

Pre-surgical psychotherapy for transgender individuals diagnosed with gender dysphoria

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Abstract

In 2011, transgender individuals were divided in two groups for a weekly psychotherapeutic follow-up in the Sexuality Studies Program (ProSex) of the Psychiatric Institute (IPq) at Clinics Hospital of University of Sao Paulo Medical School (HC-FMUSP). The first group was composed of transgender women – male sex assigned at birth – diagnosed with gender dysphoria (TW), and the second one of transgender men – female sex assigned at birth – diagnosed with gender dysphoria (TM). These groups' clinical and psychodynamic data were collected. Over the years, such approach has been considered to be highly relevant in settling conflict and distress associated to that condition, besides the fact that some other specific characteristics related to the gender in which the individuals identify themselves with have also been observed during the study.

Keywords: Gender Dysphoria, Group Psychotherapy, Psychodrama, Sex Reassignment Surgery

INTRODUCTION

Transgender people (frequently called trans people) diagnosed with gender dysphoria (GD) are characterized by the permanent desire to live and be accepted as someone belonging to the gender with they identify themselves. Such desire is followed by a persistent feeling of great distress and inadequacy towards the sex assigned at birth. That condition triggers clinically significant distress and/or social and occupational operating loss as well as in other important areas in life, according to *Diagnostic and*

Statistical Manual of Mental Disorders, 5th edition (DSM-5), American Psychiatric Association – APA, 2013 (ABDO, 2014).

The International Classification of Diseases (ICD - 10) (World Health Organization (WHO, 1993) applies the diagnostic term *Transsexualism* to designate people who present a cross-gender identification, a wish to live as a gender different from the sex assigned at birth and those people who are willing to be submitted to sex reassignment surgery. According to the DSM-5, in turn, *Transsexualism* is not considered a disease. Nonetheless, it will be taken as such in case it is followed by a clinically significant distress being denominated GD. These changes which were addressed in the DSM-5 criteria will probably be incorporated to the ICD-11 to be issued in 2018. Moreover, in order for an individual in his/her adult life or childhood/puberty to be diagnosed GD, he/she will have to present significant distress for at least six months, according to the DSM-5 criteria (APA, 2013; Spizzirri, 2016).

Sexual identity disorders in childhood begin before puberty and are characterized by an intense and persistent distress in relation to belonging to a specific sex with a desire of being or insisting on the idea of belonging to the opposite sex. Such state generates deep distress in femininity and masculinity senses, and the evolution to transsexualism in adult life is not considered a general rule (Abdo, 2014; WHO, 1993). Trans children are known to frequently not identify themselves with the given gender at birth showing this incongruence through several different behaviors. For instance, those born male have a tendency to show interest to dress in female outfits, are not attracted to activities socially considered male or violent having preference to the company of girls as well as their activities. Many times they refuse to stand to urinate besides expressing themselves they are, or would like to be, girls. They may show a strong aversion to their penis and/or testicles and wish they had a vagina instead.

In their childhood, those assigned female at birth, in turn, present behaviors and negative reactions to everything referring to the female sociocultural context including clothing, child's play and other activities which remind them they should look and behave like girls. They feel like doing activities and playing games together with other boys, with whom they will have strong affinity. Many times they state they will be men when they grow up and feel great anguish during puberty, as soon as the hormones reveal female characteristics in their bodies (APA, 2013).

It's necessary to point out that not every transgender individual will develop GD, which is characterized by psychological distress either caused by such condition (due to difficulty adapting to the social environment), or the lack of adaptation to the body (use of hormones or surgical procedures). The present study aims at focusing on transgender women – male sex assigned at birth – diagnosed with GD (TW), and on transgender men – female sex assigned at birth – diagnosed with GD (TM). Trans sexuality exceeds the desire to obtain social advantage. It can affect people's self-esteem as well as the concept of self, what makes it difficult for the individual to meet affective and/or sexual partnership. It is not unusual for these individuals to present history of depressive clinical picture, many times followed by suicidal ideation, self-mutilation, isolation, prejudice and discrimination. It is worth mentioning that some of them report suicidal ideation in case they do not have means to adapt their body to the gender they identify themselves with (Spizzirri, 2016). In Brazil, individuals who are willing to be submitted to sex reassignment surgery (adequacy through surgical process to the desired sex) shall be, among other procedures, assisted with at least two years of psychotherapy. These series of interventions to GD transgender individuals beginning with psychiatric intervention is denominated Transgender Transitioning process. The ProSex is part of this program at HC-FMUSP. The flow of such procedures is mentioned below.

Transgender Transitioning Process

- Sorting with psychiatric evaluation aiming at establishing the diagnostic hypothesis of transsexualism according to CID-10 at the ProSex (in order the Brazilian Health System provides the necessary resources for the treatment of transgender individuals with GD, the diagnostic criteria proposed in the CID-10 are still being applied).
- After sorting, the patient is sent to psychotherapeutic process at ProSex and is informed that psychotherapeutic follow-up is essential (either individually or in group).
- After a six-month psychotherapy and having a diagnostic confirmation, the patient is sent to the Endocrinology Service of the HC-FMUSP in order to be prescribed hormonal therapy with sexual steroids.
- After a two-year period of follow-up by the interdisciplinary team, the patient is given a psychological report on which either the sex reassignment surgery is allowed or he/she is redirected to psychotherapy for some more time.

Psychotherapy, according to Dias (1994, 1997, 2000), is one of the resources for the individual to speed up his/her search process before the following aspects: basal sensation of incompleteness, basal sensation of insecurity, basal fear of life and partial loss of identity. Such sensations are present in all human beings from the ego structure formation in the very first months of life. Both satisfaction and lack of satisfaction experiences, associated to external moods expressed by the children's caregivers, being these moods inhibiting or facilitating, will make him/her have fewer or more incidence of such sensations of loss. Psychotherapy: (i) clarifies and raises awareness on the search process while guiding the individual on the internal and external sensations of emptiness; (ii) systematizes search procedures by using techniques for the approach to internal contents, besides helping on the management of intrapsychic defenses and symbiotic bonds; (iii) controls internal and external factors when allowing the individuals to know their reactive defenses and tendencies when close to the search process; (iv) controls external factors by creating artificial situations like dramatizations, questioning, contact with people during group sessions, besides helping the individual to search for those in life. Psychotherapy does not create a search process, once it only happens when the individual has that process activated within and associated to the presence of pathological anguish (Dias, 1994, 1997, 2000).

Psychotherapy enables the creation of new responses to old behaviors and the finding of a meaningful sense of being. It enables the construction of a new project of life or its readjustment. It increases the individual's resilience, causing tolerance to be easier before difficulties. It may help in the possibility of dealing with their existence difficulties in all shapes human suffering may assume besides benefitting personal growth and maturing. It is one of the facilitators in the therapeutic process of self as well as in the acknowledgement of the real identity concept, besides fostering the distance from previously learned self-concept and other stereotypes learned as subdued by family and social standards.

PURPOSE

The present study aims at reporting aspects of clinic and psychodynamic process resulting from psychotherapeutic follow-up, with a psychodrama focus, of transgender individuals diagnosed with GD who seek sex reassignment surgery.

METHOD

During information collection in order for the present study to be conducted, the following procedures were adopted:

1) Clinical and psychodynamic data have been collected from two groups of transgender individuals diagnosed with GD in therapeutic follow-up since 2011 in the ProSex: Group 1 (G1) constituted of TW and Group 2 (G2) constituted of TM. Table 1 below presents socio demographic data of the individuals participating in the study at the beginning of the study, in 2011.

2) Weekly psychotherapy sessions, which lasted 1 hour and 30 minutes each, were conducted and coordinated by psychologists who have psychodramatic background.

3) Psychodramatic techniques were applied. These include games, drawing and sharing on themes either proposed by the group or suggested by the psychotherapists.

Table 1. Socio demographic aspects of transgender individuals diagnosed with gender dysphoria participating in two groups in the ProSex, in 2011.

Variables	Group 1 (G1) Transgender women	Group 2 (G2) Transgender men
Participants (number of individuals)	16	8
Average age (in years)	32,7	30,5
<i>Education</i>		
Incomplete Primary or Secondary Education (%)	9 (56,2%)	3 (37,5%)
Secondary Education (%)	3 (18,7%)	2 (25%)
Incomplete Higher Education (%)	4 (25%)	1 (12,5%)
Complete Higher Education (%)	0	2 (25%)
<i>Professional Activity</i>		
Student (%)	2 (12,5%)	-
Employed (%)	13(81,2%)	6 (75%)
Retired (%)	-	1 (12,5%)
Unemployed (%)	1 (6,2%)	1 (12,5%)

PROCESS DESCRIPTION AND DISCUSSION

Group psychotherapy, among other aspects, is an available resource aiming at helping patients to know and/or recognize their feelings, as well as to manage them on a daily basis. During the psychotherapy sessions, the patients were able to tell their life stories, difficulties, fears and anger and, as time went by, they could identify common ground in their lives. Nurturing, confidence and disagreement were considered to be essential elements for elaboration in this process.

Group psychotherapy enables life reflections and questioning, paving the way to new emotional adaptations including the ones related to body changes, as a consequence

of hormonal treatment. Find below some considerations on the psychotherapy process of the two groups (G1 and G2) in two different times during the study: (i) the first one, after 2 years; and (ii) the second one, after 5 years (even the patients who were apt to sex reassignment surgery after a two-year follow-up, stay in the groups until they undergo surgery).

(I) There were changes in the groups during the two-year follow-up, including:

a) G1 was then composed of eleven participants while G2 of six (not considering the psychotherapists).

In G1, four participants were suggested to take individual therapy due to high competitiveness and aggressiveness during group sessions. These kinds of reactions, according to our experience, are not unusual whatsoever. Nevertheless, they were expressed in an enhanced way which made us interpret the situation as non-therapeutic as far as group management was concerned. In G2, one of the participants was sent to the individual process because of self-aggressiveness associated to suicidal tendencies. In view of that fact, individual follow-up was agreed to be more beneficial.

One G1 subject decided on not being submitted to sex reassignment surgery because such perspective would interfere with her activities as a sex professional and quit the therapeutic process. Similarly, a G2 participant, who had good financial situation, did the same after a decision on seeking help on his own means.

b) During this time, some differences between these two groups (G1 and G2) are worth being observed:

1) Parental, affective-sexual and economical relationships

In G1, six participants used to live with their original family, and two of them did not feel responsible for providing financial help to their families. In turn, fourteen of them used to help or send the family some money. Only two of the participants had a steady relationship at the beginning of treatment and other six started a relationship during the first year of psychotherapy.

In G2, five of them used to live with their original family, and two decided on returning home during that period. None of the participants felt responsible for economically helping the family. Three of them had steady partners in the beginning of treatment and after a year of therapy together with changes in their body due to hormone therapy, only one of them kept on having the relationship. One thing worth pointing out is that in relation to father figure, six of them presented alcoholism history.

The independence and commitment relation with family was remarkably different between the two groups. In the TW, the necessity to economically care for their families was observed. That was not the case with the TM. One possible explanation for that to have happened may be due to the social roles learned during their upbringing in the childhood, taking into consideration that the male gender is the provider and the female gender, the caregiver.

2) On aggressiveness

In G1, when facing situations of discrimination and rejection, the TW responded more aggressively in the social groups they lived in. Moreover, they showed less tolerance

in biased situations. The TW have an inclination to be more articulate and their quick responses are very common as well as intolerance to what they consider insulting. Apparently, the TM present more tolerance when facing situations suggesting prejudice, in spite of the fact they feel a lot of indignation. Again, due to what was above mentioned, the conflict between what was learned about their assigned at birth gender and the one they identify themselves with is clearly noticed. In other words, men belonging to Latin-American culture have a tendency to be more aggressive when intimidated, while women understand feelings involved in such situations better.

3) On the use of alcohol

In G1, when questioned about this issue, two TW reported consuming alcoholic drinks unreasonably. Most of them understand that as social drinking. In G2, 4 of the participants reported to abuse of alcohol. These TM showed more openness while being questioned about the topic and confirmed more easily that, generally speaking, such attitude could bring problems to their lives. They reanalyzed such behavior during the process.

After two years of psychotherapy, we would like to quote the following utterances by two TW from G1.

“I have sought my femininity all my life above everything. I feel well psychologically, I am aware of all the risks, and even it does not work well, for sure, anything is much better than having a penis that makes me feel disgusted about besides sadness.”

“I feel well after these two years. Previously I wasn't because of problems I had with myself. As a consequence of the therapy process, everything in my life changed for the better. I feel happy, I am working a lot on love. I am dealing better with my family and myself.”

(II) After five years from the beginning of group therapy

G1 has now seven participants. Two of them were submitted to sex reassignment surgery and eventually sent to post-surgical individual therapy. Two TW started individual follow-up: one for having difficulty reconciling work and the group scheduled time and the other for having presented aggressiveness. As previously mentioned, situations like that bring no benefit to the group process and, also, suggest better results if the follow-up is done individually.

Themes related to envy and anger seem to be recurrent during the therapeutic process. Other topics are always being mentioned during sessions, and most of the times they are related to female and male roles, besides idealizations generating a lot of frustration. Although they feel and perceive themselves as women, TW idealize the meaning of what to have a vagina is, that is, it is common to hear “I will only be a real woman after surgery...” Working in the deconstruction of this ideal of what will make them complete and happy is to have a vagina helps towards the objective of making them feel closer to their real identity. Some TW from G1 underwent surgeries in order to get their bodies adapted to secondary female characteristics like: breast implants, Adam's apple surgery, nose cosmetic surgery and feminization of facial features. Such procedures were followed by improvement in self-esteem.

All the TW reported a feeling of suffering while waiting for the sex reassignment

surgery to be conducted.

G2 continued with six participants, having occasional individual support sessions whenever necessary. Four of them were submitted to hysterectomy and from these, three underwent mastectomy. One participant had the surgery suspended due to family conflicts such situation could cause. We must reaffirm how important family support is, what has been continually emphasized during sessions. Considering these TM surgeries were close to each other, our option was not to send them for individual follow-up.

Despite the fact the TM have reported satisfaction in relation to the surgeries they had undergone, some depressive mood was observed in the group due to bigger pressure by their family members, once after the surgical procedures, their relatives had expectations on the fact that the so desired physical adaptations would be followed by attitude which is socially much more accepted in accordance with the role suggested to the male gender. The construction of a male identity is an important topic in group therapy as well as the fears of internal and external confrontation resulting from such situation. Like the TW, the TM mentioned the feeling of suffering they had felt while waiting for the surgical procedures.

FINAL CONSIDERATIONS

Most of the patients reported a quality of life improvement after these years of group psychotherapy, besides acquiring more respect for themselves as well as from their social environment and their relatives. Even though the very beginning of the psychotherapy process had been considered mandatory and essential for the surgical procedures to be carried out, the group participants (patients and psychotherapists) created an affectionate bond, contributing for the facing of situations associated to the process.

Over the years, group psychotherapy has been proving to be a fundamental therapeutic resource as far as these individuals' follow-up is concerned, going beyond the mandatory initial objective and being useful to expand the construction of new projects of life, as well as enabling ways to achieve them.

It is worth pointing out that TM need special attention because, for not being used to receiving a bigger amount of testosterone in their body, they end up expressing themselves and/or acting more impulsively or aggressively. In turn, TW apparently present fewer conflicts towards the female model despite the desire of having perfect bodies, what goes way beyond tangible reality.

Finally, it is also worth emphasizing that transgender people's psychodynamic issues do not differ whatsoever from those not presenting that condition. The difference lies in the distress associated to that, allowing us all to be in touch with so fundamental emotions bringing a better understanding of the world we live in and the human being sexual diversity.

REFERENCES

Abdo, C. H. N. (2014). *Sexualidade humana e seus transtornos* (4a. ed.). São Paulo: Leitura Médica.

Associação Psiquiátrica Americana (APA) (2013). *Manual diagnóstico e estatístico de transtornos mentais* (DSM-5). Porto Alegre: Artmed.

Dias, R. C. V. (1994). *Análise psicodramática: Teoria da programação cenestésica*. São Paulo: Ágora.

Dias, R. C. V. (1997). *Psicodrama: Teoria e prática*. São Paulo: Ágora.

Dias, R. C. V. (2000). *Vínculo conjugal na análise psicodramática*. São Paulo: Ágora.
Organização Mundial da Saúde (OMS) (1993). *Classificação de transtornos mentais e de comportamento da CID-10*. Porto Alegre: Artes Médicas.

Spizzirri, G. (2016). *Morfometria cerebral e imagens de tensores de difusão da microestrutura da substância branca em homens para mulheres transexuais antes e durante o processo transexualizador* (Tese de Doutorado). Faculdade de Medicina da Universidade de São Paulo (USP), São Paulo.

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