

Group Psychotherapy with Female-to-Male Transsexuals in Turkey

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The change in Turkish law to allow local sex reassignment surgery was passed in May 1988. By law, a candidate for such surgery must obtain a medical certificate attesting that the operation is necessary. However, the law does not specify conditions for granting such a certificate, so any physician can give a certificate based on his own criteria. Sex reassignment surgery can therefore be performed without preoperative psychiatric evaluation and preparation. This is a report of 40 female-to-male transsexuals. They had completed psychiatric assessment and participated in group therapy. These meetings provided a valuable setting for getting to know transsexuals and their families. Participants' long, regular attendance and low dropout rate demonstrate high group cohesion. The aim of the study is to report characteristics of a group of transsexuals living in a different cultural setting from other studies of this patient population in order to identify problems of Turkish transsexuals and advocate changes in current Turkish laws for sex reassignment.

KEY WORDS: transsexuals; sex reassignment; group therapy; law.

INTRODUCTION

The change in Turkish laws to allow local sex reassignment surgery was passed in May 1988 (Resmi Gazete). The National Health Service does not reimburse costs for this operation and sex reassignment surgeries are performed based on patients' request. Transsexuals who have undergone surgery achieve the right to change their birth certificate and get married. According to the Turkish laws,

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a candidate for sex reassignment surgery must obtain medical clearance attesting that the operation is necessary. The law does not specify the requisites for granting this request (Will and Öztan, 1994). Any physician therefore can provide medical clearance based on entirely subjective criteria.

It is well attested that diagnostic procedures for transsexualism are time-consuming and require many counseling sessions. The procedure is even more complex in cases of female-to-male sex reassignment surgery, since recognition of the existence of female transsexuals in Turkey is of recent origin. The required surgery calls for a high level of expertise not possessed by surgeons in general. This can cause more psychiatric referrals to be made for female-to-male transsexuals. In contrast, male patients may more readily undergo sex reassignment surgery on demand without sufficient psychological and psychiatric evaluation. Since this is a procedure paid for by the patients, many surgeons prefer to operate on males in Turkey, while female-to-male transsexuals travel abroad for the surgery, i.e., England (Walker *et al.*, 1985; Yüksel *et al.*, 1994).

In 1987, a special unit with an associated clinic was founded at the Psychiatry Department of Istanbul School of Medicine to evaluate gender identity problems. The unit offers pre- and postoperative counseling to transsexuals about sex reassignment surgery. The unit also provides counseling to patients' family members (Yüksel *et al.*, 1992). This study reports the outcomes of psychological assessment and other evaluation procedures of female-to-male transsexuals admitted to this specialized clinic.

SUBJECTS AND METHOD

Diagnosis and Evaluation

The group included biological females older than 16 years of age who had requested sex reassignment surgery. They had a preliminary diagnosis of transsexualism according to the criteria of the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed., revised (DSM-III-R) (American Psychiatric Association, 1987) and were neither psychotic nor mentally retarded. Participants agreed that they would not undergo hormone therapy or surgery before obtaining permission of their assigned therapists.

Endocrinological, genetic, and gynecological assessments were carried out by specialists working in coordination with the clinic. Sexual and gender identity history starting from childhood were obtained through a semistructured interview. Patients' professional, social, and family relationships were evaluated pre- and posttherapy. Special attention was given to sexual experiences. Family members and partners were interviewed with the patients' permission.

Therapy

Members were assigned to group sessions after 1 to 4 months of individual evaluation. Clients with other psychopathologies were treated individually before being invited to join the group. For instance, an agoraphobic patient had behavioral therapy for 2 months and joined the group after improvement of this phobia. All patients attended group therapy for a minimum of 2 years. Individual patients were reevaluated once every year. Additional individual therapy sessions were provided on per need in response to crises situations.

Group sessions were held monthly, facilitated by two therapists who also received supervision from a more experienced therapist. Groups consisted of 8–14 members and meetings were carried out as open groups (Yalom, 1985).

At the beginning of each session, members briefly recounted important positive and negative events of the prior month. After sharing their problems, the therapists and group members determined the agenda together. Endocrinologists and surgeons were invited to provide information on relevant medical issues. This allowed group members to receive direct answers to their problems, which were then discussed among themselves. Changes were assessed by self-ratings as well as therapists' observations.

RESULTS

Sociodemographic Characteristics

The group included 40 members, all of whom were unmarried except for 2 widows. Age at referral ranged from 16 to 38 years, with a mean of 25.3 years ($SD \pm 5.2$ years). The majority (85%) joined the group at an age of less than 30 years, and more than half (60%) before 25 years. Only a few were illiterate and approximately 25% had only primary school education. One-third were high-school or university graduates. Half were brought up in metropolitan areas, some in shanty towns. Half had stable professional lives, while one-quarter frequently changed jobs. One-quarter were self-employed (Table I).

Family Characteristics

More than half of the patients (25/40) were brought up by parents until the age of 16. One-fourth were raised without a father. The mean number of sisters (2.2; $SD, 1.89$) was greater than the mean number of brothers (1.47; $SD, 1.98$), but the difference was not statistically significant. Of the 40 cases, 27 reported having a close relationship with female family members, i.e., mother (45%) or sister (22%).

Table I. Sociodemographic Characteristics

	No. of people	%
Age at admission		
16–20	11	27.5
21–25	13	32.5
26–30	10	25
>31	6	15
Marital status		
Divorced	2	5
Single	38	95
Education		
None	4	10
Primary school	15	37.5
High school	15	37.5
University	6	15
Background		
Metropolitan	29	72.5
Rural	11	27.5
Place of settlement		
City	37	92.5
Village/small town	3	7.5
Profession		
Worker	21	52.5
Civil officer	1	2.5
Small business	10	25
Business owner	5	12.5
Not working	3	7.5
Regularity of work		
Regular	21	52.5
Part-time jobs	5	12.5
Frequently changing jobs	11	27.5
Not working	3	7.5

More than half were still living with their families and only 7.5% were living with a partner. One-third were raised in traditionally structured families, while only a small proportion was raised either in a liberal environment or in a rigid, deeply religious family (Tables II and III).

Cross-Gender Role

A great majority of patients (80%) had realized that they were different from their same-sex peers before puberty. Half preferred not to wear girls' clothes before adolescence and fantasized about becoming a boy. At first interviews, most presented looking like males and more than half ($N = 22$) wore typical men's outfits. The rest wore unisex clothes. None wore makeup and all had short hair.

Although aware of being "different" from others since early childhood, their families were reluctant to recognize their predicament and were typically in denial.

Table II. Family Characteristics

	No. of people	%
Family integrity		
Intact	26	65
Single parent (father)	1	2.5
Single parent (mother)	8	20
No parent	5	12.5
Closest (most intimate) person		
Mother	18	45
Father	3	7.5
Sister or female relative	9	22.5
Brother or male relative	2	5
	4	10
Siblings of the same sex (no)		
0	11	27.5
1	4	10
2	10	25
3	5	12.5
4	6	15
5	3	7.5
8	1	2.5
Siblings of the opposite sex (no)		
0	10	25
1	11	27.5
2	11	27.5
3	6	15
4	2	5

More than half first disclosed their gender identity differences to close family members but even after disclosure some families continued to deny the condition. Other families accepted the situation with relief after a detailed explanation. Some family members found it comforting to talk to their children about these matters. Some reacted with strong rejection and tried to impose an explicit female identity on their child (Tables III and IV).

Sexual History

Mean menstruation age was 13.8 ± 1.87 years. A quarter experienced hormonal and/or menstrual irregularities. Half reported having masturbated with the imagery of themselves as men. The rest stated they could not masturbate without a penis. The two widows, who had a history of sexual intercourse with men, stated that these experiences were unsatisfactory. Female transsexuals considered their sexual identity to be male and objected strongly to being referred to as "lesbians." The average duration of stable relationships with an intimate partner was 3.9 ± 1.2 years, and 27.5% had emotional relations without genital intercourse. Seventy percent reported sexual experiences of some sort which were preferred to

Table III. Family Characteristics as Regards Sexual Identity

	No. of people	%
Family reaction to sexual preference ^a		
Acceptance as if it is a trivial thing	11	17.5
Oppressive	20	50
Denial	5	12.5
A strongly disapproving person in the family	14	35
A very understanding person in the family	13	32.5
Characteristics of the milieu in which the person was reared		
Very traditional and religious	13	32.5
Not very oppressive despite practicing beliefs	22	55
Liberal	5	12.5
Person's own attitude toward religion		
Very traditional and religious	4	10
Practicing believer but not too strong beliefs	20	50
Liberal	6	15
Not answered	10	25
Family attitude toward sexuality		
Traditional and oppressive	14	35
Not too traditional	21	52.5
Liberal	5	12.5
Age at which family became aware of the person's sexual preference		
Before elementary school	15	37.5
During elementary school or before puberty	4	10
After puberty	21	52.5

^aSome of the participants have chosen more than one option for this category.

Table IV. Recognition of Sexual Identity

	No. of people	%
Age at which sexual choice first became apparent		
Before elementary school	23	57.5
During elementary school (between age 7 and age 11)	8	20
Adolescence	9	22.5
Age at which a change in dressing style first occurred		
≤12	18	45
12–15	13	32.5
16–20	5	12.5
≥20	2	5
Age at which a desire to be of opposite sex first felt		
Before puberty (≤12 years of age)	24	60
Adolescence	12	30
≥16 years of age	4	10

take place in darkness, not to undress completely, and strictly avoided sex during menstrual bleeding periods. They did not let their partners touch their genitals or breasts. Menstrual periods were considered a great burden for those living with a partner (Table V).

Table V. Sexual Attitudes and Characteristics

	No. of people	%
Reaction to developing breasts		
Bandaging the breasts	6	15
Wearing loose clothes, adopting an arched gait, etc.	10	25
Bandaging the breasts and wearing loose clothes, etc.	24	60
Hormonal delaying		
Absent	32	80
Present	8	20
Relations to the opposite sex		
None	32	80
Temporary relations under pressure from the family	6	15
Temporary, voluntary relations to give it a try	2	5
Relations to the same sex		
None	1	2.5
Emotional relations only	11	27.57
Emotional and physical contact	28	70
Reaction to menstruation ^a		
Feeling unbearable and disgusting	35	87.5
Would rather not have it	5	12.5
Adopting a name of the opposite sex		
Using her own name	2	5
Name suitable for both sexes	2	5
Using a male name	36	90
Outward appearance		
Looking like a male	23	57.5
Wearing unisex clothes	17	42.5
Masturbation		
Not masturbating	16	40
Fantasies containing members of the same sex	19	47.5
Not answered	5	12.5

^aThe mean age of menarche in our group was 13.8 years (SD, ± 1.9 years).

Table VI. Additional Psychiatric Diagnoses

	No. of people	%
None	25	62.5
Anxiety disorders	3	7.5
Depressive disorder	7	17.5
Mental retardation	3	7.5
Psychotic disorders	0	0
Personality disorders	2	5

Psychological Status

The participants' intellectual capacities (IQ) were normal. Half had a psychiatric diagnosis according to the DSM-III-R criteria, but none was psychotic. Depressive disorders were the most frequent comorbidity (Table VI).

Treatment Process

After preliminary evaluation, 25 patients were invited to participate in group therapy without prior individual therapy. Five had a course of independent individual therapy or were prescribed antidepressant medications. Two patients with personality disorders, two female homosexuals, and one with learning difficulty did not progress with the group therapy. Four dropped out in the course of group treatment. Average attendance for group work was nearly 3 years (33 ± 23.3 months).

Group Themes

At the commencement of the group experience, the members' only expectation was to present themselves as true transsexuals and at an appropriate time secure medical approval to proceed with surgery. During the sessions some common themes emerged with time, including relationship difficulties with their families, work, and partners. The group also provided an opportunity for participants to meet other transsexuals. They had typically tried to prove themselves to be male. They found that they could share the burdens and hardships of being a transsexual in a friendly, supportive environment. The group quickly established itself as a self-help resource.

Decision About Surgery

Twenty-two of the participants received medical clearance for reassignment surgery after attending group therapy (mean time, 28 ± 4 months). The certificate obtained for the patients is that of a transsexual for whom sex reassignment surgery can be provided. For those not certified, evaluation and counseling continues. At the end of 1 year of group therapy, two identified as female homosexuals rather than transsexuals; they had not recognized at the start of the therapy and both withdrew their applications for sex reassignment surgery.

Of the 22, 12 had surgery without major complications and applied to the court to have their birth certificate changed. Five were later married and one couple adopted a child. No obvious psychological problems have been encountered in the operated transsexuals, either during the surgery or in their the later life.

DISCUSSION

This study provides information about female-to-male transsexuals living in Turkey, a country that is characterized by marked influences of both Western and Islamic cultures. Discussion of sexuality and gender identity problems is

of recent origin and has led to the recognition of a group of people whose existence has been denied for a long time. There is a shortage of clinicians with experience in assessment and advising on appropriate management plans for the individuals concerned. Although this study summarized results of the largest series in Turkey; the database has limitations. Since male-to-female transsexuals rarely apply to our unit, a male-to-female transsexual group could not be formed or studied. The reason for this may be that surgeons do not request a psychiatric evaluation of their patients before operating on male-to-female transsexuals. In consequence, males are not required to spend a long time waiting for the psychiatric decision-making process. A similar report has been published from Poland (Godlewski, 1988) which accounts a ratio of 5.5 females to 1 male transsexual admitted to psychiatric clinics. In contrast to that report, surveys reported from the other countries (Van Kesteren *et al.*, 1996) are contradictory in sex ratio, which may be the result of legal or social differences. The study design does not include a control group and the number of patients included in this study is small.

Growing up in a traditional, conservative cultural background did not prevent our patients from acting in accordance with their perceived gender identity even though experiencing many difficulties, for example, in religious practices. Islam demands different prayer practices for men and women; our patients who held deep religious beliefs faced difficult conflicts. For example, one of the basic forms of praying in Islam, "namaz," involves different body movements in different compartments of mosques for each sex. All women must cover their heads in their daily life and there is some strict discrimination in life styles of women. Accordingly patients had to make a decision totally to give up religious practices or adopt male gender-assigned forms of religious behaviors. Homosexuality and transsexualism are strictly unacceptable to Islamic laws. The majority of female-to-male transsexuals in our group wanted to be considered male during their daily religious life and, in time, at their own funeral.

Feelings and presentations as males were clear and frank since childhood. Their self images had been male and this was reflected in their appearance. Verchoor and Poortinga (1988) reported female-to-male transsexuals to have better parental relationships than male-to-female transsexuals. Female transsexuals in this sample were generally close to at least one female family member, typically their mothers. This finding differs from the Tsoi (1990) report of female-to-male transsexuals having unsatisfactory relationships with mothers. Interpretation of these findings could be an account of different child raising practices in different countries. In Turkey mothers tend to assume a highly influential traditional role. Mothers carry most of the responsibilities of child rearing and fathers are rarely involved in problems during this period.

In this group, there is a low male:female sibling sex ratio ($59/86 \times 100 = 69$). Homosexual males have been found to have the opposite: an excess of brothers

(Blanchard *et al.*, 1995). This finding may indicate a sibling dominance exerted by the same sex or may be a cultural effect specific to Turkey. Having a son is deemed important for Turkish families to inherit the family name and traditions. Some families choose to continue having more children until a boy is born. In the studied group there was a member who had eight sisters.

According to traditional Turkish norms a sexual relationship before marriage is strictly forbidden for girls but not for boys. Some of our patients reported that their families were “allowing” their transsexual girls to have sexual relationships and some arranged unofficial, but nevertheless religious, wedding ceremonies for their “female-son.”

The average age of menarche for this group was slightly above the national norm reported for Turkey (Tümerdem *et al.*, 1984). Menstrual irregularities and ovarian pathologies seemed frequent among the group. This has also been described by Futterweit *et al.* (1986) and Heresova *et al.* (1986).

As emphasized by some authors, transsexuals are prone to depression. Althof and Keller (1980) stated that during group sessions participants realized that they are not unique and alone and that they can support each other to overcome their hopelessness. They use the strategies emphasized by other group members to solve problems. There were no suicide attempts during group therapy. During therapy, the rate of oversensitivity, aggression, and withdrawal reactions reported prior to joining the group decreased. Unstable behavior and lack of assertiveness reduced during the course of group therapy and tolerance for frustration increased as they developed realistic expectations for their own future.

Long, regular attendance, with a low dropout rate of 10%, compared favorably with a 30–40% dropout ratio reported in other therapy groups (Yalom, 1985). This demonstrates the high value attached to group relations, group cohesion, and solidarity. This finding indicates that individuals who are stigmatized and excluded by society in general have a need to share their experiences and problems with others. Meeting in a place where they were not considered “rotten,” “perverted,” or “harmful to society” allowed group members to speak of their experiences in the company of other transsexuals for the first time. Many started to make distinctions based on the criteria of “before the group” and “after the group,” thus revealing its importance to them.

Patients showed repeated, stable, and consistent attitudes toward their bodies from an early age and avoidance and disgust felt toward their bodies during masturbation and other sexual activities. Many had scars caused by wearing a tight flattening girdle around their breasts so as not to accentuate this sex characteristic (Blanchard, 1990; Walter and Ross, 1986). However, in spite of having had long-term relationships, some could not tell their partners of their situation. This was especially so for those who preferred having nonsexual emotional affairs and avoided physical contact. A frequently stated excuse presented to their partners was having urogenital anomalies. Most group members were hoping to get

married after the operation. This might be explained by female transsexuals being monogamous with tendencies toward nonpromiscuous relations.

When working with female transsexuals, family issues should be given prominent consideration. In the Turkish culture, family approval is expected when someone is effecting a major lifestyle change. For instance, before an operation, a recognition of the facts of the situation by family members is extremely important. Sometimes subgroups visited families to demonstrate that transsexuals belong to nondeviant families. The family meetings proved to be of benefit both to transsexuals and their families. Interfamilial support systems have also been formed. During the group therapy period, many families changed their attitudes, behaviors, and knowledge about transsexualism. Their denial usually ended as well.

An important and recurring topic discussed by the group was “the realization of the limits of surgery.” When they talked about gender reassignment surgery, they spoke of their breasts as “a tumor” to be removed from their bodies. Some seemed to believe as if their female past would not exist after the operation. After appropriate education, patients denied unrealistic expectations.

Furthermore, seven members introduced other transsexuals to the group who in time became regular attendees.

CONCLUSION

This report summarizes what has been learned from transsexual group therapy in Turkey. Working with them in group therapy created a valuable opportunity for the therapists to get to know each of them and their families. The participants come from “ordinary,” “nondeviant” families. They have regular jobs, friends, partners, and family lives. In a society where sexual taboos are strong and prominent, where differences in sexual orientation are not readily accepted, and sexual education is not given properly, group therapy is a valuable resource beyond that of individual therapy.

Problems centered on gender identity differences are not only medical and psychological but also sociopolitical. Recognition of the structure of the social setting in which female transsexuals live is essential for understanding their behaviors and reactions. Based on this, an ethical committee within the Turkish Medical Association and the Forensic Psychiatry Department will be organized to determine the rules for sex reassignment surgery.

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