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## Gender identity issues

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### Background

PEOPLE experiencing uncertainty about their gender identity frequently present with high levels of distress and anxiety.

Although these complex and puzzling conditions are relatively rare, they now present to medical practitioners more often because of increased social acceptance, and they require comprehensive assessment.

Gender identity refers to a person's subjective sense of self as male or female. Although concepts of masculinity and femininity vary across cultures and show historical change, all human societies have concepts of sexual difference and socialise children accordingly.

In all known human societies throughout time there have been

well-documented examples of individuals and groups who did not conform to the gender norms of their particular social system.

Societies vary in their attitudes and responses to gender-aberrant individuals and, in some groups, variation in gender expression is seen as acceptable and even desirable.

Among Native Americans, for example, a group known as *berdaches* are seen as neither male nor female and this is valued in their particular spiritual world-view. In the Hindu tradition, several gods transcend the categories of male and female and change their gender regularly.

Anthropologists have argued that gender is a highly variable construct and the label of 'gender disorder'

reflects social concerns about a person's conformity to a rather arbitrary category.

Gender identity develops in the first four years of life and is a complex outcome of interplay between biological and psychosocial factors. For most people, a sense of gender is clearly established and does not change during later development.

The sense of gender identity is usually congruent with anatomical, or bodily, sex — for instance, an individual with a male body usually develops a sense of male identity.

Difficulties in the development of gender identity can produce a variety of experiences of incongruence or 'lack of fit' between anatomical and

psychological sense of gender. These conditions are referred to as gender dysphoria.

This is a profoundly distressing experience for the individual who lives with the sense that they are 'in the wrong body' or for the person who has a strong desire to live as the opposite sex.

Gender issues can present at all stages of life, from the preschool period to older age, and pose major challenges for families, partners and communities.

Increasing numbers of adolescents are presenting with considerable information about available interventions, such as hormonal treatments and surgery, which raise complex ethical issues for clinicians.



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## Definitions

### Gender

CURRENT models distinguish sex from gender. Gender refers to the socially defined characteristics of 'masculine' and 'feminine'.

Children are socialised into patterns of behaviour, attitudes and personality traits, although there is ongoing debate about the extent to which these are influenced by biological and environmental factors.

Biological theories of gender argue that biological sex determines psychological characteristics of gender; that is, personality and gender role emerge from genetic, neurobiological and hormonal influences.

Recent biological models focus on 'brain-sex' and hypothesise that the neuro-anatomical differences between male and female brains account for gender differences.

Sociocultural accounts of gender argue that gender is a socially constructed and environmentally determined role and thus inherently variable. These accounts focus on the social conditioning and learning of gendered behaviours in early childhood and see biology as having little influence on gender.

Sex of rearing refers to the socialisation of the child as male or female and involves learning and reinforcement of gendered behaviours. It is thought to be the most important contributor to gender role.

These varying accounts represent the ongoing discussion about nature versus nurture and remain unresolved.

### Sex

Sex refers to biological sex and anatomy and can be defined on many levels, including chromosomal sex (XX, XY and others), hormonal sex and internal and external anatomical sex.

Stoller (1968) defined 'core gender identity' as the fundamental sense of belonging to one sex. This is an emotionally valued sense of identity and develops between the ages of 18 months and three years.

Children begin to distinguish male and female persons at about age two and later develop a sense of 'gender constancy', or the notion that sex is an ongoing and usually fixed characteristic of a person.

In adolescence, a major development task is to solidify a sense of identity that incorporates gender and sexual orientation into a mature sexual identity.

Psychoanalytical developmental theories have stressed the role of parental attitudes and feelings about gender in



**In adolescence, a major development task is to solidify a sense of identity that incorporates gender and sexual orientation.**

**Table 1: Problems associated with sexual identity**

Component of sexual identity	Example
Biological sex	Intersex conditions, ambiguous genitalia
Core gender identity	Gender dysphoria, gender identity disorder
Gender role	Atypical gender behaviours
Sexual orientations	Concerns over sexual object choice



Boys who have feminine mannerisms and personality style, and are more comfortable in the company of girls, may experience social difficulties and teasing or bullying at school.

the development of the child's gender identity.

Stoller identified maternal conflicts about gender and a tendency for mothers to be overly close to male infants in cases of gender identity confusion in boys.

Other theorists have found that some mothers with a history of poor relationships with men and unresolved feelings of anger towards males may not support the development of a male identity in their child and 'feminise' the boy.

Although these dynamics may be apparent in some families, and child abuse may contribute to some cases of gender dysphoria, there are many families in which these issues are not apparent and a child has expressed clear cross-gender

interests from a young age.

In healthy relationships, parents are able to support the child's development of a core gender identity but are also flexible enough to tolerate individual differences in gender behaviour. For example, in the pre-school period most children enjoy playing with dolls and themes of nurturance and care, and most parents find this acceptable.

However, some families may find this behaviour in boys concerning and seek advice about normal development. It is not uncommon for anxious families to have concerns about later homosexuality and to need considerable reassurance and education about child gender and sexual development.

In clinical practice, more boys than girls are presented in early childhood with concerns about aberrant gender behaviour, and there appears to be a greater tolerance of 'tomboyish' behaviour at this stage.

In the range of intersex conditions there are variations in sexual differentiation, and decisions may need to be made about assigning the infant to a particular sex and sex of rearing.

It has been argued that this decision and any surgical intervention should be made as soon as possible after birth to allow the child to be raised unambiguously in a particular gender.

However, this view has been challenged recently by those who argue that brain-sex may be an important contributor to sense of gender and that a child should be allowed to express their own gender identity rather than have an identity imposed upon them, possibly in error or prematurely.

There is greater acceptance of the need for a cautious approach and also recognition of the dilemma faced by some individuals who believe the sex assigned to them as a neonate was incorrect.

The development of sexual identity can be affected at several levels, resulting in a range of presenting problems (table 1).

Atypical gender behaviours include behaviours and characteristics that do not readily conform to the socially defined gender categories.

The most common presentations are of so-called 'effeminate' boys. These boys may present with interests in typical girls' activities and play, and a dislike of typical boys' activities.

They may have feminine mannerisms and personality style, and be more comfortable in the company of girls. These children may experience social difficulties and teasing or bullying at school.

Although some children with this type of presentation have gender dysphoria, many do not have any confusion about their assigned sex, or any wish to change sex. Rather, they are often puzzled about why other children of their sex do not share their interests and why this is a problem.

It is important to explore parental concerns and expectations about their child's development, with the aim of increasing the parent's tolerance of the child's interests and lessening their anxiety.

In adolescents, the concerns are more clearly related to choice of sexual partner and sexual orienta-

tion. Adolescents may be confused by homosexual feelings and wonder if these reflect some underlying biological or hormonal problems.

In some cases the young person may think their life would be less problematic if they changed sex, but most do not have underlying gender dysphoria.

The clinical approach here is to reassure and support the young person in accepting homosexual feelings as a normal part of sexual development, to reduce anxiety and allow time for the young person to develop a clear sense of sexual orientation while avoiding risk-taking behaviour.

### Gender identity disorder

Gender identity disorder is defined in the *DSM-IV* as a condition of strong and persistent cross-gender identification and discomfort with one's own sex. In children there may be cross-sex play and interests and preference for opposite-sex peers.

Some children will express the desire to "change into" the opposite sex and may describe negative feelings about their own genitals. Adolescents and adults may have a clearer conviction that they are "in the wrong body" and actively want to live as their desired gender.

Children as young as 30-36 months — when they express and attend to gender differences — may express gender dysphoria and even genital aversion.

Parents should be reassured that it is normal for children of this age to express the desire to have the genitals and characteristics of the opposite sex — for example, the girl who would like a penis and the boy who would like to have breasts and be able to have a baby.

The child with gender identity disorder expresses a desire to be the opposite sex and may be distressed by their own sex and anatomy. It is this sense of distress and difficulty accepting their own body that, if persistent, suggests the need for referral and advice from an expert about support and intervention.

Occasionally, gender dysphoria can emerge in the context of family stress and be a transient response in a child.

Intervention with young children aims to address any family or parental stressors and to support the child in acceptance of their body and gender role in a flexible fashion.

In practice this involves working with parents to allow the child access to a range of activities, both male

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and female, and supporting the child in experiencing the positive aspects of their assigned sex.

It is not appropriate to punish gender-aberrant behaviours — this attitude is more likely to lead a child to feel depressed and to hide their interest. It is important to reassure families that gender is a flexible spectrum of behaviours and that some children take time to develop a stable gender identity.

More specialised intervention may be appropriate when there is a clear diagnosis of gender identity disorder and the family or school are experiencing difficulties in managing or accepting the child's behaviour.

The focus of intervention is to help the child negotiate peer relationships and school in a gendered society and to cope with their own sense of difference while maintaining a flexible approach to gender behaviour.

This may involve negotiating with the child about appropriate times for cross-gender expression and helping the child to learn acceptable social rules regarding gender behaviour.

Although this may be difficult for some families, there is no clear evidence that cross-gender identification can be 'altered' by any sort of therapy, and management is much more usefully focused on accepting the issues, promoting overall psychological development and preventing secondary problems such as peer difficulties and depression.

While gender identity disorder is not a diagnosis made in the presence of a physical intersex condition, it is clear that gender dysphoria can be a significant issue for some individuals with physical intersex characteristics.

The term transsexual is also used to describe individuals who wish to change their anatomical sex and who may undergo various sex-modifying procedures, including hormone therapy, cosmetic interventions and sex-reassignment surgery.

Transvestism (known in the *DSM-IV* as transvestic fetishism), refers to cross-dressing behaviour usually occurring in heterosexual men for the purpose of sexual excitement.

Transvestism is not usually associated with a history of early-onset cross-gender identification and most individuals do not actively seek sex change.

In practice there appears to be a spectrum of gender dysphoria — some people experience significant confusion about their gender identity but do not clearly fit into either diagnostic category.



## DSM-IV diagnostic criteria for gender identity disorder

### A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the opposite sex).

In children the disturbance is manifested by four (or more) of the following:

- Repeatedly stated desire to be, or insistence that they are, the other sex.
- In boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing.
- Strong and persistent fantasies of being the opposite sex.
- Intense desire to participate in the stereotypical games and pastimes of the other sex.
- Strong preference for playmates of the opposite sex.

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent presentation of themselves as the opposite sex, desire to live or be treated as the opposite sex, or the conviction that they have the typical feelings and reactions of the other sex.

### B. Persistent discomfort with their sex or sense of inappropriateness in the gender role of that sex.

In children the disturbance is manifested by any of the following:

- In boys, assertion that the penis or testes are disgusting or will disappear, or assertion that it would be better not to have a penis, or aversion to rough-and-tumble play and rejection of male stereotypical toys, games and activities.
- In girls, rejection of urinating in a sitting position, assertion that they have or will grow a penis, or assertion that they do not want to grow breasts or menstruate, or marked aversion to normative feminine clothing.

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with eliminating primary and secondary sex characteristics (eg, request for hormones, surgery or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that they were born the wrong sex.

### C. The disturbance is not concurrent with a physical intersex condition.

### D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

#### Code based on current age:

302.6: Gender Identity Disorder in Children

302.85: Gender Identity Disorder in Adolescents or Adults

These individuals may present with some gender dysphoria as well as features of transvestic fetishism but will not necessarily seek surgical sex reassignment.

Some may request hormonal treatment because they wish to experience some degree of bodily change, and some will be content to live in an ambiguous fashion as neither male nor female.

Others may find their degree of confusion about gender distressing and experience associated psychological problems and broader identity issues. These individuals may benefit from psychological intervention aimed at improving a stable

sense of identity.

In practice, a key component of assessing the person with gender dysphoria is to understand their individual sense of gender and how stable this is.

For some, the degree of distress and confusion leads them to see sex-reassignment surgery as the solution to their difficulties, although there may be other underlying issues that need to be addressed.

For others, the lack of social acceptance because of ambiguous appearance encourages a quest for an acceptable appearance and investment in cosmetic procedures.

**It is important to review psychological and psychosexual development and ... establish the age of first cross-dressing.**

## Assessment issues

INITIAL discussion with an adult presenting with gender issues should focus on clarifying their beliefs about their gender identity and their wishes about support and intervention.

Explain that you need to understand their gender experiences and concerns, and enquire about:

- The person's current concerns about their gender identity — "Can you tell me what questions you have about your gender?"
- The person's current gender identification and wishes — "How do you see your gender at the moment? Have you had thoughts about changing your gender or your body? What gender do you feel most comfortable as?"
- The sense of stability of gender identification — "Does your sense of gender identity vary from time to time? Are you uncertain about your gender identity?"
- Previous interventions — "Have you ever had counselling regarding gender issues, taken hormones or undergone cosmetic procedures?"
- The person's specific request at the present time — "Are you wanting additional information about support and treatment?"

It is not uncommon for a person to have struggled with their wishes to be the opposite sex for several years before disclosing this to a clinician. Increasingly, patients will have already researched the issues and may have decided that they wish to proceed to sex change. Some will seek hormone therapy as an initial intervention and may have already engaged in self-medication.

Physical examination should include screening for cardiovascular risk factors, signs of liver disease and endocrine disorder, and assessment of secondary sexual characteristics.

There may be signs of virilisation or feminisation if hormones have been used. For patients considering hormonal treatment, baseline hormone levels and LFTs are indicated.

Chromosomal studies are not routinely performed but may be useful if there are physical indications of a sex chromosome disorder such as Turner's syndrome or fragile X, which may be associated with disorders of sexual development.

It is important to review psychological and psychosexual development and, in particular, to establish the age of first cross-dressing and wish for gender reassignment.

Those with clear cross-gender identification are likely to report long-standing cross-gender feelings and identification and are seen as more suitable for hormonal intervention.

There may have been early-onset cross-gender fantasies, or a less defined experience of gender dysphoria. Establishing the pattern of gender dysphoria is important in assessing the person's commitment to gender change and capacity to live in the desired gender.

Differential diagnosis includes transvestic fetishism, homosexuality with gender dysphoria and, less commonly, a psychotic illness with delusional beliefs concerning gender.

In clinical practice it is not uncommon to see individuals with significant gender confusion and distress who may also be depressed or have other mental health issues that need to be addressed.

A history of early abuse and trauma should be considered, as this may have interfered with the child's developing sense of gender identity, and unresolved trauma may have ongoing effects on psychological health.

Understanding the individual's trans-gender experiences should be seen as part of an overall assessment of mental health issues.

Treatment guidelines for people with gender issues have been developed by the Harry Benjamin International Gender Dysphoria Association and are widely referred to by clinicians.

The Benjamin Standards of Care recommend that all patients considering hormonal and surgical treatments should be reviewed by a mental health professional before starting treatment and undergo psychotherapy if indicated.

It is also recommended that all individuals should have a 'real-life experience' of living in their gender of choice before surgical intervention.

### Understanding the presentation

A person with gender issues may present with unrelated or related mental health problems or a focus on gender identity itself. There may be a direct request for sex-modifying procedures or a more general wish to clarify gender identity or explore cross-gender behaviour.

Some patients present in crisis or distress and may have experienced interpersonal, family and/or social problems.

Depression, anxiety and relationship problems are common, particularly in those who have hidden their gender issues for some time. Being 'discovered' by a spouse or partner may precipitate seeking advice, and this requires sensitive discussion with the family.

Some people have great difficulty in disclosing gender issues to a clinician and may not immediately label the issues, but instead refer to “sexual” concerns. In this situation it is important to ask general questions about both sexual and gender concerns.

Children and adolescents with gender identity issues are usually a cause of anxiety for those around them, such as families and school teachers or counsellors. Parents may be anxious about a child’s ongoing development and later sexual orientation. In some cases, the child’s presentation to the clinician may represent the parent’s intolerance of gender variation and their underlying sexual anxiety.

Schools may be the referral point for some children whose cross-gender behaviours are causing concern or are the basis of peer problems such as teasing. Child mental health staff and school counsellors may become involved.

Anxiety and depression may be significant and



anyone in crisis should be assessed for the presence of suicidal ideation and risk of self-harm.

**Understanding gender issues**

Exploring gender identity

and wishes and the history of gender development helps clarify issues that may be important in ongoing psychological support. This support is aimed at facilitating self-knowledge and self-acceptance and resolving

underlying trauma rather than providing a ‘diagnosis’ for its own sake.

Discussing gender issues with partners and family members is important, particularly when a person is contemplating sex change. In some cases, relationships survive this process.

The patient may need advice about changing their name on documentation, legal issues, and disclosing their sex change to children and work colleagues and their social network.

Parents of those having sex-change treatment may also need support and counselling and frequently experience feelings of loss and grief.

**Assessing the role of sex-modifying procedures**

Part of the process of assessing a person’s mental health needs is understanding the role of sex-modifying procedures as a component of gender transition.

For some, these are seen as the final solution to problems of gender identity and there is considerable emo-

tional over-investment in the results of surgery or hormonal treatment.

It is important to assess whether the patient has a realistic understanding of the role and limitations of surgery and other procedures and that they can appreciate that adjustment to their new gender is a complex issue.

Traditional gender clinics have been criticised for enforcing a rigid gender model — for example, by focusing on the likelihood that the person seeking treatment will ‘pass’ as a female — but it is also clear that for some patients this is the desired result.

If a male is unlikely ever to be accepted as a female — for example, because of his size or appearance — it is important that he is aware of this and can cope with social stigma and negative attitudes.

Issues of informed consent and providing adequate support for exploration of non-medical interventions such as psychotherapy are important in clinical practice.

**Treatment issues**

GENDER clinics and clinicians referring patients for sex-modifying procedures are guided by the Benjamin Standards of Care (see box). These suggest:

- A comprehensive assessment and diagnosis.
- A period of three months of living full time in the desired gender role (the ‘real-life test’).
- Ongoing psychotherapeutic support.

Treatment is a staged process involving counselling, cross-gendered living and hormonal sex reassignment.

People receiving hormonal treatment require regular monitoring of hormone levels, liver function and bone density and regular assessment of cardiovascular risk factors. Routine health checks, including breast examinations and Pap smears, and prostate examinations, should continue as usual.

The role of the clinician is to decide which patients will benefit from sex-modifying procedures and achieve a sense of desired gender identity and subjective relief.

For some, changing sex involves changing sex of partners, while for others sexual relationships are of little interest. Some transsexual people wish to remain with their current partner. There is tremendous variation in terms of sexual behaviour and choices, and clinicians should support safe exploration of options if the person is uncertain.

Candidates considered inappropriate for surgical intervention include those with:

- Ambivalence and confusion regarding subjective gender.
- Acute major psychiatric illness.



- Substance abuse.
- Lack of success in living in the new gender role.

It is important to maintain a supportive and therapeutic involvement with candidates not accepted for surgery and to explore other varieties of gender expression such as cross-dressing.

A series of follow-up studies of patients having sex reassignment surgery found that most of those who were appropriately selected benefited from the procedure in terms of personal satisfaction and functioning.

Lack of personal and social supports, difficulties in interpersonal functioning and social disadvantage have been implicated in post-surgical dissatisfaction and distress.

Clinicians need to co-ordinate

Candidates for sex change procedures should spend three months living full time in their desired gender role before starting hormone therapy.

**Benjamin Standards of Care**

- Hormone therapy for adults may be started after either:
  - A documented real-life experience of three months’ duration.
  - A period of psychotherapy of three months’ duration.
- During these periods the individual should demonstrate further consolidation of gender identity.
- Surgery will be considered after 12 months of continuous hormone treatment and 12 months of successful continuous real-life experience.
- Success in the new gender role involves managing work, family and relationship issues and maintaining stable mental health.

support and work towards improving post-surgical adjustment and minimising the patient’s preoccupation with excessive surgical intervention.

**Co-ordination of ongoing support**

The level and type of support needed should be classified as part of the general assessment. Organised support and counselling services through the trans-gender community should be used and may cover issues such as housing and employment. Referral to other services such as speech pathology may be needed.

Longer-term psychotherapy has several roles, including:

- Exploring issues of identity and understanding gender issues.

- Improving self-esteem and interpersonal functioning.
  - Supporting the social process of disclosure.
  - Assisting with the emotional trauma of gender change.
- These roles are best kept independent of the referral process for sex-modifying procedures.

**Trans-gender services**

The provision of appropriate health services for trans-gender communities remains a relatively neglected issue. Service planning involves assessing the health needs of the community and providing education and training in gender issues for professionals.

Education and training need to address the requirements of specific groups, such as youths, those who are HIV positive and older people with gender concerns, and to address the needs of families and children of trans-gender clients.

There is continuing concern that mainstream health service providers do not adequately meet the needs of trans-gender people and that, as a group, the trans-gender community has elevated rates of health problems, particularly mental health problems.

Services are largely limited to the private health sector and there is limited expertise in the public sector.

The care of trans-gender people in mental health, hospital and correctional institutions has also been criticised. Several institutions and organisations now have as policy the rights of the trans-gender individuals to safety and protection and to receive hormone treatment while in custody or care.

## Author's case studies

### Bruce

BRUCE, 55, is married with two adult children. He has recently retired from his role as an engineering consultant.

Bruce tells you he has had desires to be a woman since about age seven. He recalls dressing in his sister's clothes and being severely punished for this.

At school he was shy and never comparable to other boys. He continued to secretly cross-dress and had dreams of turning into a girl.

Bruce found puberty and adolescence traumatic and felt that something was wrong with him hormonally or that he must have been homosexual. He was teased for being effeminate and became depressed.

He decided to try to become more masculine and modelled himself on the men around him. He married at 28 and, although fond of his wife, was not particularly interested in sex. Throughout his marriage Bruce had persistent wishes to be female and felt envious of his wife.

Facing retirement, and with his children having moved out of home, Bruce has decided that he can no longer suppress his need to be female and he requests hormonal treatment. He has told his wife about his decision and she has been extremely distressed.

### Comment

Bruce needs to explore his current desire to have hormonal treatment and his expectation of this. He needs advice about potential side-effects, including effects on sexual functioning, and a physical health review.

He also needs to consider



the potential effects on his marriage and children and how he would feel if these relationships broke down. He should be advised that these issues deserve serious reflection and he could be referred to a mental health professional for advice.

It may be appropriate to see Bruce's wife and discuss the situation with her and offer support.

### Nicola

NICOLA, a 13-year-old pubertal girl from a conservative immigrant family, is assessed for depression.

She describes increasing distress since the onset of breast development and has recently had her first menstrual period. She says she dislikes these changes, would prefer to be male and requests hormones to stop further female development.

Nicola describes women

as "weak and stupid" and sees her own mother as being controlled by her father. In Nicola's family it appears that she is harshly treated by her father and two elder brothers. Her brothers have considerable freedom, while Nicola is expected to assist her mother around the house.

Nicola describes her longstanding wishes to be a boy. As a pre-schooler she would stand to urinate, refused to play with girls' toys or wear dresses and had dreams of having a penis.

She is currently strapping her breasts and has adopted a masculine style of dress and hair. As an adolescent she is aware of the existence of sex-change surgery and is wondering if this would help her. She is adamant she is not a lesbian but admits she is sexually attracted to feminine-looking girls.

### Comment

As Nicola is already aware of possible hormonal intervention, it is important to discuss this with her and inform her that this is not readily available and requires legal approval (currently from the Family Court). Another option would be continuous use of the oral contraceptive pill if she cannot tolerate menstruation.

All hormonal intervention requires advice from an endocrinologist, and many parents also seek advice about the possibility of underlying hormonal or genetic problems.

In the first instance it is important to involve Nicola's family in a discussion of her feelings and to assess their capacity to support her or to understand that the family dynamics may be contributing to her gender dysphoria.

Referral to a child and adolescent mental health service or child psychiatrist for assessment of the family is appropriate.

### Peter

Peter, 12, has shown clear interest in girls' activities and play since pre-school. He has girlish mannerisms and wears only girls' clothes at home. Peter's parents have been unable to limit or change his cross-gendered interests and have decided he should be able to express himself as he chooses.

Peter is entering puberty and now wishes to go to secondary school as a girl. His family requests that he be treated with puberty-blocking hormones.

### Comment

Peter appears to present with cross-gender identification and, although this is unlikely to reverse at age 12, there is still some malleability of gender identity in adolescence.

The aim of intervention at this age is to support overall development, prevent secondary problems such as depression and to work with the family to help Peter in his later decision-making.

Puberty-blocking hormones are not routinely used in Australia. At this stage Peter should be assessed for his degree of pubertal development and general health and referred to an endocrinologist for discussion of hormonal interventions.

He also requires a comprehensive mental health assessment and discussion with the family about helping him with his peers and social functioning.

## GP's contribution



**DR JEREMY THOMPSON**  
Fairlight, NSW

### Case study

'RAYLENE', a 28-year-old who had been a biological male, saw me two years after apparently successful sex-change surgery. He was very sensitive and reluctant to talk about his history, so would only tell me bits of his story.

As a male, Raylene had never been happy. He had experienced quite a disturbed childhood, with abuse from his argumentative parents. He had lacked confidence at school, was bullied, and never felt comfortable in the male sex.

The idea that he "should have been born female" came in his high-school years. He had tried living life as a homosexual but was dissatisfied with that. He said that, following several consultations, a psychiatrist recommended he have a sex change.

Raylene's current issue was an annoyance that people did not treat him as female. In fact, neither males nor females could warm to him. This was not surprising to me

## As a male, Raylene had never been happy.

because, unfortunately, his obviously male height and build could not be disguised by a dress and make-up.

I'm afraid that I never thought of him as a woman either, which is why I cannot help but use the pronoun 'him' in this description.

Most of the consultations with Raylene involved me listening to his grievances and depressive symptoms without really being able to offer him any constructive help.

### Questions for the author

**In cognitive behaviour therapy there is a premise that often our thoughts are distorted and do not fit with reality. If we act on those thoughts, the outcomes can be disastrous. After surgery has taken place, what happens to those who have second thoughts?**

There have been some widely discussed but, fortunately, rare cases when individuals have regretted having sex-change surgery. Clearly the consequences of this can be

major and these people experience distress, depression and often resent their previous advisers.

More commonly, we see people who have had unrealistic expectations of the results of sex-reassignment or who had hoped that surgery would be a solution to a whole range of other emotional issues. Again, depression can result and may need treatment with psychological support.

It is most important that a person considering sex-reassignment has an adequate period of counselling to explore the issues and reduce the risk of a poor outcome.

**In the assessment of a patient with a gender issue, should the history-taking also involve input from family members and friends to check for any cognitive distortions in the patient's story?**

With consent, it is often useful to discuss the broad issues with

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family members, particularly to focus on their capacity to support the individual and understand the desire to change sex. Psychosocial outcomes for people who have sex reassignment is influenced by the maintenance of relationships and social acceptance.

**What is the reasoning behind some people with sexual identity issues deciding they are homosexual, while others go the further step of deciding that their own sex is not right and that they will undergo sex-change surgery?**

Homosexuality refers to sexual preference and does not necessarily involve any gender dysphoria. People seeking sex-reassignment surgery typically experience severe gender dysphoria and may be homosexual, heterosexual or bisexual within their gender of choice.

In clinical practice it is important not to assume a particular sexual preference but to ask what type of relationships the person would like. Many transsexual individuals are concerned that they not be 'classified' as homosexual.

**What would you suggest is the best way to manage and help Raylene?**

It is important to assess Raylene's level of depression and, if clinically significant, to consider antidepressants in conjunction with psycho-



logical intervention. Counselling should focus on improving her interpersonal and social functioning and overall level of support. She may benefit from attending a peer-support program, if available, or meeting others who have undergone surgery.

If she is troubled by issues relating to her harsh childhood she may require a period of psychotherapy. Cognitive behaviour therapy may help with her negative self-image.

She may desire a more conventional female presentation and could consider speech therapy and deportment. If it is clear she will never 'pass' as female, she needs support to accept this. If you can, model acceptance by referring to Raylene as "she".

**General questions for the author**

**As a GP, to whom is it best to refer a patient with a gender issue — an**

**It is most important that a person considering sex-reassignment has an adequate period of counselling.**

**endocrinologist, a psychiatrist, a specialist unit in a large public hospital, or a sexual health clinic?**

On initial presentation the patient should be referred to a psychiatrist or mental health professional, if medical interventions are being considered. Some individuals may initially wish to explore available interventions and consider later specialist referral. Some baseline investigation may be helpful.

If the patient is requesting hormonal treatment they should have a period of counselling before seeing an endocrinologist. In some areas sexual health physicians manage hormonal treatment and are experienced in the issues.

**Is there any connection between in-utero exposure to hormones usually associated with the opposite sex and gender disorders? Are there any medications that, if taken by a pregnant woman, have been implicated in later gender issues?**

Hormonal exposure in-utero is implicated in several intersex conditions, the most common being congenital adrenal hyperplasia. However, these conditions are not equivalent to gender identity disorders. There are hypotheses that in-utero hormonal influences on brain development are involved in gender identity disorders, but the mechanisms are as yet undefined.



## How To Treat Quiz

Gender identity issues — 10 June 2005

### INSTRUCTIONS

Complete this quiz to earn 2 CPD points and/or 2 PDP points by marking the correct answer(s) with an X on this form. Fill in your contact details and return to us by fax or free post.

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1. Which ONE statement about gender identity is correct?

- a) It is the equivalent of chromosomal sexual identity
- b) Gender issues appear from teen years until the mid-30s
- c) Gender identity develops by age four
- d) It is the result of psychosocial factors only

2. When assessing a person with gender dysphoria, which ONE question is least likely to help?

- a) How long have you wanted to change gender?
- b) What gender do you feel most comfortable as?
- c) Does your sense of gender vary from time to time?
- d) Has anyone else in your family experienced similar feelings?

3. Which TWO statements about gender identity disorder are correct?

- a) It is a diagnosis that can be made in the presence of a physical intersex condition
- b) The individual has a persistent discomfort with their sex
- c) Gender identity disorder only occurs in

adolescents and adults

- d) People with the disorder may want to live and be treated as the other sex

4. Riley, four, has recently told his mother he would like to have a baby and have breasts. He is not distressed by his own sex or anatomy. His mother asks for advice. What advice are you likely to give (choose TWO)?

- a) Try to reduce any family stress
- b) Support Riley in experiencing the positive aspects of his sex
- c) Riley should be assessed for a gender identity disorder
- d) Riley should be punished for expressing these desires

5. Sam, 42, is heterosexual, married and enjoys cross-dressing. He has been told he has transvestic fetishism. Which ONE statement about transvestism is correct?

- a) Transvestism is not normally associated with a history of early-onset cross-gender identification
- b) Cross-dressing in this situation is done because of a desire to live as the opposite sex
- c) Cross-dressers in this situation

frequently request a sex change

- d) This behaviour is the same as transsexualism

6. Lesley, 50, requests a sex change. She is divorced and has one adult child. For many years she has felt that she would be more comfortable as a man. She has researched the issue and requests surgical and hormonal treatment. Before considering intervention, which ONE assessment is not routinely done?

- a) Screening for cardiovascular diseases
- b) Chromosomal studies
- c) Screening for liver disease
- d) Review by a mental health professional

7. Lesley has a comprehensive assessment and decides to proceed. Which TWO choices would she usually be offered next?

- a) Immediate surgery
- b) Immediate hormone therapy
- c) A documented, trial, three-month real-life experience of cross-gendered living
- d) She should have psychotherapy for three months

8. Les has now been living happily as a man for several years and requests

sex-modifying surgery. In which THREE situations would a candidate not be suitable for sex-modifying surgery?

- a) Current or past mild depression
- b) Difficulty in living in new gender role
- c) Ambivalence regarding subjective gender
- d) Occasional recreational use of narcotics

9. In which THREE ways do gender-related issues often present?

- a) Depression
- b) Psychotic episode
- c) Relationship issues
- d) Anxiety

10. Ben, eight, has had persistent fantasies of being female and has always preferred the games played by girls. He is experiencing difficulties at school and at home because of this. Which TWO actions are most likely to help Ben?

- a) Promoting his psychological development
- b) Arranging for him to attend an all-boys school
- c) Helping him to have a flexible approach to gender behaviour
- d) Arranging for him to see a therapist to alter his cross-gender identification

### CONTACT DETAILS

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RACGP QA & CPD No: ..... and /or ACRRM membership No: .....

Address: ..... Postcode: .....

The mark required to obtain points is 80%. Please note that some questions have more than one correct answer. Your CPD activity will be updated on your RACGP records every January, April, July and October.

**NEXT WEEK** The next How To Treat explores the often excruciating experience of knee injuries in sports. The author is Dr John Orchard, sports physician, sports medicine, Sydney University, NSW.

Australian Doctor  
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