Transgendered people: the plasticity of gender

Introduction

Even the earliest written records (that is from roughly about 5000 years ago) contain evidence of variations in gender identity, including evidence of the existence of individuals we might now call intersexed or transgendered (Markowitz et al. 1999). In modern times the legal and medical treatment of both intersexed and transgendered people has sparked debate which has extended beyond the bounds of the therapeutic and into the political realm. Transgendered and intersexed people can present therapists with a range of predicaments and dilemmas particularly if they are supposed to control access to certain treatments. In this chapter the spectrum of intersex and transgendered conditions is outlined. Then causal theories are reviewed followed by a preliminary discussion of direct treatment options. Political debates are aired next and this paves the way for a more differentiated discussion of the role and value of psychotherapeutic treatment.

Definitions

Intersex

In intersex conditions a child is born with genitalia which are ambiguous between male and female morphology or discordant with chromosomal sex. These conditions may result from anomalies in development or from inborn errors of metabolism which expose the developing foetus or infant to abnormal levels of hormones. They manifest at all ranges of severity from the barely

noticeable to severe abnormalities with life-threatening consequences. Androgen insensitivity syndrome (AIS) is one of the commonest causes. It results from insensitivity to testosterone, which causes genetically male individuals to be born to a greater or lesser extent feminised in their external appearance. Because the development of the internal genitalia initially proceeds independently of testosterone people with androgen insensitivity syndrome who appear to be female have two rudimentary testes found in the abdomen, groin or labia. These structures, ironically, produce some oestrogen and this produces the feminisation. Many children with this condition are assigned a female sex at birth and are raised as girls. Often the first sign of anything wrong is failure to menstruate and go through a normal puberty. Almost all have a secure female gender identity (their chromosomal sex notwithstanding) and their main psychological problems arise over issues of fertility and of secrecy:

Frances presented in distress, at the age of 22 after a consultation with an English physician. She had consulted him because she still had no menstrual periods. The physician had examined her and diagnosed androgen insensitivity syndrome. His explanation of the syndrome was abrupt and unsympathetic, possibly because he found it hard to believe she did not know the nature of her condition. She became distressed and was referred for assessment. Frances was born in Germany and raised by loving parents who had frequently taken her to the doctor for check-ups of a condition which they never quite named. Her failure to menstruate had been dealt with by explanations that some women didn't menstruate for a while and assurances that everything would be “fine in the end”. Frances needed help to cope with a range of issues, such as the sudden loss of her expectations over fertility, her sense of betrayal by her family. She also needed to have an operation to remove her residual testes which, her doctor told her, might become malignant. She firmly identified herself as a woman and found the revelation of her male chromosomal sex irrelevant to her gender identity. She wanted therapy to cope with her infertility and found the removal of her testes difficult because she felt emotionally that her only hope of fertility was being removed.
Francis presented as a typical case of androgen insensitivity syndrome which seems to have been dealt with in a somewhat old-fashioned manner. From a psychodynamic perspective her regret over losing potentially cancerous testes could possibly be ascribed to sadness over losing a residual sense of maleness. However, overtly she experienced no sense of conflict in this area, being concerned mainly with a shocking loss of fertility.

Not all cases of androgen insensitivity syndrome result in complete feminisation. When partial feminisation occurs the genitalia may be far more ambiguous. Children in this situation have been reared as girls or as boys depending on the appearance of the genitalia. Virilisation as well as feminisation can occur. In congenital adrenal hyperplasia (CAH), excessive androgen production either before or after birth partially virilises a female foetus or baby girl and a more or less masculine appearance may result. In such cases children have been raised either as girls or as boys (although most often as boys). As well as AIS and CAH there are a huge range of other syndromes mostly, fortunately, rare, which cause every kind of intermediate anatomical arrangement. The study of these conditions has been exploited by scientists interested in furthering debates over the relative contributions of nature and nurture in determining human gender identity (see Money 1993; Diamond 1982, 1999, 2000). A disadvantage of these struggles has been that, on occasion, the needs and wishes of the patients have come a poor second to academic debate (Colapinto 2000).

Furthermore some intersex patients have begun to protest against being subjected as children to surgery designed to ‘normalise’ their genitalia, surgery which has sometimes assigned a sex which the adult intersexed person finds un congenial and which often reduces genital function, sensation and sexual pleasure.

Transgender

Unlike intersexed people, transgendered individuals are born with no discernible structural deviation from their chromosomal sex. However, at some point they come to feel dissatisfied with their biological sex and wish for a change. In the classical definition of the condition a strong desire to change biological sex and a hatred of the sex at birth, particularly combined with an aversion to their own genitals, is required. Both men and women can wish for a change in gender. Incidence estimates vary but a UK figure for people seeking gender reassignment is 1 in 33,000 for male to female transgendered people and 1 in 108,000 for female to male transgendered people (Bancroft 1989):

Amy, a male to female transsexual consulted in order to be referred to a gender reassignment clinic for surgery. She had been living exclusively in the female role for the past year having changed her name on all her papers. She talked knowledgeably about the different effects of various hormone combinations and gave her interviewer a thick and helpful wage of information on transgender issues. She had presented to the clinic because friends of hers had given it good reports and she had a clear agenda of items to discuss. Amy found having a penis disgusting. She said, ‘I feel like a woman. When I look down I am shocked. It feels all wrong.’ However, she was also clear that her penis was a source of sexual pleasure and this made her confused whenever she did have sex with her partner, who was a woman. Her agenda at presentation was first to secure referral to a gender reassignment programme that would ultimately offer her surgery. Once she was assured that this would be forthcoming she began to talk about other issues she found confusing. One which preoccupied her was whether she was heterosexual or homosexual.

Amy is typical of many transgendered patients who want gender reassignment. She has found out a great deal about her condition. She is already part of a lively community of transgendered individuals who swap information and give support both in meetings and on the internet. Discussing Amy’s case raises issues of terminology, which is often a problem in case accounts of transgendered people. Patients are often referred to by pronouns which oscillate between gender assigned at birth and current gender role. The oscillation probably signals difficulties in dealing with patients who challenge classical notions about gender binaries. Transgendered people mostly prefer to be referred by the sex they would like to be or have already been reassigned to. In this account therefore a genetic male who wants to live in the female role will be referred to as a male to female transgendered person, or woman.
Amy's anxieties over her sexual orientation are shared by 
experts, who find that the sexual orientation of transgendered 
people gives them trouble partly because they cannot decide 
whether to classify it in relation to chromosomal sex or by refer-
ence to preferred gender. Until recently transgendered patients 
whose pre- or post-operative partner or sexual preference was not 
standard had difficulty in obtaining treatment. Sullivan, a gay 
female to male transgendered person, was rejected for reassign-
ment because of his interest in men sexually. Many years later 
following reassignment elsewhere he died of AIDS and remarked:

I took a certain pleasure in informing the gender clinic that 
even though their program told me I could not live as a gay 
man, it looks as if I am going to die like one. (Califa 1997:187)

The early studies which show both homosexual and heterosex-
ual adjustment before reassignment and a majority with heterosexual 
adjustments after surgery do not reflect a growing range of sexual 
choices made pre- and post-operatively so that many different pre-
and post-operative sexual object choices are now being made, 
including choosing to live with another transgendered person 
(Califa 1997).

Transvestism

Transvestites are people who, for a whole range of reasons, wish 
to dress in clothing of the opposite sex. Those who do so, for 
reasons of sexual pleasure or as a result of wishes to experience the 
female gender, are almost overwhelmingly male in current 
culture. However, strong traditions exist of women dressing as 
men for a variety of reasons and Caplan (1987) argues that there 
are true female transvestites. At first glance, transvestites seem 
rather different from transgendered individuals and they used to 
be separated sharply, in relation to diagnosis, from transgendered 
men. In fact there is considerable overlap between the two groups 
and Bancroft defines a continuum ranging from fetishistic tran-
vestite at one end through to the 'full-time' transsexual:

Simon, a large and imposing man, worked as a lorry driver all 
over Europe. He presented at the clinic because of anxieties 
surrounding his increasing desire to dress in female clothing. 
Initially he had been interested in isolated items of female 
clothing (often underwear) and had used these as an aid to 
masturbation. However as time passed he began wearing 
women's clothes and experienced himself as more comfortable 
when doing this. He began to think of himself as having a 
female personality who alternated with his male personality. 
When dressed he was Joan, when he was working he was 
Simon. Recently during a long journey he had dared to present 
himself at a place where lorry drivers meet dressed as Joan. He 
was amazed at the high level of acceptance he received and at 
the aggressive defence of him by some of the truck drivers when 
another group began to make disparaging comments. At 
present he was not seeking gender reassignment and acknowl-
dged that this would be difficult for him for medical reasons. 
He was however concerned about his future if his gender 
dysphoria became stronger.

Simon is a fairly typical transvestite who may be moving slowly 
from a transvestite identity towards a more transgendered one. 
Bancroft points out that many transvestites are married and, typi-
cally, transvestite behaviour first shows itself in adolescence but 
recedes in the early years of marriage, returning later on when 
problems develop in the marriage. In such circumstances he 
argues that the transvestite behaviour is a substitute for hetero-
sexual behaviour. Other transvestites like Simon are characterised 
by Bancroft as having a tendency to become more transsexual as 
time goes on. This transvestite transsexual shift may, according to 
Bancroft, either be due to underlying transsexualism or to condi-
tioning in enjoying the female role as a result of repeated orgasms 
while cross-dressed. Bancroft likens the progress from transvestite 
to transsexual status and the breakdown of the marital relation-
ship which often results as 'a psychological malignancy because of 
its unstoppable destructive effect' (1989:355). This rather pejor-
ative judgement overshadows the important fact that in cases such 
as Simon's the transition between transvestite and transgendered 
status often gathers speed and force with age. This must be taken 
into consideration in managing such patients. The continuum 
between transvestism and transgendered status, and also the range 
of strengths of transgendered wishes, make it sensible to see all
these conditions as points along a continuum of dissatisfaction with gender. As a result it is often better to use the term gender dysphoria to describe them.

Causes of gender dysphoria: biological and sociocultural issues

Theories about the cause of gender dysphoria are difficult to formulate largely because no reliable theory of gender identity has yet been formulated. Patients with intersex conditions have often become debating grounds for considering these issues, but even here controversy reigns. There is, for instance, the now infamous case of John/Joan a genetic male whose penis was mutilated in a botched surgical operation. He was then reared as a girl on the advice of John Money, an expert in the field. John/Joan rebelled against this as a teenager and now lives as a man. This case has been taken as evidence that gender identity depends on sex of rearing and, more recently, as evidence for the primacy of biology (Colapinto 2000). The influence of prenatal androgens does seem to be important but not decisive (Bancroft 1989). Bancroft also suggests that in transgendered men in particular there may be elevated testosterone levels. Pillard and Weinrich (1987, in Devor 1999) have developed a more complicated hormonal theory to try to classify different kinds of gender identity in relation to perinatal hormonal influences but even this theory leaves much unexplained. Notwithstanding the current lack of firm evidence, most transgendered people and the great majority of people who work with them are fairly convinced of the view that a biological cause for the condition will be uncovered sooner or later.

Sociocultural studies of gender identity reveal that gender dysphoria is quite common although it is socialised differently in a range of cultural settings. Aversion to biological sex is expressed by a proportion of girls and boys, with a peak of expression in adolescence. There are large variations between cultures in this proportion, which parallels the proportion of individuals seeking gender reassignment. Thus more people seek gender reassignment in the USA than in Sweden and, there is more gender dysphoria expressed at adolescence in the USA than in Sweden (Bancroft 1989).

Some other cultures have made institutional roles to accommodate gender dysphoria. Indian mythology is hospitable to non-standard gender roles containing numerous examples of androgyny. In the worship of Krishna, male devotees may imagine themselves to be female, and even dress in female clothing. Another example is the Hijra, who represent an institutionalised third-gender role in India that is neither male nor female. They are believed to be intersexed, or impotent men, who undergo emasculation, adopt female dress and earn their living by collecting alms. Rituals exist within the community of the Hijra for creating family relations, such as taking a daughter. The daughters of one mother consider themselves sisters. Although their role requires Hijras to dress like women, few make any real attempt to imitate or to pass as a woman and it is not rare for them to have beards. Hijras have sexual relationships with men. They may work as prostitutes or take a husband but Hijras do not characterise their male sexual partners as homosexuals and they quite explicitly distinguish themselves from homosexuals. Many Hijras see themselves as women trapped in male bodies.

Other groups with transgendered elements include the Bherul钱财, who are Native American Indian men living as women and honoured as shamans, and the Xanith in Oman, who retain a male name but act as the receptive partner in gay sex. The Xanith dress in clothes which are intermediate between male and female and can move freely among women in purdah, or join women singers at a wedding, but like men they have the right to go about unaccompanied. Money, discussing roles such as these, talks of 'gynereminetics', men who want to look like women but not be them. Money says that gynereminetics may take oestrogens but do not desire surgery (Money 1997). Money's distinction may be valid for the transgendered performers of Latin America, although some of these do opt for surgery, but for cultures where surgery is or was not an option his categorisation seems at best a piece of casuistry. It points up the dangers of carrying across western concepts about gender identity and role, which are embodied in the notion of transsexuality, to different cultures where gender roles are differently structured. Indeed, scholarly wars have reigned over the exact classificatory status of the practices of different cultures (a good summary can be found in Califi 1997). This debate feels far less academic if transgendered people in our
Causes of male to female transsexualism

For American theorists, the work of Margaret Mahler (1968), who charted the slow and conflicted progress through many hard to remember stages of the child from fusion with the mother to a separate existence, has been a decisive theoretical influence. Person and Ovesey (1974a) argue, in common with Stoller (1968) and Segal (1965), that the origins of transsexualism, transvestism and effeminate homosexuality are pre-oedipal and stem from unresolved separation anxiety from mother. In male transsexualism the child is said to resort to a fantasy of symbiotic fusion with the mother thereby allaying separation anxiety but at the cost of ambiguous gender identity. This ambiguity of gender identity then impedes sexual development and leads to relative asexuality. This theory sets transsexuals at the most primitive end of a spectrum of developmental deficits of gender identity and sexuality. Stoller (1968), less influenced by Mahler, argues differently, suggesting that the typical male to female transsexual is a beautiful boy and the son of a depressed mother who, herself, felt unwanted in early life. She keeps the boy close and he leads a blissful life with his mother who excludes the father and makes the child into her longing for phallic. As a result he does not want to separate from her and so tries to be her.

In England, Limentani is an important theorist. He begins by discussing castration anxiety, which is seemingly absent in transsexuals who actively seek castration. This represents a major theoretical conundrum for any classical Freudian analysis of a transgendered patient. However, although castration fears are generally directed at father Limentani ultimately identifies mother as the prime source of difficulties. He argues that transsexuals seek to assuage profound early anxieties by seeking to obtain a female body which allows fusion with mother and blots out a sense of unbearable separateness. Limentani (1979) characterises the thinking of transsexuals as psychotic, by which he means that they deny the reality of their gender. Kleinians believe that acknowledging the truth of the reality of the breast, the difference between the sexes, and the parental relationship involves an emotional achievement and is a requirement for psychological health. Transsexuals are denying the reality of their bodies and this signals, from a Kleinian perspective, a fundamental disturbance of consciousness and of emotional and moral capacity. Limentani's accounts of analytic treatments of transsexual patients, and other accounts in this analytic tradition, concentrate on uncovering other signs of this disturbance.

Richard Green's view of the etiology of male to female transsexuals is conditioned by his long-running study on 'sissy boys' (1987). These are boys who display feminine behaviours and wish to cross-dress in childhood. Green and Stoller both think effeminate behaviour in childhood may be a precursor of transgendered behaviour in adult life. Green thinks that a range of factors turns childhood gender non-conformity into adult transgendered behaviour. The factors he lists are: parental unconcern over gender non-conformity, encouragement of feminine behaviour, permitting repeated cross-dressing, maternal over-protection, inhibition of boisterous play, excessive maternal attention and physical contact, absent father, physical beauty of the boy, and lack of male playmates (Bancroft 1989:352). Green's list is problematic because it appears to subscribe to and universalise a very parochial and now rather dated vision of healthy boyhood. Furthermore it is not at all clear that childhood effeminate behaviour does predispose to later transgendered behaviour. Ovesey and Person disagree both with Green and Stoller in this and, on the basis of a study of ten patients, argue that male to female transgendered patients do not have effeminate childhoods. Indeed, when Green followed these children up over a long period of time he found an elevated rate of homosexual orientation among them but no evidence of an elevated rate of transgendered develop-
ment. While, in support of Green, there is some evidence of a lack of male role models in some transgendered people (Rekers et al. 1983), other retrospective surveys of cases show that in as many as half there is no evidence of early parental conditioning of the kind he elaborates. The evidence to support upbringing as a factor in the development of transgendered feelings seems weak and, at best, equivocal:

Amy’s childhood had been a happy one as far as she could remember until she went to school. In school however she had been picked on and teased for being insufficiently masculine. Certainly she would choose girls over boys for companions. She said that at this time she began to feel different from other boys and was confused by this. By about eight she was sure that she should be a girl but unclear what to do about this problem. Amy’s mother was rather preoccupied with her other children and her father was ‘not the sort of person you could talk to about that kind of thing’. In retrospect Amy wondered if she and her father had grown apart because her father had disliked his effeminate son. As a late adolescent Amy had become very involved in bodybuilding in order to overcome her ‘odd ideas’. In this she was successful and accepted.

Elements of Amy’s story accord with psychoanalytic case descriptions. Others do not. Perhaps her preoccupied mother didn’t help her manage separation issues when these became more intense with schooling, as Person and Ovesey suggest. On the other hand there is no evidence of parental conditioning of the sort Green thinks important, nor does Amy’s mother seem to have been over-intrusive. Rather, Amy’s story is closest to the trajectory proposed by Isay (1996) for gay men, in which the psychodynamics of childhood are those of a child trying to puzzle out a sense of pre-existing difference unmediated by adults or helpful social structures.

Causes of female to male transsexualism

In general, female to male transsexuals have received less interest than male to female ones. Bancroft argues that a wish to avoid homosexuality is a strong determinant, suggesting that some lesbians who become aware of sexual attraction to females first reject these feelings and try to make relationships with boys. When this fails, they choose lesbian relationships with innocent girls who have no sexual experience and, instead of regarding themselves as lesbian, decide to regard themselves as a male in order to maintain a heterosexual identity. This theory seems far-fetched since, from the point of view of social opprobrium, choosing to be transgendered is hardly a great alternative to choosing to be lesbian. It is also not supported by the common trajectory of female to male transsexuals’ lives, which often include long periods living as a lesbian before concluding that gender reassignment is the only option.

Green’s view (Devor 1999) is identical to that produced for boys. He stresses early gender nonconformity and says:

Give a female child a male derivative name, provide a stable warm father, and make mother an unpleasant or emotionally unavailable woman and reinforce rough and tumble play.

While a substantial minority of adult transsexuals displayed tomboy behaviour in childhood it is not clear what can be argued from this since virilising hormones predispose to tomboy behaviour (Bancroft 1989) girls who are exposed to them mostly grow up into heterosexual women. Bancroft does, however, think it relevant to tell us that (1989:250) ‘They may continue to show some typically male characteristics, putting careers before marriage or preferring male-type clothes.’ It should by now be clear that both Green’s and Bancroft’s work is diminished by unexamined and dated assumptions about gender roles.

Stoller believes that female to male transsexualism is different from male to female transsexuality because females, unlike males, always become transgender as a result of psychological trauma. Stoller argues that the process begins with grandparents who instil in the mothers of female to male transsexuals a sense that to be female is of little value. As children, these mothers dream of being boys and as adults they dream of having boys. The daughters of these mothers later became transsexual because, being girls, they did not get enough attention from their mothers. The daughters naturally turn to their fathers for comfort. They learn that their
mothers are sources of frustration, take up a lot of emotional space in the family but provide little succour. Furthermore, fathers may present femaleness as less than desirable. The daughters learn that their fathers expect them to take on masculine roles and look after their weak mothers. Stoller says that most will find they are becoming romantically attracted to girls in early adolescence. Lesbianism or transgendered status follows. Stoller's work is important largely because it is contained in a lengthy and sympathetic study of a female to male transsexual seen by him over a long period of time. Although many of the views expressed are somewhat dated, Stoller does seem to have been interested in listening to his patient's experience in a non-judgemental way.

As usual there is disagreement. Person and Ovesey (1974a) do support Stoller's line of reasoning but go further, claiming that female transsexuals are all at first homosexuals with a masculine gender role identity. Limentani (1979) disagrees with Stoller and suggests that female to male transsexuals have an even more profound disturbance than to male to female ones. He says they fail to feel they can ever have a body of their own because an intrusive, over-engulfing mother has taken up all the available space. They adopt a male body in a desperate flight into the only remaining gender.

Causes of cross-dressing

Cross-dressing is a far more common presenting problem than transgendered status. Bancroft suggests that a major mechanism is sexual learning, in which the pubertal boy discovers the erotic effect of a woman's clothing, finding it exciting because of its association with female genitals and used as a masturbatory aid just like a pornographic picture. He then suggests that cross-dressing may come to be used to create a fantasy woman or doppelganger partner (Bancroft 1972). Against this theoretical suggestion must be set the fact that not all fetishistic transvestites begin with erotic transvestism, some begin with non-erotic cross-dressing which only later becomes eroticised.

From a classical psychoanalytic perspective cross-dressing is a fetishistic activity. The little boy is supposed to discover the fact that his mother does not have a penis by seeing his mother with no clothes on, and in a flash, knowing that she has been castrated. This thought is unbearable to the boy, who takes the last item seen before the sight of mother's genitals as a substitute for the mother's absent/present penis. Later analysts have been less impressed by the traumatic effect of castration. Stoller prefers to suggest that the adult transvestite was actually humiliated by an older powerful woman who forced him, as a child, to dress up in female clothes. Adult cross-dressing repeats this trauma, masters it, feeds revenge fantasies against women (in ways Stoller fails to elucidate) and identifies the man with the masterful phallic woman. Kaplan suggests that the mortification of being excluded from the parental bed is a key factor. Characteristically, Person and Ovesey (1978) suggest that pre-oedipal mechanisms are involved and argue that in transvestism the mother's clothes represent mother as a transitional object and are used as a fetishistic defence against Oedipal anxieties.

The various mechanisms to which psychoanalytic theorists tend to appeal are of a sort which ought to produce character pathology as well as cross-dressing, and this character pathology is frequently described in the analytic literature. However, there is survey evidence (Brown et al. 1996) to show that transvestite men are not more likely to suffer from psychosocial difficulties than are normal people. Perhaps a tendency to pathologise transvestism as a perversion fundamentally involving hatred, has blinded analytic theorists to a gentler view of the origins of this condition. As Person and Ovesey point out, many children have blankets or other comfort items to hold and these are also often parts of their mother's clothing. These may be prized because they are soft and remind the child of mother's body. They are comforting and protective. The same terms are also used by transvestites to describe their experiences of being dressed. It is also common for children to masturbate both for pleasure and for comfort when anxious. Thereafter, as Bancroft points out, associative mechanisms may link the holding of, or rubbing with, an item of female clothing, with sexual arousal and particularly with sex for comfort. The link that this sexual activity retains with childhood self-reassurance in times of stress explains why it is increased in adult life when stresses multiply. Person and Ovesey's appeal to pre-oedipal anxieties and Bancroft's doppelganger theory seem to add no helpful extra-explanatory element.
Treatment options

Therapists' attitudes to transgressed patients

Patients who are being offered treatment deserve to be looked after by therapists who are able to regard them as valuable and can treat them with respect. By now it should be clear that denigration, either intentional or otherwise, is a major problem in psychologically based causal accounts of transgressed people. Person and Ovesey (1974a), for example, don’t think much of their patients, characterising them as un-psychologically minded and impoverished in fantasy:

In sum, then, primary transsexuals are schizoid-obssesive, socially withdrawn, asexual, unassertive and out of touch with anger... they have a typical borderline syndrome characterized by separation anxiety, empty depression, a sense of void, oral dependency, defective self-identity and impaired ojective relations, with absence of trust and fear of intimacy... they most closely resemble a subgroup of the borderline syndrome that Grinker calls 'the adaptive, affectless, defended, “as if” persons'. (Person and Ovesey 1974a:126)

Quotes in this vein can be discovered in good quantities from all sections of the analytic and much of the medical literature. Carefully conducted survey evidence contradicts these views. Haraldsen and Dahlis (2000) compared 86 transgressed patients awaiting surgery with similar numbers of personality disordered patients and normal controls. The transgressed patients scored in the same range as the normal controls whereas the personality disordered patients scored as having severe pathology. A chart review of more than 400 transgressed people revealed similar findings (Cole et al. 1997). In the light of this sort of evidence continued pathologising of transgressed people is unwarranted, prejudicial to their treatment and represents unethical and unacceptable practice. Therapists who are unable to accept transgressed people, or who might wish to deny them access to the full range of treatment options available, should not practice in this area.

Medical and surgical interventions

Transgressed patients seek a range of interventions, from hormone treatments to feminise or masculinise them through to a range of surgical options. For many patients hormonal treatment and subsequent surgical intervention produces a satisfying outcome with high levels of interpersonal satisfaction and adequate sexual adjustment. Other patients, particularly female to male transgressed people, may chose to adopt solutions which only involve taking hormonal treatment, with limited or no surgery. Here, too, outcomes are good. However, a proportion of transgressed people regret having had reassignment surgery. Because of this, gender dysphoria clinics in England operate stringent criteria (albeit without much evidence that these criteria improve ultimate satisfaction rates) before consenting to irrevocable interventions. Often regret post-operatively is based on a poor surgical outcome or on unrealistic expectations for surgery.

Surgical and hormonal interventions carry risks which increase with age and with poor health status. Some patients who are judged a poor surgical risk may be refused intervention. Some patients have found their doctors make unilateral decisions about risks and benefits in this area rather than adopting a co-operative approach. Both surgical and medical options need to be accompanied by psychological support and education, before and after intervention. This is often difficult because gender clinics tend to be few and far between so that patients travel a considerable distance to them for relatively infrequent appointments.

Some years after I had referred her to a gender dysphoria clinic Amy returned in considerable distress. She had been judged a poor candidate for both surgical and hormonal intervention and had left the programme in disgust. Since that time she had lived in the female role but had found it increasingly difficult to have any kind of sexual relationship. Amy and I spent a number of sessions discussing the difficulties involved in both surgery and hormonal intervention which resulted in part from her age - 52 - and from other medical factors which made both surgery and hormone therapy very risky in her case. It emerged that she had not fully appreciated the risks involved in hormonal therapy and surgery when they were explained to her, possibly because
of the strength of her desire to begin reassignment, and possibly also because the explanation had been rather rapid.

More recently dissatisfaction about surgery has been more openly expressed in the transgendered community. Califia (1997) discusses post-operative sexuality. She points out that surgical results are disappointing, especially for female to male transsexuals, but that no attempt is made to provide sex therapy or sex education post-operatively. She suggests that some transsexuals might retain their existing genitalia if a compromise way of having sex, which did not cause increases in gender dysphoric feelings, could be found. Informal user-led surveys of outcome show that the results of reassignment surgery are not very impressive in relation to functional outcome, particularly in relation to sexual sensation. Califia is particularly scathing about the evaluation of the sexual results of male to female surgery solely in terms of vaginal size. She suggests that surgeons' puzzlement about transsexuals' sexual satisfaction when the neo-vagina is small may result from a total incapacity on their part to imagine non-vaginal sex:

Joan was a male to female transgendered patient whose surgery had been halted after she developed a severe post-operative infection. Her neo-vagina was extremely short. Joan had been referred to the psychiatric clinic after creating an angry disturbance in the surgical outpatients, shouting 'I haven't even got a vagina, what are you going to do?' At assessment she was livid at having been dumped by the surgeons and keen for me to arrange further surgery. We agreed to have further psychotherapy sessions while at the same time seeking a further operation. Eventually Joan was seen by a surgeon who took time to explain that further surgery could be undertaken but that there was a risk it would not work and could make her much worse. Being offered the choice to go ahead allowed Joan to choose to leave matters. In therapy Joan and I talked a lot about female sexuality and what she called 'the penetration thing'. It was something of a surprise for Joan to discover that not all women liked 'the penetration thing' and that there were other ways of expressing herself sexually. She said, 'It wasn't the sort of thing they taught me when I was a man!'

Joan also suffered initially, therefore, from incapacity to imagine non-vaginal sex. Like the surgeon's, her view of female sexuality was profoundly phallocentric. Male to female transgendered people often have not had much education of their erotic imagination in relation to female sexuality. Despite their longing to be women they, in common with men, often have highly stereotyped views of female sexual experience. Califia is right to call for sex education programmes. In some male to female transsexuals, developing erotic awareness as a woman comes as a considerable surprise once surgery is complete. Such individuals embody the radical capacity for development that the erotic imagination can display.

**Psychological treatment**

Psychoanalytic theorists have voiced an almost universal opposition to gender reassignment surgery, some authors comparing it to psychosurgery (Kavanaugh and Volkan 1978). Limentani's position is fairly characteristic:

Finally I must state that as I regard the transsexual syndrome as a personality and characterological disaster, it cannot be corrected by mutilating operations which are often carried out in response to suicide threats amounting to blackmail. (Limentani 1979:150)

Making an argument against surgical treatment can be important for some patients because surgery does not always achieve all that might be hoped from it. Psychoanalysts have argued this point, but with such ferocity and in terms which seem to indicate a deep dislike of their patients that their stance is radically weakened. It would also be easier to support if there was any evidence that psychological treatments can affect the basic gender dysphoria which transgendered people experience. Accounts of analytic treatments do not give cause for optimism. Limentani and others describe analyses which are always conducted in the light of a refusal to refer for sex reassignment. Frustrated or partial (often broken-off) treatments are described. Although a few patients are reported to give up their wish for gender reassignment it is difficult to be sure whether, in the face of such implacable opposition,
the patient hasn't simply suppressed the information. Given the increasing analytic tolerance for homosexuality one might have hoped for a less immoderate position in relation to transgendered people. Sadly, this does not seem to be emerging. Chiland (2000) bemoans the difficulty of analysing 'these patients because they are fixated on the body and continually press for gender reassignment'. She characterises them as having an unpsychological attitude and a narcissistic disorder.

A better therapeutic approach is to offer supportive and psychodynamically oriented therapy aimed at empowering the patient to make their own decisions about treatment and to adjust to its effects. An increasingly important area of treatment concerns the relationships of transgendered patients. Beyond documenting the likelihood that marriages will break up (even requiring it before surgery), none of the clinics give much thought to managing the pre-existing relationships of transgendered patients or to preserving them:

Lynda and Ben presented for therapy because of difficulties in their relationship. They had been partners before Ben had gender reassignment surgery and had wanted to stay together. Lynda, however, complained that she did not see herself as a heterosexual woman but as a lesbian. She found that she now resented Ben expecting her to dress up nicely or wanting to initiate sex even though this had been their pattern of relating before gender reassignment. Ben however was struggling with difficulties about his gender reassignment. He had not opted for phalloplasty because of the poor outcome of this kind of surgery. Because his genitals were 'not properly male' he felt the need to prove himself. The atmosphere was tense and hostile. Therapeutic intervention was based on a systemic approach. The therapist theorised that Lynda and Ben had developed a well-functioning system prior to reassignment surgery but the change of roles was confusing both parties. Paradoxically, Ben was asked by the therapist to exaggerate his masculine behaviour while Lynda was asked to behave like 'a woman out of Dallas'. Next session both parties spoke freely about the experiment, some bits they had liked others seemed ludicrous beyond belief. Their tensions had reduced to an extent and it felt as though the system could reorganise more freely.

**Treatments for cross-dressers**

There are no well validated treatments for cross-dressing, although sporadic accounts in the literature report success in single cases. Probably, like any well established sexual wish, the urge to cross-dress is unlikely to respond to treatment although if necessary the behaviour itself could be suppressed. Behavioural interventions are particularly likely to be useful if the patient gets into risky situations which might have unpleasant consequences if he was discovered. Obviously in the rare situations where the patient behaves in ways which are a risk to others then therapy needs to deal with that as a matter of urgency and a wider team of professionals should be involved.

Supportive treatment for transvestites should often focus on their relationships. Many are married and these marriages can be placed under considerable strain when cross-dressing is discovered. Sometimes couple therapy can resolve matters, on other occasions the relationship may end. Often transvestites without relationships can be lonely and depressed. Psycho-education about support groups for cross-dressers is helpful, as is medical or therapeutic intervention aimed at low mood.

**Treatments for patients with intersex conditions**

Physical treatments for patients with intersex conditions are highly controversial. Many medical experts believe that early surgery on the small baby to make the genitals clearly one or other gender is vital. By contrast, some gender activists are dissatisfied with what they regard as mutilating surgery and the consequent reduction in sexual functioning it produces. They oppose early surgery. Studies of the adult life of intersex patients show general satisfaction with life but often dissatisfaction with body image and sex life. Even so, only two in a sample of 30 said they trusted doctors and of those who had had surgical interventions on their genitalia none were satisfied with the outcome (Schober 1999). Cheryl Chase, a gender activist, is a case in point. She was assigned male gender at birth but her parents, ashamed of her small penis, reassigned her to a female gender at which point her small penis was reclassified as an over large clitoris and a clitoridectomy was performed. Cheryl points out that as a result
all sexual function was removed. She founded 'Hermaphrodities with Attitude' and has picketed the American Academy of Paediatrics, pressing for a change in policy over surgery and arguing that delaying surgery until the child is old enough to express an opinion is a more respectful way of treating intersexed patients. In adult life, intersex patients need support for a wide range of potential emotional problems. Advice guiding them towards self-help organizations is useful. Therapists should also avoid the urge to fit their patients into a particular gender and be particularly careful to allow the patient freedom to move between identifications as they need.

**Political considerations**

Califa (1997) presents an extended analysis of the political issues involved in the management of transgendered patients. Repeatedly she demonstrates how the wishes and needs of transgendered people are subordinated to the gender prejudices and paternalism of their doctors. Even those doctors who have been willing to allow gender reassignments to occur appear to regard themselves as doing their patients a favour. Many doctors still advise transgendered people to actively conceal their previous lives. Doctors dealing with patients seeking gender reassignment also find non-standard post-operative sexual choices more than they can handle. Green (1969, cited in Califa 1977:66) describes a man who wished to live as a lesbian post-operatively, as wanting to live the social life of a woman but not the sexual one - a comment which implies that lesbians do not have the sexual lives of women. While Green attacks his male to female transgendered patients for not wanting to be fully female, as he sees it, Money and Primrose (1969) cannot bear the thought that they might be fully female as mothers. They say that male transsexuals lack maternal wishes and when they are faced with a group who wish to adopt older children they suggest that wish is like wanting to own a fashionable pet:

A woman may do an excellent job of caring for a fashionable pet. So also a post-operative transsexual, married as a female, may do an excellent job of mothering an adopted or foster child. (Money and Primrose 1969, cited in Califa 1977:75)

Doctors have not been the only people with worries about transgendered patients. There has also been a feminist backlash against them. Raymond is the most vocal (1996). Her work has been enthusiastically supported with blurbs on the cover by Dworkin and Rich (Califa, 1997:86). These feminists deny female status to transsexuals in the most virulent terms, seeking to exclude them from female colleges or organisations and suggesting, like psychoanalysts and the International Olympic Committee, that only chromosomes determine gender. This is an argument which sits uneasily with feminist rejection of essentialist theories of gender or psychoanalytic acceptance of constitutional bisexuality.

Analysts, feminists, medical and non-medical gender dysphoria specialists all seem to have at times found it acceptable to adopt views which are plainly unprofessional or unreasonable. Samuels' (1985b) theory of gender certainty may provide a helpful way of understanding why this might occur. Samuels argues that gender certainty and gender confusion are in reciprocal relation to each other. Political opponents of transgendered choices, doctors and parents who deal with intersexed children are threatened with an increase in gender confusion. They attempt to preserve the balance by manoeuvres designed to increase gender certainty. The construction of a medical category for people who wish to change sex role serves our culture's need to preserve order as much as in other cultures do the construction of roles like Xanith and Hijira. It preserves gender certainty by creating a little 'cordon sanitaire' in which to place anything threatening. The strategy is not entirely successful. Assessors often comment on the capacity of an applicant for reassignment to pass as, or carry off, the role of a woman. The use of a term like 'passing' to denote successful entry to the new role is filled with connotations of secrecy, infiltration and betrayal while the phrase 'carry off' implies acting and dissimulation. Even if the possibility of a change of sex is granted the idea of a fluid sexuality, of remaining married to a previous partner, or of opting only for a partial gender reassignment becomes too threatening to gender certainty and doctors, analysts and feminists alike rebel.
Psychotherapy of transgendered transvestite and intersex conditions

Neither neutrality nor ignorance are helpful adjuncts to the treatment of these conditions. Successful therapy with transgendered, transvestite or intersexed patients needs to be conducted from a position that is well informed about the condition and benignly disposed towards the patient. ‘Curative’ efforts are pointless and also start from the position that patients who present these difficulties are ill – something which they may well deny. The best therapeutic input may either be supportive or exploratory but should always be aimed at exposing and coming to terms with the reality of the current situation rather than bending it to fit the will of the therapist:

Charlotte presented in clinic in the female role. She was a tall young woman dressed casually and impressed the interviewer as an extremely beautiful woman. She was seeking referral for gender reassignment. Charlotte wanted to live in the female role until masculinising hormones had started to work and a bilateral mastectomy had been performed. She said, ‘I don’t want to be a half man I want to be a real man.’ The therapist found herself struggling after the session with sexual fantasies about the patient and regret over the proposed reassignment.

Supervision concentrated on the therapist’s countertransference reaction to the patient. A particularly trusting atmosphere pervaded the supervision so that the therapist’s sense of regret over gender reassignment could be explored in terms of the therapist’s lesbian sexual orientation, with supervisor and therapist both sharing openly thoughts about sexual attraction to women and also to more androgynous people. Once personal issues had been discussed, the possibility that the therapist’s countertransference was driven by the patient’s own ambivalence about gender reassignment could also be tackled:

During the second session the therapist suggested to Charlotte that she might be ambivalent about changing orientation. Charlotte reacted angrily saying that this clinic was like everywhere else and imposed its own views on how gender reassign-