TRANSSEXUALISM IN INDIA
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SUMMARY
A retrospective analysis was done on 9 cases of transsexualism seen over a 8 year period. The findings were compared with reported literature and differences highlighted. The need for gender identity clinics is stressed.

Introduction
Transsexualism is a sexual deviation centred around the fixed belief that overt bodily sex is wrong (WHO 1978). The term was first used by Cauldwell (1949) and later Stoller (1968) used it strictly to refer to biologically normal males who believed that they are members of the opposite sex. The concept of gender dysphoria was introduced by Fisk (1974) which loosened the criteria for this disorder, so much so that even a heterosexual subtype is now recognised (APA 1980). Earlier descriptions tended to confuse this disorder with transvestism and related deviations, and hence earlier anecdotal literature is not very reliable.

Reports about the community prevalence of this disorder have varied from 1 in 37,000 (Walinder 1967) to 1 in 400,000 (Pauly 1968). The prevalence may be much less in India than abroad, or such behaviour is socially sanctioned. In this paper we have attempted to present an outline of transsexualism in an Indian setting.

Material and Methods
All cases seen in the period 1977 to 1984 in the Psychiatry Out Patient Department of the National Institute of Mental Health and Neurosciences, Bangalore formed the universe of this study. There were 11 cases in whom a diagnosis of transsexualism (WHO 1978) had been given. In 2 cases the diagnosis was not clear hence they were excluded from our study. The remainder of the 9 case files were analysed using a semi-structured proforma. Follow up for a period of 2 years minimum was not available for most of the cases, and hence this data and response to treatment modalities was excluded from the purview of this study.

Results
All 9 cases were single. Sociodemographic data is presented in Table 1. Birth order was calculated using Slater's index (Slater 1962), and indicates an over-representation of later borns in the sample. In all families there were elder siblings of the opposite biological sex. In no family was there any history of sexual deviation or other psychopathology in the first degree relatives. In 3 male patients, there was maternal deprivation in the form of death, before the age of 5 years. 2 of males were strongly attached to the mother and one to an elder sister.

In 7 of the cases the illness started in
Table 1
Sociodemographic Data

| Age       | 23 years | SD = 2.7889 |
| Sex       | Male 7   | Female 2   |
| Education | PUC 2    | Bachelor's degree 7 |
| Occupation| Student 4 | Skilled 4 |
|           | unemployed 1 |
| Locality  | Urban 4   | Rural 5   |
| Family size | 6.8571   | SD = 2.3561 |
|           | (range 3-11) |
| Birth order | 0.7189 [Slater's index] |

Table 2
Clinical Data

| Onset     | under 10 years | 7 |
|           | 10-20 years    | 2 |
| Course    | Deteriorating  | 7 |
|           | Improving      | 1 |
|           | Same           | 1 |
| Precipitating factor | 1 |

Clinical symptomatology and reasons for consultation are presented in Table 3. The orientation in most of the cases was homosexual and there were no heterosexual cases. 6 of the patients had experienced orgasm, and 4 found it pleasurable; 5 of them used to masturbate. Although 4 of the patients had sought sex change, 3 had come to try and change their gender orientation to their biological sex. In 2 the consultation had been sought due to resultant dysphoria.

In 3 cases psychometry was done, and did not reveal any evidence of psychosis. An EEG in one patient showed bilateral anterior temporal lobe slow and sharp wave bursts.

Discussion

Currently the clinical definition of transsexualism is based on a composite set of characteristics (Roberto 1983). These include the belief that one is a member of the opposite sex, dressing and appearing in the opposite gender role, perceiving oneself as heterosexual although one's sexual partners are anatomically identical (Fisk 1947), repugnance for one's genitalia (Pauly 1969) and the wish to transform them (Gascon 1977), history of cross gender activities (Stoller 1968), and a persistent desire for sex change surgery (Meyer 1974). Some of these are not present in our series of patients. The occurrence of pleasurable orgasms denies the concept of repugnance to one's own genitalia. Many of our patients came to change their gender orientation rather than their biological sex. This may partly be explained due to the fact that there are no gender identity clinics in India, and experience with sex change surgery limited.

One other interesting finding has been the very low prevalence of 0.18% in the hospital population in our mental hospital set up. That the prevalence in a psychiatric set up is low is indirectly indicated by the paucity
of previous studies on this disorder in the Indian Literature. There are many Indian reports about a high prevalence of cross dressing among Indian children; perhaps even this extension of deviant behaviour is accepted culturally. There have been many proponents of a deviant family playing a role in the role of etio-pathogenesis of transsexualism (Stoller 1968). Although we found that there was closer attachment to a member of the opposite sex in 3 cases, 3 male transsexuals had maternal deprivation. All of them had elder sibs of the opposite sex on whom they could have modelled. All of the patients came from relatively large families, and middle and later borns made up the bulk of the sample. The importance of psychosocial factors in the development of this disorder is still not clear.

There were no heterosexuals in our group. Nor did we find any patients with schizoid personalities or psychosis (Robert 1983). Depression was a common complication as has been reported earlier, (Paitich 1974). Most of our patients came from rural backgrounds and were educated more than the norm. This is difficult to interpret and may reflect an awareness of the psychiatrist’s role in such disorders, and may not be representative of the population.

Treatment modalities available for this disorder in the West have been aided by the development of gender identity clinics (Ro­berto 1983). The absence of these clinics perhaps deters the patient from attending the psychiatric clinic.

In this study we have tried to describe an Indian experience with the presentation of transsexualism and have found that in addition to probably being more uncommon, there are clinical differences in the symptomatology as compared to the Western literature. The need for gender identity clinics to raise awareness about these disorders and to resolve gender dysphoria seems to be essential.

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