ORIGINAL ARTICLE

Journals BAHIANA
SCHOOL OF MEDICINE AND PUBLIC HEALTH

TORNAR-SE HOMEM, TORNAR-SE MULHER - RELATO DE CASO

ON BECOMING A MAN, ON BECOMING A WOMAN – CASE REPORT

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RESUMO | Introdução: Visando promover o bem estar da população transexual, mundialmente há alterações nas recomendações de condutas clínicas. Os critérios para os tratamentos visam minimizar os efeitos da Disforia de Gênero desta população resguardando-lhes o direito à dignidade humana, e devem ser adotados pelas condições de elegibilidade e de presteza; dentre eles, a complexa Cirurgia de transgenitalização. **Objetivo:** Discutir a atípica situação de sujeito transexual que não deseja passar pelo procedimento cirúrgico. Método: Emprego de entrevista qualitativa que visou estudar as relações dos significados atribuídos pelo sujeito da pesquisa. **Resultados:** Relato de Caso descritivo de sujeito que se contrapõe a um dos elementos do diagnóstico psiquiátrico de transexualismo: atendendo aos critérios de elegibilidade à transgenitalização prefere conservar suas características físicas, mas mantém uma atitude positiva em relação ao seu corpo devido a eficiência de suas defesas psicológicas. **Conclusão:** Este caso nos convida a refletir que a mudança de sexo, apesar de aliviar a disforia de gênero, pode não ser suficiente como tratamento para o transexual. A recomendação do tratamento deve ir além da elegibilidade e deve avaliar o préstimo ofertado à qualidade de vida do sujeito dentro de novas perspectivas despatologizadas promovidas por entidades de cuidado humanitário na área da saúde.

Palavras Chaves: Cirurgia de Redesignação de Sexo; Transexualismo; Disforia de Gênero.

ABSTRACT | Introduction: Intending to promote the welfare of the transsexual population there are worldwide changes in clinical management recommendations. The criteria for treatments aim at minimizing the effects of Gender Dysphoria of this population safeguarding their right to human dignity and shall be adopted by the conditions of eligibility and readiness; the complex sex reassignment surgery is among these treatments. **Objective:** To discuss the atypical situation of a transsexual subject who does not want to go through the surgical procedure. Method: Use of qualitative interview aimed at studying the relationships of meanings attributed by the research subject. **Results:** Descriptive Case Report of atypical subject opposed to one of the elements of the psychiatric diagnosis of transsexualism: meeting the eligibility criteria for gender reassignment, prefers to keep its physical characteristics but maintains a positive attitude to the body due to its efficient psychological defenses. **Conclusion:** This case invites us to reflect that sex change, although alleviating gender dysphoria, may not be sufficient as a treatment for the transsexual. The treatment recommendation must go beyond the eligibility and must assess the benefit offered to the quality of life of the subject within unpathologized new perspectives promoted by humanitarian organizations in health care.

Key Words: Sex Reassignment Surgery (SRS), Transsexualism, Gender Dysphoria

Submitted 09/09/2017, Accepted 11/16/2017, Published 11/30/2017
DOI: 10.17267/2317-3394rpds.v6i4.1612

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INTRODUCTION

This case study report was extracted from the postdoctoral research of the first author, entitled "Becoming a man, becoming a woman: reports of transgender patients under outpatient care about gender reconstruction at a university hospital," submitted and approved by the Research Ethics Board of the School of Medical Sciences from the University of Campinas (Unicamp), according to the decision CEP 842/2010, and developed at the Department of Medical Psychology and Psychiatry of Unicamp.

Human sexuality depends on certain interrelated psychosexual factors, such as sexual identity, gender identity, sexual orientation, and sexual behavior (Costa, 1994, p. 40). These factors affect the growth, development, and functioning of personality. Sexual identity comprises the pattern of biological sexual characteristics. In what is considered the normal development, those aspects form a coherent pattern that defines a person as to their sexual identity. Gender identity is the perception of masculinity or femininity and is the result of multiple factors, such as parental and cultural attitudes, the baby's external genitalia, and a genetic influence. At the age of two to three years, the gender identity would develop in most people and often it is consistent with the biological sex (Costa, 1994, pp. 11-54). Thus, the gender identity involves essentially psychological and cultural aspects of behavior related to masculinity and femininity (Sadock & Sadock, 2012). Gender is social and sex is biological. Often, both are congruent. Men tend to see themselves as male and women tend to see themselves as female, which does not exclude the possibility of sex and gender being opposite or conflicting in the same person, as in the example of transsexuals (Costa, 1994, p. 12). Two types of transsexuals are recognized (Costa, 1994, pp. 161-163). The primary are those who, starting at the age of three years, start recognizing themselves and behaving as belonging to the group of the opposite gender of their birth; and the secondary, those who, due to social or family conditions, remain aligned to the gender role of their birth, even if their internal feeling is of belonging to the opposite gender.

Although the causes are not yet fully understood, the discourse on transsexualism in the health area has assumed the direction of depathologization (Coleman et al. 2012, pp. 165-232). The American Psychiatry Association warns that, with the publication of the DSM-5, the criteria used to define the condition in which "people whose sex at birth is in contrast with the one they are identified to"- was reviewed and that these subjects should be "diagnosed with gender dysphoria" (APP, 2013), replacing the old categorization of "Gender Identity Disorder." The amendment aims at making access to this population of mental health care easier, and thus avoid the imposition of stigma coming from categorizing terms. However, despite the fact that this change in the DSM-5 seems to be an important step for the depathologization, trans activists from around the world are fighting for the withdrawal of such classifications from the manuals of Psychiatry. They state that their right to self-determination over their bodies is dissociated from the need of psychiatric evaluation (Murta, 2011; Sampaio, et al., 2017).

We recall that in the Classification of Mental Disorders and Behavior of the CID-10 (Classificação de Transtornos Mentais e de Comportamento da CID-10 – 1993), the diagnosis of transsexualism (F 64.0) in an adult requires that at least three criteria be met: (1) The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make the body as congruent as possible with the preferred sex through surgery or hormone therapy; (2) this desire has been present persistently for at least two years; (3) the disorder is not a symptom of any mental disorder or chromosomal abnormality. In 1997, the sex reassignment surgery came to be officially performed in Brazil, and in August, 2008 the Ministry of Health issued the Ordinance 1,707 establishing, within the framework of the Unified Health System (Sistema Único de Saúde - SUS), that the Transexualizing Process should be deployed to the different regions of the country (accessed on: December, 2009). The Ordinance states that through this act the State would protect the transsexual population's rights to "health, dignity, non-discrimination, autonomy, and to the free development of personality."

The resolution 1,955/2010 of the Federal Council of Medicine (accessed in 2013) agreed on the selection

criteria for the so-called Sex Reassignment Surgery (SRS). The resolution pointed out that "it will obey the evaluation of a multidisciplinary team consisting of a psychiatric doctor, a surgeon, an endocrinologist, a psychologist, and a social worker," respecting three criteria: "(1) medical diagnosis of transsexualism; (2) being over 21 (twenty-one) years of age; (3) the absence of inappropriate physical characteristics for the surgery."

The issue of transsexuality reaches the cultural, political and health spheres, which makes its clinical management, aiming at approving the SRS, somewhat peculiar, in addition to other forms of effective treatments in the promotion of human dignity to transsexuals who feel uncomfortable with their condition. The World Professional Association for Transgender Health (WPATG) is one of the leading entities that promote clinical humanized assistance guidelines to the transsexual population. The WPTAG is heir to the legacy of Harry Benjamin (Green, 2010, pp. 1457-65), one of the first authors to write about transsexualism and SRS. This association maintains a multidisciplinary and global forum that promotes and updates research on health practices for this population, resulting in the publication of the "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People" (SOC). The SOC, currently in its 7th version, aims to "articulate the consensus of this international organization of professionals on psychiatry, psychology, medical, and surgical management of the gender identity disorder" (Coleman et al. 2012, pp. 165-232). Furthermore, the SOC proposes to mental health professionals, among other tasks, "to recommend the various forms of treatment and its implications" and "to assess the eligibility and promptness of hormonal and surgical therapy" (Coleman et al. 2012, pp. 165-232).

The situation reported here is the story of a subject who fulfilled the eligibility criteria of the Brazilian and the global health systems, but who declines both his right and the possibility to go through the procedure of SRS, efficiently developing the defensive mechanisms that ensure a satisfactory quality of life, becoming an example of conditions that do not grant the expected use of the SRS.

The subject of this case study report has masculine sexual identity (anatomical), feminine gender identity (social), and heterosexual sexual orientation and sexual behavior considering her gender identity. The subject will be treated as a woman and identified by the letter P. She is 21 years of age, is 1.78 m tall, and is of appropriate weight for her height. She is the only child of separated parents, studied until high school and works in a beauty salon in the city where she was born and lives. She reported that when she was a child, she would rather play with dolls and among girls instead of playing with boys. At the age of 11 she had a homosexual experience, and after that, she defined herself that way to her family. When she was 15, she experienced the feeling of being "different," she talked to her mother and, following her advice, consulted a psychiatrist and an endocrinologist for treatment, "everything as it should be." She started taking hormones, let her hair grow long and started wearing women's clothes.

Expressing herself clearly during the interview, although with some hesitation, but in a serious tone of voice and somewhat masculine, which did not strike too discordant a note, most of the time P. demonstrated disinhibition and security. She was sent by the primary medical care service in her city to the Outpatient Clinic of General Psychiatry for Adults of the Hospital das Clínicas (HC) – UNICAMP in October, 2010. She complained she was feeling sad, had insomnia, was losing weight and had developed some anhedonia, she had no suicidal ideas and thus fulfilled the criteria for a Moderate Depressive Episode. She had no history of psychiatric disorders. This scenario started three months earlier, when the breakup of a romantic relationship, which lasted two and a half years, took place. She started treatment with Paroxetine 20 mg/day and maintained a treatment with Diazepam 10 mg that she was already in, and which was prescribed by the clinician in the Basic Health Unit. The response to the antidepressant was satisfactory, with remission of symptoms, allowing the end of the maintenance treatment after six months.

METHOD

Case study is a procedure used in clinical intervention intended to understand and plan an intervention with

the possibility of integrating different techniques and fields of knowledge. In this method, the theoretical knowledge is directed to the singular and particular level, in an authentic act of "leaning over the bed," i.e., from a direct and thorough observation, one will explore and seek to understand the meanings present in the actions of the subject (Barbier, 1985). Accordingly, the present report was extracted from the material resulting from the use of qualitative methodology for the above-mentioned survey. The survey studied the relationships of the meanings assigned by the informants. Excerpts chosen by the authors of this article came from the use of a non-directed interview comprised of open-ended questions applied according to the method pointed out by Turato (2011, p. 306). Clinical-psychological in-depth interviews were conducted with the initial goal of investigating psychological meanings conveyed by transsexual subjects, under outpatient care at our psychiatric service, to the experiences of personal phenomena associated with gender identity. Consistent with the studied sample, the interview with P. was recorded in audio and transcribed in full with the permission of the patient after she had read and signed the informed consent. Subsequently, fluctuating readings were made for the analysis of content. The authors point out that the definition of the theme of this article was made with the intention of favoring the particular report of not wanting to undergo sex-reassignment surgery, which would contrast with one of the elements of the psychiatric diagnosis of transsexualism.

RESULTS AND DISCUSSION

"I don't see myself as a transvestite, I really see myself as a transsexual. I live as a woman, I act like a woman, I think like a woman, but the surgery hypothesis does not exist in my life."

The patient in question lives, since her adolescence, as a woman. She takes a feminine stance during her daily life and adapts her physical characteristics through hormone therapy. She did not present periods of resuming the birth-gender behavior, and she seems to be familiar with the surgical procedures and risks. Due to the general conditions of her sexuality, she can be included in the secondary group of transsexuals, because the process of recognizing her gender identity came when she was between 11 and 15 years of age. During childhood, when she felt different from others, her social ties were established with girls. At 11 years of age, she recognized herself as homosexual. At the age of 15, she assumed the female identity and sexual role, and at that time expressed the wish to have the surgery. As for the diagnosis of her sexual identity, the seemingly irreversible character of the assumed sexual role, the permanent desire to develop the female form, and a first desire to perform the SRS, stops us from considering her a case of transvestism; her later desire to keep her birth genitals making her an example of a transsexual.

Regarding her attitude towards sex reassignment, she is an example of contrast with the following statement: "It is possible that there are cases of transsexuals who do not transform the body, but that person will spend their entire lives feeling 'weird' in it" (Costa, 1994, p. 162). However, P. seems to have lost feelings of "weirdness," and tells us she found advantages in her peculiar way of being. "I am trans! I don't think about doing surgery, it would be an aesthetic thing!" While she is an enigma, she does not see any contradiction in being a woman while having a male genital organ. She says that this is not a problem for her emotional relationships. On the other hand, why would a transsexual transform his or her own body? Baranyi, Piper & Rothenhäusler (2009, pp.548-57) claim that the sex-change procedures are painful, with lengthy post-operative care, and the final result – even when it is aesthetically good – is not always functional. Another study shows that people with transsexualism, after sex-reassignment surgery, have considerably higher mortality risk, suicidal behavior and psychiatric morbidity than the general population (Kuhn, Santi & Birkhäuser, 2011, pp. 2379-82). It is not enough that candidates for surgery meet the eligibility criteria. According to the SOC, surgical treatment readiness criteria also need to be considered: "to demonstrate the consolidation of a gender identity" and social and emotional stability (Dhejne et al. 2011).

The following affirmation of P: "I don't feel the need for surgery and I'm terrified of it," allows us to infer that by refusing to resort to sex-reassignment surgery, she is using a psycho-social adaptive mechanism:

rationalization. These mechanisms include the ways, techniques, or strategies developed along the human evolutionary process for dealing with internal conflicts and the ones resulting from external reality (Turato, 2011, pp. 472-75). Rationalization is considered a psycho-social adaptive mechanism used universally (Chvatal, Böttcher-Luiz & Turato, 2009, pp. 9-14). In this sense, regardless of the possibility of body modification, and with the satisfactory development of defenses, the patient, according to her account, managed to establish good family relationships, and to properly fulfill social and emotional activities. On the other hand, she is not comfortable with the conditions of the sexual-reassignment surgery. This leads us to question what would the value of the surgery be to her? In her case, the surgery would not bring relevant benefits to her quality of life. The initial desire of complete transformation was not lost. However, it has been adapted to the current situation of acceptance, on the part of her companions, which alleviate the symptoms of distress coming from the conflict between the desire (for sex changing) and the fear (of surgery). Both her ex-boyfriend and the current one accept her as a woman, according to her, even without performing the sex-reassignment surgery.

External factors can be motivating to a voluntary change, especially when secondary gains are present, as in the case of P, who demonstrates that she feels accepted and her family and partners do not put pressure on her to change her body. She is convinced about what she wants for herself: "I have three dreams: attending university, getting married, and adopting a son. ..." In her plans, there seems to be no place for radical physical and aesthetic changes. In fact, her desires are common to most women in our culture: to establish emotional bonds, to have her own family, and to obtain financial independence.

FINAL THOUGHTS/CONCLUSION

It can be the case that people do not want to give up certain peculiarities in order to maintain a satisfactory quality of life. At the same time, we confirmed that the boundaries between the psychological characteristics of male-female, man-woman, are particularly tenuous; just as the models that are considered dominant, escape the demands of affective order. This case study report invites us to reflect on gender changing. Even if this change potentially alleviates gender dysphoria, it may not be enough in the global treatment for transsexualism. Therefore, it should inspire greater attention in addressing physical health for this group of patients in the treatment project, and that does not include patients in possible pathological models dominated by the predominantly biological worldview or of a particular psychosexual orientation. The criteria of conduct must go beyond the eligibility protocol; it should also aim at assisting patients through eligibility in the quest to offer them the best way to access their rights to human dignity.

COMPETING INTERESTS

No financial, legal or political competing interests with third parties (government, commercial, private foundation, etc.) were disclosed for any aspect of the submitted work (including but not limited to grants, data monitoring board, study design, manuscript preparation, statistical analysis, etc.).

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