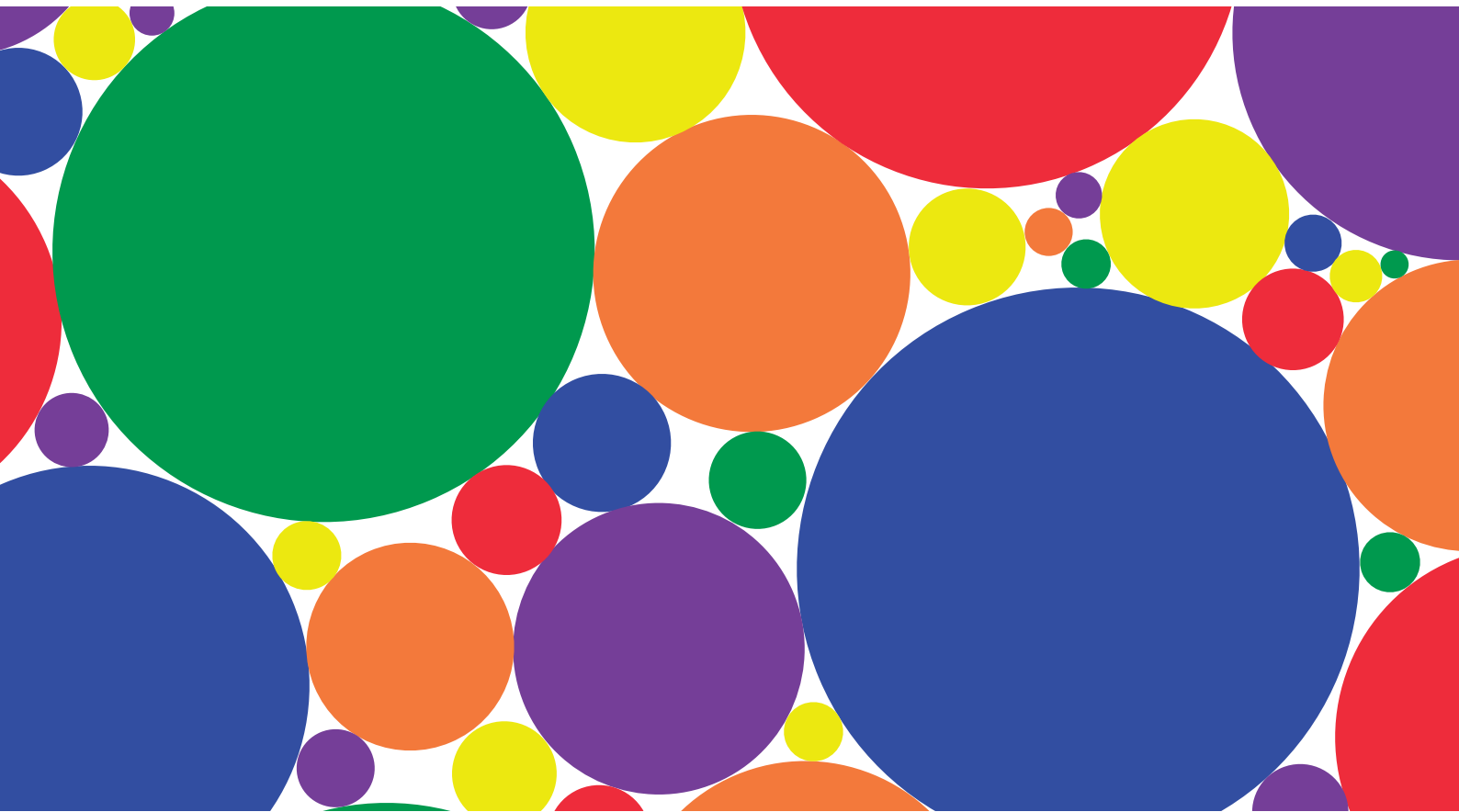


Guidance for GPs, other clinicians and health professionals on the care of gender variant people



Transgender wellbeing and healthcare

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About this publication

Gender variant (trans or transgender) people are relatively rarely seen in GP surgeries. Many GPs say that they lack the knowledge to treat those experiencing gender variant conditions and, consequently, they are not confident to do so. The first part of this publication provides an overview of care for trans people that is particularly applicable to GPs. Hormone therapy is central to transgender primary care, and issues such as assessment and diagnosis are also relevant to general practice. These topics are discussed in greater detail in Annexes C and D.

Clinical care for gender variant people should be provided within a framework of good practice that emphasises patient autonomy, allows for the wide variety of needs among trans people and is flexible in its clinical responses to those needs. It should also take account of the social context in which trans people live. Care should be holistic and may involve a number of different professionals. Accordingly, Annex C also covers a range of information regarding family, social and employment issues that are relevant, not only to GPs, but to a range of health and social care professionals who may be involved in providing a broad spectrum of support and advice to trans people and to their wider families. The information in this publication aims to enable these professionals to respond confidently and appropriately when they are approached by trans service users.

The publication is written by a team from the Gender Identity Research and Education Society that includes doctors and trans people. All the team members have specialist knowledge and experience in the transgender field.

Dr Richard Curtis, BSc, MB, BS, DipBA

Professor Andrew Levy, PhD, FRCP

Dr Joyce Martin, MB, ChB, DObstRCOG

Professor Zoe-Jane Playdon, BA (Hons), PGCE, MA, MEd, PhD, DBA, FRSA

Dr Kevan Wylie, MB, MMedSc, MD, FRCPsych, DSM

Terry Reed, BA (Hons), MCSP, SRP, GradDipPhys

Bernard Reed, MA, MBA

1 Gender variant conditions

Gender variance (sometimes still called gender dysphoria) describes the personal discomfort experienced by individuals whose psychological identification as men or as women (the gender identity) is inconsistent with their phenotype and with the gender role typically associated with that phenotype. Both gender role and phenotype may, therefore, be sources of distress. The condition may be experienced to varying degrees, and be expressed in a variety of ways. These may be intermittent or permanent. Sometimes, gender variance that is initially expressed intermittently, later becomes permanent.

When gender variance is profound and persistent, it is usually referred to as transsexualism. Since it is a subjective experience, it can only be diagnosed in accordance with what is said by the individuals who experience it. There are no tests that provide an absolute diagnosis. Transsexualism is neither a 'lifestyle' choice nor a mental disorder, but a condition that is now widely recognised to be largely innate and somatic.¹ It is one that responds well to medical care.

1 Besser, M, Carr, S, Cohen-Kettenis, PT, Connolly, P, De Sutter, P, Diamond, M, Di Ceglie, M (child and adolescent section only), Higashi, Y, Jones, L, Kruijver, FPM, Martin, J, Playdon, Z-J, Ralph, D, Reed, T, Reid, R, Reiner, WG, Swaab, D, Terry, T, Wilson, P, Wylie, K (2006) Atypical Gender Development – A Review. *International Journal of Transgenderism* 9(1): 29–44, GIRES et al. Available at www.gires.org.uk/Text_Assets/Atypical_Gender_Development.pdf
See also Annex A below for ICD–10 and DSM–IV diagnoses and summary of aetiology from the Parliamentary Forum 'Guidelines For Health Organisations Commissioning Treatment Services For Individuals Experiencing Gender Dysphoria And Transsexualism'.

2 The role of the GP

GPs are usually at the centre of treatment for trans people, often in a shared care arrangement with other clinicians. GPs may prescribe hormones and make referrals to other clinicians or services, depending on the needs of the particular service user. Sometimes a GP has, or may develop, a special interest in gender treatment and may be able to initiate treatment, making such local referrals as necessary. Otherwise referrals may be made to a specialist Gender Identity Clinic (GIC) where there are multidisciplinary teams of professionals. Private treatment with a gender specialist may be preferred by the service user.

Although gender variance is alleviated to a greater or lesser extent by treatment, to the point that many individuals say that they no longer experience any discomfort, they may, nonetheless, continue to need hormone therapy and monitoring throughout life. This will usually be the responsibility of the GP.

3 The right to respect, privacy and appropriate care

Whatever their medical needs, trans people (trans men, female to male/FtM; and trans women, male to female/MtF) should be addressed and accommodated according to the gender in which they present, unless they specify otherwise. This applies, as far as possible, to any correspondence. If medical and administrative staff are unsure about whether to address an individual as Mr, Miss, Ms or Mrs, it is better to ask, **discreetly**.

Confidentiality is required for all service users, but this is a particularly sensitive issue for trans people. Reception staff and practice nurses, as well as doctors, need to be aware that unnecessary and unwanted disclosure of the transsexual status of service users is bad practice and, in respect of those who are covered by the privacy provisions of the Gender Recognition Act, could amount to a criminal offence. Furthermore, this information may be irrelevant to their reasons for attending the surgery, since people experiencing gender variance may seek medical treatment for conditions that are totally unrelated to transsexualism.

People are entitled to treatment for transsexualism by law as stated in the case of *North West Lancashire Health Authority v A, D & G*, Court of Appeal, 1999 (see the forthcoming NHS publication *A guide to trans service users' rights*). This is not a condition that clinicians may decline to treat. When trans service users present for the first time for help with their gender discomfort, it is important that they are treated non-judgementally and sympathetically. Doctors who feel unable to do this, should refer them to a colleague who can.

4 General notes for the treatment of trans women and trans men

Those experiencing gender variance have often lived with the discomfort 'as far back as they can remember'. Many, perhaps most, attempt to repress their feelings and to live according to society's rules for many years. Nevertheless, some may have already embarked on their own solutions, including buying hormones on the internet. Some may be experimenting with cross-dressing, or even living full-time in the gender role that is more comfortable than the one assigned at birth. They may have changed their names, and possibly have support from family and employers. Some have a clear idea about what they want and how they see their future.

Many, however, have repressed their own needs, often for many years, in order to comply with the demands of society, families, employers and so on, and are only just beginning to accept that they are unable to continue their present way of life. Addressing their gender discomfort may feel urgent, their level of distress may be high and they may be feeling suicidal.

Approaching a doctor is often a last resort, and it takes great courage. It is imperative that the GP (or any other professional whom gender variant people may approach) offers support in a holistic way, taking account of personal circumstances. It is also important to reassure service users that treatment is available, and that outcomes can be good.

If trans people themselves wish to have a supportive family member (significant other, close friend) present, then this should be encouraged. Outcomes for trans people have been shown to be better when their families are supportive. This is more likely to be the case if they are involved in the trans person's treatment process, than if they feel excluded from it. Family members often experience a wide range of uncomfortable emotions: grief and betrayal (especially for partners), embarrassment, anger, guilt, helplessness and, in some cases, revulsion. Support for the family as a unit may also be appropriate, and families may be put in touch with voluntary groups and charities working in the field.²

Any requirement for a trans person to divorce before medical intervention is not regarded as acceptable practice.

2 Reed, T (2006) Draft *Good practice guidelines for the assessment and treatment of gender dysphoria*, Appendix C, Family Support. Available at www.rcpsych.ac.uk/pdf/Standards%20of%20Care%20Draft%20v8%203b%20final.pdf
See also Mermaids and DEPEND, whose details appear in the 'Information and support' section at the end of Annex D in this publication.

5 Primary care; secondary referrals; tertiary referrals

GICs provide several services in-house: mental health support, endocrinology, speech and language therapy and, sometimes, image consultancy. At their best, these clinics provide a sensitive and well-rounded approach. Many service users do very well under the GIC regimes, but others have found that these are too inflexible to meet their needs. The draft *Good practice guidelines for the assessment and treatment of gender dysphoria* in the UK (2006) promises a change in approach to the treatment of gender variant individuals. It is anticipated that the guidelines, once finalised, will allow greater autonomy, flexibility and choice for service users.

“We herald a new approach to care which has evolved from a linear progressive sequence to multiple pathways of care which recognise the great diversity of clinical and presentation needs.” (Kevan Wylie)³

It is, therefore, desirable that service users are offered the choice of a local service, and are not automatically referred out of area to a specialist GIC unless local provision proves impossible to set up. Although severe gender discomfort raises some complex issues, most elements of the treatment are relatively straightforward and can be sourced locally. GPs, especially those who are regarded as having a special interest in the field and are acknowledged as gender specialists, can make the necessary secondary referrals to ensure that multidisciplinary input (endocrinology, mental health, speech and language therapy, facial hair removal and so on) can be provided locally. It is not essential that all services are under one roof.⁴ This approach to treatment may be less traumatic for the service user since it usually results in more flexibility of treatments, less travelling to appointments, and shorter waiting times.

A model for such locally accessed treatment is the Trans Care Project in Vancouver, Canada. When the hospital gender dysphoria programme was closed in 2002, a decentralised community-based model of care was set up. Care for the trans population became the responsibility of clinicians with varying degrees of transgender training and experience out in the community.⁵

3 Wylie, K (2006) Preface to draft *Good practice guidelines for the assessment and treatment of gender dysphoria*. Available at www.rcpsych.ac.uk/pdf/Standards%20of%20Care%20Draft%20v8%203b%20final.pdf

4 Wylie, K (2006) Draft *Good practice guidelines for the assessment and treatment of gender dysphoria*, p13. Available at www.rcpsych.ac.uk/pdf/Standards%20of%20Care%20Draft%20v8%203b%20final.pdf

5 Feldman, JL, Goldberg, JM (2006) Transgender primary medical care. *International Journal of Transgenderism* 9(3/4): 1, introduction. Available at www.vch.ca/transhealth/

GPs may also consider that:

“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” (Parliamentary Forum Commissioning Guidelines).⁶

This is in accordance with the British Medical Association policy that states:

“Patients who are entitled to NHS funded treatment may opt into or out of NHS care at any stage. Patients who have had private consultation for investigations and diagnosis may transfer to the NHS for any subsequent treatment. They should be placed directly on the waiting list at the same position as if their original consultation had been within the NHS.”^{7,8}

- 6 Parliamentary Forum on Transsexualism (2005) *Guidelines for Health Organisations Commissioning Treatment Services for Trans People*. Available at www.gires.org.uk/web-page_Assets/frontframeset.htm
- 7 British Medical Association (2004) *Caring for the NHS@60. Interface between NHS and private treatment*. Available at www.bma.org.uk/ap.nsf/Content/NHSprivate
- 8 See also Annex B, Treatments that may be commissioned, for a list of the range of treatments potentially fundable by PCTs, whether treatment is provided by the NHS or in the private sector, including, in some cases, outside the UK.

6 Assessment and diagnosis

Before treatment begins, a thorough assessment should be undertaken of service users' past and present gender experiences, the anticipated gender development, and any historical and current discomfort with the phenotype. This should take place as soon as possible after they first seek medical help for their gender concerns. It may take more than one session, but will vary from person to person, and will depend on a number of factors, one of which will be the stage at which the individual presents for treatment. As suggested above, this could be anything from an early acknowledgement of the gender discomfort, to an advanced stage of physical and psychological transition. A suggested approach to this exploration is set out in Annex C.

The assessment may be carried out by the GP if he or she feels competent to undertake it. If not, then the GP should refer the service user to a local mental health or gender specialist. Where the individual expresses a convincing long-term discomfort with their phenotype and with the associated gender role, a provisional diagnosis of severe and persistent gender variance may be made, although this may remain open for reconsideration. If the GP has reason to believe that there are co-existing conditions that may need prior, or parallel, treatment, those conditions too may require a referral to a relevant local health professional. However, treatment for the gender condition should not be delayed unless strictly necessary for clinical reasons.

A Care Plan may be drawn up jointly between the service user and the clinician (GPs are not obliged to do this formally), but it may be necessary to amend or even abandon the Care Plan when circumstances change. Trans people often need to 'feel' their way forward, in their own time.

7 Treatment options

Most trans people prefer an approach to treatment that starts with hormone administration. This is, in the short term, reversible and should precede steps that are largely irreversible, such as living full-time in the opposite role (this is still sometimes known as the 'real-life experience' or RLE) or undergoing genital surgery. Accordingly, the typical triadic pathway set out in the Harry Benjamin International Gender Dysphoria Association (HBIGDA) is: hormones ==> real-life experience ==> surgery.⁹ Clinical experience indicates



Successful doctor



Successful lawyer

that treatment outcomes, using this model or other combinations of its elements, are good.¹⁰

The lawyer and doctor shown in these photographs are both trans people who have undergone successful treatment and transition.

So the triadic approach, supported by some psychological counselling, may suit many people; however, it must be recognised that individuals will experience their condition differently and respond to it differently. Some people will regard themselves as neither man nor woman and may prefer to live androgynously, or they may regard themselves as 'gender queer' (any gender experience or expression that is not recognised as 'typical'). As mentioned in Section 5, clinical responses should be flexible and should recognise the personal need for some feminising or masculinising treatments, without the need to follow any one particular pathway or arrive at one specific destination.

Treatment should be patient-led; no aspects of treatment should be imposed rigidly. The clinician will need to allow choices that were not necessarily foreseen at the outset to be made along the way.

Psychotherapeutic support

Psychotherapeutic support will usually be required by service users initially and possibly at ongoing stages of their personal development. It is important – and, for many, essential – for service users to undergo the exploration of their own feelings about their gender identity, in a non-threatening, non-judgemental, supportive environment (see Annex C). The GP may make an appropriate secondary referral where the service user agrees and would benefit from such psychotherapeutic help.

9 Harry Benjamin International Gender Dysphoria Association (2001) *The standards of care for gender identity disorders*, sixth version. Symposium, Düsseldorf. Available at www.wpath.org/Documents2/socv6.pdf

10 Smith, YLS, van Goozen, SHM, Kuiper, AJ, Cohen-Kettenis, PT (2005) Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine* 35: 89–99.

Within a supportive framework, the mental health professional should remain neutral regarding outcomes, so that the client does not feel that one outcome rather than another is favoured. However, once a good rapport is established, the therapist may encourage trans individuals themselves to make a realistic appraisal of the advantages and disadvantages of any changes in their future lives.

Where necessary, the issue of sexual relationships should also be a part of any psychotherapeutic input. For partners who have always regarded themselves as heterosexual, the prospect of having their relationship transformed into a homosexual one – or vice versa – will be daunting, but it is not always insurmountable. Couples may benefit from joint therapeutic support, and voluntary support groups may also be able to offer help.¹¹ In addition, partners and other family members may also need reassuring that transsexualism, *per se*, does not pose any threat to children, whereas losing a parent is damaging.

Hormone therapy

“Hormones are often medically necessary for successful living in the new gender. They improve the quality of life and limit psychiatric co-morbidity ... In some patients hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross-living or surgery.”¹²

Hormone treatment can be initiated once a working diagnosis of gender dysphoria is obtained. This may be managed effectively by the GP, but a local endocrinologist, GP with special interest or other gender specialist may provide back-up if the GP is not confident about following hormone treatment guidelines (see Annex D). Those service users who are already self-medicating should be brought into a prescribed regime as soon as possible. However, insisting that the service user stop hormone treatment altogether at this point is not necessarily the safest health option, since it can cause serious stress and have adverse physical and psychological consequences. Some clinicians suggest a ‘bridging’ prescription for an agreed period – up to three months – to tide a service user over until a basic health profile is available and then, if necessary, the prescription can be modified to accommodate any contraindications that may be found.¹³

A strong warning should be given to the service user about the **additional and greater risk to health posed by obesity, smoking, illicit drugs or excessive alcohol**. Advice should be given, where necessary, to support a healthy lifestyle. If the clinician is the service user’s usual GP, then he or she may already be aware of any personal or family history of risk factors such as liver disorder, cardiovascular

11 See national helplines at the end of this booklet. Relevant information for families includes the NHS publication *Transgender experiences. Information and support for trans people, their families and healthcare staff* (2007). Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081579

12 Harry Benjamin International Gender Dysphoria Association (2001) *The standards of care for gender identity disorders*, sixth version, p.20. Symposium, Düsseldorf. Available at www.wpath.org/Documents2/socv6.pdf

13 Feldman, JL, Goldberg, JM (2006) Transgender primary medical care. *International Journal of Transgenderism* 9(3/4): 3–34.

disease and pulmonary embolism. These conditions will not rule out hormone treatment, but would suggest a cautious approach to products and dosages, and ongoing monitoring would be advisable.

Trans women will have oestrogens to promote feminisation. It is particularly important to initiate this treatment early because the psychological and physical effects are very beneficial. The growth of beard and body hair appears to be weakened so that removal, using electrolysis, laser or other hair-removal techniques, is greatly facilitated. Where hormones do not bring about the anticipated benefits, it may be that this treatment is not an appropriate way to deal with that individual's discomfort. The treatment can be stopped immediately – before physical changes become marked.

Early treatment for trans women sometimes includes hormone blockers (e.g. gonadotrophin releasing hormone analogue – GnRHa) or an anti-androgen (e.g. Cyproterone Acetate) to limit the effect of endogenous gonadal hormones.

Trans men will have testosterone treatment but the physical changes initiated by testosterone, especially the drop in the pitch of the voice, tend to be more rapidly initiated, perhaps in two or three months. The change in the voice cannot be reversed. Trans men may also benefit from GnRHa treatment but testosterone alone is often adequate. In both trans men and trans women, any blocking treatment undertaken will cease at the time of, or soon after, gonadectomy.

Informed consent is essential when embarking on hormone treatment. Extra caution would be needed where a learning disability exists, but hormone treatment is not ruled out.¹⁴ Clinicians must discuss with service users all the expected benefits, the potential unwanted side-effects and the risks of taking hormones. The NHS publication *A guide to hormone therapy for trans people* may be given to service users to help them in the decision-making process. It also facilitates any discussion they may wish to have with partners or friends.

Some doctors like to have a formal consent form signed by service users, before initiating treatment.

Service users should not undergo a pelvic examination as a prerequisite for starting hormones unless it is clinically indicated. This is an especially sensitive issue for trans people because they are usually uncomfortable with their physical sex characteristics. In cases where it is regarded as necessary, some may find it preferable to have this examination done by their GP, if the GP is willing, even if he or she is not the gender specialist in the case. Some service users may refuse genital examination and this should be respected. Where an initial examination has taken place and has revealed the need for further investigation, pelvic ultrasound may be undertaken.

N.B. Hormone treatment is not conditional upon any particular legal changes to name or gender status.

14 Wilson, D (2006) Draft *Good practice guidelines for the assessment and treatment of gender dysphoria*, Appendix B, The needs of people with learning disabilities who have gender dysphoria. Available at www.rcpsych.ac.uk/pdf/Standards%20of%20care%20/Draft%20v8%203b%20final.pdf

8 Embarking on the change of gender role

Clinicians may encourage, but not oblige, service users to experiment with androgynous or even cross-gender dressing. Adjustment to the new role is not just about dress, but also about speech, mannerisms and deportment. For trans women, there are also issues such as make-up and, sometimes, hair-pieces. It takes time to achieve a reasonable presentation so it is important that trans service users do not feel pressured into rushing this stage. It is at the point of transition to the opposite gender role that trans people are at their most vulnerable to relationship difficulties, hostility on the street and discrimination in the workplace.¹⁵ As mentioned above, a few people will choose not to transition to the opposite role. However, once trans people are living full-time in the changed gender role, this is regarded as helpful in supporting any future requirement for genital surgery (see Annex C).

During the initial period of living in the new role, other interventions and treatments may continue.

- For trans women there is speech and language therapy (this can be initiated at any time), facial and body hair removal, thyroid chondroplasty (frequently described by trans people as ‘tracheal shave’) and sometimes breast augmentation (although this should not be undertaken until the individual has been on oestrogen for about two years). Occasionally, facial feminising surgery (rhinoplasty, for example) is undertaken by trans women.
- Many trans men find that the most important treatment for them, in the early stages, is the surgical reconstruction of the chest. Living as a man with heavy breasts is virtually impossible and the change of gender role is not regarded by many clinicians as an absolute requirement prior to chest surgery.¹⁶ Breast binders can be worn for a short while, but they may cause back problems and possibly also distort breast tissue, which may make the final surgical outcome less successful.

15 Whittle, S, Turner, L, Al-Alami, M (2007) *Engendered penalties: transgender and transsexual people's experiences of inequality and discrimination*. Available at www.pfc.org.uk/files/EngenderedPenalties.pdf

16 Feldman, JL, Goldberg, JM (2006) Transgender primary medical care. *International Journal of Transgenderism* 9(3/4): 3–34.

9 Interventions for gender variant children and young people

Where the service user is a child or young person, family support is essential and local psychological support may be necessary. Liaison with schools should also be undertaken where a child insists on presenting in the opposite gender. Pre-pubertal children exhibiting cross-gender behaviours are statistically more likely to become gay adults than transsexual ones; a few outgrow their atypical behaviours and feelings. As puberty begins, however, those who are destined to live permanently in the opposite role usually develop an increasing disgust for their phenotype. Their distress reaches suicidal proportions in some cases. With support from a paediatric endocrinologist, hormone-blockers – gonadotrophin releasing hormone analogue (GnHRa) – may be prescribed once puberty is under way but before secondary sex characteristics become apparent. The timing of this intervention is important, so it is vital to follow an established protocol¹⁷ such as that used in the Vrije Universiteit Medical Centre Amsterdam, The Netherlands (see the NHS publications *Medical care for gender variant children and young people answering families' questions* and *A guide for young trans people in the UK*). Contact with support groups may be helpful for families.¹⁸

17 Delemarre-Van de Waal, H, Cohen-Kettenis, PT (2006) Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology* 155(1): 131–137. Available at www.eje-online.org/cgi/content/full/155/suppl_1/S131

18 See Mermaids, GIRES and DEPEND in 'Information and support', page 70.

10 Gender confirmation surgery

Gender confirmation surgery (sometimes known as gender reassignment surgery) is usually conditional upon the service user being over the age of 18, and having lived for a period of 12 months – sometimes more – in the ‘new’ gender role. This length of time is arbitrary; it represents the understandable caution of clinicians who are afraid that irreversible surgery may be mistakenly undergone if there has been a shorter period of living full-time in the new role. The surgeon will require two clinical opinions before undertaking genital surgery. Genital surgery is not necessarily required for an individual to obtain a Gender Recognition Certificate (see the NHS publication *A guide to trans service users’ rights*). Fully informed consent regarding possible complications and a realistic understanding of outcomes are prerequisites for all surgeries.

Surgery for trans women may include:

- mammoplasty (usually a day case, under general anaesthetic);
- orchidectomy (sometimes done separately from the following surgeries);
- penectomy;
- vaginoplasty;
- clitoroplasty (sensate); and
- labiaplasty.

Major genital surgery usually necessitates several days in hospital. The most usual technique involves penile skin inversion to create a functional vagina. Sexual sensation is an important objective in vaginoplasty and clitoroplasty.

Post-surgical care, as with any major surgery, may require the services of a district nurse. Trans women have to use dilators to ensure that the vaginal tissue does not shrink. Surgeons usually give their own instructions regarding dilating and douching because these may depend, to an extent, on the surgical techniques and the tissue used to create the vagina. Otherwise, the following is a suggested regime that may be adapted by the individual to her own personal needs and circumstances:

The vagina is ‘packed’ post surgery. Once that pack is removed:

- twice-daily baths, or washing in a bidet, may be commenced;
- dilating twice daily with a 25mm dilator for five minutes, followed by a 30mm dilator for 10 minutes, is recommended, and should be followed once a day by douching with a Betadine vaginal kit;
- liquid Simple soap or pH 5.5 handwash can be used later on for douching and douching can be reduced to twice a week;
- dilatation should continue, twice daily if possible, for three months and then once daily for a further three months;

- dilatation twice a week, followed by douching, is then usually sufficient to maintain the diameter and depth of the vagina;
- sexual intercourse can commence three months post-operatively. This will help dilatation and reduce the need for it; and
- in the longer term, dilatation and douching may be reduced to once or twice a week and can be done while having a bath.

Surgery for trans men may include:

- chest reconstruction;
- hysterectomy and salpingo-oophorectomy;
- vaginectomy;
- metoidioplasty (forming a micropenis by releasing the clitoris, with the option of bringing the urethra to the tip);
 - scrotoplasty (usually with testicular prostheses); and
- phalloplasty (creation of penis using skin from donor site);
 - scrotoplasty with testicular prostheses;
 - prosthesis (or prostheses) to enable erection of the penis.

Phalloplasty involves several surgical procedures over a period of time, depending on the level of sophistication of the proposed outcome. Where this is to be undertaken, the GP may need to refer the individual for electrolysis or for laser treatment, in order to remove hair from the donor site. The donor site is most commonly the forearm (radial flap) but may also be the abdomen, the thigh or elsewhere. Phalloplasty may involve up to five surgeries, or more if there are complications. The most common complication arises with urethroplasty.

Post-surgical care will also include care of the donor site. This care may be provided by a practice nurse.

Although many surgeons can undertake mastectomy, special skills are required to create the appearance of a male chest. It may be best that any referral made by the GP or other clinician should be to a surgeon who has experience in undertaking chest reconstruction in trans men.^{19,20}

19 FtM London (2002) *Chest reconstruction for female to male trans people*. Published in conjunction with consultant surgeon Mr Dai Davies. This booklet gives comprehensive advice on all aspects of chest surgery. For further information email info@ftmlondon.org.uk or contact Mr Davies: enquiries@plasticsurgerypart.org.uk or via the website: www.cosmeticsurgeryuk.com

20 Bowman, C, Goldberg, JM (2006) Care of the patient undergoing sex reassignment surgery. *International Journal of Transgenderism* 9(3/4): 135–165.

11 Ongoing care for trans service users

Hormone treatment for transsexualism will usually be lifelong but, after gonadectomy, the dosage of hormones may be quite low. Ongoing health checks and monitoring are usually undertaken. Guidance is provided in Annex D, Clinical guidance on hormone therapy for gender variant people.

If necessary, a referral to an endocrinologist can be made. Regular monitoring will usually be undertaken, but in cases where no health problems are identified, the frequency of monitoring tests may be reduced at the discretion of the service user and the GP.

It is not uncommon – particularly for those transitioning from living as a man to living as a woman – to report a sense of anticlimax and even depression, owing to the loss of status which is still sometimes associated with the inequalities between the sexes. Both trans men and trans women may be over-optimistic about any negative effects of their transition on their family and social lives. Sometimes they have had unrealistic expectations of surgery and are therefore disappointed and frustrated by the limitations of the outcomes. Although surgical techniques are improving all the time, trans men are still relatively disadvantaged in comparison with trans women. Further psychotherapeutic support may be desirable in such cases. Even though full transition may be an essential and life-saving step, some trans people will continue to struggle, psychologically and practically, with the impact of the social changes on their lives.

Older trans people, whether they have transitioned recently or many years ago, may benefit from the help of their GP in making plans for their medical and social care in their later years. They may wish to write instructions about how they should be treated, especially if they have not undergone full surgery and/or do not enjoy the legal status attained with a Gender Recognition Certificate. A written document may help to guard against gender-inappropriate treatment in hospital or a care home. A useful guide for the ongoing needs of older trans people is provided in the Age Concern leaflet *Planning for later life: transgender people*.²¹

Trans people will continue to have some mixed sex characteristics. They must be treated in accordance with these, and not necessarily in strict accordance with their legal gender or their apparent sex. For instance, trans women – even those who have had gender confirmation surgery – will still have a prostate gland. If they have started hormone treatment and undergone gonadectomy when young, it is unlikely that they will develop prostate cancer, but those who transition late may be more susceptible. Breast cancer in both trans women and trans men is a possibility. Where there is a family history of breast cancer, breast screening may be undertaken according to local protocols. Trans men may still have a vagina and, if they are having vaginal sexual intercourse, may benefit from smear tests. In later life, DEXA bone scans may be advisable for both trans men and trans women.

21 Age Concern (2007) *Planning for later life: transgender people*. Information sheet IS30. Also available online at www.ageconcern.org.uk/AgeConcern/Documents/IS30TransgenderJan2007.pdf

12 Managing medical records

Medical record-keeping for trans people can be a challenge for clinicians and staff. Names and titles must be changed to reflect current gender status (this should always be done as a matter of courtesy and is not dependent on having a Gender Recognition Certificate). However, the name change may lead, for example, to trans women being offered smear tests, and trans men being offered PSA tests. In neither case is this appropriate. It is advisable that clinicians devise their own simple marker to alert the practice team to the need for **appropriate** tests in these cases, without the need to mention any previous gender status. This protects the long-term health and the personal dignity of the service user.

The same care will need to be taken if and when the central NHS Care Records Service (HealthSpace) is introduced. Patients' rights to opt out, and their (limited) right to say what can be included, must be taken into account (see the NHS publication *A guide to trans service users' rights*).

13 Providing letters for the Gender Recognition Panel and other referrals

In order to obtain documents such as new passports, driving licences and Gender Recognition Certificates, GPs may be requested to provide written evidence of a service user's permanent transition and any associated treatments. In the case of the Gender Recognition Certificate, a substantial amount of detail is required by the Gender Recognition Panel, including dates of the start of the change in gender role, hormone therapy regimes, surgery dates and procedures. Further advice is available at the websites given below.²²

With regard to letters of referral for medical treatment other than for gender issues, trans people often complain that doctors write only in terms of their transsexual status, and that other aspects of their medical care suffer as a result. Correspondence with another doctor sometimes emphasises the service user's trans status, even where it is totally irrelevant. Guidance for clinicians on an appropriate approach to letter-writing is provided in the NHS publication *A guide to trans service users' rights*.

22 www.grp.gov.uk/formsguidanceinformationformedicalpractitioners.htm
www.grp.gov.uk/documents/guide_med_prac_standard.pdf

Annex A

Diagnosis and aetiology

This extract is taken from the *Guidelines for health organisations commissioning treatments for trans people* (2005).²³ These guidelines were agreed in consultation with the gender specialist clinicians and trans people who form the Parliamentary Forum on Transsexualism. This document will be updated from time to time.

The International Statistical Classification of Diseases (ICD-10), published by the World Health Organization and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) offer the following diagnostic criteria:

Gender Identity Disorder (DSM-IV) is a 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”.*²⁴

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”.*²⁵

The ICD-10/DSM-IV entries provide useful reference points for the medical practitioner. However, diagnosis can only be determined by the individual concerned. There are no tests that provide a definitive diagnosis. Accordingly, it is important to take account of the personal experiences and insights of trans people themselves, as well as the biological evidence that emerges from a variety of scientific studies (for a more comprehensive review of the relevant research see the Gender Identity Research and Education Society (GIREs), ‘Atypical Gender Development – A Review’, which was published in the *International Journal of Transgenderism* (2006) 9:1.²⁶

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.

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

23 Available at www.gires.org.uk/Web_Page_Assets/frontframeset.htm

24 American Psychiatric Association (1994, revised 2000) *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition. Available at www.psychiatryonline.com/content.aspx?alD=9855. See also http://wikipedia.org/wik:/Gender_identity_disorder

25 World Health Organization (2007) *International Statistical Classification of Diseases*, version 10. Available at www.who.int/classifications/apps/icd/icd10online

26 Besser, M, Carr, S, Cohen-Kettenis, PT, Connolly, P, De Sutter, P, Diamond, M, Di Ceglie, M (child and adolescent section only), Higashi, Y, Jones, L, Kruijver, FPM, Martin, J, Playdon, Z-J, Ralph, D, Reed, T, Reid, R, Reiner, WG, Swaab, D, Terry, T, Wilson, P, Wylie, K (2006) Atypical Gender Development – A Review. *International Journal of Transgenderism* 9(1): 29–44, GIREs et al. Available at www.gires.org.uk/Text_Assets/Atypical_Gender_Development.pdf

individual circumstances but on cultural norms and mores. In cultures where greater allowance is made for gender expression that 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).²⁷ 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.

Instances of inconsistent sex differentiation are estimated to occur in about 1% of live births (Blackless *et al.*, 2000).²⁸ 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)²⁹ 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).³⁰ Conversely, there is evidence of a correlation between low androgen input to the fetus (associated with medication of the pregnant mother) and a raised incidence of male to female transsexualism (Dessens *et al.*, 1999).³¹ Certain chromosome disorders, also characterised by low androgen levels, are associated with a raised incidence of male to female

- 27 Connolly, P (2003) Transgendered peoples of Samoa, Tonga and India: diversity of psychosocial challenges, coping, and styles of gender reassignment. Paper presented at the Harry Benjamin International Gender Dysphoria Association Conference, Ghent, Belgium, 10–13 September 2003.
- 28 Blackless, M, Charuvastra, A, Derryck, A, Fausto-Sterling, A, Lausanne, K, Lee, E (2000) How sexually dimorphic are we? Review and synthesis. *American Journal of Human Biology* 12: 151–166.
- 29 Wilson, P, Sharp, C, Carr, S (1999) Prevalence of gender dysphoria in Scotland: a primary care study. *British Journal of General Practice* 49: 991–992. Figures for UK extrapolated from Scottish figures which seem to be the most relevant to the UK. (Since 2005, estimates have risen from approximately 5,000 trans people in the UK to nearer 10,000. At the moment none of these figures can be absolutely verified.)
- 30 Hines, M (2004) *Brain gender*. Oxford University Press, New York. A very small minority of female individuals with congenital adrenal hyperplasia (CAH) who have been raised as girls choose to live in adulthood as males (estimates range from about 1% to about 3%). (Since the publication of these figures, the literature has been reviewed in: Dessens, AB, Slijper, FME, Drop, SLS (2005) Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. *Archives of Sexual Behaviour* 34(4): 389–397. Dessens found a much higher frequency of individuals within this group who identify comfortably as men: of 250 individuals raised as girls, 13 (5.2%) experienced female to male gender dysphoria; of 33 individuals raised as boys, four experienced male to female gender dysphoria. It therefore appears that of the total 283 individuals, 42 must be living comfortably as men or uncomfortably as women. These figures do not represent the whole XX, CAH population and therefore, although interesting, should be viewed with caution.)
- 31 Dessens, AB, Cohen-Kettenis, PT, Mellenbergh, GJ, van der Poll, NE, Koppe, JG, Boer, K (1999) Prenatal exposure to anticonvulsants and psychosexual development. *Archives of Sexual Behavior* 28: 31–44.

transsexualism (Snaith *et al.*, 1991; Grumbach and Conte, 1998; Diamond and Watson, 2004).^{32,33,34,35} 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).^{36,37,38}

Research also demonstrates that XY infants who are sex-reassigned as a result of medical and surgical responses to observable sex developmental anomalies, or as a result of 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.*, 2003³⁹) may have an impact on brain development that is indelible in some individuals (Diamond, 2004; Reiner, 2004).^{40,41}

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).^{42,43}

- 32 Snaith, RP, Penhale, S, Horsfield, P (1991) Male-to-female transsexual with 47 XYY karyotype. *Lancet* 337: 557–558.
- 33 Grumbach, MM, Conte, F (1998) Disorders of sexual differentiation. In JW Wilson and DW Foster (eds.) *Williams Textbook of Endocrinology* (9th edition) pp. 1400–1405. WB Saunders, Philadelphia.
- 34 Diamond, M, Watson, LA (2004) Androgen insensitivity syndrome and Klinefelter's syndrome. *Child and Adolescent Psychiatric Clinics of North America (Sex and Gender)* 13(3): 623–640.
- 35 Bearman, G (2007) Karyotyping and genetics in the transgendered population. In R Ettner, S Monstrey and AE Eyler (eds.) *Principles of Transgender Medicine and Surgery* pp. 261–280. Haworth Press, New York.
- 36 Green, R (2000) Family co-occurrence of "gender dysphoria": ten sibling or parent-child pairs. *Archives of Sexual Behavior* 29: 499–507.
- 37 Coolidge, FL, Theda, LL, Young, SE (2002) The heritability of gender identity disorder in a child and adolescent sample. *Behavior Genetics* 32: 251–257.
- 38 Diamond, M, Hawk, ST (2003) Transsexualism among twins has a high concordance for GID among monozygotic twins and a strong but lesser concordance among dizygotic twins with the effect more noticeable among males than females. Paper presented at the Harry Benjamin International Gender Dysphoria Association Conference, Ghent, Belgium, 10–13 September 2003.
- 39 Dewing, P, Shi, T, Horvath, S, Vilain, E (2003) Sexually dimorphic gene expression in mouse brain precedes gonadal differentiation. *Molecular Brain Research* 118: 82–90.
- 40 Diamond, M (2004) Sex, gender, and identity over the years: a changing perspective. *Child and Adolescent Psychiatric Clinics of North America (Sex and Gender)* 13(3): 591–607.
- 41 Reiner, WG (2004) Psychosexual development in genetic males assigned female: the cloacal exstrophy experience. *Child and Adolescent Psychiatric Clinics of North America (Sex and Gender)* 13(3): 657–674.
- 42 Zhou, J-N, Swaab, DF, Gooren, LJ, Hofman, MA (1995) A sex difference in the human brain and its relation to transsexuality. *Nature* 378: 68–70. This evidence was cited by Professor Louis Gooren of the University Hospital, Vrije Universiteit of Amsterdam, in his affidavit to the court in *Bellinger v Bellinger*, (17 July 2001).
- 43 Kruijver, FPM, Zhou, J-N, Pool, CW, Hofman, MA, Gooren, LJ, Swaab, DF (2000) Male-to-female transsexuals have female neuron numbers in a limbic nucleus. *Journal of Clinical Endocrinology & Metabolism* 85(5): 2034–2041.

Annex B

Treatments that may be commissioned

This list is taken from the *Guidelines for health organisations commissioning treatment services for trans people* (2005). These guidelines were agreed by the gender specialist clinicians and trans people who form the Parliamentary Forum on Transsexualism.⁴⁴

The list of treatments below, 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.

In cases of adult gender dysphoria/transsexualism health commissioners may be expected to be 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, a package that includes an image consultant, and facilities for peer support groups (facilitated or self-led) and relatives' support groups;
- hormone treatment including a referral to a specialist endocrinologist, or other relevant specialist;
- referral to a 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 chest reconstruction 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 and clitoroplasty for trans women; and
 - hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty and phalloplasty for trans men.

44 See full text at www.gires.org.uk/Web_Page_Assets/frontframeset.htm

- 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 a GP or, where appropriate, an endocrinologist); and
- follow-up review by a gender specialist (at 12 months).

Commissioning of treatment of young trans people

In cases of young people experiencing gender variance, their treatment services should be well integrated with adult services. Few gender dysphoric pre-pubertal children become gender dysphoric adults, whereas those experiencing the condition as young people almost invariably require access to adult services.⁴⁵ Commissioners are responsible for funding:

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

45 Wren, B (2000) Early physical intervention for young people with atypical gender identity development. *Clinical Child Psychology and Psychiatry* 5: 220–231.

Annex C

Assessment and psychological support: embarking on the change of gender role

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C1 Life stories

Carol (name changed)

I didn't know I was gender dysphoric. In fact, I'd never heard the term. The only cross-dresser I had seen was Danny La Rue – liked the guy, but that wasn't me.

As a teenager I was bullied at school, but then who isn't? Just before going to university a friend gave me Jan Morris's book *Conundrum*. Funny, I didn't think I had been giving off signals but I obviously had. I'd done such a good job of lying to myself that I figured I'd fooled everyone else as well. Reading that book made it all fall into place – so **that** was me!

The transition years were a misery. Hormones weren't available on the internet until later, and my GP knew nothing and cared less. I can look back now and say it was all worthwhile – the struggle to get treatment, family problems, breaking up with my then girlfriend. I'm glad I transitioned early and didn't do what so many do – marriage, kids, the whole bit, so I had less to lose if it all went pear-shaped.

Now, I have a great partner. She used to pass her HRT pills on to me in the early days, and she helped me pay for surgery too. GPs are a little better informed now so I don't have to cheat to get my hormones. My partner and I have been together for 20 years – a couple of old lesbians sliding gracefully into old age.

Mary (name changed)

I struggled for many years before finally admitting to myself that enough was enough. I overdosed twice, and on both occasions my increasingly distraught wife found me, called an ambulance and I ended up in hospital. After the second attempt, I told her that I was transsexual. She cried for months and I was wracked with guilt. When she stopped crying, she was very, very angry. She felt that I had betrayed her and married her under false pretences. I suppose I had, in a way, but I hadn't meant to.

It took me three years to access medical treatment. By the time I got an appointment at a clinic I had already started taking hormones I had bought over the internet. The psychiatrist at the clinic made me stop taking hormones altogether while I lived full-time as a woman. My wife threw me out at that point and got a court injunction to stop me seeing the children. It was a dreadful time for me. I was at rock bottom and came very close to taking another overdose. I lost my job and lived in rented accommodation in a bad part of town where I was terrified of even opening my front door, let alone getting some kind of work to keep the psychiatrist happy. It had to be done though, because I couldn't face the prospect of not getting back on hormones. I toyed with the idea of cheating and taking them anyway, but I felt too scared of getting caught.

I went to the Citizens Advice Bureau for advice, and hit lucky. They needed help in the back-office, so I worked as a volunteer behind the scenes; this meant that I was able to provide written evidence of being 'out' and functioning in society.

I never let on to the psychiatrist that I was as miserable, lonely and scared as I had ever been in my entire life. So I did get my hormone prescription, finally.

Now I just take life a day at a time. I'm not sure about surgery. That's something for the future. I'm beginning to make a few friends, some of them trans. I'm starting to look better and get the hang of dressing without looking like a complete prat.

I sent my younger daughter a small present for her 11th birthday. I put my address on the card, but didn't expect anything back. Then a few days later I received a little thank-you note from her. It may not seem like much, but I felt like it was **my** birthday. I'm not going to push it, and I don't expect my wife to ever accept me back, but just a little bit of acceptance from the kids feels like the most important thing in the world to me right now.

Lucy's story (name changed)

I struggled through my teenage years because I was disgusted with my body. It distracted me from studying and it made me moody and difficult to live with. My parents made heroic efforts to be patient, but our relationship was strained.

The day after I left school, I went to see our GP. It is to her credit that she didn't throw me out after the allotted seven minutes, but just listened as I poured out my feelings that everything was wrong with me: the way I looked, the way everyone assumed I was a boy, my terror about the future, which looked completely black to me at that time.

She asked a few questions like "Have you talked to your parents about this?"; "How long has this gone on?"; "How do you see yourself in, say, five years' time?"; "Have you had any intimate relationships?"; and "Have you ever felt like harming yourself, or even taking your own life?". The last question was brave, but it was hugely helpful to me, because I **had** felt like that in my darkest moments, and she made it possible for me to talk about it. Prompted by her gentle questions, I just blurted all the pain, anger and frustration.

The poor woman didn't get any lunch that day, but she saved my life. She said it was okay to be different; she said she would help me tell my parents if I liked and she asked if I would like to speak to a counsellor of some sort, and I agreed that I would like that.

She explained about the various treatment options – most of which I was aware of – and she asked what I thought would be the best way forward. I said I needed to 'quieten' my body (I didn't know how else to explain it) and I had read about 'hormones' and thought that was the place to start.

She explained about the precautionary blood tests she would like me to have before starting on hormones. While I waited for the results to come through I had an initial appointment with a local psychologist who was also a good listener.

He covered some of the same ground but it was just wonderful to be able to talk about my feelings. All of this was a bit like lancing a boil. Life was looking better.

About four weeks after my first appointment I went back to my GP. The blood tests were fine and from a health point of view I could start taking hormones. She said that, as I was still young and living at home, she would **prefer** my parents to know what was happening but she made it clear that this wasn't essential and she would treat me anyway. I took her up on her earlier offer to talk to them for me. They were dreadfully upset, but also relieved in a way, because they understood why I had been such a pain to live with. Our relationship improved immediately and dramatically.

A month later, after a further session with the psychologist, I started on hormone blockers to limit testosterone, and oestrogen to make me feel and look more feminine.

I didn't know it at the time, but by chance, my GP had spent some time in a GIC so she knew the ropes. She had educated the local psychologist and both had worked together before with people like me.

For the first time ever, I was looking forward – to being Lucy, to making proper relationships that weren't just play-acting, to university, to life!

Alex's story

I was small and feisty as a child. I still am. Until I was about 14, I played with both boys and girls. I didn't particularly mind which, but I always liked kicking a ball around.

As puberty started to hit other girls in my class, I started to panic. I couldn't bear the thought of breasts. Mine arrived late, but I got them in the end – with a vengeance. I tried really hard to cover them up, but nothing worked. I find it hard, even now, to put into words the feeling of disgust that they gave me. I wasn't feminine, and they didn't fit. The boys wouldn't play with me any more, so I became withdrawn and spent a lot of time on my own. I kept my head down, I collected stamps, I played the flute, I studied hard and was successful academically.

My parents and my brother tried to make me join in social events but I was increasingly uncomfortable in company. To cut a very long story short, one day I was with my brother in our local pub and a casual acquaintance of his strolled over and joined us. The three of us chatted for a while, and then my brother went off to pick up his girlfriend. My brother still maintains that it wasn't a set-up, but I only half believe him.

This guy, I'll call him George, shared my passion for stamps. All right, it sounds really nerdy, but we really hit it off. He didn't seem to mind that I wasn't your typical girl. A few months later we were married in a registry office – nothing fancy, just him and me, my parents and brother and George's dad. My parents were relieved that I was 'settled'.

Only I wasn't. George and I were good friends and we still are, but I was still searching for an identity. I don't know how else to explain it. I talked to my GP who referred me to a therapist. The therapist suggested to my GP that she should refer me to a psychologist. The psychologist gave up on me and the GP sent me to a psychiatrist. This being knocked back and forth like a ping-pong ball was distressing. It went on for more than a year and nobody seemed to have any answers. The psychiatrist finally referred me to a gender specialist who said I was gender dysphoric and it therefore followed, as night follows day, that I must identify as a man. But I didn't, and I still don't.

To get a doctor to take me seriously has been the hardest thing of all because I don't feel like either a man or a woman. I feel completely gender neutral. These days I mix quite a lot with people who are transgender and I hear some others say they feel like **both** men and women at different times. Some have social or work circumstances that prevent them from going the whole way so they live in between – as men during the week and as women at the weekend or just when they go away on holiday. They take hormones and so they often have to camouflage their breasts when they are in male mode. I finally met two other people who, like me, see themselves as **neither** men **nor** women.

I did finally persuade a doctor to refer me for surgery to remove my breasts. The surgeon came closer to understanding my position than anyone, because he said he had seen people like me before. It was rare, but I was not alone. He explained to me that as I wasn't a 'classic' transsexual – whatever that might be – he would have to give a different reason for removing my breasts. As it happens, we have a history of breast cancer in our family. So that's what went in my medical notes.

For the moment, I feel much more comfortable. I use male pronouns, even though I'm not a man as such, but it helps me to distance myself from the girl that I never was. I know people find my choice of pronouns awkward, but if I could choose neutral pronouns I would. I have a good job, friends, and a supportive, if slightly bewildered, family. I'm still into stamps and my best friend is still George, although we don't live together any more.

I hurt George a lot, and that is my biggest regret.

Robin's story

When I was seven, I was invited to the birthday party of a boy at school. He was someone I really liked so I was excited about going. My mother put out my party frock. I can see it now, hanging from the handle on the wardrobe door. The hanger was one of those pink ruched jobs. I ignored the dress and put on jeans and a checked shirt. Mum went ballistic and said I wasn't to come out of my room until I had put the dress on.

I felt sick. I had some not-very-sharp scissors in my room so I half cut, half tore that awful dress so that I absolutely couldn't wear it. I never did get to that party or any of the other parties that my school friends invited me to over the next few years.

When other girls started wearing jeans for parties, my mother finally relented and let me go. I was 14 by then. I still didn't look anything like the other girls because I wore a loose fitting shirt to hide my revolting boobs whereas they wore really tight hipsters with their midriffs showing and they wore pretty blouses, painted their nails and wore lipstick.

I thought I had never seen anything so ridiculous – sort of lamb dressed as mutton. I thought, why would anyone want to look like a **woman**?

My father never said anything about my appearance and, looking back, I think that that early episode with the dress alerted both my parents to something fairly profound going on. It was as though there was a tacit agreement that nobody would mention it – ever again – that elephant in the room!

It did occur to me that I was something more than a tomboy but I couldn't pin it down, even to myself, and I certainly couldn't explain it to others. I thought periods were the worst thing ever – but then so did most of the girls in my class. My teenage years were spent in limbo. I survived superficially by trying not to fathom what was going on in my head and by just getting on with the routine of school and exams. I can't say I was bullied at school and, apart from this underlying unease, I wasn't exactly unhappy.

It was really at university that I suddenly had a moment of insight. I just looked at all those students coming and going, and I asked myself, where do I fit? It was a moment of pure joy, quickly overtaken by the enormity of what it would mean. It was a mixture of relief and despair.

I went to see the university 'counsellor', Mrs Smith (not her real name). She was a complete waste of space. She started by being all sweetness and light, and offered me a cup of tea, which I accepted. But when I started talking about my conviction that I was actually a man, that I had never been a girl and that God had played this unpleasant trick on me (I said that in a jokey way because I didn't want things to get all bogged down in emotion), she said I would have to leave university and re-apply a few years down the line when I was 'sorted out'. Her distaste was palpable. She made me feel like a leper and actually moved the sugar bowl out of my reach in case I contaminated the spoon!

I went back to my room and cried – really cried like I'd never cried before. The girl from the next room heard me and came in. Goodness knows how she made sense of what I was saying through the sobs, but she turned up trumps. She said it was nonsense that I would have to leave; this was nearly the 21st century (it was 1999), not the Dark Ages; Mrs Smith was a lunatic and I should go straight to the Dean and get him to have her forcibly removed from the premises.

She was so indignant that she made me laugh and I started to feel better. I saw the Dean, who, very sensibly, asked me how I wanted to deal with the situation and said that **he** would fit in with **me**! Between us we decided that I should wait

until the summer holiday to initiate my treatment and come back in my new persona in September.

I decided that over that Christmas break I would see my GP and tell my parents. I did, in that order. The GP was great; he said he was out of his depth but he'd do some homework. My parents were also out of theirs. But not so much as they might have been if it hadn't been for my butchery of the dress when I was seven. My mother said she had thought about it almost every day since. She tried not to, but it was such a dramatic statement that it just nagged away at her over the years.

They looked really shell-shocked when I explained that I wasn't really a girl at all. Mum cried; Dad looked very strained and white; I felt very guilty.

The GP found out that there was a long waiting list to start treatment but said he could refer me to a local psychiatrist to get the ball rolling. What?! I protested that I wasn't dotty but, apparently, 'they' (the medical profession) needed confirmation of this. I saw the psychiatrist before going back for the spring term and was pronounced 'sane'. My parents stepped in when they realised how important it was that I dealt with some of the more difficult aspects of treatment while I was away from university. The only way to take control over my own schedule was to have some treatment privately. They paid for me to see a 'gender specialist' during the Easter break so that I could start taking hormones when I was ready. I owe them, big time.

We also decided between the three of us that they would tell aunts, uncles and cousins. The aunts and uncles were aghast and said, 'You must stop her.' The cousins said, 'Cool, wish him luck.' I delayed hormones through the first few weeks of the summer term because I didn't want to start sprouting facial hair until the summer holidays.

During that summer there were small but unmistakable physical signs of my transformation. The testosterone helped me to feel right about myself, and (incidentally) did wonders for my libido. When I returned to university for my second year I felt more at ease with myself and in my presentation to the world. I used breast-binders that were hell in hot weather. I needed chest surgery urgently and I had chest reconstruction during the Christmas break – again privately.

I am now, several years down the line, on a waiting list for a hysterectomy under the NHS. I know not all trans men want this but it's important to me. It's taking ages but I feel better able to cope with the waiting now that people relate to me as a man, so my social life is good. I have a great job which I love and nobody there knows about my trans past. Sex life? I don't really have one. I did have a few embarrassing forays and one relationship for about three months with a lovely girl. It didn't work out but it gave me the confidence to believe that one day it might. So I have put that on the back-burner until I have decided how far I need to go with surgery.

I was one of the lucky ones. I have realised that after listening to the horror stories from other trans men. At university, Mrs Smith had miraculously vanished and the

other staff and my friends acted as though nothing had happened. There were big changes in my appearance but they happened slowly and we all got used to the new me – together. People who didn't know me never looked twice. The Dean changed my name 'unofficially' on all documents immediately. It wasn't hard; I had switched from Robyn to Robin – or as I liked to put it, from 'why' to 'I'.

C2 The history of treatment of trans people in the NHS

As outlined in the initial comments in this publication, clinicians in the UK are working towards improving the quality of treatment and support for trans people within a framework of good practice that emphasises patient autonomy, allows for the wide variety of needs among trans people and is flexible in its clinical responses to those needs.

However, in providing psychological support for trans people it is important to understand that, until recently, many of them have felt fearful and often reluctant to seek gender-related treatment.

*"This group has historically been averse to accessing medical services for a number of reasons, including: prior negative experience in clinical settings, expectation of discriminatory treatment, the requirement of psychiatric treatment ..."*⁴⁶

Health professionals need to take account of this and strive to create and sustain a respectful relationship, in which the client⁴⁷ feels confident enough to explore gender concerns. Many trans people need to be supported and assisted in this task of self-exploration, in order to decide where their gender needs lie and how they can be met. For many, this will be part of an ongoing process. It should not be assumed by clinicians, other health professionals, or indeed by clients themselves, that one particular pathway or one particular outcome is expected.

There has been a tendency for trans people to say what they think doctors and other health professionals want to hear. They fear that if they do not recount a stereotypical narrative that includes very early childhood discomfort, leading to adolescent agonies, their treatment may be delayed or withheld altogether. Whilst for many this narrative represents the real story, for a few it may obscure a more variable storyline. Clients should, therefore, be reassured that they are not expected to produce one standard version of past events and feelings, and that departure from a stereotypical history will not jeopardise their access to treatment. Also, caution, uncertainty and experimentation with regard to dress and gender role should be regarded as a useful part of the process,⁴⁸ rather than a reason for delaying or denying treatment.

It may be many months before any firm decisions are made, and in any case these may remain subject to revision.

46 Tom Waddell Health Center (2006) *Protocols for hormonal reassignment of gender*. Available at www.dph.sf.ca.us/chn/HlthCtrs/HlthCtrDocs/TransGendprotocols122006.pdf

47 'Client' rather than 'service user' is used in Annex C as it is the preferred term of many mental health professionals for whom this section is particularly relevant.

48 Feldman, JL, Goldberg, JM (2006) Transgender primary medical care. *International Journal of Transgenderism* 9(3/4): 3–34.

C3 Psychological support versus psychiatric treatment

The role of 'gate-keeper' (the health professional who has the capacity to prevent or delay treatment) conflicts with the supportive role that is central to a health professional's relationship with a client.

Some suggest that these roles – the gate-keeper function and the provision of psychological support – should be undertaken by different health professionals, thus overcoming any potential conflict. Others in the trans community suggest that the gate-keeper role, usually undertaken by a psychiatrist, could disappear altogether from the scene, since psychiatric treatment is not applicable to gender variant conditions. Psychological support, however, is regarded as helpful for those gender variant people in whom the condition causes a high degree of stress. It is important that such support is based on the understanding that:

- *"the condition cannot be cured by any conventional psychiatric interventions: psycho-analytic, eclectic, aversion treatment, or by any standard psychiatric drugs, it is not responsive to psychiatric treatments alone";*⁴⁹
- the diagnosis of this condition can only be derived from the self-reports of those experiencing it; and
- research indicates that neurodevelopment of the brain before birth is implicated in severe gender dissonance.⁵⁰

The rationale for retaining psychiatry in the spectrum of medical interventions for trans people is that a differential diagnosis is deemed necessary in order to identify any co-existing psychopathology that may require prior, or parallel, treatment. GPs may be well placed to recognise any such symptoms in a service user. However, GPs and other health professionals who have developed an expertise in gender issues are competent to carry out the initial assessment and to arrive at a diagnosis. If there are any co-existing mental health and/or competency concerns, or perhaps substance misuse, then it is clearly appropriate for the GP to refer service users, locally where possible, for a mental health assessment and treatment.⁵¹

Often, co-existing difficulties are a direct result of suppressed transgender feelings, and they will start to improve once the gender conflicts are addressed. However, clinicians should, as far as possible, make sure that any co-existing conditions are

49 Green, R (1999). Affidavit cited in *Bellinger v Bellinger*, Court of Appeal, para 32, Judgment, 2001,TLR 22-11- 2000.

50 Besser, M, Carr, S, Cohen-Kettenis, PT, Connolly, P, De Sutter, P, Diamond, M, Di Ceglie, M (child and adolescent section only), Higashi, Y, Jones, L, Kruijver, FPM, Martin, J, Playdon, Z-J, Ralph, D, Reed, T, Reid, R, Reiner, WG, Swaab, D, Terry, T, Wilson, P, Wylie, K (2006) Atypical Gender Development – A Review. *International Journal of Transgenderism* 9(1): 29–44, GIRES et al. Available at www.gires.org.uk/Text_Assets/Atypical_Gender_Development.pdf

51 Bockting, W, Knudson, G, Goldberg, J (2006) Counselling and mental health care of transgender adults and loved ones. *International Journal of Transgenderism* 9(3/4): 35–82. Available at www.vch.ca/transhealth/resources/library/tcpdocs/guidelines-mentalhealth.pdf

under control and that the patient is competent to consent to medical treatment. Rarely, thought-disorders and severe distress about sexual orientation can cause a transient wish for sex reassignment, which disappears when the underlying mental health condition is treated. Caution should be exercised where gender unease seems to be episodic or only recently experienced.⁵²

General psychological support may be especially helpful through the transition period, when trans people may face many personal losses and sometimes much public humiliation and even danger.⁵³

Nevertheless, some people experiencing severe gender discomfort have already reached a point where they are confident in their self-diagnosis and are so healthy in their mental, emotional and interpersonal functioning that they require only assessment and guidance rather than in-depth exploration.

“Psychotherapy is Not an Absolute Requirement.”⁵⁴

However, this may be the exception rather than the rule among trans service users.

C4 Assessment

The initial assessment is likely to be undertaken in the context of the factors outlined above. Other issues arising from the trans person’s interaction with family and society are outlined in Sections C6–C17.

The following table⁵⁵ is an aide-memoire for the professional undertaking the assessment. It provides **suggestions** to be used flexibly and should be adapted to the individual client. The assessment is **not** intended to be an interrogation, but a supportive, non-judgemental discussion around a number of points. Not all of the topics mentioned will be relevant to every client. The important matters relate to how individuals see their own past, present and future gender identification, and how they view their emotional relationships with significant others and, generally, within their families. For many, discomfort experienced with the phenotype will be relevant.

Questions relating to sexual relationships and sexual orientation are useful in building a picture of a client’s history, but pursuing these topics may be particularly resented by some trans clients. Health professionals need to be aware that many trans people regard issues to do with their sexuality and sexual behaviour as irrelevant to their gender discomfort. Nevertheless, if they are facing disruption to existing sexual relationships, this will cause an added dimension to their own discomfort and that of their partners.

52 Tom Waddell Health Center (2006) *Protocols for hormonal reassignment of gender*, p.2. Available at www.dph.sf.ca.us/chn/HlthCtrs/HlthCtrDocs/TransGendprotocols122996.pdf

53 Whittle, S, Turner, L, Al-Alami, M (2007) *Engendered penalties: transgender and transsexual people’s experiences of inequality and discrimination*.

54 Harry Benjamin International Gender Dysphoria Association (2001) *The standards of care for gender identity disorders*, sixth version, p.17. Symposium, Düsseldorf.

55 Table adapted from Bockting, W, Knudson, G, Goldberg, J (2006) Counselling and mental health care of transgender adults and loved ones. *International Journal of Transgenderism* 9(3/4): 35–82. Available at www.vch.ca/transhealth/resources/library/tcpdocs/guidelines-mentalhealth.pdf

Gender identity	<ul style="list-style-type: none"> • How would you describe yourself? How do you feel about your gender identity? • How did you come to recognise that your experience of gender is different from that of most other individuals? • Have there been changes in your gender identity over time? • What do you remember feeling about your gender as a child and during puberty/adolescence? • How do you feel about your gender now? • How does your gender identity impact on your relationships, your family, your work and social life?
Gender expression	<ul style="list-style-type: none"> • Are there any activities you did as a child, or that you do now, that you think of as cross-gendered? • Did you prefer to be with individuals of any particular gender as a child? Is this different from your preferences now? • Have you ever cross-dressed? If so, how often, and what is that experience like? If not, what do you imagine it would be like? • Is your gender identity in conflict with your present gender role? • If you could change your appearance to match your gender identity, what would this look like? • Have you already taken any steps to alter your appearance? If so, what is that like for you? • How would you like to be in, say, five years time?
Perceptions of others	<ul style="list-style-type: none"> • How do you think others perceived your gender identity when you were a child? And now? • How important is it to you that there be a fit between how you feel about your gender identity and how others perceive you? • If you do cross-dress, how do others react to you when you are cross-dressed?
Phenotype and sexuality	<ul style="list-style-type: none"> • What are your feelings about the parts of your body that signify your sex, such as your genitals and your chest/breasts? • Is there a sexual aspect to your gender discomfort? In the future, do you see yourself as having sexual relationships with men, women, both or neither? • Do you think of yourself as a woman, a man, a transsexual or a transgender person?

<p>Support resources</p>	<ul style="list-style-type: none"> • Are you in a long-term relationship? Do the people in your life know that you are trans? If so, what was it like to tell them? If not, how do you feel about them not knowing and are you planning to tell them? Have you thought about how to do that? • Have you had any contact with other transgender individuals? What was that like for you? • What is your relationship to the transgender community now? How would you like it to be in the future? • Have you used the internet to access support and information about being transgender? What have you learned? In what ways was it helpful or not helpful for you?
<p>Hormones and trans identity</p>	<ul style="list-style-type: none"> • Have you tried hormones? Do they help? • (If not), what are your hopes and dreams relating to hormones? What do you expect hormones to change? What do you think is not likely to change? • How do you think hormones may affect your relationships with loved ones? What do you think the impact will be at work/school or in terms of your involvement in the broader community? • What will you do if the change process does not turn out as you had hoped? • Are there any issues in your life that you think might complicate a decision to take hormones, or that might increase stress during this time? What kinds of support do you feel might be helpful? • Which changes are you most looking forward to? Are there any changes you are not sure about?

C5 Therapeutic support

Therapeutic support may be given by a wide variety of health and social care professionals. Often these will be mental health professionals (psychiatrists, psychologists, psychotherapists, therapists or counsellors) but they may also be speech and language therapists, social workers, probation officers and Cafcass officers⁵⁶ and so on.

Trans people may present for treatment at a late stage, having changed gender role, self-administered hormones and informed families and friends. A frequent scenario, however, is that trans people are still hiding their condition and have told no-one. Such is the pressure to conform to the binary man/woman norms that they may feel overwhelmed by guilt and shame.⁵⁷ Sometimes they may be clinically depressed and even suicidal. Trans people do not live in a vacuum, and they understand only too well that revealing their gender discomfort may cause great disruption in their families, in the workplace and socially; they face stigma, rejection, the loss of their job, the loss of their status and many practical difficulties, such as finding alternative living accommodation. Religious beliefs and cultural mores may also complicate an individual's social situation, creating delays in seeking access to treatment and increasing the likelihood of being rejected by the family and the community.

*"The process of leaving what one has, to become what one is, has profound costs."*⁵⁸

Health professionals should respond with respect, sensitivity and empathy by accepting the gender name that the client has chosen (even if different from the legal status), and by using pronouns appropriate to that gender identity. The health professional should listen to the hopes and fears of trans clients and acknowledge any distress caused by their current situation. Creating a safe space for the in-depth exploration of the gender identity is always important, but it is particularly so for those who are still uncertain about their future and are feeling their way forwards.

Whilst the health professional should be supportive of the gender identity experienced by the client, as mentioned above, he or she should also be neutral with regard to the final outcome. The client should not be made to feel that one outcome is preferred to another. It is not the role of a professional offering psychological support to encourage a client to transition or to have medical treatment. Conversely, the therapist needs to be careful not to appear to **discourage** a client from following this pathway. Opposition could be counter-

56 Cafcass stands for Children and Family Court Advisory and Support Service. Cafcass provides advice and support for children and their families. It also provides independent advice to family courts. For more information, see www.cafcass.gov.uk

57 Schaeffer, L, Wheeler, C (2004) Guilt in cross-gender identity conditions: presentation and treatment. *Journal of Gay and Lesbian Psychotherapy* 8(1/2): 117–127.

58 Pirelli Benestad, EE (1999) To treat, not to treat or how to meet possibly TG/TS individuals. Harry Benjamin International Gender Dysphoria Association Symposium, London, 17–21 August.

productive because it may make the client defensive and, therefore, less able to make balanced decisions.

Throughout assessment, and in the provision of psychological support, it is advisable to follow the guidance given by Professor Peggy Cohen-Kettenis:

*“It is paramount that any form of psychotherapy offered ... is supportive. The more the patient is confronted with doubts on the part of the therapist, the less chance he or she has to explore his or her own doubts if they exist.”*⁵⁹

A health professional who is unfamiliar with gender variant conditions may feel, from a non-trans perspective, that the potential for damage to personal relationships and social and employment status may be insurmountable barriers to happy outcomes. These difficult topics will need exploration to ensure that the client is realistic about the impact on others, of change of gender role and medical treatment, if transition of gender role is being considered.

However, the professional also needs to understand that, from the perspective of trans people experiencing extreme discomfort, transition to live in the other gender role, supported by medical intervention, offers some prospect of a future life, whereas without treatment they may feel that they have no future at all. This is not necessarily about achieving ‘happiness’; rather, it is about achieving personal authenticity for people whose childhoods have often been tainted by *“patterns of worthlessness and shame ... and a chronic need to apologize for oneself”*.⁶⁰ Many trans people complain that their adult lives have felt like a charade. They have made strenuous efforts to conform to society’s norms and, sometimes, in a forlorn endeavour to overcome their condition, have chosen stereotypical relationships, leisure activities and employment.

In addressing the shame and guilt that some trans people experience, it may be reassuring for them to understand that there are biological elements to the condition (see C6 and Annex A).

C6 Relationships and families

Trans people do not live in a vacuum. They may have partners, families, friends, neighbours and jobs – or they may already have lost some or all of these when they first seek, or are referred for, psychological support. There is a ripple effect across many lives when one individual transitions, or plans to transition, to live in the opposite gender role.

In addressing the initial shock that family members often experience, it may be helpful if they also understand that there is a biological aspect to the development

59 Cohen-Kettenis, P, Pfäfflin, F (2003) *Transgenderism and intersexuality in childhood and adolescence: making choices*. Sage Publications, Thousand Oaks, London and New Delhi.

60 Schaeffer, L, Wheeler C (2004) Guilt in cross-gender identity conditions: presentation and treatment. *Journal of Gay and Lesbian Psychotherapy* 8(1/2): 117–127.

of gender variance. Landén's dissertation, published in 2000, looked specifically at the issue of the impact of a presumed psychological aetiology on attitudes of others. He found that those who believed that transsexualism is caused by psychological factors had a more restrictive view on transsexualism than people who held a biological view.⁶¹

It follows that families will share the 'less restrictive view' once they understand something of the biological influences in the development of severe gender variance.⁶² It is important that they accept that this is not a lifestyle choice or some passing phase or whim. It is neither caused by, nor can it be prevented by, being raised in any particular gender. It is nobody's 'fault', and nobody is to blame – not parents, not partners, and certainly not trans people themselves.

Results of feedback questionnaires following workshops for the families of trans people confirmed that both trans people and their relatives benefited from some information about atypical gender development. A parent commented that "*understanding and knowledge that upbringing was not at fault [had brought] relief from guilt*". A spouse said "*at last, some proper information!*" and one trans woman commented that it was "*very useful having an independent (referenced) medical explanation ... for people to see that it's a genuine condition*".⁶³ So information of this kind seems to enable family members to move on from 'why', and start to concentrate on 'how' they might address the important issues of support and integration of the trans relative.

As far as possible (and **with the agreement of the client**), partners, significant others and sometimes parents should be included in at least some of the counselling sessions offered. In the UK, many families have complained of being alienated from the treatment process. Yet Arlene Istar Lev, working in New York, says that her aim is "*to include ... families as much as is reasonably possible through all phases of treatment*". She adds that "*families should be regarded as connected, like a system*".⁶⁴

Where breakdown in family relationships occurs, it can trigger a range of further disadvantages. Trans people may, for instance, have to move out of the shared home and find alternative accommodation.⁶⁵ This, in itself, may cause financial hardship that is further aggravated if they have lost their job. They may find it hard to obtain alternative employment, and even if they do, it is often not at the level of

61 Landén, M, Innala, S (2000) Attitudes towards transsexualism in a Swedish national survey. *Archives of Sexual Behaviour* 29(4): 357–388.

62 GIRES (2006) Response to the critiques of Atypical Gender Development – a Review. *International Journal of Transgenderism* 9(1): 61–74.

63 Reed, T (2006) *Family matters. Families and transsexualism – a better understanding*. Available at www.gires.org.uk/Text_Assets/Family%20Matters1.pdf

64 Lev, AL (2004) *Transgender emergence: therapeutic guidelines for working with gender variant people and their families*. Haworth Clinical Practice Press, New York.

65 45% report family breakdown whilst 37% are totally excluded, according to Whittle, S, Turner, L, Al-Alami, M (2007), *Engendered penalties: transgender and transsexual people's experiences of inequality and discrimination*. Available at www.pfc.org.uk/files/EngenderedPenalties.pdf

previous employment, either financially or in terms of status. Those who have difficulty in making new relationships may find themselves completely isolated. Family breakdown can cause an intense sense of loss, leading to quite profound depression. Therapists need to be aware that depression may advance to suicidal proportions in these circumstances, and they will need to allow clients to explore these feelings.

The initial emotions experienced by close family members are extreme, and may include shock, guilt, grief, anger, embarrassment and a sense of helplessness, perhaps even revulsion. Partners may feel a sense of bereavement; they may feel betrayed, frightened, both for themselves and their loved one.

Partners and family members often struggle to 'catch up' with a situation that may fill them with horror; they are often resistant to change and they may even reject the trans person altogether. Partners, especially spouses, may feel that they have been deliberately deceived and their marriage vows broken. Yet trans people seldom set out to deceive; they have simply tried to conform to society's norms and may have deceived themselves in the process.

Once the secret is out, trans people may, understandably, feel that they have lived by the rules of others all their lives and that this is, at last, **their** time.⁶⁶ Around the time of disclosure, there can be mutual accusations of selfishness, as "*neither can leave their own heartache to hear the other's pain*".⁶⁷ Understanding for the anger and grief of family members must not lead the therapist to undermine the integrity of the trans person's identity. It is imperative that the core gender identity be acknowledged and respected.

Breakdown in relationships is certainly not inevitable. Despite the disruption, potential or actual, to their relationships and, in particular, their sexual relationships – often irrevocably altered by hormone treatment and possibly surgery – some couples do remain together. They need to work through these difficulties, which may include moving from a heterosexual relationship to a homosexual relationship (or vice versa); they may need specific counselling and support, both as individuals and as a couple, to address these issues of adaptation of their sexual behaviour. Some may settle for an asexual relationship.

Trans people sometimes say that they are not sure quite what their sexual orientation will be after transition until the process is complete and they have had time to settle into their new role. For instance, a trans woman may have been in a heterosexual relationship with a woman before undergoing transition, yet wish to be in a heterosexual relationship with a man after transition. A few may experiment with sexual relationships with men as a way of consolidating their identity as women.

66 Reed, T (2006) *Family matters. Families and transsexualism – a better understanding*. Available at www.gires.org.uk/Text_Assets/Family%20Matters1.pdf

67 Cole, S (1999) A transgender dilemma: the forgotten journey of the partners and families. Paper presented at the XVI Harry Benjamin International Gender Dysphoria Association Symposium, London, 17–21 August.

For those couples who wish to stay together, further difficult and stressful decisions need to be made. Those trans people who are in a legal marriage have to choose between:

- retaining this marriage and foregoing the opportunity to obtain a Gender Recognition Certificate; or
- annulling the marriage, obtaining a Gender Recognition Certificate and, possibly:
 - entering a civil partnership; or
 - living together without any legal protection of their status.

Without a Gender Recognition Certificate, trans people are denied the rights of recognition of their legal gender (see NHS publication *A guide to trans service users' rights*).



Lin and Emma are still together but, reluctantly, they annulled their marriage so that Emma could obtain a Gender Recognition Certificate, giving her full legal rights. Since the annulment they have obtained a civil partnership.

These two women are still legally married; one of them has a transsexual history. They do not wish to annul their marriage so the trans partner will not be able to obtain a Gender Recognition Certificate.



C7 The impact on children when a parent transitions

Most keenly felt perhaps, where it occurs, is the enforced separation of trans parents from their children. Other family members sometimes believe that trans people are a danger to children, or that the condition may be 'catching'. In their desire to protect the child, they may insist on no contact, or contact only in the pre-transition gender presentation of the trans person. This fear of damage to the child is misplaced, and if a health professional has the opportunity to prevent any

such ideas taking root, it is vital to do so. There is research showing that having a trans parent is not damaging in itself, whereas loss of a parent is.

“Children of transsexual parents are not themselves likely to develop features of gender dysphoria, nor do they experience mental health problems associated with gender identity disorder.”⁶⁸

It is important that non-trans parents be given positive and encouraging images of trans parenthood. The parents in this picture are a married trans couple; the father, on the left, is also the natural mother of their daughter.



The impact on family dynamics through the period of transition should not be underestimated. Keeping the family on an even keel is not easily achieved.

Young children are inclined to be matter-of-fact in their attitudes, and they cope very well as long as the adults around them do. Naturally, where parental relationships have broken down, there will be the usual range of unhappiness, and possibly depression, in children of any age. Teenagers may find a parent’s transition more of a challenge and be more conscious of what others, especially their peers at school, may think.

Occasionally, teenagers react very aggressively to a parent who has transitioned. Others feel a devastating sense of loss, even while the parent is still physically present. This becomes a painful reality if, and when, the trans parent is obliged to leave the family home. As with any rift in parental relationships, both parents may need help to put their children’s needs first. This may be especially hard for the non-trans parent who is struggling with his or her own grief and anger.

Siblings within the same family may react very differently to the situation. Children need a great deal of reassurance that the trans parent still loves them and will always be their parent.

Age-appropriate literature is available to help trans parents, or other family members, explain the changing situation to their children.⁶⁹

68 Freedman, D, Tasker, F, Di Ceglie, D (2002) Children and adolescents with transsexual parents referred to a specialist gender identity development service: a brief report of key developmental features. *Clinical Child Psychology and Psychiatry* 7(3): 423–432.

69 See GIREs’s website for pdf documents: for small children, *Your Dad’s Adventure* (available at www.gires.org.uk/Text_Assests/your_dads_adventure.pdf) and *Your Mum’s Adventure* (www.gires.org.uk/Text_Assests/your_mums_adventure.pdf); and for teenagers, *Your Dad’s Story* (www.gires.org.uk/Text_Assests/your_dads_story.pdf) and *Your Mum’s Story* (www.gires.org.uk/Text_Assests/your_mums_story.pdf). GIREs will amend these to suit the particular circumstances of a family upon application.

Some children and young people are bullied at school because they have a trans parent. This can be very painful both for the parents and for their children. Liaison with the school and providing sensible information for teachers can be a help. Trans groups may be able to assist by providing information or actually visiting the school (see the list at the end of this document).

C8 Embarking on the change of gender role: the impact on the client

The uninterrupted change of role prior to surgery has been referred to, historically, as the 'real-life experience'. This is a period of time living in a gender role different from that established from birth. The aim is for the individual to function socially under a gender-appropriate name and persona. This may help trans individuals to consider whether or not they have the determination to live the rest of their lives according to the new role. It is not a diagnostic test.

"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 International Gender Dysphoria Association (2001) *The standards of care for gender identity disorders*, sixth version. Symposium, Düsseldorf.)

Trans people may change their roles whenever they feel it is appropriate, with or without treatment. *"The decision as to when and how to begin the real-life experience remains the person's responsibility."*⁷⁰ It is vital that trans clients are not set up to fail, so therapists and clinicians should not pressure trans people to change roles, in case they do so prematurely. A public and continuous change of role should not be undertaken lightly, and should not be recommended by health professionals in the absence of a provisional diagnosis of severe gender variance⁷¹ that is judged, by the client, to be likely to lead to a permanent change of role.

The need for caution is because this public statement is not easily reversed. This is especially so for trans women whose initial appearance may transgress societal norms more dramatically than that of a trans man. So the transition from living as a man to living as a woman is an event that will not easily be overlooked if the person concerned later decides that this was a mistake, or unnecessary.

Once a trans woman has ventured out of the front door and into family circles and the workplace dressed as a woman, it is impossible to retrace her footsteps without leaving permanent footprints in the social snow.

70 Harry Benjamin International Gender Dysphoria Association (2001) *The standards of care for gender identity disorders*, sixth version, p.25. Symposium, Düsseldorf.

71 Harry Benjamin International Gender Dysphoria Association (2001) *The standards of care for gender identity disorders*, sixth version, p.20. Symposium, Düsseldorf.

The social transition of trans men is, in some ways, easier to achieve as they blend in more readily than do trans women, yet in their intimate lives they face greater challenges. Unlike genital surgery for trans women the results of which, in the best examples, are virtually indistinguishable from other women, genital surgery for trans men is more complicated and has less certain outcomes. Trans men may 'pass' more easily on the street, but in changing rooms and the bedroom they are more often disadvantaged.

However hard the process of transition may be, for many trans people it is a relief to be finally achieving some public acknowledgement of who they really are. The pretence of fulfilling a role that feels alien is finally over, and they are able to express themselves as who they know themselves to be. Families, friends and work colleagues often comment that the individual's personality is more relaxed and happier. This poem by a trans woman provides insights for mental health professionals regarding the client's experience of newness combined with an underlying sense of continuity. Trans people often say that, at the point of changing gender role, their families are so focused on their own sense of loss that they fail to see that their loved one is still present and, to a large extent, unchanged.

transsexualism is seldom understood
it's an end with a new beginning –
all things past but ever present
it's a changing of life, like art
still, silent but not forgotten
captured in a similar form of canvas

C9 The timing of the transition of role

Clients may be at any stage of transition – or none – when they first present for treatment. Some will only just be acknowledging to themselves that they cannot continue living the way they are. The public change of gender role is arguably the most difficult and the most traumatic event in a trans person's life. As mentioned above, it may destabilise the family, putting trans people at risk of private anguish, and possibly public humiliation and danger. Research indicates that trans people are at their most vulnerable to transphobic incidents, and even crimes, at this point in their lives.⁷²

So, when the change of role is undertaken, it is better that the timing and management of that experience is in the control of the individual concerned, so that it may be tailored to his or her personal circumstances. Timing should not, therefore, be dictated by medical professionals. Some will successfully change role overnight, but many will need time to ease themselves into the new role. Sometimes trans people's commitment to a change of gender role and medical

72 Whittle, S, Turner, L, Al-Alami, M (2007) *Engendered penalties: transgender and transsexual people's experiences of inequality and discrimination*. Available at: www.pfc.org.uk/files/EngenderedPenalties.pdf

treatment fluctuates. They may try to convince themselves that they can manage without pursuing further changes, only to find that weeks, months or even years down the line, the discomfort becomes stronger than ever and they return for further medical or other professional help.

Even for those trans people who are secure in their determination to continue, it may be best not to change gender roles overnight, but rather to experiment with androgynous clothing, moving gradually to cross-dressing in private, if possible with the help of a supportive relative or friend. Some GICs have an image consultant and provide a room for changing within the clinic. A GP or gender specialist may also have image consultant contacts to whom a client may be referred. For some trans women, wearing a hair-piece will be necessary. Becoming comfortable in the new role takes time; it requires not only appropriate dress, but altered deportment, behaviour and speech patterns.

At the time of writing (2008), a few GICs in the UK still insist that, in order to be prescribed hormones, trans people must already be living full-time in the new role, without the benefit of hormones and usually without psychological support from within the clinic. Psychological support from elsewhere may be extremely important in these circumstances.

C10 Duration of living in the 'new' role to qualify for genital surgery

Irreversible genital surgeries are not usually undertaken until an individual has lived continuously in the new role for 12-months. This accords with the Harry Benjamin *Standards of care* (2001). However, the length of time that is required in order to qualify for such surgery is arbitrary, so need not be rigidly enforced. Some studies indicate that compliance with the 12-month minimum eligibility requirement for genital surgery is not associated with more favourable outcomes.^{73,74} Some individuals may be deemed ready for surgery in a shorter time; others may not feel ready for two or three years.

Gender confirmation surgery is not an absolute requirement for obtaining a Gender Recognition Certificate, but having the intention to continue to live for the rest of one's life according to the 'new' role is essential. Gender clients are required to provide detailed letters of support to the Gender Recognition Panel in order to obtain a Gender Recognition Certificate. Health professionals may be asked to provide relevant information (see 'letter writing' in the NHS publication *A guide to trans service users' rights*).

73 Lawrence, AA (2001) Sex reassignment surgery without a one-year real life experience: still no regrets. Paper presented at the XVII Harry Benjamin International Gender Dysphoria Association Symposium, Galveston, Texas.

74 Lawrence, AA (2003) Factors associated with satisfaction or regret following male to female sex reassignment surgery. *Archives of Sexual Behavior* 32: 299–315.

C11 Other treatments undertaken alongside the change of gender role

Many trans people will have started hormone treatment before changing their role. Some may be trying the effect of self-prescribed hormones – they should be encouraged to obtain properly prescribed and monitored treatment (see Annex D and the NHS publication *A guide to hormone therapy for trans people*).

If service users have not already started this treatment, the lead medical practitioner should provide a prescription following the usual health checks. This supports living in the new role, both physically and psychologically. It is also reported by trans women that hormone therapy facilitates the process of facial hair removal by, for instance, electrolysis or laser treatment. If possible this should be well under way before the gender role is changed, as it facilitates ‘passing’ in the new role. Electrolysis requires two days’ beard growth – an obvious disadvantage to an individual living as a woman. Hair-removal treatment may continue over several years.

Speech therapy is usually undertaken by trans women, as oestrogen treatment does not raise the pitch of the voice.⁷⁵ Testosterone does lower the pitch somewhat in trans men, but even so, some will benefit from speech therapy. Surgical procedures other than irreversible genital surgery may be undertaken at any stage: for instance, for trans women, mammoplasty (breast augmentation); feminising facial surgery; crico-thyroid approximation to raise the pitch of the voice; and thyroid chondroplasty (reduction of the Adam’s apple, often incorrectly described as tracheal shave); and for trans men, chest reconstruction.⁷⁶

Some trans men prefer to have chest reconstruction surgery before starting hormone treatment, or both may take place around the same time. Clinicians are increasingly recognising that living full-time as a man is not always possible before such surgery is undertaken. Change of gender role is not, therefore, an absolute prerequisite.⁷⁷

Breast binders are only a temporary measure and, in any event, are not appropriate for heavy-breasted people. Binders may strain the back and distort breast tissue, making surgical reconstruction less successful.

75 Adler, RK, Hirsch, S, Mordaunt, M (eds.) (2006) *Voice and communication therapy for the transgender/transsexual client*. Plural Publishing, San Diego, Oxford and Brisbane.

76 FtM London (2002) *Chest reconstruction for female to male trans people*. Published in conjunction with Mr Dai Davies, consultant surgeon. For further information email info@ftmlondon.org.uk or contact Mr Davies via the website www.cosmeticsurgeryuk.com

77 Bockting, W, Knudson, G, Goldberg, J (2006) Counselling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism* 9(3/4): 3–34.

C12 Role change in the workplace

Despite better legal protection in the workplace (see the NHS publication *A guide to trans service users' rights*), a recent survey indicated that 42% of trans people said they did not feel able to transition at work⁷⁸ (and therefore were unable to comply with any specific requirement of the gender identity clinic to do so); among those who had transitioned at work, many endured horrific bullying around the time of transition. This can often become embedded behaviour in co-workers and can continue unabated for years.

These are just a few examples:

- A trans woman, working in an area separated from the large open-plan office by a glass partition, was instructed to turn her desk around so that, instead of facing out into the main office, she was facing the wall, 'so that co-workers did not have to look at her face'.
- Upon transition, co-workers tampered with the brakes on a trans person's motorbike.
- A trans woman had used tampons put on her workstation, and on another occasion, a coffin painted black with RIP and her name on it.
- The co-workers of a trans woman told her that they were running a 'book' on her, and had £100 saved up to go to the person who could 'get her fired or badly hurt'.
- Co-workers sprayed a trans woman's clothes with obscenities.

Many trans people find themselves isolated in the workplace and excluded from facilities such as appropriate toilets and changing areas.

C13 Risky behaviours

Stress leads a number of trans people to self-harm and even to attempt suicide. In one survey, 34% of trans people reported having attempted suicide – many of them more than once⁷⁹ – and, of course, others have succeeded in taking their own lives. These feelings may occur at any time, but they are often associated with the realisation that it is impossible to continue life in the pre-transition role. For some, the choice is stark: either the gender issue is addressed, or there is no future. It may be literally a matter of life or death. It is appropriate for the therapist to make it possible for suicidal feelings to be expressed. The inability to access timely treatment may also be a cause of suicidal feelings.⁸⁰ Through frustration or anxiety, or both, some trans people self-harm by cutting their arms and legs and,

78 Whittle, S, Turner, L, Al-Alami, M (2007) *Engendered penalties: transgender and transsexual people's experiences of inequality and discrimination*. Available at www.pfc.org.uk/files/EngenderedPenalties.pdf

79 Whittle, S, Turner, L, Al-Alami, M (2007) *Engendered penalties: transgender and transsexual people's experiences of inequality and discrimination*. Available at www.pfc.org.uk/files/EngenderedPenalties.pdf

80 Whittle, S, Turner, L, Al-Alami, M (2007) *Engendered penalties: transgender and transsexual people's experiences of inequality and discrimination*. Available at www.pfc.org.uk/files/EngenderedPenalties.pdf

occasionally, their offending sex characteristics, such as breasts (trans men) or the penis and scrotum (trans women). Alcohol and other substance misuse may also be a factor, especially where there is family breakdown and social isolation.

Delay in accessing treatment may also drive some trans people into sex work in order to pay for private services. They may be living very risky lives both in terms of sexually transmitted diseases and potential violence. Worldwide, the number of transgender people who are HIV positive is high.⁸¹ Figures for the UK are not known, but they might be anticipated to be lower since treatment for gender variance is available on the NHS.

Psychological support should not be coloured by moral judgements, but should aim at helping the individual to develop strategies to minimise risks. Advice should be given about the use of condoms, and contact details should be provided of agencies that specialise in drug and alcohol rehabilitation.⁸²

C14 The focus on achieving surgery

It is perhaps not surprising, given the significance that our society bestows on genitalia in our understanding of what constitutes a man or a woman, that many clinicians and trans people see genital surgery as the end point of treatment for gender dysphoria. And for many, it is a logical and necessary part of the process of becoming a whole person. Sometimes, however, it becomes not only a desirable, but an urgent and constant preoccupation – even an obsession. Delays in the ‘system’, whether clinical or financial, cause a great deal of stress. There are also understandable concerns about being dressed according to one gender while concealing the sex of the other.

New sexual relationships are also complicated by the threat of disclosure of incongruent genitalia. How and when do trans men or trans women tell a potential partner, of either sex, that their dressed appearance conceals an unexpected inconsistency? Physical security checks by police or by security staff when entering certain buildings are also situations that create the potential for imminent disclosure.

However, although breast enhancement (trans women) is often undertaken and chest reconstruction (trans men) is almost inevitable, genital surgery is not essential for all trans people. The need for this surgery is a very personal matter. Surgery should not be seen as a ‘goal’ to be achieved in order to be accorded personal or social status, or to be regarded as a ‘true’ transsexual person; it is merely one of a number of possible responses to the distress caused by gender variance and will not be necessary in all cases. A decision not to have genital surgery does not indicate that the diagnosis of severe gender variance is incorrect.

81 Clemenz-Nolle, K, Marx, R, Guzman, R, Katz, M (2001) HIV prevalence, risk behaviours, health care use, and mental status of transgender persons: implications for public health intervention. *American Journal of Public Health* 91(6): 915–921.

82 For help with drug and alcohol issues, contact Antidote LGBT services (Hungerford Drug Project); www.turning-point.co.uk; www.thehungerford.org/antidote.asp; grainne.walley@turning-point.co.uk

Some may feel that it is unnecessary to undertake surgery, or may be unable to do so for reasons of health or in deference to a relationship with a partner. A few people are scared of the surgical procedure itself, which can lead to an individual cancelling surgery at the last minute. This should not be interpreted as ambivalence about the self-diagnosis, nor that surgery is not desired. Health professionals should not, therefore, make assumptions about this, but should be entirely neutral in their approach. They should help clients to explore their own feelings about their bodies, in the context of their personal and social environment.

C15 Regrets after surgery

Surgical results are generally good, and substantially achieve the aims of maintaining erotic sensation and a reasonable appearance.

Research in the transgender field has concentrated on post-surgical outcomes rather than the variety of outcomes that involve hormone therapy alone, or are combined with an intermittent or permanent change of gender role. However, studies using the post-surgery end-point, such as Landén's, which showed only a 3.8% regret rate, indicate that regrets are few. His study also revealed that these regrets were more likely where there was a lack of family support.⁸³ Poor surgical outcomes were also a factor in some cases. This was echoed in the Smith *et al.* (2005) study that found that no patient was actually dissatisfied, 91.6% were satisfied with their overall appearance and the remaining 8.4% were neutral.⁸⁴ Occasionally, optimistic expectations of what can be achieved through surgery may prove to be unrealistic, leading to a degree of disappointment regarding outcomes. The possibility of expectations being unmet is a subject that should be discussed with the client at the appropriate time.

C16 Successful outcomes: successful lives

There are major obstacles that many trans people have to overcome: prejudice and stigma (often from medical practitioners themselves); harassment, bullying and violence on the street and at work; distancing of family members; loss of friends and social status; and loss of employment and financial hardship. However, despite all of these possibilities, many trans people make extremely successful transitions: their families remain supportive; they continue to enjoy successful careers; and they make a valuable contribution to society.

83 Landén, M, Wålinder, Y, Hambert, G, Lundström, B (1998) Factors predictive of regret in sex reassignment. *Acta Psychiatrica Scandinavica* 97(4): 284–289.

84 Smith, YLS, Van Goozen, SHM, Kuiper, AJ, Cohen-Kettenis, PT (2005) Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine* 35: 89–99.

Most become invisible in the community, leading active and fulfilling lives as ordinary men and women. Trans people now have the option of consolidating their gender identity under the legal protection of a Gender Recognition Certificate. This gives them the legal and social status that is in accordance with their gender identity (see the Gender Recognition Act 2004 in the NHS publication *A guide to trans service users' rights*).

C17 The change of gender role in children and young people

Gender dissonance is sometimes evidenced from an early age by, for instance, non-stereotypical choices of dress and leisure pursuits. Phenotypically female children may refuse to wear dresses, and phenotypically male children may be drawn to flowery, girlish clothes. They may 'borrow' clothes from their mother or their sister.



A trans man and his bride

Children and young people who are experiencing extreme gender discomfort may undertake limited or even full transition of their gender role, supported by their clinician, school and family.

Notions of the binary male/female divide are so strongly embedded in our culture that children and young people who show tendencies to cross the gender boundaries are very likely to be bullied by other children and, sometimes, by teachers as well.⁸⁵ If a full-time gender transition is contemplated, this may be timed to coincide with a change of school. It is unhelpful to make children or young people feel that their cross-gender feelings are unacceptable. In the past, some psychiatrists and psychologists have suggested therapies that reinforce gender stereotypes. Many clinicians no longer consider this approach appropriate^{86,87} because it undermines the young person's feeling of self worth, and the condition cannot be overcome by "consistent psychological socialisation as male or female from very early childhood".⁸⁸

85 Whittle, S, Turner, L, Al-Alami, M (2007) *Engendered penalties: transgender and transsexual people's experiences of inequality and discrimination*. Available at www.pfc.org.uk/files/EngenderedPenalties.pdf

86 Cohen-Kettenis, P, Pfäfflin, F (2003) *Transgenderism and intersexuality in childhood and adolescence: making choices*. Sage Publications, Thousand Oaks, London and New Delhi.

87 Reed, B (2006) *Early medical treatment for transsexual people*. GIRES, London. Available at www.gires.org.uk

88 Green, R (1999). Affidavit cited in *Bellinger v Bellinger*, Court of Appeal, Judgment, 2001, TLR 22-11-2000.

As they approach puberty and secondary sex characteristics start to become more apparent, young trans people experience intense distress and may become suicidal.⁸⁹ They and their families need a great deal of psychological support at this time. Schools will usually need to be aware of the situation, so that they can ensure that their anti-bullying policies are adequate to protect the young person (see the NHS publication *Medical care for gender variant children and young people: answering families' questions*, the Anti-Bullying Alliance website⁹⁰ and local child and adolescent mental health services⁹¹).

89 Brown, ML, Rounsley, CA (1996) *True selves: understanding transsexualism – for families, friends, coworkers and helping professionals*. Jossey-Bass, San Francisco.

90 www.anti-bullyingalliance.org.uk

91 www.everychildmatters.gov.uk/health/camhs/

Annex D

Clinical guidance on hormone therapy for gender variant people

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D1 Introduction to hormone therapy

It has become customary in the UK for those experiencing gender variance to be treated in gender identity clinics (GICs) – usually within the NHS. The first prescription for hormone treatment may be provided by a gender specialist working in a GIC team or by a private gender specialist. Subsequent prescriptions and monitoring may continue to be provided, under a shared care arrangement, by the GP or specialist nurse within a service user’s local practice. However, it is possible for hormone treatment to be initiated locally by the GP, if he or she is comfortable with undertaking this treatment, or by a local endocrinologist, or by both these clinicians working together (these and others, such as psychiatrists, may be regarded as gender specialists). Where long distances and long waiting lists must be overcome in order to access treatment at a GIC, it may be desirable to provide all relevant treatments locally. A model for a de-centralised community-based approach that does not involve a GIC exists elsewhere, notably in Vancouver, Canada.⁹²

“Primary care providers are well-suited to provide safe and effective masculinizing or feminizing hormone therapy ... It is not necessary for the prescribing clinician to be an endocrinologic expert, but it is important to be familiar with relevant medical and psychosocial issues.”⁹³

The following text provides guidance and should be used flexibly. Clinicians should take account of the individual responses of service users to hormone treatment and tailor the prescription to their personal needs and circumstances.

Cross-sex hormone treatment (testosterone for trans men, and oestrogen for trans women) is usually the first, and sometimes the only, medical intervention that a trans person seeks, since *“hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross-living or surgery”* (Harry Benjamin Standards of Care, HBGDA).⁹⁴

Generally speaking, those who experience gender variance to a severe degree find cross-sex hormones both psychologically and physically beneficial, and most regard this treatment as *“medically necessary for successful living in the new gender. They improve the quality of life and limit psychiatric co-morbidity ...”*⁹⁵

When people first seek help for severe gender discomfort, they are often in an extremely vulnerable emotional state. The clinician must use his or her judgement as to whether or not it is prudent to delay treatment in these circumstances.

92 Dahl, M, Feldman, JL, Goldberg, JM, Jaber, A (2006) Transgender primary medical care – introduction. *International Journal of Transgenderism* 9(3/4): 1. Available at www.vch.ca/transhealth

93 Tom Waddell Health Center, *Protocols for hormonal reassignment of gender*. Available at www.dph.sf.ca.us/chn/HlthCtrs/HlthCtrDocs/TransGendprotocols122006.pdf

94 Harry Benjamin International Gender Dysphoria Association (2001) *The standards of care for gender identity disorders*, sixth version, p.21. Symposium, Düsseldorf.

95 Harry Benjamin International Gender Dysphoria Association (2001) *The standards of care for gender identity disorders*, sixth version, p.20. Symposium, Düsseldorf.

Clinicians need to take account of the extreme sense of urgency that is often experienced by those who may have suppressed their gender discomfort for many years, perhaps denying it to themselves and concealing it from others in an attempt to ignore or to overcome this discomfort. It is not unusual for trans people to say that, at this point in their lives, they are unable to sustain the discomfort of their present situation; it is often a matter of life or death.

There is always the possibility that without a prompt response from the clinician, a service user may self-harm or access hormones by another route. Unless there are contra-indications, ascertained when undertaking health checks, the clinical judgement may be that the prescription of a standard preparation may be safer than withholding treatment at that point. Hormones are not inherently dangerous substances but service users must be made aware of potential risks and side effects so that their consent to treatment is well informed (see Sections D4, D10 and D11 of this Annex).

D2 Clinical response to adult service users who are self-administering hormones

In the circumstances outlined above, it is not surprising that some trans people, faced perhaps with delays in accessing hormone treatment on the NHS or wishing to try the effects of hormones without family or employers being aware of the situation, have already bought hormones – usually via the internet, where they are readily available.

Clinicians should make service users aware of the principal dangers:

- The products may be of poor quality.
- The dosage and method of delivery may not have been properly considered in the light of any pre-existing health concerns, or any family predisposition to circulatory or liver disorders.
- Service users may not have adequately considered the potential risks and side effects.
- They may not have considered the impact of combining hormones with any other drugs.
- They will not be benefiting from any monitoring of the impact of hormones on their general health.
- There may be co-existing conditions that could be aggravated by hormones.
- The products may not be genuine and may therefore have no effect at all or be positively harmful, especially if taken in inappropriate dosages.

In view of the potential dangers of self-medication, it is important that clinicians faced with this situation should “discourage patients from using such sources”, and take a compassionate and sensible view by prioritising the health of service users and bringing them into a regulated treatment programme, with products of known quality, as soon as possible. This applies whether treatment is in the private or in the public sector.

Insisting that service users stop taking hormones altogether for a period of time is not necessarily the safest option. It causes enormous stress since the ground gained in, for instance, the removal of facial hair and the arrest of male-pattern baldness may be eroded. This may seriously damage psychological wellbeing at a time when trans people may just have achieved some emotional stability for the first time in years. Self-harm and suicidal thoughts are real risks. Some experienced clinicians in this field recommend providing a short-term (one to three months) ‘bridging’ prescription until the individual can be brought into a monitored regime.⁹⁶ It should be noted that hormone treatment is initially slow to take effect, so baseline levels can still be measured in the blood for a few weeks after the commencement of hormone administration (see Sections D10 and D11).

D3 Anticipated benefits of hormone treatment

In trans women, oestrogens have subtle feminising effects on appearance. The size of the penis and testicles will be slightly reduced; erections and orgasm may be less readily achieved; breasts may feel tender and sometimes, but not always, increase modestly in size; redistribution of fat helps to achieve a more feminine appearance. Over time, there is also likely to be a loss of muscle bulk and power. Some clinical experience indicates that oestrogens also have a calming effect and augment the efficacy of, and even replace, antidepressants over a period of time, should these have already been prescribed.⁹⁷ It is anticipated that, in those who experience persistent and profound gender dysphoria, hormones will be routinely prescribed throughout their entire lives, albeit in lower doses following surgical removal of the gonads.

Trans women often report that hormone administration facilitates the process of facial hair removal by electrolysis, laser or other means.⁹⁸ Male-pattern baldness is also arrested. Both of these factors support the eventual transition to live as a

96 Feldman, JL, Goldberg, JM (2006) Transgender primary medical care. *International Journal of Transgenderism* 9(3/4): 3–34.

97 Tom Waddell Health Center, *Protocols for hormonal reassignment of gender*. Available at www.dph.sf.ca.us/chn/HlthCtrs/HlthCtrDocs/TransGendprotocols122006.pdf

98 Moghetti, P, Tosi, F, Tosti, A, Negri, C, Misciali, C, Perrone, F, Caputo, M, Muggeo, M, Castello, R (2000). Comparison of spironolactone, flutamide, and finasteride efficacy in the treatment of hirsutism. A randomised, double-blind placebo-controlled trial (in non-trans women). *Journal of Clinical Endocrinology and Metabolism* 85: 89–94.

woman. The use of certain products, (e.g. Finasteride),⁹⁹ may prompt modest hair regrowth on the head so long as follicles are still active. Substantial regrowth is not possible once male-pattern baldness is marked. It is important that trans women are realistic about what can be achieved; hair-pieces are usually necessary where baldness has already occurred.

In trans men, testosterone administration promotes beard and body hair growth and also male-pattern baldness; the clitoris increases a little in size; libido may be heightened; muscle bulk increases; the voice irreversibly deepens, but not usually to the pitch of genetic males; and menstruation will cease. Occasionally there may be some break-through bleeding requiring adjustment of the dosage. Some individuals develop acne. These physical effects render most trans men indistinguishable, on the street, from other men. Testosterone will continue to be administered throughout trans men's lives but dosage may be reduced once gonadectomy is undertaken.

Service users should be made aware that responses to hormones can appear slow, but taking more than the prescribed dosage may make no difference to the speed of the desired changes and higher dosage will put them at greater health risk.

It is sometimes appropriate to use medications that limit the impact of endogenous hormones and thereby enhance the efficacy of prescribed hormones. In both trans men and trans women this may be done with a gonadotrophin releasing hormone analogue (GnRHa) or, in the case of trans women, an anti-androgen (cyproterone acetate or spironolactone) may be prescribed that will also reduce the effects of androgens produced by the adrenal glands (which the analogue does not), as well as that of the testes. This is not necessary in all individuals, and trans men, in particular, will often obtain good results from taking testosterone alone.

Many trans people are likely to benefit from hormone administration **before** changing the gender role and this is regarded as the 'typical' treatment pathway in the Harry Benjamin *Standards of care*.¹⁰⁰ In any case, some may continue indefinitely in their original gender role while continuing to take hormones. Once a diagnosis of gender dysphoria has been agreed, a trial of hormones may be a helpful indication to both service user and clinician regarding the appropriateness of such intervention.

*"Satisfaction with the hormone's effects consolidates the person's identity ... and further adds to the conviction to proceed."*¹⁰¹

This endorses the view that the treatment is likely to continue to be helpful and may even be sufficient in itself. Meanwhile, continuing to live according to an unchanged gender role (i.e. not immediately embarking on what has historically been referred to as the 'real-life experience') has the added benefit of causing less

99 McClellan, KJ, Markham, A (1999) Finasteride – A review of its use in male pattern hair loss. *Drugs* 57(1): 111–126.

100 Harry Benjamin International Gender Dysphoria Association (2001) *The standards of care for gender identity disorders*, sixth version, pp.8 and 21. Symposium, Düsseldorf

101 Harry Benjamin International Gender Dysphoria Association (2001) *The Standards of care for gender identity disorders*, sixth version, p.24. Symposium, Düsseldorf.

disruption in family, social and employment situations until the individual is more sure that a change of role will be necessary.

Disadvantages of continuing to live in the original role while taking hormones long-term:

- A person still living as a man (some or all of the time) while taking oestrogens would eventually develop breast tissue (over a period of about two years) that may be hard to camouflage. Nonetheless, some people do choose this route on a permanent basis.
- For a person still living as a woman while taking testosterone, the physical effects of testosterone may become impossible to camouflage. These effects are: the start of beard growth; drop in the pitch of the voice (which may be initiated within three to six months); and possibly the onset of male-pattern baldness.

If hormone treatment does not alleviate the gender discomfort and cannot be improved by adjusting the product and/or dosage, then the service user and clinician, may conclude that *“this indicates ambivalence about proceeding to surgical interventions”*.¹⁰² If, in the judgement of the service user and the clinician, the underlying difficulty may not be gender-related, then hormone treatment can be stopped before any significant bodily changes have occurred.

D4 Informed consent

Properly informed consent should be obtained before treatment with cross-sex hormones is initiated. Ideally, clinicians should have in-depth discussions with service users, preferably supported by written information that can be taken away and considered carefully (see the NHS publication *A guide to hormone therapy for trans people*). Information should include anticipated benefits, risks, potential side effects, impact on sex life, relationships and reproductivity (see Section D7). Some clinicians may be more comfortable if they have a consent form signed by the service user. This may be particularly desirable where existing health conditions and/or medications may be regarded as increasing the risk, sometimes to a level that makes the prescribing clinician cautious.

In these instances, the service user may need to take responsibility for making informed choices about balancing the level of risk of taking hormones against the personal level of discomfort associated with not taking them. The clinician should assist the service user by discussing any risks fully. It is important both for the clinician and the individual concerned that the latter is well-equipped to make the decision whether or not to continue with hormone treatment.

102 Harry Benjamin International Gender Dysphoria Association (2001) *The Standards of care for gender identity disorders*, sixth version, p.24. Symposion, Düsseldorf.

It may also be necessary for more than one clinician to be involved in the decision-making process. It is possible to envisage circumstances where it would be appropriate for liaison to take place between, for instance, an oncologist, a gender specialist and a trans person. It is just as important, maybe even more so, when people have life-threatening illnesses that they should be allowed the dignity of personal choice.

D5 Hormone blockers for young people

A young trans person, whose secondary sex characteristics are developing during puberty, may feel a strong sense of conflict between appearance and gender identity. Medical help may be sought in extreme cases, where parents and perhaps teachers interpret this departure from the norm as problematic.

Treatments for these young people will usually be staged: reversible interventions; partially reversible interventions; and irreversible treatments such as surgery (usually not until the age of 18).

In carefully screened individuals, who are experiencing extreme stress and who have a disgust for their phenotypic pubertal development, it is possible to use hormone blockers (GnRHa) to suppress the development of secondary sex characteristics. The circumstances and timing of medical intervention are important (not usually before Tanner Stage 2).¹⁰³ Treatment and monitoring should follow careful protocols,¹⁰⁴ in the context of a stable environment, supported by a team that includes a paediatric endocrinologist and a counsellor or therapist providing psychological help for the young person and perhaps for the family as well.

As with the adult population, informed consent for young people is essential. Those under 16 years old must be Fraser (Gillick) competent and, in all but the most unusual circumstances, support from parents or guardians will be required (see the NHS publication *A guide to trans service users' rights*). The adverse implications of hormone blocking that are relevant for young people must be discussed fully; they include potential loss of fertility and, in male to female youngsters, a diminished amount of tissue available for genital surgery. The latter is not insurmountable, and for some young people who are experiencing extreme

103 Harry Benjamin International Gender Dysphoria Association (2001) *The standards of care for gender identity disorders*, sixth version, p.16. Symposium, Düsseldorf.

104 Delemarre-Van de Waal, H, Cohen-Kettenis, PT, (2006) Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology* 155(1): 131–137.

stress, potential difficulties may be outweighed by the psychological and physical benefits of early medical intervention.^{105,106,107,108,109,110,111}

Some young people self-medicate (see box in Section D2 of this Annex). For further information see the NHS publications *A guide for young trans people in the UK* and *Medical care for gender variant children and young people: answering families' questions*.

D6 Contraindications and risks

Service users must be warned of the added health risks associated with smoking, drug taking, excessive alcohol consumption and obesity. They should also be made aware of the possible impact of these factors on their ability to respond to hormone treatment or to undergo surgery. Smoking represents a significantly greater risk than does hormone treatment and, in the case of trans women, it is anti-oestrogenic and therefore reduces the feminising effects of treatment. Clinical services should include support and advice about addressing these health concerns and encourage service users to adopt a healthy lifestyle. The following contacts may be useful:

Antidote LGBT services (Hungerford Drug Project);
www.turning-point.co.uk; www.thehungerford.org/antidote.asp;
grainne.walley@turning-point.co.uk

The most serious risks associated with oestrogen usage are deep vein thrombosis (DVT), cerebrovascular accident (CVA), pulmonary embolism (PE), altered liver function and oestrogen-related cancers. Prolactinoma is also a theoretical risk, but in practice is extremely rare. Trans men on testosterone therapy may be at risk of polycythaemia.

Research in this field is limited. A study in 2003 by Toorians *et al.*¹¹³ of trans women suggested that a risk of DVT existed with ethinylestradiol (EE) usage. Previous studies

- 105 Houk, CP, Lee, P (2006) The diagnosis and care of transsexual children and adolescents: a pediatric endocrinologists' perspective. *Journal of Pediatric Endocrinology & Metabolism* 19(2): 103–109.
- 106 Spack, N (2005) Transgenderism. *Lahey Clinic Medical Ethics Journal*, Fall. Available at www.lahey.org/NewsPubs/Publications/Ethics/JournalFall2005/Journal_Fall2005_Feature.asp.
- 107 Wren, B (2000) Early physical intervention for young people with atypical gender identity development. *Clinical Child Psychology and Psychiatry* 5(2): 220–231.
- 108 de Vries, ALC, Cohen-Kettenis, PT, Delemarre-Van de Waal, H (2006) Clinical management of gender dysphoria in adolescents. *International Journal of Transgenderism* 9(3/4): 83–100. Available at www.vch.ca/transhealth/resources/library/tcpdocs/guidelines-adolescent.pdf
- 109 Giordano, S (2007) Gender atypical organisation in children and adolescents: ethico-legal issues and a proposal for new guidelines. *International Journal of Children's Rights* 15(3/4): 365–390.
- 110 Cohen-Kettenis, PT (2007) Gender identity disorders in children and adolescents. In R Ettner, S Monstrey and AE Eyler (eds.) *Principles of Transgender Medicine and Surgery*, pp. 261–280. Haworth Press, New York.
- 111 See also references on the GIRES website at www.gires.org.uk/Web_Page_Assets/Hormonal_Medication.htm
- 112 Toorians, AW, Thomassen, MC, Zweegman, S, Magdelyns, EJ, Tans, G, Gooren, LJ, Rosing, J (2003) Venous thrombosis and changes of hemostatic variables during cross-sex hormone treatment in transsexual people. *Journal of Clinical Endocrinology & Metabolism* 88(12): 5723–5729.

had indicated that in the first year of taking it the rate was 2.6% falling to around 0.4% per annum after that.¹¹³ The medications that replaced EE, such as 17 β oestradiol, are safer. Overall, short-term and medium-term usage is found to be safe; the risks of long-term usage are unknown.¹¹⁴

Otherwise, the potential risks and adverse side effects are largely inferred from studies on the use of hormone products in the non-trans population. With the exception of one of the testosterone preparations, these products are not licensed in the UK for use in the trans population. Nevertheless, there is now a wealth of clinical experience demonstrating the benefits of cross-sex hormone administration in the treatment of those experiencing gender variance to the point where medical intervention is sought.¹¹⁵

Although adverse consequences are unusual, serious untoward side effects can occur and can be difficult or even impossible to anticipate, even with regular monitoring. There are no monitoring tests, for instance, that would predict the occurrence of DVT or CVA. A cautious approach should be taken if service users and/or their family members have medical histories of DVT or other circulatory disorders, liver disorders or cancers, so it is very important to obtain a full account of these. Trans people must be encouraged to understand the importance of being honest with the clinician about their medical history, any current concerns and any medication or other drug that they may be taking. They should also be encouraged to provide an honest update if the situation changes.

Service users may be reluctant to be open about health problems in case hormone treatment is withheld. It is important, therefore, that clinicians reassure them that it is very unlikely that there will be any absolute contraindications to taking cross-sex hormones, but that product, dosage and method of delivery will be chosen to reflect the safest course of treatment for the individual. Where a pre-existing condition such as HIV is present and is being treated with anti-retroviral drugs, this is not a reason for cross-sex hormone treatment to be withheld. Drug-drug interactions may occur but they are seldom a reason for not providing hormone treatment. Interactions associated with oestrogen are given on page 69.¹¹⁶ Some interactions, testosterone and anticoagulants for instance, can have serious adverse consequences.

113 van Kesteren, PJ, Asscheman, H, Megans, JA, Gooren, LJ (1997) Mortality and morbidity in transsexual subjects treated with cross-sex hormones. *Clinical Endocrinology* 47: 337–342.

114 Gooren, LJ, Gitlay, EJ, Bunck, MC (2008) Long-term treatment of transsexuals with cross-sex hormones: extensive personal experience. *Journal of Clinical Endocrinology & Metabolism* 93(1): 19–25.

115 Gooren, LJ, Gitlay, EJ, Bunck, MC (2008) Long-term treatment of transsexuals with cross-sex hormones: extensive personal experience. *Journal of Clinical Endocrinology & Metabolism* 93(1): 19–25.

116 Tom Waddell Health Center, *Protocols for hormonal reassignment of gender*. Available at www.dph.sf.ca.us/chn/HlthCtrs/HlthCtrDocs/TransGendprotocols122006.pdf

Before treatment is started, clinicians should alert service users to the symptoms of DVT (tenderness, heat and swelling in calf), PE (breathlessness, sudden sharp chest pain and coughing up blood) and CVA (unusually frequent and/or severe headaches, especially migraines with unilateral neurological symptoms (numbness, vision disturbance)) and should encourage them to report these immediately.

D7 Reproductive capacity

The implications of hormone treatment on future fertility must be carefully explained to service users:

- Cross-sex hormone treatment seriously impairs fertility. Removal of the gonads, with or without full gender confirmation surgery (sometimes still referred to as gender reassignment surgery), produces permanent sterility.
- Before any such surgery is undertaken, and for an unknown and variable length of time, sperm production may be restored to pre-treatment levels in trans women by discontinuing hormone treatment. The length of time for which hormone treatment must cease in order to restore fertility is also not known and will differ from individual to individual. Trans women who are on oestrogen and/or hormone blockers will ultimately become infertile since cross-sex hormones will down-regulate the gonads and spermatogenesis will not be restored.
- Testosterone administration in trans men does not, at least in the short to medium term, eliminate reproductive capacity, but again, the timing is not predictable and will vary between individuals. Pregnancy is impossible once a hysterectomy is performed.

If the service user wishes to ensure future reproductive capacity, written information should be provided about the possibility of cryogenic storage of reproductive material,¹¹⁷ as well as details of where this service can be accessed.¹¹⁸

Trans men and women should have the same reproductive options within the NHS as the non-trans population.¹¹⁹

117 Hamilton, M (2007) Draft good practice guidelines for the assessment and treatment of gender dysphoria: Appendix 1, gamete storage. Available at www.rcpsych.ac.uk/pdf/Standards%20of%20Care%20Draft%20v8%203b%20final.pdf

118 Human Fertilisation and Embryology Authority – www.hfea.gov.uk

119 De Sutter, P (2007) Reproduction and fertility issues for transpeople. In R Ettner, S Monstrey and AE Eyler (eds.) *Principles of Transgender Medicine and Surgery*, pp. 209–221. Howarth Press, New York.

D8 Hormones and surgery

In view of the enhanced risk of DVT, it is usual for trans women to stop taking oestrogen about four to six weeks prior to any surgery and to restart from two to three weeks following surgery, provided the individual is reasonably mobile. It is beneficial for trans women who are also taking GnRHa (e.g. goserelin or leuprorelin) to remain on it or, if they are taking oestrogen alone, to replace it with GnRHa through the peri-operative period; this will overcome any resurgence of the endogenous hormones, that may cause a regrowth of facial hair, which is particularly distressing.

It is not usually necessary to discontinue testosterone before surgery. However, as it has a slightly antithrombotic effect,¹²⁰ some clinicians prefer service users to discontinue its use two to three weeks prior to surgery.

Dosages of hormones should be reduced after any surgery involving gonadectomy, but they must be sufficient to maintain feminisation or masculinisation, prevent menopausal symptoms, support general wellbeing and protect against osteoporosis.

D9 Summary: feminising and masculinising hormone treatment

Initial checks (as for anyone prescribed oestrogen or testosterone) should include:

- family and personal health history, noting any medication, health or lifestyle matters that could influence hormone therapy; and
- properly informed consent (see Section D4).

Many clinicians feel that regular monitoring is necessary, and this is usually carried out on a regular basis when an individual is taking cross-sex hormones (see Sections D10.2 and D11.2 for monitoring suggestions). This is also useful in providing feedback to trans service users regarding hormone levels in the blood, as this helps them to be patient in the early stages of treatment when the desired changes are slow to appear. It also alerts the clinician to situations where service users are continuing to self-medicate at the same time as taking prescribed hormones. However, some service users may choose not to be frequently monitored. Some clinicians agree to undertake only limited monitoring, while warning about the more obvious dangers mentioned in Section D6: smoking, drugs, excessive alcohol use and obesity.

Service users should not undergo a pelvic examination as a prerequisite to starting hormones unless it is clinically indicated. This is an especially sensitive issue for trans people because they are usually uncomfortable with their physical sex

120 Toorians, AW, Thomassen, MC, Zweegman, S, Magdelyns, EJ, Tans, G, Gooren, LJ, Rosing, J (2003) Venous thrombosis and changes of hemostatic variables during cross-sex hormone treatment in transsexual people. *Journal of Clinical Endocrinology & Metabolism* 88(12): 5723–5729.

characteristics. In cases where it is regarded as necessary, service users may find it preferable to have this done by their GP. Some may refuse genital examination and this should be respected. Where an initial examination has taken place and has revealed the need for further investigation, pelvic ultrasound may be undertaken.

The following sections provide **GUIDANCE**. They are not intended to be followed to the letter, but to be used flexibly in response to the needs of the individual. Choice of hormone product, dosage and method of delivery should be aimed at providing maximum efficacy in terms of psychological wellbeing, and masculinising or feminising effects on overall appearance and sex characteristics.

D10 Trans women

D10.1 Pre-treatment warnings about side effects

Clinicians should warn about the usual side effects associated with oestrogen treatment (Section D3).

N.B. There will be diminished genital tissue available for creating a vagina, and, in time, they will become infertile.

Clinicians should also remind service users that:

- smoking diminishes the feminising effect of oestrogen and increases cardiovascular and general health risks; and
- alcohol intake should be in line with the advised limit for women – no more than 14 units per week.

D10.2 Monitoring suggestions

Baseline tests could include: weight, height, blood pressure and urine tests; full blood count; renal and liver function tests; lipid profile; thyroid-stimulating hormone; fasting glucose; testosterone; oestrogen; luteinising hormone and prolactin; and clotting profile (where history indicates there may be a problem).

Further checks after starting treatment, at approximately:

- three months may include oestrogen and testosterone levels;
- then every six months for 18 months, oestrogen and testosterone levels plus liver function tests and prolactin (possibly also lipids and glucose); and
- then yearly if no problems.

The aim is to maintain feminisation and to help the patient to feel better; measurement of serum oestrogen levels does not necessarily yield this information. As mentioned above, there is little research in this field.

D10.3 Guidance for hormone treatment

Oestrogens to bring about and maintain feminisation

Oestradiol-based formulations are naturally occurring oestrogen (17 β oestradiol). Ethinylestradiol is not recommended as it is associated with increased risk of side effects. Newer and better products are available. Conjugated equine oestrogen is also not recommended because it cannot be measured effectively in relation to human physiological circulating levels of oestrogen (most laboratories do not have the facilities to measure it). Also some people regard the method of collection from horses as unethical.

- Oestradiol patches: least risk, best for over-40s, smokers, or those with circulatory problems; transdermal administration, 50–150 μ g daily dose, applied twice weekly (post gonadectomy: 25–50 μ g).
- Oestradiol gel: low risk, 0.75mg, two applications, three times daily applied to skin (post gonadectomy: 0.75mg applied twice daily).
- Oestradiol, oral: some risk, 0.5–2mg, one to three times daily, up to 6mg daily, usually in divided doses (post gonadectomy: 1–2mg once daily).

Where androgen suppression is deemed necessary in addition to oestrogen administration

Anti-androgens:

- Cyproterone acetate (CPA): taken orally, 50–150mg daily. Blocks androgen receptors, and therefore reduces the impact of testosterone on cells, and also acts on the pituitary gland to down-regulate the gonads. There is some evidence that, in high doses, CPA can give rise to abnormal liver enzyme function, hepatitis and jaundice. Most common side effects are fatigue and depression. It may also cause weight gain, dry skin and hair changes, anaemia and gynaecomastia.

Heavy drinkers will not benefit from CPA, and those with liver impairment, malignant disease, diabetes, sickle cell anaemia or pulmonary embolism may do better on an alternative product.¹²¹

- Spironolactone: taken orally, 100–300mg daily. Blocks androgen receptors and therefore reduces the impact of testosterone. It has diuretic and antihypertensive effects. Monitor renal function before starting and one month later. Can cause headache, liver and kidney impairment, and decreased clotting.

Contraindicated in Addison's disease.

121 Gooren, LJ, Giltay, EJ, Bunck, MC (2008) Long-term treatment of transsexuals with cross-sex hormones: extensive personal experience. *Journal of Clinical Endocrinology & Metabolism* 93(1): 19–25. (This research showed that cyproterone acetate (CPA) is associated with a greater impairment of the lipid profile than are GnRH agonists. Therefore, GnRH α is considered safer than CPA by some clinicians.)

Long-acting GnRH analogues that act on the pituitary gland to inhibit the production of gonadal hormones (no effect on the production of testosterone by the adrenal glands) may be used, if necessary, to reduce the effect of endogenous hormones and, therefore, enhance the effect of the prescribed hormones, up to the time of gonadectomy, or they may be started at the point in the immediate pre-surgery period (around four weeks) when oestrogen is no longer being taken. This helps to suppress any resurgence of facial hair growth. May be used briefly after gonadectomy but not in the long term.

- Goserelin: subcutaneous depot injection (abdomen), 3.6mg per month. May be given in three-month dose if tolerated. Few side effects.
- Leuprorelin: subcutaneous depot injection (abdomen), 3.75mg per month. May be administered on a three-monthly basis. Regarded as posing a higher risk of eating and digestive disorders (nausea, diarrhoea), altered lipids, pulmonary embolism, low blood pressure and mood alteration.
- Finasteride: 5mg (half a tablet) daily. Inhibits 5 α reductase, thus preventing conversion of testosterone to the more powerful dihydrotestosterone. May be used if some hair regrowth would be worthwhile, i.e. if balding is not too far advanced. Finasteride prompts a modest regeneration of hair on the head.¹²² However, it cannot overcome male pattern baldness and service users should not have over-optimistic expectations.

Progestogens are rarely part of a treatment plan for trans women since they may have **androgenic effects** such as encouraging facial hair growth, and provide no obvious benefits. They increase the risk of breast cancer and CVA and may cause additional side effects. Anecdotally, some trans women say that they feel better when taking them alongside oestrogen; they report that progestogens heighten libido and some also say that breast development is more satisfactory. In non-trans women, progestogens are combined with oestrogen to protect the uterus from cancer. Clearly, this is not applicable to trans women so there is little rationale for prescribing them.

D10.4 Surgery and long-term care

Clotting profile is not done routinely before surgery, but may be undertaken if the medical history indicates a need for caution. Stop oestrogens four weeks prior to surgery to minimise the risk of thrombosis. GnRH α as above through to surgery. Resume oestrogen when patient is mobile (approximately two weeks after surgery).

122 McClellan, KJ, Markham, A (1999) Finasteride – A review of its use in male pattern hair loss. *Drugs* 57(1): 111–126. The 5 alpha-reductase inhibitor finasteride blocks the conversion of testosterone to dihydrotestosterone (DHT), the androgen responsible for male pattern hair loss (androgenetic alopecia) in genetically predisposed men. Results of phase III clinical studies in 1,879 men have shown that oral finasteride 1mg/day promotes hair growth and prevents further hair loss in a significant proportion of men with male pattern hair loss.

Lifelong oestrogen is required at the lower dosages mentioned above. The dosage must be sufficient to maintain feminisation, and prevent osteoporosis and menopausal symptoms. Monitor blood pressure, and levels of luteinising hormone and follicle-stimulating hormone; if these are in the non-menopausal range then dose should be adequate – six-monthly for 18 months then, if no problems arise, yearly.

Ongoing monitoring may include checks for osteoporosis, prostate cancer and breast cancer.

- Breast screening in accordance with local protocols. Low risk in trans women. Mammography not necessary unless over 50, oestrogens taken for over five years, and/or family history of breast cancer.¹²³
- In older trans women, DEXA bone scans may be advisable (compare with male scan).
- Prostate cancer is a (slight) possibility in trans women. Cancer may already be present before hormone administration starts, especially when this is later in life.

D11 Trans men

D11.1 Pre-treatment warnings about side effects

Side effects may be minimal, but they could include: polycythaemia, nausea/vomiting, abdominal pain, headaches, weight gain, water retention, skin changes (rash), infertility in the long term, altered lipids and bleeding tendencies and, rarely, liver tumours, breast cancer, osteoporosis, (severe) depression, mood changes and occasionally aggression.

- Inform the service user that smoking increases cardiovascular and general health risks.
- Alcohol intake should be no more than 14 units per week.

D11.2 Monitoring suggestions

Baseline: initially, record weight, height, blood pressure and urine tests; full blood count; liver and renal function; lipid profile; thyroid-stimulating hormone; prolactin; fasting glucose; luteinising hormone; follicle-stimulating hormone; oestradiol and testosterone; and clotting screen. Further checks after start of treatment at approximately:

- three months, check testosterone levels. If using injectable testosterone, measure trough testosterone (just prior to next injection);
- then every six months for 18 months, check testosterone, full blood count (possibly also liver function tests, lipids, glucose); and
- then yearly if no problems.

123 Feldman, JL, Goldberg, JM (2006) Transgender primary medical care. *International Journal of Transgenderism* 9(3/4): 3–34.

D11.3 Guidance for hormone treatment

Androgens to bring about and maintain masculinisation

The available formulations are as follows:

- Testosterone esters: intramuscular injection; 250mg every two to three weeks (licensed in the UK for the treatment of trans men (eMC.org, electronic medicines compendium) (post gonadectomy: 250mg every four weeks or 100mg every two weeks).
- Testosterone enantate: (if peanut allergic) 250mg intramuscular injection every two to three weeks (post gonadectomy: 250mg every four weeks).
- Testosterone undecanoate: injection, 1,000mg every 10–14 weeks (post gonadectomy: 500mg every 10–14 weeks).
- Testosterone undecanoate tablets can be given for those who wish to masculinise slowly or who do not want injections: 120–160mg daily; this is less recommended because of the extensive ‘first pass’ metabolism that reduces bio-availability and increases likelihood of abnormal liver function tests (post gonadectomy: 40–80mg once daily).
- Testosterone gels: 50mg/5g applied twice daily (post gonadectomy: once daily).
- Testosterone patches: 5mg twice daily (post gonadectomy: once daily).
- Buccal testosterone: 30mg twice daily (post gonadectomy: once daily).

Medication to lower oestrogen levels

This medication is not always regarded as necessary because testosterone alone can be very effective for trans men.

- Goserelin – 3.6mg subcutaneous implant, four-weekly, or 10.8mg 12-weekly.
- Leuprorelin – 3.75mg, subcutaneous implant, four-weekly. Regarded as posing a higher risk of gastro-intestinal side effects and altered lipids, pulmonary embolism, low blood pressure and mood alteration.

D11.4 Surgery and long-term care

Clotting screens are not done routinely, but may be done as a precautionary measure prior to surgery. It is not usual to stop testosterone before surgery unless there are bleeding problems anticipated. Where this is the case, it may be stopped four weeks prior to surgery to minimise any bleeding tendency. Medication should be resumed once the patient is fully mobile. Dosages will be lowered post gonadectomy (as above) but must be sufficient to maintain masculinisation, and prevent osteoporosis and menopausal symptoms.

If a total hysterectomy has not been performed (and the service user has had unprotected vaginal intercourse with men):

- cervical smear tests should be offered; and
- three-yearly pelvic ultrasound scans may be done to detect: ovarian/uterine changes (e.g. polycystic ovaries, endometrial hyperplasia, and/or ovarian/uterine cancers).

Post gonadectomy

Monitor blood pressure, luteinising hormone, follicle-stimulating hormone and testosterone at approximately six-monthly intervals for 18 months.

If there are no health problems, this can be reduced to yearly. Full blood count should be done yearly. Ongoing monitoring should include checks for osteoporosis and breast cancer.

- Breast screening according to local protocols (low risk after chest reconstruction).
- In older trans men, DEXA bone scans may be advisable (compare with female scan).

D11.5 Drug interactions with oestrogens

Oestrogens may increase or decrease the blood levels of other medications. For instance, oestradiol significantly reduces blood levels of **lamotrigine** (Lamictal); patients prescribed both should therefore have their lamotrigine dosage increased.

Antiretroviral drugs

Antiretroviral drugs have been studied for interactions with the components of oral contraceptives (mostly ethinylestradiol at low doses – at the normal range of prescribed doses to achieve feminisation). There are no data on interactions with other oestrogens.

Amprenavir and **fosamprenavir** are the only antiretrovirals whose concentration decreases in the presence of ethinylestradiol. We recommend caution when using these agents, since we cannot predict the clinical effects with the high doses of oestrogens used for transgender care.

Otherwise, levels of oestradiol and ethinylestradiol are:

increased by:

astemizole
cimetidine
clarithromycin
diltiazem
efivarenc
erythromycin
fluconazole
fluoxetine
fluvoxarnine
grapefruit
indinavir
isoniazid
itraconazole
ketoconazole
miconazole
nefazadone
paroxetine
saquinair
sertraline
triacetyloleandomycin
verapamil

decreased by:

atazanavir
benzoflavone
carbamazepine
dexamethasone
kaletra
nelfinavir
naphthoflavone
nevirapine
phenobarbital
phenylbutazone
phenytoin
progesterone
rifampin
ritonavir
suffamidine
sulfinpyrazone

The impact that these drug interactions may have on oestrogen dosage varies greatly. Some interactions may be slight and will not, therefore, necessitate any change in oestrogen dosage. These lists are taken from the protocols for Hormonal Reassignment of Gender (2006) followed at the Tom Waddell Health Center in San Francisco.

D12 Information and support

The following national organisations offer trans people and their families a wide range of expertise. They may also be able to provide details of local support organisations.

a:gender

Tel: 020 7035 4253

Email: agender@homeoffice.gsi.gov.uk

Website: www.agender.org.uk

Support for staff in government departments/agencies who have changed, or who need to change permanently, their perceived gender, or who identify as intersex.

The Beaumont Society

27 Old Gloucester Street, London WC1N 3XX

Tel: 01582 412220

Email: enquiries@beaumontsociety.org.uk

Website: www.beaumontsociety.org.uk

For those who feel the desire or compulsion to express the feminine side of their personality by dressing or living as women.

The Beaumont Trust

27 Old Gloucester Street, London WC1N 3XX

Telephone helpline: (Tuesday and Thursday, 7–11pm) 07000 287878

Email: bmonttrust@aol.com

Website: www.beaumont-trust.org.uk

Assists those troubled by gender dysphoria and involved in their care.

DEPEND

BM Depend, London WC1N 3XX

Email: info@depend.org.uk

Website: www.depend.org.uk

Free, confidential, non-judgemental advice, information and support to family members, partners, spouses and friends of transsexual people.

FTM Network

BM FTM.org.uk, London WC1N 3XX

Tel: 0161 432 1915 (Wednesday 8–10.30pm)

Website: www.ftm.org.uk

Advice and support for female to male transsexual and transgender people, and to families and professionals; 'buddying' scheme; newsletter – 'Boys Own'; annual national meeting.

The Gender Trust

PO Box 3192, Brighton, Sussex BN1 3W

Tel: (office hours) 01273 234024

Helpline: 0845 231 0505 10am–10pm, Monday to Friday
1pm–10pm, Saturday and Sunday

Email: info@gendertrust.org.uk

Website: www.gendertrust.org.uk

Advice and support for transsexual and transgender people, and for partners, families, carers and allied professionals and employers; has a membership society; produces magazine – ‘GT News’.

Gendered Intelligence

Email: jay@genderedintelligence.co.uk

catherine@genderedintelligence.co.uk

Website: www.genderedintelligence.co.uk/index.html

Company offering arts programmes, creative workshops and trans awareness training, particularly for young trans people.

GENDYS Network

BM GENDYS, London WC1N 3XX

Email: gendys@gender.org.uk

Website: www.gender.org.uk/gendys

Network for all who encounter gender problems personally or as family members, lovers or friends, and for those who provide care; quarterly journal; biennial conferences.

GIRES

Gender Identity Research and Education Society

Melverley, The Warren, Ashted, Surrey KT21 2SP

Tel: 01372 801554

Email: admin@gires.org.uk

Website: www.gires.org.uk

Promotes and communicates research; provides information and education to help those affected by gender identity and intersex conditions. Offers range of literature, e.g. to help families deal with ‘transition’. GIRES will adjust these to a family’s circumstances on application.

Mermaids

BM Mermaids, London WC1N 3XX

Tel: 07020 935066

Email: mermaids@freeuk.com

Website: www.mermaids.freeuk.com

Support and information for children and teenagers who are trying to cope with gender identity issues, and for their families and carers. Please send SAE for further information.

Press For Change

BM Network, London WC1N 3XX

Tel: (emergencies only) 0161 432 1915

Website: www.pfc.org.uk

Campaigns for civil rights for trans people. Provides legal help and advice for individuals, information and training; newsletter and publications. Please send SAE for further details.

The Sibyls

BM Sibyls, London WC1N 3XX

Website: www.sibyls.co.uk

Christian spirituality group for transgender people.

WOBS

Women of the Beaumont Society

BM WOBS, London WC1N 3XX

Tel: 01223 441246, 01684 578281

Email: wobsmatters@aol.com

Website: www.gender.org.uk/WOBSmatters

Operated by and for wives, partners, family and friends of those who cross-dress.

Notes

Notes

Notes

Guidance for GPs, other clinicians and health professionals on the care of gender variant people was prepared by the Gender Identity Research and Education Society's team:

Dr Richard Curtis, BSc, MB, BS, DipBA

Professor Andrew Levy, PhD, FRCP

Dr Joyce Martin, MB, ChB, DObstRCOG

Professor Zoe-Jane Playdon, BA (Hons), PGCE, MA, MEd, PhD, DBA, FRSA

Dr Kevan Wylie, MB, MMedSc, MD, FRCPsych, DSM

Terry Reed, BA (Hons), MCSP, SRP, GradDipPhys

Bernard Reed, MA, MBA



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