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Behavioral Treatment in Crossdressing & Transsexualism, A Review of the Literature and a Call for Reform

by Dallas Denny, MA

(At AEGIS, we are beginning to present papers at professional conferences—as the peers of the attendees—and to publish in professional journals. We believe that the best way to introduce change into a prejudicial literature is to become a contributor to that literature. To that end, our exhaustive annotative bibliography—weighing in at more than 650 pages—has been published by Garland Publishers, and we are preparing an edited text, also to be published by Garland, entitled New Concepts in Cross-Gender Identity. Confirmed contributors include Dr. John Money, Dr. Richard Green, Dr. Holly Devor, Dr. Barbara Warren, Dr. Jerilynn Prior, Dr. Walter Bockting, Dr. Eli Coleman, Dr. Eugene Schrang, and Holly Boswell.

This article is an excerpt from a paper I presented at the annual meeting of the Association for Behavior Analysis in Atlanta, Georgia, 29 May, 1994. Please bear in mind that I was speaking as a peer; my words as a woman of transsexual experience would have been much harsher.)

Articles about the behavioral treatment of transsexualism and crossdressing began appearing in the professional literature in the 1960s. British authors typically used extremely aversive methods in attempts to reduce the frequency of crossdressing. I am about to make an extreme statement, but I feel it is justified, for these attempts to create social conformity are documented in black-and-white in journals like The British Journal of Psychiatry. Some of their experiments might have been done by Nazis, had the applied behavioral techniques been available to them.

In the first published account of aversion therapy with a crossdresser, Lavin, et al., (1961) kept a 22-year-old married man awake for days with amphetamines, giving him frequent injections of apomorphine to make him violently sick to his stomach while he was forced to look at slides of himself crossdressed. Treatment did not stop until the subject became confused and his vital signs became abnormal. Barker, et al., (1963) required a man who sought treatment for his transvestism to dress and undress 400 times in six days. He was given electric shock to his feet (or a buzzer sounded to signal him to undress). In both studies, the subjects reported themselves “cured” at follow-up six months post-treatment. I think I might have, also.

We must remember that this extremely aversive treatment was given for behaviors which were essentially harmless, and which could have been dealt with in any number of less aversive ways. It’s not as if crossdressing behavior is life-threatening. Clark (1963), for instance, gave apomorphine to a man with anxiety and marital stress produced by his wearing of girdles. Considering even the relatively limited repertoire of behavioral techniques available at the time, it’s difficult to understand why such extreme treatment was used in these studies, and especially why other, less aversive techniques were not tried.

These workers never questioned that what they were doing was justified. In 1965, Barker compared the effectiveness of electrical shock and purgatives in the treatment of transvestism. He never mentioned the use of nonaversive techniques, and he certainly never discussed the possibility that the subjects might be counseled to accept their need to crossdress and integrate it into their lives.

The British workers came very close to disaster. In 1963, A. J. Cooper published a paper about an incredibly aversive and even life-threatening behavioral treatment of a crossdresser. The subject was kept awake for one week with amphetamines and given drugs to make him violently nauseous on an hourly basis. He developed cardiac problems and had to be hospitalized for a month in a cardiac unit. The author suggests frequent EKGs for persons being given nausea-producing drugs. He did not suggest that his treatment may have been a bit extreme.

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If you have a bit of imagination, a word, I know, I should not use at a meeting of behavior analysts, you can see this man, this crossdresser, wild-eyed and perspiring from the amphetamines, smelling of vomit, going into cardiac distress. It's a scene straight out of Kubrick's *A Clockwork Orange*, but let me remind you that the protagonist in the film brutalized and killed people. Cooper's patient did nothing except sometimes wear women's clothing.

In 1969, Gelder and Marks reviewed aversion treatment in transvestism and transsexualism. They noted that while aversion was a valuable treatment with crossdressers, it was less useful in persons with pronounced transsexualism. This was because there was little or no motivation to change in this population. Gelder and Marks did not question whether it was appropriate to attempt to make such changes in persons who did not want to be changed, although they did discuss the conditions under which they considered it ethical to use aversive and noxious stimuli.

As the field of applied behavior analysis became more sophisticated, so did the treatments, although let me say that aversive procedures delivered as part of a treatment package are no less aversive than aversion delivered alone. Barlow, Reynolds, and Agras (1973) used such a treatment package consisting of a variety of nonaversive methods and electric shock to alter a variety of measures of a 17-year-old boy's transsexualism. In 1979, Barlow, Abel, and Blanchard followed up the subject and presented data from two additional subjects treated with a similar treatment package. One subject, a genetic male, while successfully crossliving, developed anxiety about passing as a woman and came into treatment. After treatment, she was highly sexually active as a homosexual, but as a male, despite her breasts and lack of facial hair.

Barlow et al.'s techniques have been replicated as recently as 1987, but no researcher, so far as I know, has looked at the differential effectiveness of the aversive and nonaversive components of their treatment package in transsexualism or crossdressing.

Craighead, Kazdin, & Mahoney, in their introduction to a 1979 review by Barlow and Abel, mentioned Davison's 1973 criticism that intervening in particular behavior patterns can be interpreted as an index of a therapist's values. I would argue that that has been blatantly the case in the behavioral treatment of crossdressers and transsexual people. Craighead et al. ask, "Does society have the right to prohibit certain behaviors among consenting adults? Are there any legitimate grounds for enforcing some sexual behaviors and condemning others? What are the psychological implications of labeling individuals as 'deviant' if they prefer less conventional modes of sexual expression? Is the psychologist supporting the 'establishment' as the status quo by offering therapy for culturally prohibited sexual patterns?" (p. 342) Abel, at least, doesn't think so; to this day, he continues to use aversion therapy in his treatment of transgendered persons.

The literature with children, although due to time limitations I will not present it, is even more worrisome than the literature about adults. Children with gender identity disorders have no say in their treatment, and are often subjected to humiliating procedures in clinics at the authorization of parents who are acting out of fear and ignorance. Clinics for the treatment of children exist in the United States, Canada, and England and possibly still Australia, and attempt to reprogram boys who are extremely feminine. Since Richard Green (Green, 1987) has clearly shown that these boys are much more likely to grow up to be homosexual than to be crossdressers or transsexual persons, these clinics are a back-door way for researchers to have access to a population with which it has become politically inexpedient to intervene, homosexuals.

Certainly, not all behavioral treatment of transgendered persons has had as its goal the eradication of their crossdressing or transsexualism. But although the subject has not recently made an appearance in professional journals, the literature, which has never seriously questioned when it is and when it is not appropriate to intervene, and perhaps more appropriately, how it is and is not appropriate to intervene, gives a green light to aversive treatment designed to change the basic nature of transgendered persons. This is a value judgment on the part of researchers, who are saying, by doing such treatment, that they value heterosexuality and homosexuality over crossdressing and transsexualism, and that transgender behavior is so horrible that it is justifiable to use any means necessary to eradicate it.

Because transgendered persons are such an undervalued segment of society, there has been no outcry or even commentary on their behavioral treatment. It is important that someone urge caution in the use of behavioral techniques with persons with transgender issues. That is what I am doing today. I would like to make some suggestions.

First, the same safeguards which protect persons with developmental disabilities and others should be applied to transgendered persons. When doing research, there should be peer review and human rights review of treatment—but ordinary peer review and human rights committees have the same sort of blinders as the general population, so I suggest that there be additional reviews by a committee consisting of professionals who have worked extensively with transgendered persons, and by a second committee consisting entirely of out trans-
gendered persons. These committees would look carefully at professional and human rights issues and would have the final say-so on whether treatment was allowed.

Second, care should be taken that shame and guilt is not used as a tool to convince the individual to enter a treatment program designed to eradicate his or her crossdressing or transsexualism. Such shame and guilt should be dealt with in therapy before any behavioral attempt is made to extinguish the behavior.

Third, the individual should be made aware that it is possible to embrace their crossdressing or transsexual issues. The individual should be urged to attempt to adjust to his or her condition and given the names and addresses of the considerable number of support groups and clinics which specialize in transsexualism and crossdressing.

Fourth, the therapist should consider the totality of the individual's life and the amount to which his or her crossdressing or transsexualism interferes with other life goals. Simply not passing in the other gender role is no reason to attempt to eradicate the behavior in transsexual persons, for there are medical techniques which can change physical characteristics, and because successfully passing is not necessary in order to live productively in the other gender role.

Fifth, the therapist should carefully monitor his or her feelings about crossdressing and transsexualism. If there are strong feelings of disgust or anger, it might be appropriate to refer the individual and future clients with the same issues to another therapist.

Finally, let me say this. Persons with developmental disabilities were long abused. This changed because of advocacy activities of professionals and parents. Gay men and lesbians were once powerless. This changed in 1969, with the riots at the Stonewall Bar in New York City. Crossdressers and transsexual persons were once powerless. This is rapidly changing. The transgender community is now a reality, Professional organizations, advocacy organizations, political activists, and especially the emergence of radical transsexual groups like Transgender Nation and The Transsexual Menace, with their in-your-face tactics, will increasingly make their presence known. Certainly, the experiments done in Britain in the 1960s would no longer be tolerated, but even nonaversive treatment packages will come under fire in the future.

The treatment of gendered persons at the hands of behavior modifiers brings to life the worst fear of the critics of the science of behavior, that science will be used for purposes of social control. When, in an attempt to make them "normal," harmless people are subjected to aversion therapy and occasionally sent to the cardiac unit, something is very, very wrong in Walden Two, the idyllic community described by psychologist B. F. Skinner where the behavior of the inhabitants is controlled using the same principles of reinforcement that Skinner had discovered in his work with rats and pigeons.

REFERENCES


