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THE TRANSVESTIC DISORDER

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Abstract

According to DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition), transvestic disorder is a form of paraphilia reported almost exclusively in men. Sexual arousal manifested in its most obvious form – as an erection of the penis – can be associated with transvestism in various manners. The diagnosis of transvestic disorder applies to individuals who practice transvestism and whose fantasies about disguising in clothes that are specific to the other sex and whose associated behaviours are always or frequently accompanied by sexual arousal, and to whom this type of behaviour causes emotional discomfort, or a significant dysfunction manifested clinically in various areas of their life. This paper tries to explore the onset, the evolution, the various psychological factors that emerge as a result the paraphilic disorder, and, respectively, the criteria used to the purpose of clinical assessment, and the specific therapeutic approaches to the disorder.

Key words: paraphilia, transvestic disorder, transvestism, paraphilic disorder, psychological factors, sexual arousal, hyper-sexuality.

INTRODUCTION

It is difficult to formulate a definition of paraphilia because of the fact that – up to the present day – it has not been possible to draw a clear line between normal and pathological manifestations when it comes to sexual behaviour. The reason behind this issue is represented by the evolution of sexual interests over time and has to do with cultural diversity.

Paraphilias and paraphilic disorders have existed from the very dawn of human sexuality. Currently, paraphilias are conceptualized as deviations from sexual behaviour and are considered to be pathologies, going beyond the sphere of personal choices and the lifestyle options of the individual.

According to DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*) and ICD-10 (*International Classification of Diseases, 10th edition*), the most common forms of paraphilia are represented by: voyeurism, exhibitionism, frotteurism, transvestic fetishism, sadism, masochism, paedophilia and transvestic disorder.

The term 'transvestism' is generally associated with the adoption of a manner of dressing up that is in contrast with the one specific to the biological gender of the individual, regardless of purpose. In a generic sense, it can also mean assuming the behaviour of the opposite sex. The diagnosis of transvestic disorder does not apply to all individuals who dress in clothes specific to the opposite sex – not even to

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those who do so on a regular basis. However, it applies to individuals who practice transvestism and whose fantasies about disguising in the clothes that are specific to the other sex are always or frequently accompanied by sexual arousal and to whom this type of behaviour causes emotional discomfort, or a significant dysfunction clinically manifested in their social or professional life, or in other important areas of activity.

Transvestic disorder is a specific paraphilic disorder, which is associated with the presence of intense and repeated sexual arousal obtained by trying on and wearing clothes specific to the opposite sex (disguise), manifested in the form of fantasies, sexual impulses, or specific behaviours, extending over a period of at least six months. According to DSM-5, this disorder can be associated with fetishism (in which case the sexual arousal is obtained by touching fabrics, materials, or clothing), or with autogynephilia (a form of sexual arousal that occurs as a result of a man imagining himself to be his female version or of his fantasies in this regard). The presence of fetishism decreases the likelihood of gender dysphoria in men with transvestic disorder. However, the presence of autogynephilia increases this probability. It must also be specified whether the disorder occurs in a controlled environment (an indicator applicable to people living in an institutional environment or in other environments where the possibilities of transvestism are restricted), or it is in complete remission (as a result of the manifestation of the disorder, there have been no consequences in their social or professional life or in other areas of activity, for at least five years spent in an uncontrolled environment).

Theoretical Approach

In a psychiatric or sexological sense, transvestism is defined as a way of obtaining sexual arousal by means of adopting the manner of dressing up that is specific to the opposite sex. However, the disorder is recognized as such when it induces significant levels of disability and distress.

Usually, the emergence of sexual desire does not imply the existence of a real partner, but it is stimulated by the man's fantasy consisting in the fact that he is both himself and the woman with whom he is going to engage in sexual intercourse. Some men only wear a certain piece of women's clothing, while other dress up completely in women's clothes, fix their hair in a lady-like fashion, and/or put on make-up. Cross-dressing would not be a problem if the person affected by this disorder didn't have to resort to dressing up in the clothes specific to the other sex in order to be able to arouse his or her sexual appetite or to experience an orgasm.

If the purpose for which cross-dressing is used – the disguise or the mimicking of the behaviour or of the physical appearance of the opposite sex – excludes obtaining sexual arousal, than we can speak of the following categories of persons who are excluded from the category of paraphiliacs:

- Transsexuals – persons who are dissatisfied with their biological sex, and who want to live permanently (or to be perceived) as having the opposite sex.
- Transgender – persons who are satisfied with their biological sex, but sometimes (or permanently) prefer the social role or the typical behaviour associated with the opposite sex.
- Androgens – persons who are dissatisfied with their biological sex and their gender identity, and who obtain satisfaction from trans-sexual expression.
- 'No Gender' – persons who are satisfied with their biological sex and gender identity, and who imitate the opposite sex for entertainment purposes or as a job.
- Emasculated homosexuals.

Many persons who display this habit and who fantasize about it do not meet the criteria to be included in the pathological sphere (the behaviour must extend over at least six months). According to DSM-5, transvestic disorder is a paraphilia reported almost exclusively in men. Sexual arousal manifested in its most obvious form – as an erection of the penis – can be associated with transvestism in various manners. In young men, disguise often leads to masturbation, posterior to which women's

clothes are removed. Instead, elderly men learn to avoid masturbation or penile stimulation, because avoiding ejaculation allows them to prolong the time dedicated to transvestism. Men with female partners sometimes end the transvestite episode by having sex with their partners, and some have difficulty maintaining an erection long enough to have sex with a partner in the absence of transvestism (or without intimate fantasies about it).

The clinical evaluation of the distress and of the dysfunction associated with transvestism and the evaluation of sexual arousal obtained as a result of transvestisms are usually based on the individual's statements. The 'elimination and acquisition' behaviour pattern often indicates the presence of emotional discomfort in people with a transvestic disorder. In this behavioural pattern, an individual who has spent a considerable amount of money on women's clothing and on other accessories (wigs, shoes, etc.) periodically throws away these objects in an attempt to fight back the urge to disguise and, at a later time, begins to buy this kind of items again.

The prevalence of transvestic disorder is unknown (it is rare in men, and extremely rare in women). Less than 3% of men admit having been sexually aroused by wearing clothes of the opposite sex at a given moment in the past. Most men with a transvestism disorder consider themselves heterosexual, although some individuals have occasional sexual intercourse with other men, especially when they are in disguise.

The first signs of this orientation can become manifest in childhood and are expressed as a fascination with a particular item of women's clothing or with women's clothing in general. Puberty is the period of development of the disorder in which interest in clothes of the opposite sex acquires an explicit sexual content and can, in some cases, lead to ejaculation. However, the fullest intensity of the excitatory interest and manifestations associated with this type of disorder is reached at the age of young adulthood. After this threshold, the interest in this behaviour can diminish, as people who suffer from this disorder only get to feel a state of well-being associated with the interest in the clothes of the opposite sex. Even so, the desire to disguise remains the same, or it can become even stronger.

In certain cases, subjects evolve into forms of gender dysphoria and grow increasingly interested in the female gender role. Most of them view their own sexual interest as an ego-dystonic one.

In some cases, the evolution of the transvestic disorder is continuous, while in others – episodic – thus, every so often, men with a transvestic disorder lose interest in disguise when they first fall in love with a woman and start a relationship, but this change usually turns out to be temporary. Practising behaviours specific to transvestism can interfere with heterosexual relationships or – on the contrary – distract the subject from them. This can be a source of suffering for men who want to maintain conventional marriages or emotional relationships with their partners. If the spouse does not want to accept this behaviour, the person may develop psychological or psychiatric disorders such as guilt, anxiety, depression, or shame.

Some characteristics of people who have this preference: they are men; mostly heterosexual; they are married, separated from their parents, they come with a homosexual history; they are easily aroused; they consume pornography; they have a higher masturbation frequency than the average; they like to experience pain during intercourse.

Comorbidities

Transvestism is often found in association with other paraphilias: fetishism, exhibitionism, voyeurism, masochism. A vast part of the partners of those who suffer from this disorder know about the existence of the behaviour. It is generally associated with hyper-sexuality. In a high percentage of fatal cases, a special form of masochism, self-erotic asphyxia, is associated with transvestism.

There are several theories concerning the aetiology:

- Some scholars claim the existence of psychogenic determinants: e.g. according to the

classical theory of conditioning, the source of the disorder lies in a strengthening behaviour by means of associating accidental exposure to women's clothing with a pleasant experience.
- Considerations related to the family of origin (family constellations, relationships with parents).
- The impact of sexual abuse in childhood.
- Psychoanalytic theories – concentrated around the fear of castration.
- There is no biological evidence to support such aetiology.

Differential Diagnosis

Fetish Disorder: A distinction needs to be made in case of this disorder and that of the transvestic disorder – to which it is similar – especially in men who display fetishism and who wear women's underwear while masturbating. The differentiation depends on the particular ideation of the individual during such an activity (men who display transvestic disorder rely on the idea that they are a woman, that they are like a woman, or that they are dressed like a woman), and the presence of other fetishes (e.g. silky fabrics, regardless of whether they are used as clothing, or for other purpose). As specified in the diagnostic criteria, the diagnosis of fetish disorder does not apply if the fetish objects are limited to clothing worn exclusively during disguise (specific to the transvestite disorder), or if the object used is a genital stimulation device intended for this purpose (e.g. a vibrator).

Gender Dysphoria: Individuals who suffer from the transvestic disorder do not claim inconsistency between the gender they identify with as a result of their own perception and the socially attributed gender, nor do they have the desire to actually belong to the opposite gender. Typically, these individuals do not have a history of childhood disguise behaviour that may be present in people with gender dysphoria. Individuals whose clinical picture meets all criteria for both transvestism disorder and gender dysphoria need to receive both diagnoses.

In transvestism, sexual arousal is obtained by dressing up in clothes that typically belong to the opposite sex. Transvestites are not necessarily homosexuals. In reality, a survey organized among the subscribers of the '*Transvestia*' magazine, only 10% described themselves as homosexuals. Transvestites usually report cross-dressing before puberty (Buhrich & Beaumont, 1981). Buhrich and Beaumont also state that cross-dressing is often accompanied by fantasies related to slavery (being bound or dominated by someone).

Both men and women can adopt clothing specific to the opposite sex, but it seems that men only do it with a view to obtaining intense sexual sensations. Male transvestites need not necessarily suffer from gender dysphoria. They may be perfectly happy as men, but they love to wear the clothes specific to the opposite sex.

Defining transvestism as sexual behaviour, rather than as a manifestation of gender dysphoria, Levine and Lothstein (1981) stated that all transvestites are men. Money (1981) agreed. He found that women, who dress like men, whether they are heterosexual, lesbian, or transgender, simply feel more comfortable in men's clothing and do not feel sexually aroused by performing this action.

Assessment: the clinical interview, focusing on the detailed description of the behaviour related to the preferences regarding clothes, and the connection between it and the sexual arousal. If sexual arousal does not occur during a cross-dressing experience, the clinician will not diagnose the person as suffering from transvestic disorder. However, there is a need to investigate elements related to gender dysphoria, transsexuality and/or gender identity issues.

Secondly, the existence of a certain level of distress associated with cross-dressing behaviours must be clarified. The description of the sexual history of the client will include medical information, psychiatric evaluations, family background information, the history of the psychosexual development of the person, the history of substance abuse, his relational history, the social evaluation of the person, his educational and occupational history, his previous criminal problems (if applicable), his other sexual dysfunctions, comorbidities, other

paraphilias, or the history of sexual violence (if any).

There are no psycho-diagnostic tools specific to trace this disorder, but MMPI or Millon Clinical Multiaxial Inventory intelligence tests or personality profiles can be used. Attention must be drawn to the relationship between cross-dressing and the level of distress associated with it. Therapy or medication may reduce the negative impact of arousal preferences on an individual's relational life, but in most cases, the arousal caused by the preference for women's clothing cannot be inhibited completely.

Therapeutic intervention

Various therapeutic approaches can be used – relapse prevention, distress reduction, dialectical behavioural therapy, psychoanalytic therapy (relational psychoanalysis). The purpose of therapy may be to change the excitatory preference (the elimination of the behaviour is not achieved, but the forms of manifestations can be improved), or to reduce the distress associated with the behaviour. The medication that can be used for such purposes includes SSRIs, buspirone (a serotonergic anxiolytic suitable thanks to its good tolerance), and hormone therapy (in extreme cases).

Clinical example in *Practical Guide to Paraphilia and Paraphilic Disorders (Richard Balon),* for transvestic disorder: male in his 30', single, working as a programmer annalist. He comes to the practice with the view 'to get help with his «so-called behaviour problem»', as he puts it. He states that – as far as he can remember – he has had a preference for women's clothing, especially for underwear. Wearing women's underwear excites him, causing his penis to become erect and sometimes leads to ejaculation. He is happy that he was born as a man, and he does not feel that his sexuality is not in order, although he has occasionally wondered what it would be like to be a woman, and how is a sexual experience perceived from a woman's perspective, and what is it 'that they feel differently'. He has never deemed his own behaviour to be problematic. He has been able to have regular sex with several friends, 'although sometimes I felt more aroused by wearing women's lingerie than in regular conditions' – according to his statements. Some of his sexual partners were familiar with his preferences and tolerated them. The man said that because he was not careful enough, and he walked around the house nonchalantly dressed in women's clothes, some of the neighbours noticed him, and rumours about his habits began to spread quickly in the neighbourhood. Some children called him 'a faggot' during his jogging activity, and some adults asked him whether he had deviant behaviour or not. Eventually, rumours reached the man's employer – who wanted a clarification about his behaviour and who began to fear for the company's good reputation. The man has become increasingly anxious and slightly depressed, worrying about his own safety and job. His work performance has dropped. He said that he felt like he needed to come together and to turn back into the person that he used to be before being faced with the public exposure of his sexual preferences. He was more concerned about job performance than about his own sexual preferences, claiming that the former was actually the core to his personality. He agreed to begin a cognitive-behavioural therapeutic process and to see how he would react to the administration of buspirone, starting with a dose of 10 mg/day and that would gradually be increased to 30 mg/day. However, he cancelled his second appointment and decided to leave the community. He found a new job in New York, where people are more tolerant, and where 'the individual can remain anonymous more easily'.

The therapeutic intervention develops over the following stages: stabilization, clarification, coping with the behaviour, respectively transfer of the behaviour. These steps complement each other, and the approach needs to remain flexible. Depending on the client's availability, it is possible to switch from one objective to another and to further proceed with a temporary return to the avoided objective, respectively to a final integration.

Stabilization: in the first phase, any intervention aims to identify and activate the

client's resources needed for the purpose of the therapeutic work. Clinicians should prioritize signs or risks related to (sexual) violence or self-punishing behaviours. In these cases, a risk assessment must be made. There are situations in which psychiatric interventions may be necessary. It is a good time to sign a written form of therapeutic commitment, and to build up situational control techniques, and to activate the resources that may be useful to the clinical healing process (places, people or activities that can help the patient refrain from implementing his hypersexual urges). In addition to activating the client's resources, the proposed objective for the therapeutic intervention is also very important. The premises for a therapeutic alliance are being defined as a starting point for further therapy.

Clarification: in this second phase, a deeper understanding of the client's behaviour must be intended. It starts with a behavioural analysis, by identifying the factors that have generated and maintained the problematic behaviour, followed by a functional analysis: which area is the behaviour oriented to: the search for pleasure and sensations / the reduction of tension and anxiety / the avoidance of negative emotions / boredom management / the reduction of social distance or of social isolation / the need for gaining more social approval? Together with the client, the mechanisms underpinning the manifestations of hyper-sexuality are evaluated. Sometimes the process generates distress because it exceeds the client's threshold of conflict tolerance. For this reason, techniques for clarification of the reasons that lie behind the disorder must be alternated with those for activating resources, in such a way as to avoid resistance and the termination of therapy. At the end of the process, a sort of individual profile is obtained. The interventions that will be applied in the next stage of therapy must be correlated with this hypothesis. Motivational aspects must also be investigated. Usually, clients resist when it comes to changing their hyper-sexual patterns, because certain short-term consequences are inherent. When the client has decided that he is motivated to change, he moves on to the next phase. Numerous studies Delcea C, Enache A, Stanciu C; Delcea C, Enache A, Siserman C,; Gherman C, Enache A, Delcea C, ; Delcea C, Fabian A. M, Radu C. C, Dumbravă D. P,; Rus M, Delcea C, Siserman C,; Siserman C, Delcea C, Matei H. V, Vică M. L.; Gherman C, Enache A, Delcea C, Siserman C,; Delcea C, Siserman C, confirm our results.

Coping with the situation: In this stage, clients learn specific skills to address their own problems. In some cases, the focus may be on stress management, as clients learn which are the strategies that they can apply to solve their issues. There are also clients who need to learn to deal with negative emotions and impulsivity. In this case, approaches such as emotional psychoeducation, mindfulness, and/or experiential methods are used. These usually involve (also) the activation of negative emotions. Therapeutic tasks (such as beginning emotional diaries or writing letters) can be assigned to clients. For clients who face communication problems in relationships, communication improvement techniques are used with a view to be increasing the level of closeness between the partners and achieving a high level of relationship satisfaction. When necessary, sex education or relational advice can be integrated in the approach. In these situations, it is preferable not to work with the client alone, but with his partner as well, should both partners be willing to engage in therapy.

Transfer: Finally, we teach clients how to transfer the knowledge gained in therapy in situations that they face in their own lives. The stressful stimuli and the elements that activate the anxious responses are reviewed. Clients must also be prepared for failure, while avoiding catastrophic thinking. We remind clients to contextualize each incident as a chance to learn something important about his own inner mechanisms. Therefore, in order to be effective, treatments aiming at managing paraphilic disorders must be performed in the long term, while realizing that the unwillingness by the client to observe the prescribed treatment will hinder the healing process.

CONCLUSIONS

When it comes to fulfilling sexual needs and desires, people prove to be very creative. However, it is imperative that their materialization should be manifested within the limits of social acceptance or based on the consent of both partners. Many people have atypical sexual fantasies, but in the case of paraphilias, atypical sexual acts become the main form of arousal. As we have marked out in this paper, the diagnosis of transvestic disorder does not apply to all people who wear clothes specific to the opposite sex, as many persons who display this habit and who fantasize about it do not meet the criteria to be included in the pathological sphere (the behaviour must extend over at least six months). Instead, it applies to individuals who practice transvestism, and whose fantasies about disguising in clothes that are specific to the other sex and whose associated behaviours are always or frequently accompanied by sexual arousal, and to whom this type of behaviour causes emotional discomfort, or a significant dysfunction manifested clinically in various areas of their life.

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