

CASE REPORT OF AUTOGYNOPHILLIA – FAMILY, ETHICAL AND SURGICAL IMPLICATIONS

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SUMMARY

Through the case presentation of a diagnostically and therapeutically interesting gender dysphoric individual, the authors wish to address diagnostic problems associated with this controversial category, illustrate dilemmas and emphasize the importance of diagnostic procedures in differentiating between primary transsexualism and other transgender states.

Many questions have been triggered by this case, mainly about whether this patient should be classified as a paraphilia (transvestite, transvestite with transsexual trend), primary transsexualism or autogynephilia and about the most adequate treatment (e.g., sex-reassignment surgery, hormone therapy as a way of partial feminisation or exclusively psychotherapy).

The issue of reconstructive surgery, i.e. its justification in the case of this particular condition is specifically discussed. Before any decision is made, both medical but also ethical consequences of the treatment choice need to be considered (e.g., the client is the father of two underage children).

Key words: *transsexualism – autogynephilia – transvestitism - sex-reassignment surgery*

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INTRODUCTION

Male individuals with an extreme variation of transvestic fetishism, characterised by *sexual* fantasies about being the other sex (i.e. female), have been reported and their condition (non-homosexual transsexualism, autogynephilia) proposed as differing from primary, i.e. “homosexual” transsexualism (Blanchard et al. 1988 & Blanchard 1989). The wide-ranging proponents (e.g. Blanchard 1989, Lawrence 1998, Lawrence 2000 & Fenton 2004) and critics (e.g. Orens 2004, Wyndzen 2004 & James 2004) of this category have continued to disagree, with the critics (e.g. Ekins & King 2001) arguing that autogynephilic components can be found in both “homosexual” and “nonhomosexual” transsexuals.

Pre-surgery diagnostic procedures, in which psychiatric examination takes a major role, have long-lasting consequences. Evaluations of the outcome of sex-reassignment surgery may be complex and include multiple ratings (Chiland 2003). Sometimes the outcome has negative implications (Blanchard 1989) and is regretted (Lindemalm et al. 1986), raising the questions about the most appro-

priate treatment (psychotherapy, endocrinology, surgery) for clients diagnosed with autogynephilia.

Through the case presentation of a diagnostically and therapeutically interesting gender dysphoric individual, the authors wish to address diagnostic problems associated with this controversial category, illustrate dilemmas and emphasize the importance of diagnostic procedures in differentiating between primary transsexualism and other transgender states (Benjamin 2001). The issue of reconstructive surgery, i.e. its justification in the case of this particular condition is specifically discussed.

CASE REPORT

The patient is a 44-year-old lawyer who has been married for 17 years. Respecting “psychological sex” and patient’s needs we will present our client as “she” in further text. She has two children (aged 5 and 6) and a sister who is 10 years her senior. The patient grew up in a complete family (both parents are high educated and relatively adequate in their parent’s roles and partners relationship in classic terms).

Her first contact with a psychiatrist in 1991 was when she was diagnosed as suffering from “non-psychotic depressive reaction” and subsequently treated with anti-depressants and anxiolytics (related to war circumstances and a high risk for war mobilisation). She had several further contacts with a psychiatrist and was in psychotherapy for two years. Further psychotherapy has revealed problems in her sexual behaviour. Following her female clinical psychologist/therapist’s “permission” she dressed and started to speak as if she were a woman (in sex-biological terms). She left psychotherapy abruptly after the therapist has disagreed with her wish to have sex reassignment surgery and suggested that she continue to live with her family as a woman. One year later she continued her individual psychotherapy with a male therapist. However, she soon stopped this and approached a therapist in the Clinic where the authors of this paper work to request a sex-change.

She never felt disgust towards the attributes of a male body and saw her genitals as instruments for social adaptation rather than being associated with erotic excitement. In line with this, she has never masturbated.

As a child she played boys' games and did not express any cross-dressing or cross-gender behaviour. On reflection, she feels that her father imposed male behavioural patterns and nurtured macho-style behaviour. She felt resistant to this but never expressed it overtly.

Watching cross-dressed persons with make-up and feminine behaviour provoked »strange excitement« in her which she found this to be different from erotic excitement and to be more of some kind of »personal need and deep-rooted internal drive«. She reported episodes of homosexual panic, but she has never had any homosexual experience. Her first attempt (aged 16-17) at penetrative sex failed because of her erection failure. Her first sexual experience was with her actual wife. Her interest in vintage cars has been a passion since her childhood.

Aged 25, five years after she met her wife-to-be, she started to engage in partial cross-dressing when alone in the house. This progressed further and she started to cross-dress when going out and then (around the age of 30) in front of her wife. Her cross-dressing became a necessary aid for her sexual arousal and intercourse with her wife. In her 40s she had ideas about going through sex-

reassignment surgery, becoming a (trans) woman and living with her wife in a homosexual relationship. Several years ago she started to take non-prescribed oestrogen. Her wish to have a sex-change operation had resulted in her wife’s suicide attempt and she subsequently gave up this idea. Instead, soon afterwards she reverted to exhibiting cross-dressing and cross-gender behaviours.

From the moment her wife had learned about the client’s sexual identity needs, she was supportive of her cross-dressing behaviour (as a sexual foreplay) and her hormone (oestrogen) injections (that were “protecting” her “from the environment”). The wife’s involvement in the client’s transgender behaviour included joint purchasing of women clothes, underwear and make-up for her, inventing a female name for her, accompanying her to the places where prostitutes gathered and watching them for hours searching for differences between her and male transvestite prostitutes.

The client has a complexed personality in terms of functional and structural domains of personality (Millon 1997). Her specific personality structure demonstrated, high scores on histrionic, compulsivity and narcissistic scales (Millon 1997). Such persons are distinct excentric, highly emotional persons who search for stimulation, excitement and attention. On a behavioural level they tend to be extravagant. In some way these personality dimensions are in conflict with each other (histrionic elements opposite to compulsivity). Histrionic traits make them more emotional and impulsive, compulsively rigid with mental and interpersonal control. Behaviour variability, ranging from rigidity to unusual, uncontrolled search for stimulation are fluctuations which are also demonstrated in our client. This personal style implies a specific personality disorder. The personality scales - narcissistic, histrionic and compulsive traits reflect personality pathology (Millon 1997). Emotional immaturity, confusion regarding sexual identity and many intrapsychic conflicts resulted in various atypical behaviours (Duišin 2004).

DISCUSSION

Gender dysphoria could be a common symptom of the two relevant potential disorders (transsexualism/TS, autogynephilia or transvestism/TV) of the individual concerned. A more

precise distinction between these states is sometimes difficult because of possible overlapping. From a dimensional point of view gender dysphoria is less expressed and had a more complex clinical picture and variations in autogynephilic persons as compared to persons with pure (primary) transsexualism.

Frequent and early presence of cross-dressing behaviour in autogynephilic persons implies the need for longer and more complex exploration and follow-up. This fact partially delays sex-reassignment procedures as well as the fact that these patients ask for help in later years (around their 40-ies). Cross-dressing in this case evolves from sexual motivation at the beginning (25 year old) to non-erotic (autogynephilic) dimension as a way of relief from gender discomfort (Duišin D, Nikolić-Balkoski G, Barišić-Rojnič J, 2003).

Ray Blanchard, one of the famous experts in this field classified four subtypes of autogynephilic persons:

- Transvestic autogynephilia: arousal to the act or fantasy of wearing women's clothing;
- Behavioural autogynephilia: arousal to the act or fantasy of doing something regarded as feminine;
- Physiologic autogynephilia: arousal to fantasies of female-specific body functions;
- Anatomic autogynephilia: arousal to the fantasy of having a woman's body, or parts of one (Blanchard 1993).

Many questions have been triggered by this case, mainly about whether this client should be classified as a true transvestite, a transvestite with a transsexual trend, a transhomosexual or an autogynephilic person (ICD-10 1988, DSM-IV 1994) and about the most adequate treatment (e.g., sex-reassignment surgery, hormone therapy as a way of partial feminisation or psychotherapy). This client could be recognised as a transvestic and behavioural autogynephilic person. Before any decision regarding the treatment plan is made, both the medical and also the ethical consequences of the treatment choice need to be considered (e.g., the client is the father of two underage children).

With a few exceptions, cross-dressing exists almost in all transsexuals, as defined in the diagnostic criteria (DSM-IV 1994). Cross-dressing behaviour was present in our patient as an initiation and a long term process in autogynephilia. The wish for a sex change was not present

at the very beginning in this patient (meaning at a younger age). Her attitude towards her own sex organ (as the crucial differential diagnostic point between the two syndromes: TV and TS) in adolescence and the early adult period was congruent (in accordance) with her biological sex. By the time (in her 40-ies) our patient revealed that her needs are more than just a need for cross-dressing as an act of erotisation, she decided to experience physical feminisation (e.g. breast development) by using hormones or surgical interventions. Oestrogen hormone intake provided an enormous emotional relief. This stage has been interpreted as intermediate between transvestism and transsexualism in the evolution of autogynephilia.

The main criteria for conversion surgery in transsexuals are very clear. Clinical experience and investigation in the last decade impose similar criteria for autogynephilic persons who request sex-reassignment surgery.

CONCLUSION

The diagnostic dilemma at the beginning of exploration in this case was mainly because of the slow development which has led to various atypical behaviours. The client's slow development and confusion in sexual identity arose partially from her ambivalent position and difficulties in deciding whether or not she wanted surgical transformation. The client had expressed fetishist transvestism in his 20's, with slow evolution and progression to a state between transvestism and transsexualism in his 40's. This case could be analysed by the development concept and thus predictions of his future progress (Blanchard 2004) in autogynephilia. Nevertheless, at the moment the treatment plan for this client consists of individual and family psychotherapy rather than physical interventions such as surgery.

Even though our patient could fit into the autogynephilic concept, the authors of this paper raise the question as to whether sex-reassignment surgery should be proposed as the most convenient treatment. Our opinion is that we should be more cautious in this respect bearing in mind the complexity of her personality, the specific evolution of her transgender identity and her family circumstances (Duišin 2004).

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