Is Transsexualism an Iatrogenic construction?

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This article is generated by my interest in the medical provision of hormone and surgical interventions to enable transition from male to female (MtF) or female to male (FtM) which kept gender expression within cultural 'norms' of male or female, but also gave a sense of legitimacy and validation to the wish of transsexuals that a "mistake of nature has trapped them in the wrong body", (Chiland, 2004). This belief was reinforced in the criteria set by the medical profession that to be diagnosed a 'true' transsexual rather than having a transvestite fetish (Benjamin, 1966), you had to not only have a need to be rid of the birth genitals, but also have a need to acquire those of the other. This requirement is unique to transsexuals and is why it can be described as iatrogenic as it provides the "partial realization of fantasies of sexual metamorphosis" (Pauly 1968), partial because, as yet, no surgical or hormonal treatment can enable a man to become pregnant or a woman to produce sperm.

What was there before transsexualism?

Green (1998) describes men wanting to dress as women and women wanting to dress as men as going back to antiquity. And, more recently, this was seen in eighteenth century cross-dressing men who performed mock marriages with homosexuals in the Molly houses and bordellos of Europe and North America and the women who dressed as men, married women and worked in male trades, and whose secret was only revealed after their death (Nelson-Jones, 2001). Whether or not these individuals felt the same need required for a diagnosis of a true transsexual today isn't known, though it suggests that surgical/hormonal interventions may simply be a new way of expressing an age old desire.

Though it wasn't the first such operation, the 1952 'sex change' of a former US soldier who became known as Christine Jorgensen was the first widely publicised, and resonated with many individuals who identified with Christine as they realised they were not a man who wished he was a woman, or a woman who wished she were a man; instead they were a transsexual. And, as such, came 'out of the closet' to request similar treatment, or what Denny (1996) describes as 'a move to the other side of the (cultural) closet of assimilation'. The legitimacy behind Christine's operation lay in the fact that not only was it seen as the only approach to treating feelings of gender identity dysphoria (GID) as it is diagnosed today, but the concept of transsexualism also conformed to the 'natural' order of things in terms of the clear distinction between male and female in a western binary culture (Kessler and McKenna, 1978).

When transition became possible it enabled those who, like Christine, had lived in secret with their gender issues to have a medical 'diagnosis' and, if meeting the medical criteria for a true transsexual, gave access to surgical/hormonal treatment to alleviate their distress. This, therefore, created the 'category' of transsexual. Harry Benjamin, an endocrinologist who is regarded as something of a pioneer in working with transsexuals, stated that: "Psychotherapy with the aim of curing transsexualism, so that the patient will accept himself as a man is a useless undertaking, since it is evident therefore, that the mind of the transsexual cannot be adjusted to the body, it is logical and justifiable to attempt the opposite, to adjust the body to the mind. If such a thought is rejected, we would be faced with therapeutic nihilism." (Benjamin 1966, p, 116).

It seems that what Benjamin felt couldn't be cured by psychotherapy was the desire to live as the other sex in a culture that has distinct male or female

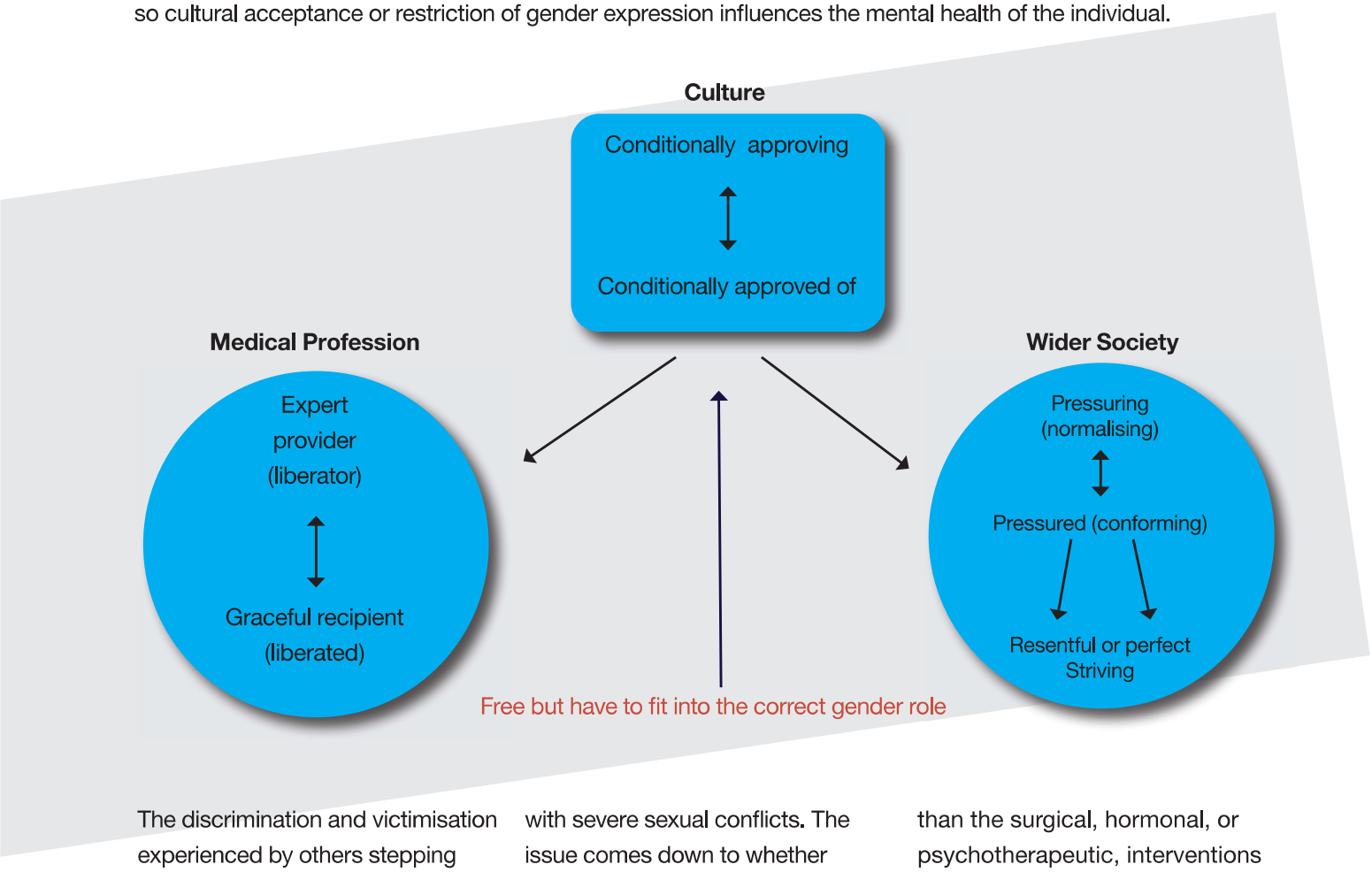
gender categories; this division is the underlying cause of gender dysphoria which hormone/surgical procedures hoped to alleviate by enabling transition from one sex to another. It is a view similar to that of Lev (2004) who sees GID as a natural outcome of living within a culture that has an explicit gender system that associates certain appearances and behaviours with particular gender categories.

Transsexualism as a release from social constriction

The importance of a more accepting culture is seen in the Samoan Fa'afafine, these individuals are biological males who behave in a range of feminine-gendered ways and have been an integrated part of Samoan communities for centuries. They "enjoy a societal acceptance and tend to see their cross-gender identity and expression as a source of pride rather than distress" (Vasey and Bartlett 2007). In contrast, the speed with which western medicine operates upon babies born with inter-sex conditions to assign the most appropriate male or female sex, according to visible genitalia, shows what Denny (1996) describes as the 'concretised' division between male and female that is necessary for transsexualism to exist as a meaningful concept in the first place. The construct of inter-sex, however, suggests sex and gender comprises considerable variance, as part of a continuum, rather than being something to be diagnosed and stigmatised (and in binary western cultures) operated on to 'normalise' the natural.

Although transsexuals are, as far as can be ascertained today, biologically normal, inter-sex conditions show the importance of 'resting on the hyphen' in relation to nature and nurture influences

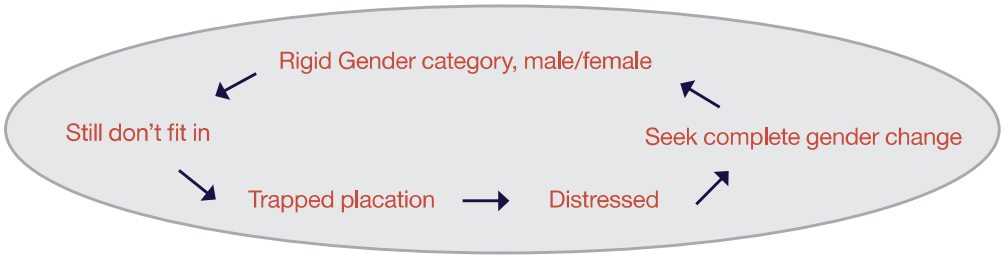
on transsexuals. As Bolin (1988) describes it is "ironic that the more scientific and complex the determinants of biological sex become, the less they can be relied on to indicate gender". This reflects the more enlightened view of less restricting cultures around sex and gender, and demonstrates how medical and cultural 'voices' can bring confusion to environmental and biological issues. To the extent that genetics influence biological development, so cultural acceptance or restriction of gender expression influences the mental health of the individual.



The discrimination and victimisation experienced by others stepping out of cultural norms, such as gay and lesbian individuals, is seen as perhaps 'worse' for transgender and transsexuals because they challenge norms attached to sexuality and gender (Marx & Katz, 2006). Similarly, the way in which gay and lesbian individuals were persecuted and stigmatised, so too transsexualism has been pathologised. Socorades (1969) said "Transsexualism represents a wish not a diagnosis. It is a wish present in transvestite homosexuals, and schizophrenics with severe sexual conflicts. The issue comes down to whether individuals in these categories of mental illness should be treated surgically for what is a severe emotional or mental disorder" (cited Lev 2004, p31)

The surgical and hormonal interventions to 'cure' can, in CAT terms, be seen as dysfunctional target problem procedures to escape feelings of gender dysphoria experienced by individuals who fail to fit into the male/female dichotomy. This belief has been around far longer than the surgical, hormonal, or psychotherapeutic, interventions that all perceive transsexualism as a problem to be 'fixed', as was homosexuality before its removal from the DSM in 1973.

Given the 'double whammy' in which culture sets the boundaries and the medical profession pathologises behaviours that step outside of them, it is not a great leap to imagine the feelings of those living 'secret' lives when Christine's sex change became known, and which gave 'hope' of escaping their secrecy via the 'cure' of transition.



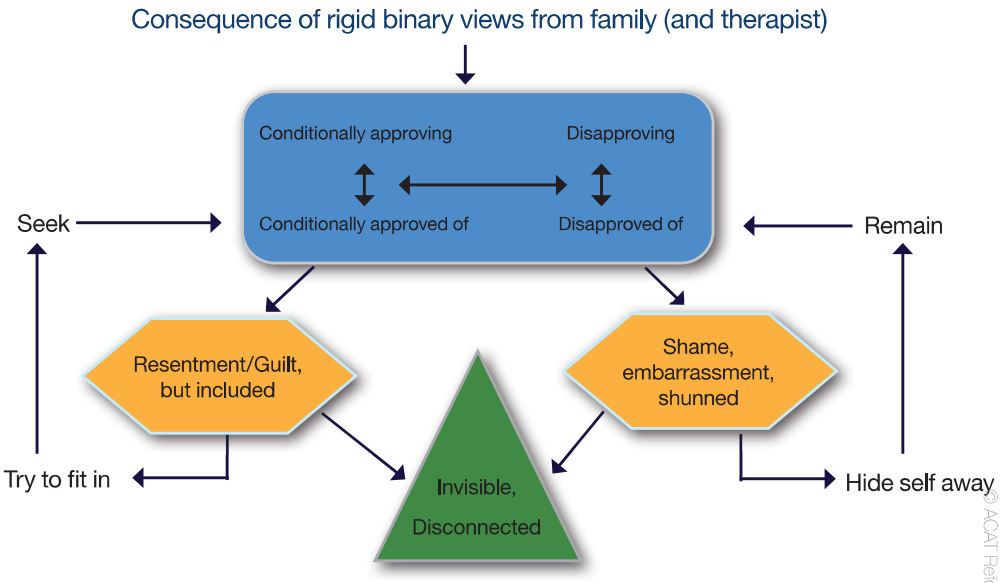
Creating a wider repertoire of gender expression

The relevance of this today is that transsexualism now sits on a sex and gender spectrum that includes Lesbian, Gay, Bisexual, Transsexual, Transgender, Inter-sex, Queer/ Questioning and Asexual (LGBTIQA). This spectrum demonstrates that there are more ways of expressing gender identity that do not require medical interventions or possibly only hormone treatments or partial surgery. The importance of this is that instead of altering the body to fit the mind, and creating the transsexual, both body and mind are allowed gender expression on a broader spectrum, as in more accepting cultures.

A broader spectrum may also show the folly of trying to fit gender expression into categories, as is shown in categorising sexuality into heterosexual or homosexual. Bi-sexuality shows sexuality to be more fluid than concretised. In transsexualism this folly is shown by a male in a homosexual relationship who wants to change sex, and who moves to the category of 'straight' once transitioned to a woman, and living with the same male partner. The permutations for this shifting of categories are enormous, but do the categories really matter? In a more pluralistic society it should be acceptable to move along the gender spectrum with a transgender, rather than a transsexual, expression of gender diversity.

As the range of gender expression expands in western societies it may be that the concept of transsexualism (i.e. transition from one to the other) is outdated in terms of being the only way of 'liberating' individuals from feeling 'trapped'; especially as there is more awareness of how the cultural norms trap individuals in its binary distinction. Cultural norms are amplified through the conduit of family, peers and wider society, and internalised by individuals in all 'walks of life', including therapists. These influences appear to contribute to the "rigid" binary perception of sex and gender described by Hakeem (2012) which may reside in the 'unconscious' but 'seep out' in conversation (and therapy) around gender issues.

An example of this, in my own work, is in a conversation I had with a female therapist about a MtF transsexual who had surgery, and wanted to transition back again. Her comment to me was "so, he found being a woman isn't as easy as he thought it would be". This appears to reflect the underlying assumptions members of one sex can have about how it is seen by the other. This may also be evidence of the transsexual, herself, holding an 'idealised' view of herself as a woman before disappointment followed transition. It is exploration and recognition of these internalised, and often out of awareness, views of sex and gender on the part of therapist and transsexual that open the way for a more meaningful therapeutic dialogue.

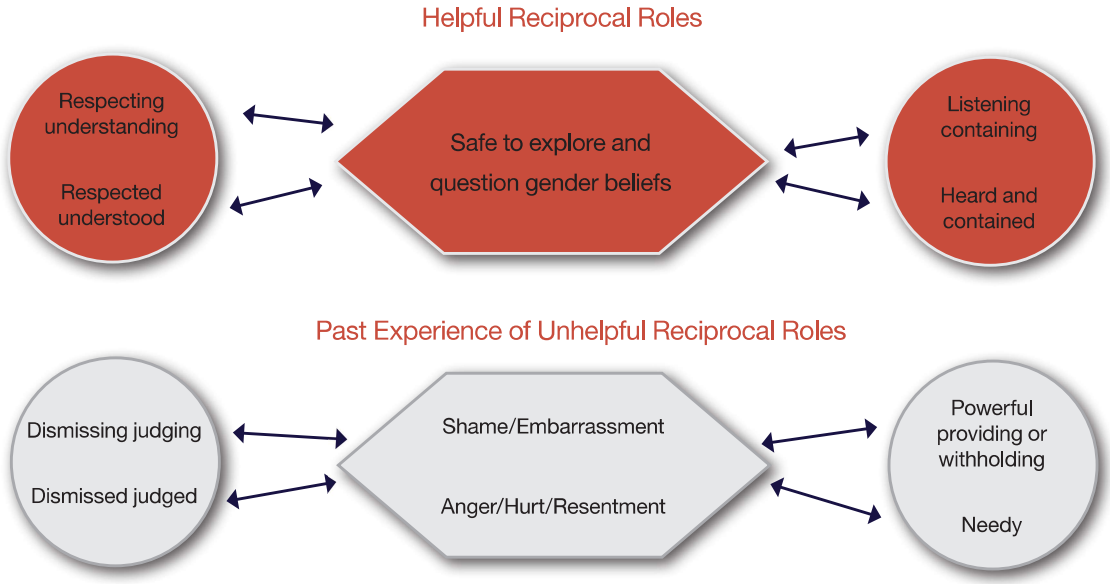


The familiarity of transsexuals' inner and outer issues to CAT therapy

Today there is recognition that the restrictive scaffolding from family, peers, media and wider society has enormous influence on individuals' views of what it means to be male or female and how the sex and gender roles attached to them should be followed. Fraser (2009) describes the consequences of this on some transsexuals as being a difficulty in locating a core sense of self and trying to be someone else by developing a "hyper masculine or hyper feminine self" in an effort to please parents, siblings or peers. This could be understood in terms of internalisation, reciprocal roles and procedures and, in CAT, can be seen as a procedural loop which implies that if the individual fails to comply with the cultural norms they must be 'mad' and which fails to explore how cultural norms may be driving the individual 'mad'.

This resonates with Benjamin's (1966) description of medical interventions being to ease distress rather than cure something felt as wrong. And, if the aims of therapy are seen as psychological rather than physical, is it to give a greater understanding of the meaning given to the concept of masculine and feminine in relation to the internalisation of social norms. Therapeutic approaches that explore the impact of internalisation of social norms on the individual have flexibility to explore both intra and inter- personal difficulties in a way that assists in making sense of their inner world; "who am I?" While others need help in managing their outer world, work, family and friends; "I know who I am, but how do I live out in the world with an authentic gendered self" (Fraser 2009).

The stereotypical sex and gender roles that are internalised from birth contribute to the difficulty experienced by the LGBTIQA in society, though from media coverage, and more individuals 'coming out', there is greater acceptance of diversity in western society which allows a 'stepping out' of the 'closet of assimilation' that individuals have found themselves in as a consequence of the prevailing medical construct and its diagnostic and categorising culture. CAT tools and concepts could provide a sound therapeutic base for exploring the inter- and intra-personal issues associated with gender variant individuals as CAT should not be bound by the prevailing cultural rules, but should instead see those rules as another 'voice' that accepts or constricts the transsexual in becoming who they feel they are.



I am a newly accredited (February 2015) CAT Psychotherapist working in secondary care for Somerset NHS Foundation Trust, my role also includes coordinating referrals for Mendip, South and West Somerset. I have a particular interest in working with Personality Disorders.
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We are one and we are many. . .

Dear Rachel and Julie (Editors of Reformulation)

I am saddened to hear that you have resigned as editors. I have valued the richness and quality of Reformulation over the years to which you both have made a big, voluntary, and sustained contribution. Reformulation has held the multiple voices within the world of CAT well. It has worked the texture between big picture and small detail, mainstream and side stream. I like the images of CAT that it has conveyed. Your resignation has left me with pause for thought about how we encourage peer-to-peer communication among members.

If I may freely misquote Shelley's famous poem to the people of Manchester: 'We are one and we are many.' We are 'one' in the sense that ACAT has been an excellent custodian of the CAT way of working and we have a well-established and very well run organisation. An organisation has to have its own leadership group and governing voice and we need to pull together to support it.

But I suspect that we are only at 'one' as long as we can also be 'many' in the number and type of affiliations, imaginations and other loyalties that we bring to CAT. We are a pluralistic crowd compared to many other organisations. I calculate well over thirty distinctive communities with their own voices and aspirations for promoting and developing CAT. These are voices from different countries, different professions, different trainings and different special-interest groups. To hold this diversity together and, more importantly, to engage with and learn from its creative variation in the use of CAT, we need an open network approach to our communications as peers.

Our very first ACAT constitution had as it principle object the relief of distress and it placed CAT very distinctively as a means to an end not as an end in itself. The founding principles of CAT are pluralistic, integrative and relational. Think of the common language paper. Or of reformulation as a sign-mediated, transparent and dynamic activity. Think of the elegant integration of procedures and reciprocal roles in the now dialogic understanding of reciprocal role procedures. Think of the Vygotskian view of other to self, self to self and self to and from other. All these dimensions of relational thinking offer an integrative and versatile approach not just to therapy but to mental health more widely. In the past ten years I have had the privilege of teaching and learning from a great variety of CAT groups all over the UK and internationally. As I travel, I see such a rich variety of ways of applying CAT. In this sense we are enthusiasts not for a model of therapy but for a way of thinking relationally. And we are only just at the beginning of developing this relational and dialogic paradigm. It is such an exciting time theoretically to be practising psychotherapy with the overlapping and dialogic developments in neuro-science, trauma dynamics, infant development and the therapeutic mechanisms of change.

Of course we must be of one mind in our business strategy, our ethics and our training plans but we must be a little careful not to lose our diversity and creativity to a corporate culture. What I find missing as a counter balance in this respect is the peer to peer conversation among members and across membership groupings. This is alive and well in various localities and in some special interest groups but it is not as alive as it could be not withstanding our excellent annual conferences.

Years ago in the early days of ACAT we had a double headed structure of a training division and a membership division. The training committee and the membership committee met independently the latter having responsibility for conferences, CPD and all manner of membership issues included the earlier incarnation of Reformulation as the ACAT Newsletter. When I was Chair we dropped the idea of a membership committee because we didn't have the resources and the priority was to build the training committee. Now with such a well-established and at times overloaded training committee and exam board structure it might be time, in the age of social media to revisit the idea of a membership committee as a container for all the concerns and interests that members have.

Yours sincerely

Steve Potter
Manchester