

Foreword from Lynne Jones MP, Chair of the Parliamentary Forum on Transsexualism on Guidelines For Health Organisations Commissioning Treatment Services For Individuals Experiencing Gender Dysphoria And Transsexualism

The Parliamentary Forum on Transsexualism has produced these guidelines for commissioners, due to the absence of any such guidelines from the Department of Health. We are sending this first edition to both the DoH and to the National Institute for Clinical Excellence as well as to Primary Care Trusts.

I have chaired the Forum since it was established in 1994 to facilitate co-operation between all the stakeholders in the social integration, de-stigmatisation and care of transsexual people in the UK. It comprises the UK's leading experts on transsexualism, in both the legal and medical fields and a number of MPs.

Many of the leading community advocates from the transsexual community also take part in our work, including those who have been instrumental in liaising with ministers and senior civil servants to bring about the successful passage and implementation of the *Gender Recognition Act 2004*. The Forum also includes the Chair of the committee set up by the Royal Colleges of Psychiatry and Medicine to develop new standards of care for the treatment of transsexual people, Dr Kevan Wylie (Porterbrook clinic, Sheffield), thus helping to ensure that there is close interplay between the material we are producing for commissioners of services and the guidance which we expect to see published and endorsed by those bodies later this year.

I would like to acknowledge the work done to compile this document for the Forum by Terry Reed of the Gender Identity Research and Education Society (GIRES). This document is not 'set in stone' and is a 'living document' however, any suggestions for changes to this first edition must be made through the Parliamentary Forum. Please email any comments to: jonesl@parliament.uk

Over time, the Forum does expect changes to be made in line with new information. For the latest edition of the document please refer to the GIRES website www.gires.org.uk which is the 'home' location of the latest version. There will also be a link to this 'home' version from my website: www.lynnejones.org.uk and I would encourage other trans-people's organisations to put a similar link.



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Guidelines For Health Organisations Commissioning Treatment Services For Individuals Experiencing Gender Dysphoria And Transsexualism

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Guidelines For Health Organisations Commissioning Treatment Services For Those Experiencing Gender Dysphoria And Transsexualism

1. Definition

- 1.1. Atypical gender development may give rise to a psychological experience of oneself as male or female, that is, a 'gender identity', which is incongruent with the phenotype (the external sexual characteristics of the body). The personal experience of this incongruence is termed gender dysphoria. In its profound and persistent form, the individual affected may need medical assistance to facilitate a transition of status, to live in accordance with his or her gender identity rather than with the phenotype; this degree of gender dysphoria is described as transsexualism. Treatment will usually include a programme of hormones and corrective surgery to achieve a closer physical alignment of the phenotype with the gender identity. These treatments should be co-ordinated with each other, and also with such psychological support as the individual needs. The condition should not be confused with the issue of sexuality, that is, the individual's sexual orientation; like anyone else, trans people may be gay, lesbian, asexual, bisexual or straight.

2. Introduction

- 2.1. This document has been produced to assist purchasers to make clinically appropriate decisions in respect of funding all aspects of the treatment of people experiencing any degree of gender dysphoria.

The document, which has been produced by the Parliamentary Forum on Transsexualism, provides authoritative advice and guidance for all those funding treatment and general health care services for adults and young people experiencing the condition. This guidance is based on the collected best practice advice of those principally concerned with advising, helping and treating transsexual people and on the personal experience of trans men and trans women. The services to which individuals are entitled should be flexible and patient-led, taking into account their particular needs and circumstances. The aim of treatment services is to achieve lasting personal comfort with the gender role.

Commissioning can also be extended to the independent sector, where those services are comparable and provide value for money, in cases where access to care and/or quality of care in respect of particular treatments cannot be provided within the NHS.

The text covers the legal responsibilities and obligations of those commissioning treatment and an outline of the various treatment

options for which funding should be provided. The text also discusses the current consensus view of "best practice" in each area. Paragraphs 7.1. to 7.9. give background information regarding incidence, and a brief overview of current scientific perspectives.

3. Terminology

- 3.1. The language used in the field of gender dysphoria and transsexualism is constantly evolving as understanding and perceptions of these conditions change.
- 3.2. Throughout this document, with the exception of material contained in "quotes", the terms trans woman (male to female individual) and trans man (female to male individual) are used, in accordance with the preference of members of the trans communities. An individual who has been assumed to have a female gender identity, having been assigned as a 'girl' at birth on the basis of genital appearance, but who later identifies as male, may be described as a trans man; similarly, an individual who has been assumed to have a male gender identity, having been assigned as a 'boy' at birth, but who later identifies as female, may be described as a trans woman. It is important to note that many people, after receiving the appropriate medical care do not identify as trans, but simply as men and women.
- 3.3. A person who is transitioning, or has transitioned, to the gender role opposite to that which was assigned at birth, should be addressed according to the name and title (Mr, Mrs, Miss or Ms) which is deemed to be correct by the person concerned. So, if personnel, whether medical or administrative, are in any doubt as to the correct title, they must ask the individual how he or she wishes to be addressed.
- 3.4. Although there has been widespread use of the terms 'a transsexual', 'transsexuals', 'male transsexuals' or 'female transsexuals', especially in the medical literature, these terms are now regarded as offensive by the client group. If the word transsexual is used, it is preferable to use it as an adjective, e.g., transsexual individual. The clinical description 'Gender Identity Disorder' still appears in the medical literature. This, also, is not regarded as acceptable terminology by the client group.

4. Legal Responsibilities and Obligations

- 4.1. There is case law confirming the obligation for Health Authorities to make treatment available for trans individuals (North West Lancashire Health Authority v A, D & G, Court of Appeal, 1999). A Health Authority (now Primary Care Trust) is still permitted to accord any treatment 'low priority'. This must not be interpreted, however, in such a way that transsexualism, (or any condition) without being

individually considered on its merits, becomes barred from treatment by a 'blanket policy'.

4.2. There is an obligation to treat trans people in accordance with current best practice and in the light of the most up-to-date research in the field. Failure to meet the demonstrable medical needs of trans individuals may result in legal challenges.

4.3. Principle 3 of the NHS Plan (2000) also expresses the need for non-discriminatory practices and comprehensive involvement of individuals with their own treatment plans. Implicit in this Principle is the overriding need for properly informed consent of the person concerned before each stage of treatment.

"The National Health Service of the 21st Century must be responsive to the needs of different groups and individuals within society, and challenge discrimination on the grounds of age, gender, ethnicity, religion, disability and sexuality. The NHS will treat patients as individuals, with respect for their dignity. Patients and citizens will have greater say in the NHS, and the provision of services will be centred on patients' needs" (Principle 3, NHS Plan, 2000).

4.4. No individual can give or withhold consent to treatment on behalf of another competent person (unless mental health legislation applies).

4.5. Any requirement for a trans person to divorce before medical intervention may be accessed, is not regarded as acceptable practice.

4.6. It is usual for children and young people under the age of sixteen, to have the consent of an adult having Parental Responsibility for them, for every stage of treatment. However, in some cases, the consent of any adult(s) having Parental Responsibility is not necessary, if the young person under sixteen is deemed, by the clinician, to be 'Gillick' competent. After the sixteenth birthday, a young person is automatically deemed to be competent (Family Law Reform Act, 1969, section 8).

'Gillick' refers to a court case, *Gillick v West Norfolk and Wisbeach Area Health Authority* (1985), in which it was stated that, in order for those under the age of 16 to be regarded as competent, the young person must have, "not merely an ability to understand the nature of the proposed treatment, but a full understanding and appreciation of the consequences of both the treatment in terms of intended and possible side-effects and, equally important, the anticipated consequences of failure to treat" (Re R, Lord Donaldson). This might apply where the child and the parent (or other person having Parental Responsibility) are not in agreement regarding treatment.

A person with Parental Responsibility will include: the natural mother,

automatically; the natural father, if married to the mother at the time of child's birth or having subsequently married her, or having a section 4[1a] Order or 4[1b] agreement (Children Act [CA] 1989); anyone with a Residence Order [s8 & s12, CA 89] or a Care Order [s31, s33(3) CA 89]; anyone appointed guardian or having an Adoption Order; in respect of children born before December 1st, 2003, a natural father may now obtain Parental Responsibility by being entered on the relevant child's birth certificate at a later date, with the agreement of the mother. In relation to births registered from December 1st 2003, a natural father who is not married to the mother of the child, but whose name was entered on the relevant child's birth certificate will automatically have Parental Responsibility. An Adoption Order will nullify any pre-existing Parental Responsibility rights.

- 4.7 All commissioning bodies and health care practitioners, whether in private practice or the NHS, should also be aware that unnecessary, non-clinical delay in administering hormones or moving to the surgical stage of treatment could result in legal challenges. Access to treatment should not be delayed on the grounds that the person concerned has only recently moved into the area.
- 4.8 The European Court of Human Rights, in *Goodwin v UK*, and *I v UK* (July 2002, under Articles 8 & 12) and the Gender Recognition Act 2004, give a strong indication to the UK government and all other agencies that they are under a positive obligation to treat trans people, in all areas of their lives, with respect and dignity, and to accord them equal rights and status with all other citizens. From Spring, 2005, the implementation of the Gender Recognition Act will enable trans people to obtain legal recognition of their new gender status, for all purposes, after they have undergone transition. However, it should never be regarded as an impediment to access to, and provision for, treatment services, that an individual, for whatever reason, chooses not to seek a Gender Recognition Certificate.

5. Health Commissioners' Funding Obligations

- 5.1. Once a diagnosis, or even a provisional diagnosis, of gender dysphoria has been made and the process of treatment is initiated, there is an obligation for funding to be provided throughout the entire process of transition and, if it is clinically appropriate, on an ongoing basis following transition. The individual must be given the necessary psychological support, hormone treatment and, where appropriate, surgery must follow. Surgery may be delayed or withheld on clinical grounds only (see paragraphs 4.7 and 13).

The list of treatments under 5.2 and 5.3 to which trans people should have access, is not intended to be prescriptive, but should be used flexibly in response to the various needs and circumstances of the individual service-users. The list is not exhaustive and may be extended in line with advances in treatment, e.g. crico-thyroid approximation.

5.2. In cases of adult gender dysphoria/transsexualism health commissioners are responsible for funding:

- Support from the GP throughout the process
- Referral to a psychiatrist with specialist experience in gender dysphoria.
- Ongoing assessment and psychological support when necessary. This should be provided by a clinician with relevant specialist experience, e.g. a psychiatrist, psychologist or psychotherapist or specialist nurse
- Within a gender identity clinic, the package offered should include an image consultant, and facilities for peer support groups (facilitated or self led) & relatives' support groups
- Hormone treatment including a referral to a specialist endocrinologist, or other relevant specialist
- Referral to specialist in reproductive medicine for advice and information about reproductive options such as cryogenic gamete storage and mechanical sperm retrieval and egg retrieval. Provision of storage of gametes and assisted fertility services should be offered in accordance with existing local policy
- Providers of removal of facial hair for trans women
- Referral for mastectomy for trans men
- Speech and language therapy
- Thyroid chondroplasty for trans women
- Breast augmentation in trans women
- Specific gender confirmation surgery when appropriate. This would include:
 - referral for hair removal from donor site
 - orchidectomy & penectomy, vaginoplasty & clitoroplasty for trans women
 - hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty & phalloplasty for trans men
- Appropriate district nurse pre-operative and post-operative advice and support
- Post-operative referral to endocrinologist or other relevant specialist
- Ongoing monitoring of hormone regime (usually by GP or, where appropriate, an endocrinologist)
- Follow-up review by gender specialist at 12 months

5.3. In cases of young people experiencing gender dysphoria, their treatment services should be well integrated with adult services. Few gender dysphoric prepubertal children become gender dysphoric adults, whereas those experiencing the condition as adolescents, almost invariably do require access to adult services (Wren, 2000). Commissioners are responsible for funding:

- GP support & liaison
- referral to specialist child/adolescent gender identity unit
- referral to endocrinologist for hormone blocking during puberty
- psychological support services

6. Treatment – Good Practice Guidelines

- 6.1. Ideally, the clinicians involved will have arrangements which will enable them to co-operate in a multidisciplinary approach.
- 6.2. The general goal of treatment for those experiencing any level of gender dysphoria, is to obtain lasting personal comfort in terms of phenotype and gender role. Usually, in order to realise his or her potential to function fully in society, and to maximise psychological well-being, a trans person needs to harmonise, to a greater or lesser extent, the inconsistencies which he or she experiences between the gender identity and the internal and external morphological sex. It should be borne in mind that, even after medical treatments to effect this harmonisation, trans individuals may have mixed biological characteristics. This factor should determine the actual treatment services made available to them, for example, a trans woman should not be denied screening for prostate cancer or access to appropriate fertility services, upon confirming her legal status as female through the acquisition of a Gender Recognition Certificate. Respect for the dignity of trans people should be maintained whatever treatments they are undergoing, whether in relation to the gender dysphoria they may be experiencing, or some unrelated condition.
- 6.3. Treatment should be patient-centred and should recognise the individual's preferences, needs, and differences in circumstances. The following guidance, therefore, is not prescriptive but should be treated as indicating possible choices for individuals with regard to their treatment. It is imperative that those experiencing this condition are accorded a major role in determining the kind of treatments that are appropriate for them, the pace at which treatment should progress and the sequencing of its individual elements. This process will, of course, take place with the support of a relevant specialist, who will work with the individual in coming to those decisions. A flexible approach to treatment, meeting as nearly as possible each individual's needs, is more likely to be successful than an imposed régime.

6.4. Treatment of atypical gender development typically involves a combination of hormone administration and, if necessary, some combination of gender confirming surgical procedures, usually following psychiatric assessment and accompanied by psychological support. This approach to treatment leads to favourable outcomes Smith *et al.*, 2005. One study found that the success rate was 97% in female to male individuals and 87% in male to female individuals (Green & Fleming, 1990). However, not all these elements of treatment will be necessary or desirable in every case, nor will their sequencing conform rigidly to a standard pattern. For some people extensive surgery may not be appropriate or possible. Treatments which are partially or wholly reversible, should precede those which are wholly irreversible. Best practice care involves informed consent by the individual concerned, at every stage of treatment.

7. Diagnosis

7.1. The International Statistical Classification of Diseases and Related Health Problems, published by the World Health Organisation (ICD 10) and the Diagnostic & Statistical Manual of Mental Disorders (DSM IV) offer the following diagnostic criteria:

Gender Identity Disorder (DSM IV) is a medical condition in which there is *"a strong and persistent cross-gender identification and a persistent discomfort with the sex or a sense of inappropriateness in the gender role of that sex"*. Transsexualism (ICD 10) is experienced when there is *"a desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex and a wish to have hormonal treatment and surgery to make one's body as congruent as possible with the preferred sex"*. The condition may be diagnosed when *"the transsexual identity has been present persistently for at least two years"*.

7.2. The ICD10/DSM IV entries provide useful reference points for the medical practitioner. These entries are due for review. Meanwhile, transsexualism continues to be diagnosed as a mental illness/psychiatric disorder. Consequently, it is treatable, in law, on the grounds of being "an illness in the nature of a mental disorder" (Auld LJ, North West Lancashire v A, D & G, 1999).

7.3. However, over the last few years many studies have indicated a different interpretation which relies less on the clinical observations of medical practitioners, and more on the personal experiences and insights of trans people themselves, as well as the associated biological evidence that emerges from a variety of scientific studies

(for a review of the relevant research please go to GIRES' website at www.gires.org.uk - Atypical Gender Development – A Review, 2004).

- 7.4. **It should be noted that medical and scientific findings are often amended and clarified but the right of individuals to appropriate care and respect remains.**
- 7.5. Transsexualism is a complex condition. Aetiological pathways vary from individual to individual so no single route to its development is likely to be identified. The influences on outcomes will be multifactorial and will depend, not only on individual circumstances, but on cultural norms and mores. In cultures where greater allowance is made for gender expression which is less distinctly either male or female, the discomfort of those experiencing transsexualism seems considerably lessened. It is suggested that the likelihood of associated psychological stress may thereby be reduced (Connolly, 2003). Autobiographical accounts of adult trans individuals indicate an early awareness of discomfort that is often not articulated during childhood. Severely gender dysphoric young people frequently succumb to the considerable pressure to comply with the gender role expectations of family and society. Thus treatment is often delayed for many years.
- 7.6. Instances of inconsistent sex differentiation are estimated to occur in about 1% of live births (Blackless *et al.*, 2000). Transsexualism is estimated to occur much more rarely, but present figures of approximately 0.00818% [1 in 12,225] of the adult population (Wilson *et al.*, 1999) are likely to be a significant underestimate. The factors which impinge on the sex differentiation of genitalia, gonads and brain, are a combination of genetic, hormonal and environmental. A raised incidence of female to male transsexualism has been shown to be associated with conditions of high pre-natal androgen levels (Hines, 2004). Conversely, there is evidence of a correlation between low androgen input to the fetus (associated with medication to the pregnant mother) and a raised incidence of male to female transsexualism (Dessens *et al.*, 1999). Certain chromosome disorders, also characterised by low androgen levels, are associated with a raised incidence of male to female transsexualism (Snaith *et al.*, 1991; Grumbach and Conte, 1998; Diamond and Watson, 2004). Studies on twins, and on other family co-occurrences, indicate that these are unlikely to be random and the potential for a genetic link in a subset of transsexual individuals is thus inferred (Green, 2000; Coolidge *et al.*, 2002; Diamond and Hawk, 2003).
- 7.7. Research also demonstrates that XY infants who are sex-reassigned as a result of medical and surgical responses to observable sex developmental anomalies or accidental damage to the penis, are not always content with the female phenotype and gender role imposed upon them. So, it appears that an innate gender identity can sometimes persist despite continuing social and medical interventions.

This indicates that pre-natal androgens (or possibly direct genetic effects, Dewing *et al*, 2003) may have an impact on brain development that is indelible in some individuals (Diamond, 2004; Reiner, 2004).

- 7.8. In two statistically-robust post-mortem studies of a small cohort of transsexual individuals, a small area of the brain, known to be sex-dimorphic, has been shown to have the potential for neural differentiation in opposition to genital and gonadal characteristics. Considered in the context of the other research, cited above, these brain studies support the paradigm that the neurobiology of the brain is an important element in the development of transsexualism (Zhou *et al.*, 1995; Kruijver *et al.*, 2000).

8. Referral

- 8.1. Given appropriate treatment, individuals with profound gender dysphoria leading to transsexualism, are able to lead satisfying and worthwhile lives, in all walks of society. Deprived of appropriate treatment, trans people are likely to function less well and to suffer ongoing health problems resulting in a greater strain on the National Health Service (Wessex Institute for Health Research and Development, 1998).
- 8.2. Gender Dysphoria is likely to present initially as a self-diagnosis. The individual may speak to his or her GP about the discomfort experienced historically and currently with the gender role in which he or she is living. However, the individual's initial request for help may be via any other member of the caring professions with whom that individual feels able to share his or her concerns. Whatever initial route is taken, the GP should endorse the treatment pathway and ensure funding from the NHS. The GP may refer the individual to a specialist clinician. This will usually be a psychiatrist, clinical psychologist or any other specialist working in the field of transsexualism. This referral may well be 'out of area', but should be within reasonable travelling distance. A first appointment at the service to which an individual is referred, should occur in accordance with NHS waiting list times.
- 8.3. At the point of referral to the specialist clinician, the individual will be further assessed and the diagnosis of transsexualism may be confirmed. There will be screening for any other conditions or any illnesses from which the individual may be suffering; these may need prior or parallel treatment to that undertaken in respect of gender dysphoria. The specialist clinician should be part of a recognised Gender Identity Clinic offering, for instance, speech therapy, hair removal, dress and deportment advice. This is usually within the National Health Service, but this is not always suitable for the person

concerned. Private services may be appropriate in individual circumstances and are not necessarily more expensive than National Health Services in this field. Services from within the private sector which meet contemporaneous standards of care can also be commissioned.

- 8.4. Some individuals will have struggled with this condition for many years, so every effort should be made to provide their treatment as soon as is consistent with clinical safety. The GP should provide regular and appropriate ongoing monitoring throughout the period of transition. In terms of hormone administration, some level of monitoring by the GP may continue indefinitely. The GP should provide written confirmation that this person is being treated for transsexualism, in order to facilitate the administration of documents, such as a Gender Recognition Certificate (GRC). Where such a certificate is not sought, documentary evidence from the GP (or other clinician) will facilitate the updating of passports and driving licences and enable the individual to use appropriate toilet and changing facilities. If the GP is uncomfortable about providing treatment for an individual experiencing gender dysphoria, or feels insufficiently knowledgeable about the condition, then that GP should endeavour to refer the individual to a more suitably qualified colleague. In any event, if a GP is unhelpful, or unwilling to make appropriate referrals, then the service-user is entitled to change his or her GP.

If an individual relocates to a different PCT/SHA or clinic, continuity of care must be maintained. It is not acceptable for individuals to be returned to an earlier stage in their treatment.

- 8.5. Where the individual concerned is a child or young person, who has symptoms which could, potentially, indicate gender dysphoria, the GP may refer him or her to a centre which specialises in the treatment of this age group. The need for referral will depend on the level of discomfort of the young person, and/or the family's capacity to cope with it. If and when the young person moves on to adult services, ideally in a facility selected by the young person, the clinician(s) involved should liaise with the adult services, preferably at a joint meeting, to ensure smooth transition from one service provider to the next. Ongoing liaison between the adult services and the previous service-providers may benefit the individual concerned.

Treatment for young people is staged as follows: therapeutic exploration; wholly reversible physical interventions, which may involve blocking the effects of puberty; partially reversible interventions which, in rare cases, may involve cross-hormone administration. Treatment should take account of any emotional and psychological difficulties.

Under current guidelines, it is unlikely that wholly irreversible treatments (surgical procedures) will be sanctioned by the clinician for a young person under the age of 18 years old but each case should be decided on its own merits and treatments should not be automatically ruled out on the basis of age alone. Treatment services should be well integrated; clinicians should consult with each other in all cases and liaise appropriately with family, school and social networks. Partnership with local child and adolescent services (a network model) is recommended good practice (Di Ceglie 2000).

As far as possible, fully informed consent must be given by the young person and, for those under sixteen years old, it is usual to obtain consent from an adult with Parental Responsibility, at every stage. In some cases, the consent of any adult(s) having Parental Responsibility may be dispensed with, if the young person is regarded as being 'Gillick' competent (see paragraph 4.6. for details of Gillick Competence and Parental Responsibility).

9. Psychological Assessment and Support

- 9.1. It is usual, although not imperative, for an adult individual embarking on treatment leading towards full transition, whether that end is achieved or not, to have the input of a psychiatrist (or other relevant clinician), practising locally, or at a specialist centre within reasonable reach. This treatment should be aimed at supporting the individual and in conjunction with him or her, seeking to confirm, or contradict, a diagnosis of gender dysphoria. In addition, screening for any other conditions needing treatment may take place. This initial process of assessment, should normally be undertaken over a period of three months, during which time the health tests required prior to hormone administration should be undertaken (see paragraph 11).

If and when the individual is ready, usually, about twelve months from the start of the 'real life experience' (RLE, see paragraph 12), he or she may be referred for genital surgery. However, the timing of treatment milestones and the extent of surgery should never be rigidly prescribed. Decisions regarding readiness for surgery should be made, jointly, between the individual (subject to properly informed consent) and the specialist medical team. Ongoing psychotherapeutic support may be desired by the individual throughout the period of transition and it may be preferable that this is provided by either a clinical psychologist or a medical practitioner who is experienced in treating people with gender dysphoria but who is separate from the one who has the role of 'gatekeeper' to surgery. Support should be offered for an ongoing unspecified period after surgery, whilst individuals are coming to terms with major re-adjustments in their lives (Smith *et al.*, 2005).

It must be borne in mind, however, that in the view of Professor Richard Green,

"Severe Gender Dysphoria cannot be alleviated by any conventional psychiatric treatment, whether it be psychoanalytic therapy, eclectic psychiatric treatment, aversion treatment, or by any standard psychiatric drugs" (Green, 1999, cited in Bellinger, 2001, paragraph 32).

The aim of the psychiatric professional working with a person experiencing gender dysphoria is not, therefore, to 'cure' the condition through psychiatric treatments.

10. Hair Removal Treatments

- 10.1. For trans women, hair removal treatment of male pattern facial hair is likely to form an early part of treatment. For most, this treatment is an essential ingredient and should not be regarded as merely cosmetic. In a few cases, adolescents may also require hair removal treatment. Treatment may be by electrolysis or, in some individuals, laser treatment. Both trans women and trans men may need hair removal treatments in preparation for genital surgery.

11. Hormones

- 11.1. *"Hormones are often medically necessary for successful living in the new gender. They improve the quality of life and limit psychiatric co-morbidity..."* (Harry Benjamin, Standards of Care, sixth version, p 20).

Hormones and anti-androgens have subtle feminising effects on the appearance of trans women, some of whom report that this treatment improves the facial hair removal process. In trans men, androgen administration may promote beard growth and male-pattern baldness.

Hormone treatment protocols may be agreed between the endocrinologist and specialist psychiatrist, usually working as part of a Gender Identity Clinic team. However, protocols may need to be adapted according to the individual's needs. GPs and physicians with relevant experience, for instance, in sexual medicine and family planning, may also be responsible for hormone prescription and dosage. Where this type of experience is lacking, early referral to a physician with relevant experience, is recommended. Once the prescription has been determined and the dosage stabilised, the individual will usually obtain repeat prescriptions for hormones from his or her GP. Because this is a minority medical usage, literature accompanying these drugs does not cover their administration to trans people, so a full explanation of the possible risks and side-effects, any

impact on reproductive ability and the possibility of gamete storage should be discussed by the practitioner and the service-user. In addition, a Patient Information sheet detailing these matters should be provided, preferably a few weeks before starting treatment so that individuals have the time to digest the information and to raise any further issues, so that properly informed consent may be given by the service-user.

- 11.2. *"Typically, the triadic therapy takes place in the order of hormones → real-life experience → surgery"* (Harry Benjamin Standards of Care, sixth version, p8).

However, alternative pathways may be acceptable, providing the individual agrees.

If an individual has an established diagnosis of transsexualism and has undertaken a period of documented real life experience of at least three months, prior to seeking treatment, then he or she qualifies for hormone treatment. Otherwise, a period of psychological assessment of three months may be undertaken to confirm the ongoing experience of gender dysphoria. In either case, a full medical assessment will ensure that the administration of hormones does not pose unacceptable health risks. Then, unless there are medical, psychological or psychiatric contra-indications, hormone administration should be initiated, in accordance with the typical triadic pathway given above. RLE may be started at any time, when the individual feels ready.

- 11.3. Historically, it has been difficult for those experiencing gender dysphoria to access appropriate treatments within a reasonable time-scale. Therefore individuals do sometimes initiate their own hormone treatments by using products which are readily available on the internet. For them, this also has the advantage of ensuring a degree of privacy, at a stage when openness about their condition could lead to personal difficulties, especially within the family, and also potentially, in the wider context of employment and society generally.

The major disadvantage to this self-help approach to treatment, is that the health checks and monitoring which should accompany such treatment are neglected, which may put the overall health of the individuals at risk.

It is advised that clinicians, faced with these considerations should offer to monitor the effects of the self-administration of hormones, and commence prescribing only when it is found to be medically safe and the possible risks, side-effects and impact on reproduction have been discussed, enabling properly informed consent in the same way as with other service-users (see paragraph 11.1 above). They should then be accorded equal treatment status with others experiencing

gender dysphoria. This is an approach which is endorsed by the Harry Benjamin Standards of Care:

"it can be acceptable to provide hormones...to facilitate the provision of monitored therapy using hormones of known quality, as an alternative to black-market or unsupervised hormone use" (Harry Benjamin, Standards of Care, sixth version, p 20).

- 11.4. Continued monitoring by the GP or other medical practitioner is required. Ongoing hormonal and psychological support must also be provided, as and when required, for those who, for whatever reason, will not progress to gender confirmation surgery.

"Hormone therapy can provide significant comfort to those who do not wish to cross live or undergo surgery, or who are unable to do so. In some patients, hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross living or surgery" (Harry Benjamin Standards of Care, sixth version, p 21).

- 11.5. In the case of young people, hormone administration to block the effects of puberty may be indicated. Patient Information/Consent forms for this kind of treatment should be signed by the individual and his or her parent or guardian, or other person with Parental Responsibility whilst the young person is under sixteen years old. However, a young person under sixteen, who is deemed by the clinician to be Gillick competent may make decisions without reference to a person with parental responsibility. After the sixteenth birthday, young people are automatically deemed to be competent to make their own decisions (see paragraph 4.6. for Gillick Competence and Parental Responsibility).

12. The Real-life Experience

The real-life experience refers to a period of time living in a gender role different from that effectively assigned at birth. The aim is for the individual to function socially under a gender-appropriate name and persona. This may help the individual concerned to be confident that further gender confirmation treatment is appropriate. It is not a clinical test of the ultimate diagnosis of transsexualism, however, a period of 12 months RLE is usually regarded as a necessary precursor to genital surgery. This time period should not be rigidly enforced. Some individuals may be deemed ready for surgery in a shorter time. Some studies indicate that compliance with minimum eligibility requirements for genital surgery specified by Harry Benjamin Standards of Care was not associated with more favourable outcomes (Lawrence, 2001; 2003).

Further research in this area is urgently required. Commissioners should require those imposing RLE régimes to undertake patient-satisfaction' audits, and to take account of the results and modify their régimes accordingly.

12.1.

"Professionals sometimes construe the real-life experience as the real-life test of the ultimate diagnosis.....This reasoning is a confusion of the forces that enable successful adaptation with the presence of a gender identity disorder" (Harry Benjamin Standards of Care, sixth version, p25-26).

12.2. When RLE is undertaken, the timing, duration and nature of that experience must be, largely, in the control of the individual concerned because it should be tailored to his or her personal circumstances. The medical practitioner should support the individual by prescribing hormones (if the individual wishes them to be prescribed) unless contra-indicated, and by mitigating any negative effects of RLE by involving families, with the agreement of the individual, and providing appropriate literature for families and employers.

During the period of the RLE, other treatments, such as ongoing counselling, continuing hair-removal treatments, speech therapy and, possibly, surgical procedures other than irreversible genital surgery may take place, e.g., thyroid chondroplasty, mammoplasty and feminising facial surgery for trans women, and mastectomy for trans men (which may mark the end of the RLE for them if they choose not to seek further surgery).

12.3. Children and adolescents may undertake limited RLE, supported by family, clinician and school.

13. Gender Confirmation Surgery

13.1. In line with the understanding of gender dysphoria as a condition of incongruence between brain sex and other sex characteristics (see paragraphs 7.5. to 7.7.) surgical procedures for this condition are regarded as corrective. Complete physical congruence of internal sex organs is not achievable at present, but a closer alignment of other sex characteristics with the gender identity experienced by the individual, is an established, successful treatment for this condition. As with any major surgical procedures, fitness to undergo surgery and anaesthesia must be assessed. More than one surgical procedure may be necessary. 'Informed Consent' documents should be completed by the individual and the surgeon before each procedure.

13.2. For irreversible genital surgery and mastectomy, two referrals from clinicians with relevant experience are required. Further referrals may not be necessary where additional surgery may be considered as part of an ongoing procedure undertaken by the same surgical team. See paragraph 12 for guidelines regarding timing of surgery and the elements of treatment which usually precede these surgical procedures. Typically these will include: hormone treatment, real life experience, and psychological assessment. Once it is agreed between the individual and the medical practitioner that gender confirmation surgery should be undertaken, any delay can increase the risk to health and well-being (Mate-Kole *et al.*, 1990).

13.3. Trans Women

Genital surgical procedures may include orchidectomy, penectomy, vaginoplasty, clitoroplasty and labiaplasty with the objective of creating a functional vagina, retaining sexual sensation and acceptable cosmetic appearance. Genital surgery and mammoplasty should only be undertaken by surgeons with experience of working with trans women. To ensure that hormone treatment has achieved its maximum effect on breast development, it should continue for a period of 18 months before mammoplasty is undertaken.

13.4. Trans Men

"...a mastectomy procedure is usually the first surgery performed for success in gender presentation as a man; and for some patients it is the only surgery undertaken (Harry Benjamin, Standards of Care, sixth version, p28).

Where no further surgery is intended, mastectomy may mark the end of RLE. It should be noted that prolonged breast-binding can lead to health problems. Both mastectomy and genital reconstruction surgery should only be undertaken by surgeons with experience of working with trans men. Genital surgery procedures may include hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, and phalloplasty. Depending on the extent of surgery, objectives may include a phallus of good appearance, standing micturition and sexual sensation (Harry Benjamin Standards of Care, sixth version, p30). Several surgical interventions may be necessary, and will be inevitable where more sophisticated results are sought.

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