplifies these differences in gender identity, and there is no one to stay his hand, there will be tragic consequences. For the effeminate homosexual who prizes the pleasures his penis brings him with other men or for the transvestite who so enjoys his fetishism and the sense of being a woman with a phallus, the realities of having been castrated can be disastrous. For the patient, this may mean a severe depression or paranoid psychosis, and for the physician the treacherous uncertainties of the medical-legal issues which have still not been clarified by the courts.

The general rule that applies to the treatment of the transsexual is that no matter what one does—including nothing—it will be wrong.

First, what happens if the procedures are completed? It is a fact that can be proved only by having seen transsexuals (not pseudotranssexuals) in intensive follow-up from months to years after they have completed their "sex transformation" procedures that many are better adjusted (we won't pause to document that vague term) postoperatively than they were before. Their anguish before the procedures is intense and genuine (one of the many points distinguishing their reactions from pseudotranssexuals). Nonetheless, they are left more or less dissatisfied, feeling that although the procedures have feminized some of their appearance and functions, the results are far from complete. The transsexual will wish not only breasts, vagina, and femalelike external genitalia, absent facial and body hair (all of which can be supplied) but also ovaries, uterus, and fertility. So if the surgeon complies with the patient's request, he is likely still to be harassed by the patient, who wants more. Some are sexually promiscuous and some become entertainers who capitalize on their notoriety. In addition, these patients are exhibitionistic and unreliable as manifested in the office by a high rate of missed appointments,

lateness, and peculiar distortions of their history even in areas outside of the development of gender. These qualities make working with such patients distasteful for some physicians.* (It adds nothing to our knowledge to apply the coup de grace by dismissing them with the statement, "They're all psychopaths.") Pauly, in his excellent review of 100 cases of transsexualism, concludes that, "Follow-up studies at the present time indicate some apparent success, but these results must be interpreted with caution."[41]

On the other hand, if one does not assist them they are deeply unhappy. The argument against treating this unhappiness by surgery or hormones is exemplified by the following: ". . . if . . . the demand for a change of sex operation is based upon a delusion [sic] conviction, then only the treatment of the underlying psychoses or personality disorder is in my view admissable or correct.

"Sometimes such patients are suffering from schizophrenia and are overtly psychotic; sometimes it is hard to see where, apart from their singular and absolute rejection of their own sexuality, their judgment is in other ways abnormal. In either case only such treatment as will enable them to come to terms with the reality of their condition is open to the psychiatrist to offer or endorse."[42]

One would not give a throne to a psychotic who delusionally felt he was a king; is it not as irrational to grant the transsexual his request just because he is unhappy? The cases are not parallel, however. Psychotics who want thrones do not become less disturbed even when they become kings, but most transsexuals are less depressed and anxious, more sociable and affectionate, etc. after "the change." Also, very few transsexuals are clinically psychotic. (While I have heard of such, in my limited experience, I happen not to have seen one who was, although one or two were a bit frayed at the edges.) Their "delusion," coming from sources we have not yet found, is placed in a setting of intact reality testing. Almost all of these patients know their request is strange; they do not question that society considers them bizarre; there is nothing grandiose or persecutory in their thinking; they are not trying to change the world or to construct a philosophic system to impose on others, etc. I go into this detail only so that we can avoid the simple answers that come by using simple words like "psychotic" and "delusion" rather than describing the data as we observe them.

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*These qualities have not been present in the few transsexual females with whom I have worked. Such patients have been dependable, quietly determined, and without flamboyance. As a result they became quite successful in living their inconspicuous lives as men.

However, for all this, if there were any psychiatric treatment that were even partly useful, it would probably be better than this disquieting "psychosurgery." It has been suggested[43] that "no psychotherapeutic procedure less than intensive, prolonged, classic psychoanalysis would have any effect. If properly done, it could probably reduce the patient's agitation and the level of his unhappiness. It is not impossible that his major symptoms may decrease in frequency and urgency." This statement has the vigorous ring of sober caution; it also must have been written by someone who has never tried to get such a patient into analysis. Unfortunately, no one has ever reported such success by any psychotherapeutic technique. We must search for such techniques, but in the meanwhile it seems haughty to say that "only such treatment as will enable them to come to terms with the reality of their condition is open to the psychiatrist to offer or endorse." Since we have nothing to offer or endorse that can give these patients any relief, to make this a rule to put into practice when sitting in one's office with the patient who asks your help means to do nothing. The problem for the psychiatrist then is only should he do this nothing gracefully or horsewhip the bloody beggar off the compound.

Benjamin, who has treated more patients requesting sex transformation procedures than anyone else, has a method of evaluation and treatment on which he has reported favorably.[44,45] After weeding out those patients who are psychologically obviously unsuited, he suggests to his candidates that they actually pass as women for many months. He has found that for some, while the fantasies of being a woman are very rich, the rigors of living as a woman are either too frightening or the person is too masculine to be able to keep it up. During this time, Benjamin prescribes estrogens, feeling that they not only give the patient an inner sense of femaleness and an observable change in body contours, but that the estrogens in themselves have a tranquilizing effect on males. If after this trial, it is Benjamin's opinion that the patient is still highly motivated and sufficiently feminine, he then refers the patient for surgical procedures. When these have been performed, he continues to follow up these patients indefinitely. He has reported on 40 patients followed postoperatively; 34 were "satisfactory" (on a three point scale of satisfactory, doubtful, or unsatisfactory).

At this point it is worth mentioning a practical difficulty that arises should the psychiatrist choose to recommend a patient for such surgery. Practically no such procedures have been performed in the last few years in major American medical centers (with the exception of patients who had already gotten parts of the operation done somewhere else or where

the patients had already mutilated themselves). There is a lot of secrecy involved in finding a surgeon who will cooperate, and even then the patient must have thousands of dollars. These operations are not being done in medical centers with facilities for nonpaying patients except in the rarest of instances. Although there are clinics in foreign countries where "sex transformation" surgery is performed, it is alleged that not all routinely adhere to the rigid standards of asepsis familiar in American operating rooms.

It is unsettling to realize that transsexualism was scarcely an issue for physicians until a few years ago. This knowledge may annoy physicians who are aware that had the techniques not been applied to transsexuals and then publicized, such people would have contained themselves, as hopeless people certainly can do. Considering the nature of this subject, it may be unwise to say that Pandora's box has been opened, but it is true that we have to come to terms with the problem. We cannot legislate it away, probably, and we do not know how to treat it psychiatrically.

I would suggest, because these procedures may be disastrous if used with the wrong patient, that they not be used except as research techniques. This would mean that they should not be done simply because the patient has the money to afford bootlegging. They should not be used unless the patient has been studied in depth and for at least six months by a team of psychiatrists, psychologists, endocrinologists, and urologists. For those who do go to surgery, the follow-up should be intensively pursued for at least a year and then at least several times a year for years, with the patient actually being talked to by members of the team. Participating physicians should be legally protected from suits. In the course of such a program, we shall not only learn about the treatment of transsexualism, hopefully so much that one will not need to continue using these procedures, but, more important, about the sources and manifestations of gender identity.

Children with Gender Perversions

This chapter can be closed with some comments, partly chilling and partly hopeful, about children with gender perversions. It is becoming apparent from reports in the literature,[46,47] which are confirmed by my own experience and that reported informally by colleagues in this country and in Europe, that childhood transvestism is much more common than we had imagined and that it may start very early, sometimes before age 1.[48] I do not mean the unremarkable manifestations of occasional, low intensity transvestic behavior, but rather the overpowering, flagrant, habitual urge to cross-dress. There are no reports of any child with this

true transvestism being followed into adulthood, but considering the hold with which this passion seizes the child, it is most likely that its natural history leads to adult cross-dressing. (I would guess that it is from these children that the transsexuals come, both male and female).

What is hopeful is that we have a few clues that the process might be modified. There are a couple of reports of transvestite boys[49,50] who, with their mothers being simultaneously analyzed, gave up their cross-dressing and other feminine interests, this accompanied by changes in character structure beyond those naturally occurring with growing up. However, there are as yet no adequate follow-ups.

At this time then, it seems that prevention by education of parents or treatment of the few who can be given such treatment are the best hopes in childhood transvestism. Unfortunately, the former requires a revolution in the attitudes of many parents and of our society (which is moving all too rapidly toward massive blurring of gender differences), while the latter is still terribly time consuming and experimental.

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