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Editor's Note: The following two articles by Thelma F. Shtasel, PhD, and Thomas N. Wise, MD, describe two patients who request sex reassignment surgery. Both cases share interesting and unique features that deserve comment. Dr. Gene Abel, in the third article discusses some of the issues raised by these contributions in reference to the evaluation and treatment of self-diagnosed "transsexual" patients.

Behavioral Treatment of Transsexualism: A Case Report
Thelma F. Shtasel, PhD

ABSTRACT: Patients who believe themselves to be transsexual seek only confirmation of their diagnosis so that they may proceed with their pre-chosen course of management: hormones and surgery. Their syntonic emotional set generates resistance to any other therapeutic direction. Despite this attitude, it is the therapist's responsibility to assess each case individually and to decide, with the patient, on realistic goals even if they be different from the original one. This case emphasizes this need since a probing history revealed underlying conflict and anxiety related to severe homophobia. With revelation of the homophobia, various behavioral techniques could be used therapeutically. These resulted in acceptance of lesbianism as a life style. Careful assessment of patients with self-diagnoses of transsexualism can sometimes uncover a different etiology to which appropriate therapy can be applied.

Patients who believe themselves to be transsexuals represent a unique challenge to the therapist. Perhaps they, more than any other group, present themselves with both an established diagnosis and a predetermined decision as to their management. They are not the typical client seeking a diagnosis and therapy from the therapist. They are seeking
from the therapist the final validation of their own diagnosis, which will then permit a sex-change procedure, performed by a surgeon, which they have already deemed essential to their cure. The therapeutic challenge and duty is to question the diagnosis. Is the proclaimed transsexual truly transsexual?

A typical background history of the transsexual includes a sense from early childhood of "being in the wrong body." Cross-dressing in early childhood, interest in what society generally accepts as opposite-sex choice in sports, play, and occupational roles, plus an intense desire to change identity and live the opposite-sex life style are commonly revealed. Desire for a normal life, including marriage and raising a family, are the treatment goals desired.

If all of these conditions are satisfied, then the diagnosis is confirmed. However, as Pomeroy has written, "Some homosexuals, because of societal proscription, have developed such phobic reactions regarding expression of homosexual interests that they believe themselves transsexuals, and would rather give up their gender than face a life of homosexual behavior." It is mandatory that the therapist explore this possibility and differentiate the homophobe from the true transsexual.

In the case to be described, the self-diagnosis of transsexualism served to reduce anxiety associated with homosexuality. The homophobia made the acceptance of lesbianism impossible. This case illustrates the extreme importance of differentiating not just female transsexualism from lesbianism (or, indeed, in the male differentiation of homosexuality, transvestism, and transsexualism), but the need to look at individual behaviors as covering the anxiety of the underlying phobia. In the following case report, having uncovered the phobia, it was possible to deal in a behavioral way with reducing that anxiety and thus allow the patient to lead a lesbian life style without distress and, of course, without having to undergo the expensive and radical procedures necessary to sex change, which are irreversible and with unknown consequences.

**CASE HISTORY**

The patient was a 25-year old, black high-school teacher. She was the youngest of 12 children, of whom 5 were boys and 7 were girls. The family grew up in poverty; the father was an alcoholic and the mother chronically ill. The patient was very close to her mother and empathized with her in relation to her difficult marriage. Closeness to the father at any time was denied. The mother died of a stroke when the patient was 9 years old.

This young lady described herself as a youthful tomboy, aggressive and independent as a child. Between the ages of 7 and 10 she felt attracted to her brother's girlfriend. She was "in love" with another girl friend when she was 12 years old. Exploratory games with boys from the age of 5 through 12 engendered feelings of disgust. She denied cross-dressing. Menses occurred at the age of 12, at which time she suffered painful cramps and "hated it." She was displeased at having to give up her tomboyish behavior and act like a girl.
While in junior high school, she was seriously attracted to a white female, but this relationship remained a casual one. In high school she became intimate with her physical education teacher: originally because of their mutual interest in sports and subsequently as a consequence of deep involvement in a religious group organized by this teacher. It was through this group that she met the partner with whom she lived and had a sexual relationship for 8 years. The patient and her partner had similar backgrounds in terms of extreme poverty and family deprivation, and both were committed to strong religious involvement. Both strongly disapproved of homosexuality, also.

Sexual relations with this partner began and continued from the age of 17. During part of this time these two women lived together. During the entire period, the patient never considered herself a lesbian. She could not have tolerated that social disapproval. From the age of 16 she had assumed she was really a male, and thought a change in her body from female to male would be desirable.

Sexuality was stereotyped and followed one pattern only. This consisted of the patient initiating sex, behaving aggressively, but not permitting her partner to respond physically. She would not allow her to touch any part of her body which she considered female; that is, breasts or genitalia. Orgasm was achieved by "grinding."

During college the women were separated. During this time the patient did not date men, although her partner did. In fact, the patient had a transitory sexual relationship with her female college roommate during the separation. After college the two women moved together, and the patient spoke often of sex-change therapy, although her partner reacted to this with great apprehension. The partner continued to date men throughout the 8 years during which they lived together.

The relationship between the two women became very stormy and was marked by frequent arguing and hostility, in large part because the patient's partner realized the world would consider two women living together lesbians. She also felt constrained sexually because she was not allowed to do more than remain passive. Jealousy and general dissatisfaction led the patient to suggest a trial separation, to test the partner's affection for her.

During this trial separation, the partner met a young man and in short order became engaged and married him. The patient was distraught and made efforts to win her back. However, the former partner told the patient she had accepted the patient as female during their relationship, never as a male, and could not be happy with her. At this juncture the patient, still in love, decided to enter therapy and seek an endocrinologist to start sex-change procedures. She felt confident at this time that as a male she could compete with her former partner's husband and perhaps win her back.

**TREATMENT**

Endocrine studies and examination by a gynecologist were conducted, and all tests were normal for a female of this age. Psychotherapeutic procedures fell into two major phases:

**Phase One**

Following extensive history taking and a behavioral analysis, cognitive distortions were revealed and corrected. These centered mainly on the patient's conception of her relationship to her female partner of 8 years and vice versa. We focused on a consideration of how she was seen through the eyes of her partner. Although originally denied, she came to realize that her partner had never really considered her a male despite
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her protestations and was not eager for sex-change therapy to take place. The partner had suggested that this would not keep her in the relationship, which she was finding increasingly difficult anyway. Issues of masculine versus feminine behavioral patterns were dealt with in a consciousness-raising framework. The patient's youthful interest in sports, boys' games, and casual dress were reevaluated as appropriate to either sex. Her lack of cross-dressing as a child as well as her early sexual attractions to girls were reexamined in terms of congruence with homosexuality. This idea caused the patient considerable distress and was for some time unacceptable to her. We related sexual orientation attitudes to social learning: the influence of cultural mores which determine, for various socioeconomic and religious groups, what behaviors are acceptable. These were then applied to the black lower socioeconomic strata of society and the deeply religious orientation from which the patient came.

The patient's partner later became a patient herself, and it became manifestly clear that she was not a lesbian. Her relationship with the patient served as a protection from her father's prophecy that she would become a "slut" if she associated with males. Protection was also afforded from a lifetime of casual sex, i.e., being a whore, like her mother. (The latter had had intercourse with a succession of men in her presence during her childhood.) Thus, living together solved each woman's problem—the patient denied her lesbiansim by associating with a woman who was straight, and the partner was prevented from fulfilling the whore prophecy enunciated by her parents. (The partner was never attracted to other females but often to males. Her present marriage is, in fact, a happy one, both sexually and emotionally.) Neither woman, however, could tolerate the adverse reaction of family or society to being considered lesbian, thus their destructive relationship.

During this cognitive restructuring phase, the patient finally admitted her own dissatisfaction with the sexual relationship in which she had lived. She described lovemaking as a "chore," "a great effort" in which she had to please her partner although she really would have liked to have been pleased too. However, this was something she would not allow her partner to do for her.

Phase Two

In this phase the emotional response to homosexuality was altered. Homophobia was discussed, and systematic desensitization suggested to alleviate the anxiety without altering the gender identity, if it were truly transsexual. The patient agreed that this procedure was more benign than surgery, than hormone therapy, or even than living as a male.

Systematic desensitization consists of teaching a new emotional re-
sponse to replace that of anxiety. The patient, while deeply relaxed, is asked to imagine a situation which ordinarily would produce anxiety. These situations are arranged in hierarchial order from least to most anxiety evoking. When the lower order situation can be imagined without anxiety, the next higher scenes are presented for the patient to imagine. The patient prepared the hierarchy of items relating to lesbianism which produced acute anxiety in her. Some of these situations were as follows:

1. Derogatory remarks by colleagues about homosexuality
2. Remarks by students about homosexuality
3. Gynecologist asking about sexual activity
4. A woman touching her affectionately
5. Approaching a female to express interest in her
6. Attending a public or private social affair, night club, etc. in which overt homosexuality is displayed
7. Someone entering her home and seeing her living with a female companion
8. Telling acquaintances, business associates, and former classmates that she is lesbian
9. Thoughts of seeing two homosexuals being affectionate in public
10. Moral feelings that homosexuality is wrong
11. Being touched sexually as a female by a female
12. Meeting friends in a variety of social situations in which she is accompanied by a regular female partner

Desensitization was begun in February 1977 with the presentation of 11 scenes. This was followed by 30 more imagined situations over the next three sessions. Six weeks after beginning desensitization, the patient was making inquiries into the gay world. Her first foray consisted of attending a gay film festival, where she felt a bit on edge. She obtained a list of gay places and visited one in New York. She did not find the women attractive, however.

One month later, the patient reported finding a club in New York where she felt very comfortable and enjoyed herself. Her affect was considerably changed from flat and somewhat depressed to animated and involved. Although she was still attracted to the idea of cross-dressing, hormones, etc., she decided to defer this action until she had sampled more of lesbian living.

During this period the patient had several occasions to have sexual relations with her former partner. These were more like testing situations in each of which she felt “short-changed”. She had met a lesbian woman at the club, felt comfortable with her, and was anxious to pursue this new relationship. Interestingly, the lesbian friend was the sexually aggressive one and the patient more passive.
On our next to last visit, the patient related that her new gay friend and she had had sexual relationships and she had even let herself be touched. At this time she decided to take a vacation and was considering moving to the West Coast. At our last session the patient stated that she and her new gay friend had gone on vacation together and were more involved than she had anticipated. In fact, they were going to California together to live. The patient never appeared so feminine as at this session; in fact, she came braless!

Two months after termination, the first of three monthly letters arrived from California. They expressed contentment in her present relationship and sexual orientation.

**SUMMARY**

This case demonstrates diagnostic and treatment difficulties when a patient presents with all the "right" symptoms of transsexualism. We have established criteria for differentiating homosexuality and transvestism from transsexualism, but homophobic patients can cloud the distinctions. They know as well as we how the differential diagnosis is made and come forearmed. Therefore, it behooves us to look for and treat phobic relations to homosexuality before proceeding with the irreversible treatment of transsexualism.

**REFERENCES**