

Scottish Needs Assessment Programme



Transsexualism and Gender Dysphoria in Scotland

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EXECUTIVE SUMMARY

Transsexualism, or Gender Dysphoria, is a condition in which there is a mismatch of an individual's body and their psychological gender identity. Through a lengthy process of self-awareness, diagnosis, long-term assessment and lifestyle change the transsexual person can achieve a comfortable state of being. This process usually requires considerable input from health professionals and has cost and service implications for the National Health Service.

In order to estimate the prevalence of transsexualism in Scotland, questionnaires were sent to all relevant professionals in Scotland, and to transsexual self help groups. It was found that about 300 transsexual people are known to be in treatment in Scotland and the prevalence of the condition was found to be 8 / 100,000.

The Harry Benjamin International Gender Dysphoria Association produces Standards of Care for treatment of gender dysphoria. These standards are adopted by most clinicians working in the NHS and form the basis of care in the main Scottish treatment centres. They state that before any surgery patients should be assessed by two professionals experienced in the field, one of whom should be a mental health clinician. They also state that before any irreversible treatment is undertaken, the patient should live successfully in the converse gender role for a minimum of one year during which time hormones may be prescribed.

Treatment consists of long-term psychosocial assessment leading on, in many cases, to hormonal treatment and eventual gender reassignment surgery. Some individuals may need post-operative psychological input.

Treatment can involve general practitioners, psychiatrists, psychologists, psychosexual doctors or nurses, speech therapists, endocrinologists and surgeons. Self-help and family support groups are very important in the gender transition process.

Initial access to treatment in Scotland is haphazard. Patients present at general practice, psychiatry, psychology, family planning and sexual health clinics, to self-help groups or the Internet. As clinical and social awareness of the condition increases, however, patients seem to present earlier at appropriate treatment sites.

There are no funded gender dysphoria services in Scotland. There are interested clinicians in the main centres who treat patients. There is no gender reassignment surgeon in Scotland and all patients are referred to England or beyond for gender reassignment operations. A poll of

professionals working with gender dysphorics in Scotland supported the setting up of a national centre.

Taking into account the prevalence of transsexualism in Scotland, the haphazard access to services and the increasing evidence of good outcomes after treatment, the report recommends the establishment of a national Managed Clinical Network for gender dysphoria in Scotland.

Aim

The aim of this SNAP report is to provide an overview of transsexualism in Scotland in order to inform clinicians and to assist Health Boards in providing a cost-effective, ethical and streamlined service for this minority group.

Objectives

- To determine the prevalence of gender dysphoria in Scotland
- To describe the clinical needs of transsexual people
- To review current health service usage by transsexual people
- To make recommendations to service planners for optimum, ethical care
- To obtain views of health care professionals on the need for a Scottish centre for gender dysphoria

NOTE

Throughout the report the terms “transsexualism” and “gender dysphoria” are used interchangeably.

“For the simple man in the street, there are only two sexes, a person is either male or female, Adam or Eve. The more sophisticated realise that every Adam contains elements of Eve and every Eve contains traces of Adam, physically as well as psychologically.”

Harry Benjamin, 1966.¹

Gender dysphoria is a psychological state in which an individual feels that he or she has been born into the body of the wrong sex. There is a strong and ongoing cross-gender identification, and an overwhelming desire to live and be identified as a member of the opposite sex. This is a condition that was first described in 1966, and is classified by both ICD² and DSM³ criteria for Psychiatric Disorder. (Appendix 1)

The reported prevalence of transsexualism varies from 1/2900 for male to female (M-F) and 1/8300 for female to male (F-M) patients in Singapore⁴ to 1/11900 for M-F and 1/30400 for F-M in the Netherlands.⁵ The sex ratios described are consistently 3:1 male: female.

Before preparation for this report, there were no published data on the prevalence or incidence of gender dysphoria in Scotland and no formal coordination of service provision.

There is increasing evidence of a biological basis for transsexualism⁶ and an increasing awareness of the condition by patients, professionals and the public.⁷ The aim of treatment should be social integration and prevention of psychological morbidity, leading to a good quality of life. The transsexual will alter lifestyle, appearance and name in order to confirm his or her gender identity, but in most cases extensive clinical input is also required.

This report on transsexualism in Scotland will provide information on the clinical condition and current services both locally and nationally, and should inform the planning of NHS service provision, to the benefit of gender dysphoric patients.

2.1 Ethical Context

Gender dysphoria is a condition with a range of treatment options varying with the needs of each individual. Some gender dysphorics do not wish clinical intervention. Those whose goal is physical gender reassignment may require multidisciplinary clinical intervention in order to achieve a body that aligns with their gender identity. Other patients with gender dysphoria may primarily require psychological or psychiatric support. Much of the life of the transsexual person may thus be managed by the medical and associated professions to paramedicals.

A clinician has a duty of care to his/her patient, and should agree a treatment framework with each individual according to the patient's particular need. However, it is important that there are accepted standards of care for these patients, as with those with any other condition. The Harry Benjamin International Gender Dysphoria Association, a professional organisation formed in the 1970s, has addressed this issue and publishes a Standards of Care document⁸ (Appendix 2) that is regularly updated. These criteria are internationally recognised as ethical guidelines for the treatment of transsexuals, and currently form the basis of best practice in clinical care.

The Harry Benjamin Guidelines state that before clinical intervention is provided to a transsexual person:

- a) The patient must be diagnosed and assessed by a suitably qualified professional
- b) No irreversible procedures should be undertaken until the transsexual has lived consistently in the converse gender role for a minimum of one year. During this time they have to show evidence of social integration in this role. This is known as 'The Real Life Test'. Hormones can be given at this stage.

Adherence to these guidelines provides protection for the patient from inappropriate treatment (or exploitation), and protection for the clinician from manipulation to prescribe or offer surgery.

There are some clinicians who express a moral objection to facilitating transsexual change. Gender dysphoria, however, is a recognised clinical condition and any treatment is carried out with full knowledge and consent of the patient and is in the patient's best interests. A physician has the right not to treat if he/she has moral objections but has a duty to refer the patient to another clinician who is able and willing to treat. The patient has a right to a second opinion if they are unhappy with the manner in which they are being treated.

It is undoubtedly in the best interests of both the patient, the health service and society to streamline clinical care in order to conclude the transsexual person's dependence on clinical

services as rapidly as is appropriate. This should enable the transsexual person to resume an independent and socially integrated lifestyle and will release clinical time that can be used to help other patients.

2.2 Clinical Context

Diagnosis and ongoing assessment

Gender dysphoria is a condition which is usually not brought to the attention of medical services for many years.⁹ Gender dysphoric individuals entering treatment are reported to have high rates of substance abuse and previous suicide attempts.¹⁰ This morbidity is likely to be due to unresolved gender identity problems but more work is required in this area. Even after diagnosis there can be major delays in accessing treatment due to lack of knowledge (by both transsexuals and clinicians) of the availability of services.

Detailed assessment is required to reach a correct diagnosis and determine whether hormonal and surgical treatment are likely to be helpful.¹¹ Once gender dysphoria is diagnosed the patient has to undertake a process of assessment and treatment in order to attain a comfortable state of being. All patients must have a mental health assessment during this process. Lifestyle changes alone may be the ultimate goal of some individuals whereas others will choose to progress to physical gender reassignment involving hormonal therapy and, in some cases, gender reassignment surgery.

Psychological/psychiatric treatment

Although there is a considerable literature¹² describing the psychological characteristics of transsexual patients, there are few studies of the effectiveness of psychological or psychiatric interventions. A few authors have reported on small numbers of patients with psychiatric co-morbidity whose gender dysphoria was resolved with treatment of the co-morbid condition.¹³ However, most such studies are of individual cases or are methodologically flawed.^{14,15}

Gender dysphoria is usually associated with severe psychological distress. Patients will require support from psychiatrists/psychologists, counselors or self-help groups regardless of progression through surgical treatment.

Hormonal therapy

If both assessing clinicians and the patient agree, cross-gender hormonal therapy is prescribed. This is usually prescribed by the general practitioner on the recommendation of the facilitating clinician. Care must be taken in treated patients to prevent the complications of hypogonadism. Long term cross gender hormonal therapy will almost certainly cause permanent infertility. Alternative fertility options should be discussed with the patient before commencement of therapy.

Surgery

The goal of the transsexual person may be gender reassignment surgery:

Male to female patients undergo removal of male genitalia with or without vaginal construction (neovaginoplasty) and clitoridoplasty. Sometimes breast augmentation is required.

Female to male patients require hysterectomy and oophorectomy before construction of a penis. (phalloplasty or metoidioplasty). Bilateral mastectomy is also performed often as a first surgical procedure.

Not all transsexual people wish to proceed to full-scale gender reassignment surgery. Some may prefer only to undergo a supplementary surgical procedure such as breast surgery, which can be beneficial to some transsexual people.¹⁶

There is a need for good psychological support both for those having full reassignment surgery and those undergoing secondary surgery.

Other treatments

Speech & Language Therapy

Although voice surgery is occasionally carried out for male to females¹⁷, current first line treatment is speech and language therapy, which is recommended particularly for male to female transsexuals.¹⁸

Hair removal

Facial and body hair growth is a major problem for many male to female transsexuals and shaving and electrolysis are the main modes of treatment. There is little evidence to support laser treatment for hair removal.

Other needs may include the removal of tattoos inappropriate to the converse gender role, and for male to female transsexuals, the provision of wigs and beauty and deportment lessons to aid social integration.

Outcomes of treatment

There is strong evidence to support treatment of transsexual people.¹⁹

For transsexual people with unequivocal cross gender identity, psychotherapy does not alter this and sex reassignment does relieve suffering.⁶ There have been no methodologically sound reports of resolving gender dysphoria with psychotherapy.

A recent review of outcome studies following surgical gender reassignment for male to female transsexual people was published by the Development and Evaluation Committee of the South and West NHS R&D Directorate.²⁰ The authors concluded that surgery is not a cosmetic procedure, but one which attempts to reconcile the individual's core identity with their physical characteristics. Although some patients report complications, dissatisfaction and regrets, it is evident that most male to female transsexual people experience a successful outcome following surgery. However, the authors add that most studies have not collected data prospectively and are hampered by losses to follow-up and lack of validated outcome measures. They highlight the need for high quality trials to determine the benefits and risks of gender reassignment surgery.

Modern surgical techniques are now leading to improved sexual functioning as well as cosmetically acceptable genitalia.^{21,22,23,24} Good cosmetic appearance and good function lead to a more satisfactory social and personal outcome.^{25,26} This makes it imperative that surgery is done by an experienced gender surgeon familiar with state of the art techniques.²⁷ Several studies, however, have highlighted the need for a period of post-operative psychotherapy.^{6,25} Regret after gender reassignment has been found to range from none to 3.8%.²⁵ Poor outcomes are rare but can be predicted by a lack of social support and presence of pre-operative psychosis.²⁸

Costs of surgical gender reassignment have been estimated at around £10,000, based on extra contractual referral costs from a large UK surgical unit.²⁰

2.3 Legal Context

There is no legal bar in Scotland to gender reassignment operations. They must be carried out with the full consent and understanding of the patient. This has not however been tested in the Scottish courts. There is a problem, however, that hormones used in treatment are not licensed for cross-gender use. This leads to reluctance on the part of some doctors to prescribe, although it is accepted clinical practice.

In England a landmark case²⁹ was taken to a high court action brought by three transsexual women. The Regional Health Authority had refused to fund their treatment under the National Health Service. The court held that the refusal to pay was “unlawful” and “irrational” and the case was upheld by the court. In an appeal, the judgment was upheld and the authority are now legally bound to fund the treatment for people with gender dysphoria. Article 8 of the European Convention on Human Rights makes a strong statement on the rights of the individual³⁰:

“Everyone has the right to respect for his private and family life, his home and his correspondence.”

Britain is one of only four members of the Council of Europe that refuses the transsexual the right to amend the birth certificate. This impinges on the transsexual person’s right to marry within UK law, when they have commenced living in their new gender role.

3 CURRENT SITUATION

3.1 Epidemiology

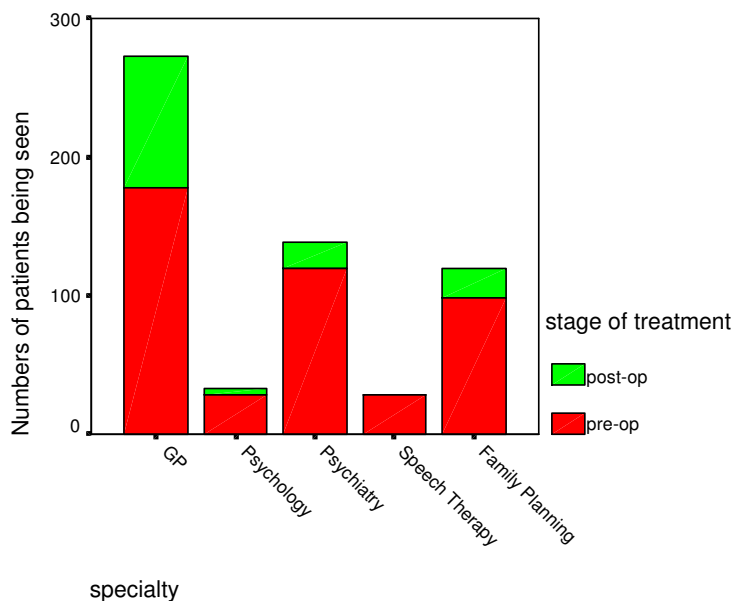
Because of a lack of recent published data on the prevalence of transsexualism in the UK, the SNAP working group surveyed health professionals and transsexual people in Scotland. A full description of the methodology and results is presented in Appendix 4. The main findings were as follows:

- About 300 transsexual people and individuals with gender dysphoria are known to public sector health services in Scotland.
- Male-to-female patients outnumber female-to-male patients by about 4:1

3.2 Health Service Use during 1997/1998

- General practitioners were involved in the care of more patients than any other professional group, and were probably providing most of the health care to post-operative patients (see chart below). About one third of the patients known to general practitioners have had gender reassignment surgery and one quarter were pre-operative but taking hormonal therapy. The remainder were either not in treatment or were receiving psychological or counselling therapy only. One third of patients known to general practitioners had presented to the GP in the past 12 months.

Number of patients seen by specialty



- 33 patients with gender dysphoria were being treated by clinical psychologists, 29 of whom had not had gender reassignment surgery
- 139 patients with gender dysphoria were being treated by psychiatrists, of whom 40% were in psychological/counselling treatment only, 46% were taking hormonal therapy and/or were in the “real life test”, and 14% had had gender reassignment surgery. Most patients were aged 18-40 years, and about half had presented within the previous 12 months.
- About 20 patients were referred in Scotland, using extra-contractual procedures, for surgery in the year 1997/8
- 29 patients were being treated by speech and language therapists, all except one of these being pre-operative male-to-female transsexuals.
- 114 patients were being seen by family planning and reproductive health care services, mainly in Glasgow and Edinburgh.
- Using a “cascade” method of sampling, 74 transsexual people were approached and completed questionnaires. The overwhelming majority of respondents indicated that there could be improvements in the services they had been offered.
- No reliable information was obtained on the amount of non-genital surgery (eg breast, laryngeal or facial procedures) carried out in Scotland or elsewhere.

The main themes emerging from questions to professional respondents about their experiences with transsexual patients included:

- Professional isolation and ignorance of gender identity problems are widespread
- Routes of referral are often not clear
- Professionals hold widely polarised views of transsexualism and gender dysphoria, ranging from strong moral disapproval to considerable empathy.

In conclusion, there appears to be a wide variation in patterns of health service use by transsexual people. Most of the clinical population are known to general practitioners, while psychiatry, psychology and speech and language therapy services are predominantly used by pre-operative patients. Family planning services in Glasgow and Edinburgh are also involved in the treatment of many transsexual people.

The extent of the “pre-clinical” population is unknown: previous research has indicated that many patients are aware of their gender identity problems many years before presenting to clinicians.⁹ We have obtained some evidence suggesting that there may be a recent increase in the number of patients coming forward for treatment, possibly as a result of increasing social acceptance of the condition.

4 RECOMMENDATIONS

- Transsexual people in Scotland should be offered the full range of services which have been shown to produce positive therapeutic outcomes.
- As contact with services is long term, the majority of provision should be local and community based.
- Surgical gender reassignment operations should only be performed by a specialist surgeon. Urgent consideration should be given to establishing a surgical facility in Scotland
- Services should be community-based and patient-centred, taking into consideration a social model of health.
- Patient responsibility and participation should be encouraged and supported in the form of self-help and family support groups.
- Difficulties in recruitment and postgraduate training of professionals should be addressed.
- There are many unanswered questions about transsexualism in Scotland. Therefore, it is imperative that an integrated programme of audit and research should be established.
- Most of these recommendations would be met by the establishment of a national service such as a Managed Clinical Network for Transsexual People in Scotland.

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APPENDIX 1: ICD & DSM Classifications


International Classification of Diseases (ICD-10), category F64.0

Transsexualism is defined as:

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 surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex.

Diagnostic and Statistical Manual of Mental Disorders (IV) category 302.85

All of the following criteria must be met for the diagnosis of gender identity disorder to be made:

- A A strong desire or persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
 - B Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
 - C The disturbance is not congruent with a physical intersex condition.
 - D The disturbance causes clinically significant distress or impairment in social, occupational or other areas of functioning.
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APPENDIX 2: Harry Benjamin Standards of Care

A BRIEF REFERENCE GUIDE TO THE STANDARDS OF CARE

CAVEAT—It is recommended that no one use this guide without consulting the full text of the SOC (Part Three) which provides an explication of these concepts.

I. Professional involvement with patients with gender identity disorders involves any of the following:

- A. Diagnostic assessment
- B. Psychotherapy
- C. Real life experience
- D. Hormonal therapy
- E. Surgical therapy.

II. The Roles of the Mental Health Professional with the Gender Patient. Mental health professionals (MHP) who work with individuals with gender identity disorders may be regularly called upon to carry out many of these responsibilities:

- A. To accurately diagnose the individual's gender disorder according to either the DSM-IV or ICD-10 nomenclature
- B. To accurately diagnose any co-morbid psychiatric conditions and see to their appropriate treatment
- C. To counsel the individual about the range of treatment options and their implications
- D. To engage in psychotherapy
- E. To ascertain eligibility and readiness for hormone and surgical therapy
- F. To make formal recommendations to medical and surgical colleagues
- G. To document their patient's relevant history in a letter of recommendation
- H. To be a colleague on a team of professionals with interest in the gender identity disorders
- I. To educate family members, employers, and institutions about gender identity disorders
- J. To be available for follow-up of previously seen gender patients.

III. The Training of Mental Health Professionals

A. The Adult-Specialist

- 1. basic clinical competence in diagnosis and treatment of mental or emotional disorders
- 2. the basic clinical training may occur within any formally credentialing discipline --for example, psychology, psychiatry, social work, counseling, or nursing.
- 3. recommended minimal credentials for special competence with the gender identity disorders:
 - a. master's degree or its equivalent in a clinical behavioral science field granted by an institution accredited by a recognized national or regional accrediting board
 - b. specialized training and competence in the assessment of the DSM-IV/ICD-10 Sexual Disorders (not simply gender identity disorders)
 - c. documented supervised training and competence in psychotherapy
 - d. continuing education in the treatment of gender identity disorders

B. The Child-Specialist

1. training in childhood and adolescent developmental psychopathology.
2. competence in diagnosing and treating the ordinary problems of children and adolescents

IV. The Differences between Eligibility and Readiness Criteria for Hormones or Surgery.

- A. Eligibility--the specified criteria that must be documented before moving to a next step in a triadic therapeutic sequence (real life experience, hormones, and surgery)
- B. Readiness--the specified criteria that rest upon the clinician's judgment prior to taking the next step in a triadic therapeutic sequence

V. The Mental Health Professional's Documentation Letters for Hormones or Surgery Should Succinctly Specify:

- A. The patient's general identifying characteristics
- B. The initial and evolving gender, sexual, and other psychiatric diagnoses
- C. The duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent
- D. The eligibility criteria that have been met and the MHP's rationale for hormones or surgery
- E. The patient's ability to follow the Standards of Care to date and the likelihood of future compliance
- F. Whether the author of the report is part of a gender team or is working without benefit of an organized team approach
- G. The offer of receiving a phone call to verify that the documentation letter is authentic

VI. One-Letter is Required for Instituting Hormone Treatment;

Two-Letters are Required for Surgery

- A. Two separate letters of recommendation from mental health professionals who work alone without colleagues experienced with gender identity disorders are required for surgery and
 1. If the first letter is from a person with a master's degree, the second letter should be from a psychiatrist or a clinical psychologist--those who can be expected to adequately evaluate co-morbid psychiatric conditions.
 2. If the first letter is from the patient's psychotherapist, the second letter should be from a person who has only played an evaluative role for the patient.
Each letter writer, however, is expected to cover the same seven elements
- B. One letter with two signatures is acceptable if the mental health professionals conduct their tasks and periodically report on these processes to a team of other mental health professionals and nonpsychiatric physicians.

VII. Children with Gender Identity Disorders

- A. The initial task of the child-specialist mental health professional is to provide careful diagnostic assessments of gender-disturbed children.
1. the child's gender identity and gender role behaviors, family dynamics, past traumatic experiences, and general psychological health are separately assessed. Gender-disturbed children differ significantly along these parameters.
 2. hormonal and surgical therapies should never be undertaken with this age group.
 3. treatment over time may involve family therapy, marital therapy, parent guidance, individual therapy of the child, or various combinations.
 4. treatment should be extended to all forms of psychopathology, not simply the gender disturbance.

VIII. Treatment of Adolescents

- A. In typical cases the treatment is conservative because gender identity development can rapidly and unexpectedly evolve. Teenagers should be followed, provided psychotherapeutic support, educated about gender options, and encouraged to pay attention to other aspects of their social, intellectual, vocational, and interpersonal development.
- B. They may be eligible for beginning triadic therapy as early as age 18, preferably with parental consent.
1. Parental consent presumes a good working relationship between the mental health professional and the parents, so that they, too, fully understand the nature of the GID.
 2. In many European countries sixteen to eighteen-year-olds are legal adults for medical decision making, and do not require parental consent. In the United States, age 18 is legal adulthood.
- C. Hormonal Therapy for Adolescents. Hormonal treatment should be conducted in two phases only after puberty is well established.
1. in the initial phase biological males should be administered an antiandrogen (which neutralize testosterone effects only) or an LHRH agonist (which stops the production of testosterone only)
 2. biological females should be administered sufficient androgens, progestins, or LHRH agonists (which stops the production of estradiol, estrone, and progesterone) to stop menstruation.
 3. second phase treatments--after these changes have occurred and the adolescent's mental health remains stable
 - a. biologic males may be given estrogenic agents
 - b. biologic females may be given higher masculinizing doses of androgens
 - c. second phase medications produce irreversible changes
- D. Prior to Age 18. In selected cases, the real life experience can begin at age 16, with or without first phase hormones. The administration of hormones to adolescents younger than age 18 should rarely be done.
1. first phase therapies to delay the somatic changes of puberty are best carried out in specialized treatment centers under supervision of, or in consultation with, an endocrinologist, and preferably, a pediatric endocrinologist, who is part of an interdisciplinary team.
 2. two goals justify this intervention
 - a. to gain time to further explore the gender and other developmental issues in psychotherapy

- b. to make passing easier if the adolescent continues to pursue gender change.
- 3. in order to provide puberty delaying hormones to a person less than age 18, the following criteria must be met
 - a. throughout childhood they have demonstrated an intense pattern of cross-gender identity and aversion to expected gender role behaviors
 - b. gender discomfort has significantly increased with the onset of puberty
 - c. social, intellectual, psychological, and interpersonal development are limited as a consequence of their GID
 - d. serious psychopathology, except as a consequence of the GID, is absent
 - e. the family consents and participates in the triadic therapy
- E. Prior to Age 16. Second phase hormones, those which induce opposite sex characteristics should not be given prior to age 16 years.
- F. Mental Health Professional Involvement is an Eligibility Requirement for Triadic Therapy During Adolescence.
 - 1. To be eligible for the implementation of the real life experience or hormone therapy, the mental health professional should be involved with the patient and family for a minimum of six months.
 - 2. To be eligible for the recommendation of genital reconstructive surgery or mastectomy, the mental health professional should be integrally involved with the adolescent and the family for at least eighteen months.
 - 3. School-aged adolescents with gender identity disorders often are so uncomfortable due to negative peer interactions and a felt incapacity to participate in the roles of their biologic sex that they refuse to attend school.
 - a. Mental health professionals should be prepared to work collaboratively with school personnel to find ways to continue the educational and social development of their patients.

IX. Psychotherapy with Adults

- A. Many adults with gender identity disorder find comfortable, effective ways of identifying themselves without the triadic treatment sequence, with or without psychotherapy
- B. Psychotherapy is not an absolute requirement for triadic therapy.
 - 1. Individual programs vary to the extent that they perceive the need for psychotherapy.
 - 2. When the mental health professional's initial assessment leads to a recommendation for psychotherapy, the clinician should specify the goals of treatment, estimate its frequency and duration.
 - 3. The SOC committee is wary of insistence on some minimum number of psychotherapy sessions prior to the real life experience, hormones, or surgery but expects individual programs to set these
 - 4. If psychotherapy is not done by members of a gender team, the psychotherapist should be informed that a letter describing the patient's therapy may be requested so the patient can move on to the next phase of rehabilitation.

- C. Psychotherapy often provides education about a range of options not previously seriously considered by the patient. Its goals are:
1. to be realistic about work and relationships
 2. to define and alleviate the patient's conflicts that may have undermined a stable lifestyle and to attempt to create a long term stable life style
 3. to find a comfortable way to live within a gender role and body
- D. Even when the initial goals are attained, mental health professionals should discuss the likelihood that no educational, psychotherapeutic, medical, or surgical therapy can permanently eradicate all psychological vestiges of the person's original sex assignment

X. The Real-Life Experience

- A. Since changing one's gender role has immediate profound personal and social consequences, the decision to do so should be preceded by an awareness of what these familial, vocational, interpersonal, educational, economic, and legal consequences are likely to be.
- B. When clinicians assess the quality of a person's real-life experience in the new gender role, the following abilities are reviewed
1. to maintain full or part-time employment
 2. to function as a student
 3. to function in community-based volunteer activity
 4. to undertake some combination of items 1-3
 5. to acquire a new (legal) first or last name
 6. to provide documentation that persons other than the therapist know that the patient functions in the new gender role.

XI. Eligibility and Readiness Criteria for Hormone Therapy for Adults

- A. Three eligibility criteria exist.
1. age 18 years
 2. demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks
 3. Either a documented real life experience should be undertaken for at least three months prior to the administration of hormones, or
 4. a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months) should be undertaken
 5. under no circumstances should an person be provided hormones who has neither fulfilled criteria #3 or #4.
- B. Three readiness criteria exist:
1. the patient has had further consolidation of gender identity during the real-life experience or psychotherapy
 2. the patient has made some progress in mastering other identified problems leading to improving or continuing stable mental health
 3. hormones are likely to be taken in a responsible manner
- C. Hormones can be given for those who do not initially want surgery or a real life experience. They must be appropriately diagnosed, however, and meet the criteria stated above for hormone administration.

XII. Requirements for Genital Reconstructive and Breast Surgery

A. Six eligibility criteria for various surgeries exist and equally apply to biological males and biological females

1. legal age of majority in the patient's nation
2. 12 months of continuous hormonal therapy for those without a medical contraindication
3. 12 months of successful continuous full time real-life experience. Periods of returning to the original gender may indicate ambivalence about proceeding and should not be used to fulfill this criterion
4. while psychotherapy is not an absolute requirement for surgery for adults, regular sessions may be required by the mental health professional throughout the real life experience at a minimum frequency determined by the mental health professional.
5. knowledge of the cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches.
6. awareness of different competent surgeons

B. Two readiness criteria exist

1. demonstrable progress in consolidating the new gender identity
2. demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better or at least a stable state of mental health.

XIII. Surgery

A. Genital, Breast, and Other Surgery for the Male to Female Patient

1. Surgical procedures may include orchiectomy, penectomy, vaginoplasty, augmentation mammoplasty, and vocal cord surgery.
2. Vaginoplasty requires both skilled surgery and postoperative treatment. Three techniques are: penile skin inversion, pedicled rectosigmoid transplant, or free skin graft to line the neovagina
3. Augmentation mammoplasty may be performed prior to vaginoplasty if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormonal treatment for two years is not sufficient for comfort in the social gender role. Other surgeries that may be performed to assist feminization include: reduction thyroid chondroplasty, liposuction of the waist, rhinoplasty, facial bone reduction, face-lift, and blephoroplasty.

B. Genital and Breast Surgery for the Female to Male Patient.

1. Surgical procedures may include mastectomy, hysterectomy, salpingo-oophorectomy, vaginectomy metoidioplasty, scrotoplasty, urethroplasty, and phalloplasty.
2. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, and/or coital ability, the patient should be clearly informed that there are both several separate stages of surgery and frequent technical difficulties which require additional operations.
3. Reduction mammoplasty may be necessary as an early procedure for some large breasted individuals to make the real life experience feasible.
4. Liposuction may be necessary for final body contouring

C. Postsurgical Follow-up by Professionals.

1. Long term postoperative follow-up is one of the factors associated with a good psychosocial outcome.

2. Follow-up is essential to the patient's subsequent anatomic and medical health and to the surgeon's knowledge about the benefits and limitations of surgery
 - a. Postoperative patients may incorrectly exclude themselves from follow-up with the physician prescribing hormones as well as their surgeon and mental health professional.
 - b. These clinicians are best able to prevent, diagnose and treat possible long-term medical conditions that are unique to the hormonally and surgically treated.
 - c. Surgeons who are operating on patients who are coming from long distances should include personal follow-up in their care plan.
 - d. Continuing long-term follow-up has to be affordable and available in the patient's geographic region.
 - e. Postoperative patients also have general health concerns and should undergo regular medical screening according to recommended guidelines
3. The need for follow-up extends beyond the endocrinologist and surgeon, however, to the mental health professional, who having spent a longer period of time with the patient than any other professional, is in an excellent position to assist in any post-operative adjustment difficulties.

APPENDIX 3: Surgical Report

Proposal for Scottish facility for male to female gender reassignment surgery

There is presently an Edinburgh-based surgeon undergoing final phase training in this technique in London, which is self-funded.

There is a major gap in surgical service provision in Scotland. It should be centrally located and initially have facilities for treating one patient per week. Treating surgically one patient per week would require two surgical beds (hospital stay ten days).

Such a centre would require to be a referral service for a network of practitioners serving transsexual people across Scotland.

It would ideally have privacy, anonymity, and specialised highly trained nursing and surgical personnel.

The surgical unit would require:

1. A high standard of comfort in a conveniently situated city within Scotland.
2. A degree of anonymity and privacy that these patients demand can be assured.
3. Willingness to train nurses to specifically care for such patients.
4. A very high standard of nursing and surgical facilities.
5. An assured bed on a regular basis so that distant referrals are guaranteed admission.
6. A multi-specialty facility such that other problems of a plastic/psychiatric/urological nature could be readily attended to.

Male to Female Surgery

The total hospital stay is ten days. Preoperatively the patient should have a final consultation with a consultant psychiatrist. Bowel preparation is vigorous and mandatory and necessitates in-hospital preparation.

Surgery takes place on the second in-patient day. Surgery requires high levels of technical expertise with meticulous attention to minute detail. Anaesthesia is similarly demanding utilising general and epidural anaesthesia. Duration of surgery is usually of the order of 5 - 6 hours, but may take as long as 9 hours on occasion.

Post-operatively the patient is confined to bed with catheter and packs in situ for 5 to 7 days. She is not allowed to eat but may drink clear non-effervescent fluids.

Drains are removed on day two. Packs are removed on day five. The urinary catheter is removed on post-operative day seven.

The patient is discharged from hospital confident in vaginal dilation techniques and vaginal toilet techniques on post-operative day nine.

Female to male surgery

As there is much less demand for female to male gender reassignment surgery at present, it is recommended that any Scottish patients continue to be referred to mainstream UK or European centres of excellence.

It is hoped in the future that a surgeon skilled in these techniques may receive the support necessary to work in Scotland together with a dedicated gender dysphoria service.

Complications of Surgery

The surgery demands an extremely high level of surgical expertise and attention to detail to achieve satisfactory results in terms of cosmesis and function. It has to be aligned with a team of nursing professionals who can offer full emotional and physical support to these patients at a critical time in their lives.

Because of the rarity of the condition of transsexuality the acquisition of sufficient surgical expertise is difficult. Morbidity and mortality figures are hard to acquire.

The figures below are based on personal communication with Mr James Dalrymple, the most experienced gender reassignment surgeon in the UK today, having a total operative experience of these patients in excess of 2000 cases. The figures below must represent the "gold standard" to which others must aspire.

In 2000 cases of gender reassignment surgery -

Mortality:	One post-operative death six months after profound hypotension related to anaesthetic administration resulted in brain damage.
Morbidity:	One case of protracted and limited recovery following profound hypotension related to anaesthesia.
Deep Venous Thrombosis:	Zero cases in the past seven years (Ted Stockings and FLOTRON leggings routine)
Reactionary Haemorrhage:	Zero cases in the last 1000 cases.
Fistulae:	Zero cases.
Vaginal Stenosis:	Zero cases in those patients who have continued dilation as instructed. Several patients have developed stenosis after abandoning regular dilation.
Tissue loss or Sloughing:	Zero cases.
Prolapse:	2 out of 2000 cases, both in older patients.
Urinary Retention:	Primary retention after initial removal of catheter on the 7 th post-operative day. 5% re-catheterised and discharged have leg bag for a week. Secondary to stenosis at muco cutaneous junction (occurs within <u>three</u> months of surgery). Treatment by dilatation or meatotomy. Approximately 12 cases in 2000 patients.
Hair Bolus:	May develop in the neo vagina and is easily removed by speculum and forceps.

Mr Trevor Crofts FRCS

APPENDIX 4: Survey Methodology & Results

METHODOLOGY

In order to assess the prevalence of transsexualism in Scotland, questionnaires (see end of this appendix) were sent to all professionals in Scotland who would potentially have contact with gender dysphoric patients. Gender dysphoria was defined as a subjective experience of incongruity between genital anatomy and gender identity. Transvestitism was specifically excluded. There were no questionnaires sent to surgeons because although there is some relevant surgery done in Scotland, there is no specialist surgical unit.

Short questionnaires were sent to all psychiatrists, general practitioners, speech & language therapists, consultant psychologists, family planning services and directors of public health in Scotland. They contained questions on the number of transsexual people seen, new presentations in the last 12 months and whether or not there should be a Scottish Centre for Gender Dysphoria. General comments were also invited. A separate questionnaire was distributed to service users.

GP Survey

In April 1998, a questionnaire was sent to the senior partner of all general medical practices in Scotland together with a covering letter. The questionnaire sought details of the total number of patients registered with the practice and the number of patients with gender dysphoria. Non-respondents were sent a follow-up questionnaire after four weeks.

Public Health Survey

A questionnaire was sent to the Director of Public Health for each of the 15 Health Boards in order to discover how many extra-contractual referrals for gender dysphoria have been made within the last 12 months.

Psychiatrists Survey

A list of psychiatrists in Scotland was obtained from the Royal College of Psychiatrists and questionnaires were subsequently sent to all psychiatrists on the list. A reminder mailing was sent.

Psychologists Survey

There is no central list of all clinical psychologists working in Scotland. A list of Grade B psychologists (roughly equating to consultant grade) was obtained from the Clinical Psychology representative to the National Paramedical Advisory Committee. Questionnaires were sent to the 105 post holders requesting that they circulated copies to all qualified staff working with them.

Family Planning Survey

Questionnaires were sent out to the Family Planning Coordinators for each Health Board area, who were asked to circulate copies of the questionnaire to any appropriate colleagues within their service.

Speech & Language Therapists Survey

A postal questionnaire was sent to a named therapist in each Scottish Health Board to ascertain the number of transsexual people currently attending Speech and Language Therapy departments and the distribution of cases across the country.

Transsexuals (patients) questionnaire

Questionnaires were given to members of the SNAP group to distribute to patients attending their treatment centres and patients were asked to circulate them to their friends. They were also circulated through gender self-help groups such as Reach Out Highland and Crosslynx in Glasgow.

RESULTS

Overall Response Rate to Questionnaires

The overall response rate from professionals working with transsexual people in Scotland was 84 %.

Figure 1: Response rate to questionnaires:

	Total Distributed	Number Returned	% Response Rate
GPs	1073	784	73%
Public Health	15	12	80%
Psychiatry	495	381	72%
Psychology	209	167	80%
Family Planning	19	19	100%
Speech & Language Therapy	10	10	100%
Transsexuals	Approx. 300	74	25%

Current Usage of Services by Transsexuals

Bar graphs of the numbers of patients seen by specialty can be found at the end of this section.

Figure 2: Number of patients seen by different services:

	M>F	F>M	Pre-Op	Post-Op	Total
General Practice	218	55	178	95	273
Psychiatry	113	26	120	19	139
Psychology	29	4	29	4	33
Speech & Language Therapy	29	0	28	1	29
Family Planning	90	24	NK	NK	114
TS respondents not using services	NK	NK	NK	NK	6

General Practice Survey

A total of 784/1073 (73%) completed questionnaires were returned from general practitioners. The number of patients registered with the respondents' practices was 4,105,872, representing 80% of the Scottish population. If we assume that the gender ratio and age structure in responding practices is the same as that for Scotland as a whole (Registrar General for Scotland), we calculate that the responding practices have 3,336,261 patients over 15 years of age. This breaks down into 1,622,090 males and 1,714,171 females. These figures were used as the denominators in calculating the prevalence figures. The number of patients identified by respondents is presented in figure 3.

A total of 273 patients with gender dysphoria were identified, representing 8.18 patients per 100,000 of the total population aged over 15 years. Among these patients, 4.79 per 100,000 were undergoing hormonal treatment or had had reassignment surgery. Respondents indicated that 85 (31%) of their patients had presented within the past 12 months. Prevalence reported by general practitioners responding to the first mailing was somewhat higher than those responding to the reminder letter.

Figure 3. Number of cases of gender dysphoria identified by general practitioners, and calculated prevalence (per 100,000 population over 15 years) using a denominator of 3,336,261 (1,622,090 males, 1,714,171 females).

	Male-to female	Female-to-male	Total	Prevalence male-to-female	Prevalence female-to-male	Total prevalence
Patients with gender dysphoria but not in treatment	53	13	66	3.27	0.76	1.98
Patients with gender dysphoria in psychological/counselling treatment only	38	9	47	2.34	0.53	1.41
Patients taking sex hormone therapy, but pre-operative	54	11	65	3.33	0.64	1.95
Post-operative transsexual patients	73	22	95	4.50	1.28	2.85
Totals	218	55	273	13.44	3.21	8.18

General Practitioners Comments

A total of 150 general practitioners added written comments to the questionnaire. Overall 14 GPs expressed positive or empathic sentiments towards transsexual patients, commenting for example that there is too much professional and/or public fear and prejudice associated with transsexuality. Four GPs made adverse comments about the condition. Three of these four respondents disapproved of the "medicalisation" of transsexuality, and commented negatively on the publicity given to the condition. A total of 13 respondents believed that treatment of gender dysphoria should receive further resources, while a further 28 indicated that they considered the treatment of transsexual people a low priority for the NHS.

Ten GPs commented on a need for knowledge about transsexuality and its assessment and treatment. In particular, the name of an interested specialist was considered important by three GPs. Two respondents commented that most of their knowledge of the condition had come via their patients accessing the "transsexual grapevine."

Three GPs thought that transsexual patients were likely to move away from rural areas. Eight GPs commented that they had had patients who experienced difficulties with the services offered in Scotland and with the accessibility of these services.

One considered that pre-operative counselling was inadequate. A further two GPs expressed dissatisfaction with communication from secondary care services. Four GPs commented that they had been very satisfied with locally provided services.

Public Health Survey

12 questionnaires were returned giving an 80% response rate.

10 Scottish Health Boards have authorised extra-contractual referrals (ECRs) in the last 12 months. 20 ECRs were for surgery and 12 were for psychiatric opinion and assessment.

5 Boards replied that this number of ECRs was more than for the previous 12-month period.

Public Health Comments

One Director of Public Health commented that although surgery had been authorized in the past, referrals from senior practitioners have been infrequent. Another called for Scottish principles to be agreed by all Boards with regard to psychological re-orientation, surgical reassignment and “other” surgery such as tracheal shaving, nose reduction and tattoo removal. Finally, one commented that a database had been set up in the Board and that this would provide details on the numbers involved.

Psychology Survey

75 responses from Grade B staff were received and 167 questionnaires returned in total, giving an 80% response rate.

Figure4: Patients being treated by clinical psychologists

Male to Female preoperative phase	27
Male to Female postoperative phase	2
Female to Male preoperative	2
Female to Male postoperative	2
Total	33

Figure 5: Age groups of patients

AGE GROUP	MALE TO FEMALE	FEMALE TO MALE
<18	1	0
18 – 65	26	4
65+	2	0
Total	29	4

33 patients with gender dysphoria were being seen by 14 psychologists in Scotland (see figure 4). The majority (76%) of patients were being seen by specialists in Adult Mental Health, but some attended specialists in Addiction Problems or in Health Psychology. Only one patient under 18 years old was reported and two were over 65 (see figure 5).

82% of the patients had been seen by the psychologists for the first time within the last 12 months. These may not all be first presentation of the gender dysphoria because some patients will only be seen for specific assessments at some point in the course of full treatment by other professionals, but the figures do support the trend to rising numbers, as seen in the other surveys.

Psychologists were also asked to say whether their clients were seeing any other professionals concerning their gender dysphoria. This was intended to elucidate whether these patients were a sub-group of those reported in the surveys of other professions or might be additional to the other samples. Patients have the right to request that information on the cause of psychological problems is not passed to their GPs and therefore the psychologist may be the only professional aware of the diagnosis of gender dysphoria. Lack of contact with other professionals would indicate also that these patients were not yet receiving treatment following the Harry Benjamin Guidelines, perhaps because they were not yet sure that re-assignment surgery was their preferred method of resolving their conflict. Fifteen patients were not seeing any other specialist professional (see figure 6).

Figure 6 : Patients not seeing any other specialist

Male to Female preoperative phase	12
Male to Female postoperative phase	0
Female to Male preoperative	1
Female to Male postoperative	2
Total	15

A small percentage of clinical psychologists working in Scotland (14 from the survey) are treating a minority of patients known to have gender dysphoria, e.g. less than a quarter (24%) of the number seeing psychiatrists and just under an eighth (12%) of those known to GPs. In view of the apparent increase in identification of gender dysphoria patients it may well be that psychologists will be receiving more such referrals in the future. The guidelines of the Harry Benjamin Standards of Care for Gender Identity Disorder give a greater emphasis to psychotherapy and to the role of the clinical psychologist again indicating that an increase in referrals can be expected. Psychologists responding to this survey indicate a need for access to information and consultation with experienced peers in order to provide good quality care. A Scottish Centre providing such professional support would therefore seem warranted.

Psychologists' Comments

Several respondents pointed out that they were able to offer services to clients with gender identity disorders but other professionals did not use them as a resource. A small number expressed concern that treatment was predominantly medical and that there was insufficient awareness of other methods of resolving dysphoria. No specific alternatives were indicated.

Psychiatry Survey

381 questionnaires were returned from psychiatrists giving a 72% response rate.

Figure 7: Number of patients identified by psychiatrists

	M-F	%M-F	F-M	%F-M	TOTALS	%TOTALS
Patients with gender dysphoria in psychological/counselling treatment only	45	40%	11	42%	56	40%
Patients taking sex hormone therapy, but not in real life test	20	18%	2	8%	22	16%
Patients in real life test	34	30%	8	31%	42	30%
Post operative transsexual patients	14	12%	5	19%	19	14%
TOTALS	113	100%	26	100%	139	100%

Tayside, Lothian and Greater Glasgow Health Board have now more than 20 transsexuals each. There were none treated by psychiatrists in Shetland, the State Hospital at Carstairs or the Douglas Inch Clinic for Forensic Psychiatry.

Figure 8: Patients being seen by psychiatrists by age group

	M-F	F-M	TOTALS
0-17 years	3	3	6
18-40 years	63	15	78
41 + years	28	4	32
TOTALS	94	22	116*

(*Some of the respondents did not complete this section, resulting in only 116 of the total 139 patients being categorised into an age group).

17 psychiatrists were seeing 2 or more patients. 64 (46%) out of the 139 patients being seen by psychiatrists were received within the last 12 months.

The greatest percentage of patients reported by psychiatry were male to female transsexual people, but it is noted that approximately one third of male to female transsexuals and female to male transsexuals were in the “real life test”. Relatively few post-operative patients (14% of the total) remain in contact with services. This tends to support reports that individuals who undergo surgery tend to “get on with their lives” although need for better post – operative psychological care is now becoming more apparent.

40% of the total of patients with gender dysphoria were receiving counselling or psychological treatment only.

Psychiatrists Comments

Comments made by psychiatrists were both negative and positive. There was the opinion that the condition is not real but is “iatrogenic”, encouraged by therapists who are expressing their own psychosexual problems. It was felt that NHS resources should not be spent on such services. At the opposite extreme gender dysphoria was recognised as a genuine clinical identity, albeit relatively rare in the practice of many psychiatrists, but a service for which there ought to be provision in Scotland.

There appears to be even less experience of dealing with children and adolescents with gender dysphoria than with adults.

A high number of psychiatrists reported a lack of knowledge and/or expertise and skill in assessing and supporting such individuals. In addition, some psychiatrists expressed views that were not supportive of the development of the development of services for transsexual patients. This highlights the need for Scottish guidelines to standardise treatment.

Speech & Language Therapy Survey

A named therapist was identified in 14 Health Board areas and was asked to circulate questionnaires throughout the area. 26 questionnaires were returned – 10 of these indicated that patients were being seen and the other 16 had no such caseload.

29 patients were being treated in Speech & Language Therapy Units in Scotland (see figure 10). Edinburgh, Glasgow and Aberdeen had 5 or more patients each.

Figure 10 :Patients seen by Speech & Language Therapy Service

Location	Pre-op male to female	Post-op male to female	Pre-op female to male	Post-op female to male	Total
Edinburgh	8	0	0	0	8
Glasgow	5	1	0	0	6
Aberdeen	6	0	0	0	6
Inverness	4	0	0	0	4
Ayrshire	2	0	0	0	2
Angus	1	0	0	0	1
Fife	1	0	0	0	1
Dundee	1	0	0	0	1
Total	28	1	0	0	29

Figure 11: Therapy

		Average	Range
Minimum no. of session	Regular therapy	4.4	1 - 20
	Review therapy*	2	1 - 4
Maximum no. of sessions	Regular therapy	11.5	8 - 36
	Review therapy*	5.6	2 - 10
Most common no. of sessions	Regular therapy	5.7	6 - 12
	Review therapy*	3.1	1 - 4

* Long term follow up

The number of therapists practicing within the NHS in Scotland is 793 (662.2 WTE)

The number of therapists currently working with transsexual people within the NHS in Scotland is 10 (at December 1997).

A second postal questionnaire requested information on new referrals (Jan - Dec 1997) and estimated number of sessions (1 hour) given per client.

The return rate was 90% with 20 new referrals over the last 12 months period.

Speech & Language Therapists Comments

- Therapists should have the opportunity to share knowledge of clinical practice, both within their own profession and at a multidisciplinary level e.g. Scottish National Study Day.
- Referrals should be concentrated in areas of highest prevalence to create a critical mass of patients and specialist therapists. However, accessibility to experienced therapists must be considered for regular voice therapy intervention.
- A UK wide survey to establish referral rates, therapist experience, clinical practice and outcome measures.

Family Planning Services

Family planning services were surveyed as they are known to treat gender dysphoric and transsexual patients in their sexual problems services.

19 questionnaires were received, giving a 100% response rate.

7 centres said they had no specific sexual problems service and 9 indicated that they had. 114 patients are being seen, the bulk of these being in Glasgow (74 patients) and Lothian (30 patients). The city of Edinburgh had until recently two centres (now one) with experience in this area and referrals would be routinely directed at them. 13 respondents replied that they thought there should be a Scottish Centre.

No Family Planning Service was available in Orkney apart from that provided by GPs. There have been occasional patients with gender identity problems and these have been managed on an ad hoc basis with referral to clinicians in Aberdeen.

Family Planning Comments

A range of useful comments were received from the Family Planning respondents:

- One replied that the treatment of gender identity disorders is too specialized for their sexual problems service and that it is better undertaken at centres where there is appropriate expertise and accumulated experience.
- One respondent has felt quite isolated treating these patients and would welcome a sharing of information (often very hard to come by) with other professionals working in the field. Another respondent also felt that general meetings and sharing information would be helpful to all involved in sexual counselling and particularly useful in the event of a patient presenting with condition.
- Services with sexual problems clinics and staff with psychodynamic training are well placed to see and assess gender dysphoric patients.
- The patients seem to like the open-access approach of a community service.

Transsexual Survey

This questionnaire was distributed in an opportunistic way and an ad hoc sample was used.

74 transsexual people returned the questionnaire - 60 male to female, 9 female to male, 2 unspecified, 2 don't know and 1 who said "a bit of everything".

Figure 12: Transsexuals' response by postcode area

Postcode Area	Number
G and PA	37
AB and IV	14
EH, PH and DD	12
Other	11

The age range for those who returned the questionnaire was between 19 and 78.

6 out of the 74 respondents had not attended any services for counselling or treatment.

When asked if they regularly attended a treatment centre, 47 (64%) said yes, 24 (32%) said no and 3 did not answer.

11 of the respondents had had surgery related to their transsexualism ranging from voice operation, mastectomy to full gender reassignment. Scottish hospitals mentioned were Canniesburn, Western General Edinburgh, St John's Hospital Livingston, Aberdeen (private) and Gartnavel Glasgow. Centres in England mentioned were London Bridge Hospital, Brighton, London and Haywards Heath.

Respondents were asked if they felt there could be any improvement in services for people with transsexualism. The overwhelming response showed lack of satisfaction with current service provision.

Figure 13: Could there be any improvement in services

Yes	61
No	7
Personally satisfied	2
Dont know	1
Did not respond	3

Views on a Scottish Centre for Gender Dysphoria

The majority of professionals working with transsexual people in Scotland felt there should be a Scottish Service.

Figure 14: Views by Specialty on whether there should be a Scottish Centre

	YES	NO	DON'T KNOW	NUMBER
Psychiatry	63%	20%	16%	366
GP	44%	36%	20%	784
Psychology	52%	21%	28%	160
Family Planning	74%	11%	15%	19
Public Health	42%	8%	50%	12

Many of the survey respondents made comments about whether or not there should be a Scottish centre for the treatment of gender dysphoria.

Psychologists comments

The majority of comments received from psychologists referred to issues of a Scottish Centre. In general, local services were seen as ideologically preferred but probably impractical given the numbers involved. Nine respondents suggested some form of resource centre providing information on treatment to local practitioners. Some psychologists shared other professionals' doubts that this group of clients justified any priority in spending.

GP comments on need for Scottish Centre

21 GPs considered it unlikely that numbers would justify a Scottish centre (at least in relation to surgery), of which seven considered that a centre should be provided if numbers proved higher than expected. One respondent thought that a first-line Scottish counselling service would be of value.

27 GPs expanded on their support for a Scottish centre. Most of the reasons for support were patient-centred: reducing isolation, reducing travel costs to London; and the current lack of treatment resources in Scotland was thought to increase patient stress. The centralisation of expertise was considered by seven GPs to be a prerequisite for effective approaches to treatment, and the potential value of a centre as an information source for doctors and of enlightenment for the public was noted by a further six. One respondent considered that a Scottish centre would be welcome, but should not be funded from NHS resources. Two GPs supported the idea of a Scottish centre, but thought that travel might still be problematic for some patients, while one thought that a centre in an "anonymous" setting (e.g. London) might be more advantageous.

Public Health comments on need for a Scottish Centre

Specific comments were:

- There are not enough numbers for a Scottish Centre
- There should be a Scottish Centre for psychiatric opinion, assessment and counselling. Surgery should only be included if there were enough numbers to maintain clinical expertise.
- Scottish Centre not necessary, provided expert centre available at UK level; more appropriate depending on numbers.
- Issue of a Scottish Centre is tenuous. Service rationalisation and priority for funding is varied.

- There is a lack of data concerning need.

Psychiatry comments on need for a Scottish Centre

Questions were raised regarding the priority for this service in relation to other demands made on NHS resources.

Of those psychiatrists who expressed a view that there ought to be a Scottish service, the view tended to be that it should be more of a network of interested professionals rather than a geographical centre.

Family Planning comments on need for a Scottish Centre

One commented that operative treatment should be carried out at a National Centre and that counselling should be closer to clients but undertaken by trained staff.

Another respondent agreed that there should be a Scottish Centre for surgery and related assessment but expressed concerns about funding such services in times of restricted budgets, particularly when much assisted reproduction is not NHS funded.

Discussion

The prevalence study undertaken by the SNAP Working Group demonstrated that the prevalence of patients undergoing hormonal or surgical treatment for gender dysphoria is similar to that reported elsewhere. Published prevalences are 4.72/100,000 in the Netherlands in 1996¹, 1.9 in England and Wales in 1974², 23.6 in Singapore in 1988³, 2.25 in Germany in 1996⁴ and 2.38 in Australia in 1996⁵. An approximate sex-ratio of 3:1 in favour of male-to-female transsexuals reported by these authors accords with our findings. About 99% of the Scottish population are registered with a general practice. Since UK general practitioners are responsible for almost all prescribing and for most referrals to secondary care, it is likely that the prevalence reported here reflects most of the patients who have presented with gender dysphoria to responding general practitioners. We used the total population over 15 years as the denominator for prevalence calculations, since other authors have reported that small numbers of under-15 patients are known to health services.

Over 40% of patients were not receiving hormonal treatment and had not had surgery: this may suggest that many gender-dysphoric patients may not be known to secondary care services. The finding that more than one third of cases of gender dysphoria had presented to general practices within the preceding 12 months is also worthy of note. Recall bias and re-registration of known gender dysphoric patients with new practices may explain part of the apparent phenomenon of increasing incidence. Nevertheless, the apparently increasingly frequent presentation of gender dysphoria may represent increasing social acceptance of the condition.

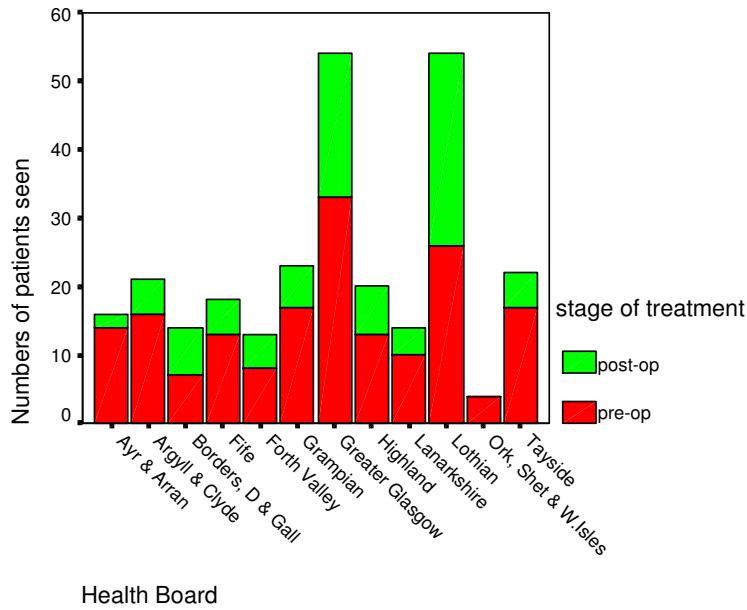
The majority of patients are being seen by general practitioners and psychiatrists as well as by the family planning and sexual health clinics. This dependence on primary care services differs from the generally accepted view that gender dysphoric treatment is being carried out mainly in hospital-based centres. Many professionals stated a lack of knowledge about the condition and the extent of service need. Both professionals and patients have highlighted the lack of integration of service provision and lack of knowledge of routes of referral for individuals with gender dysphoria. A move to consolidate and expand community-based care within a formally managed framework would address these concerns, by ensuring a streamlined, accessible and coordinated approach to gender dysphoria within Scotland.

References

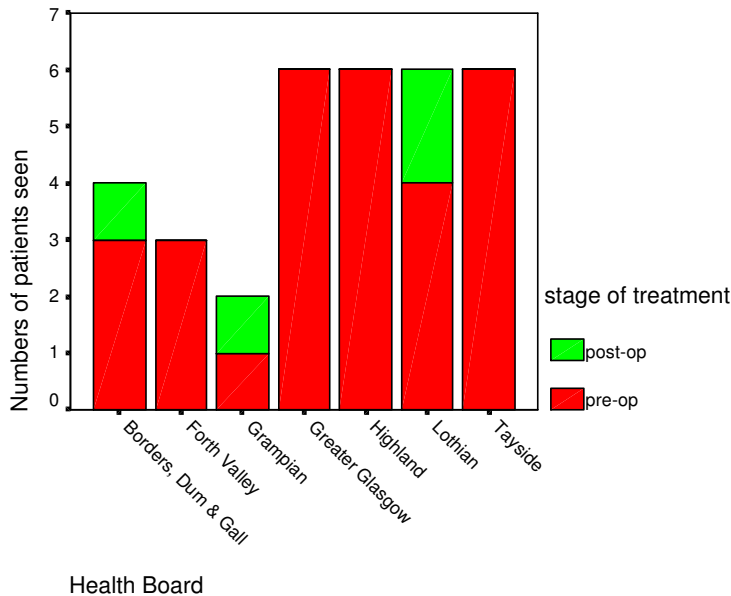
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BAR GRAPHS OF PATIENTS SEEN BY HEALTH BOARD AND SPECIALTY

Number of patients seen by GPs by Health Board

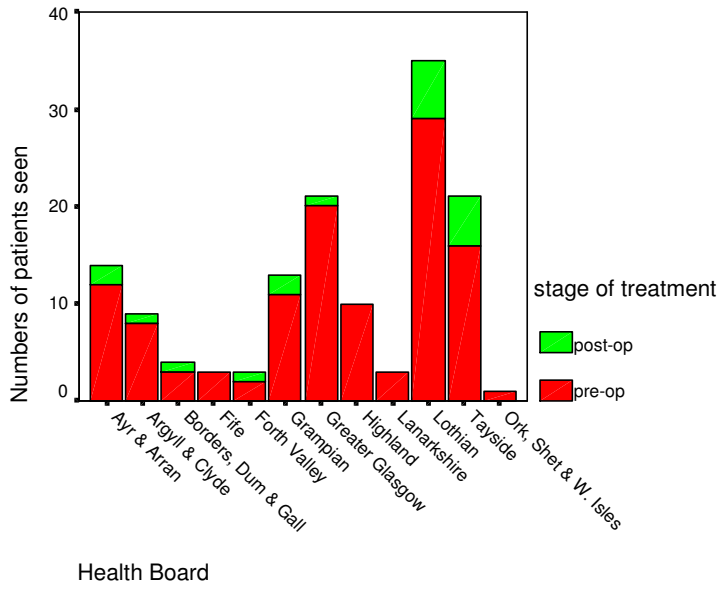


Number of patients seen by Psychologists by Health Board

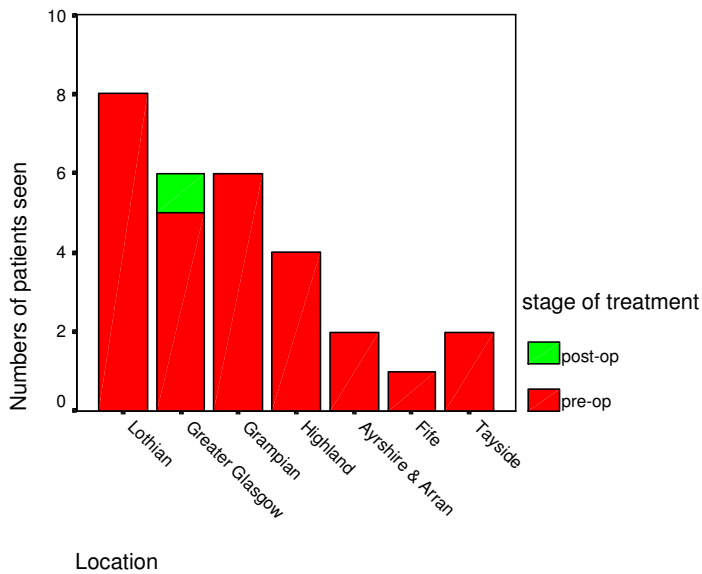


Psychologists in the following health boards saw no transsexual patients:
Argyll and Clyde, Ayr and Arran, Fife, Lanarkshire, Orkney, Shetland and Western Isles.

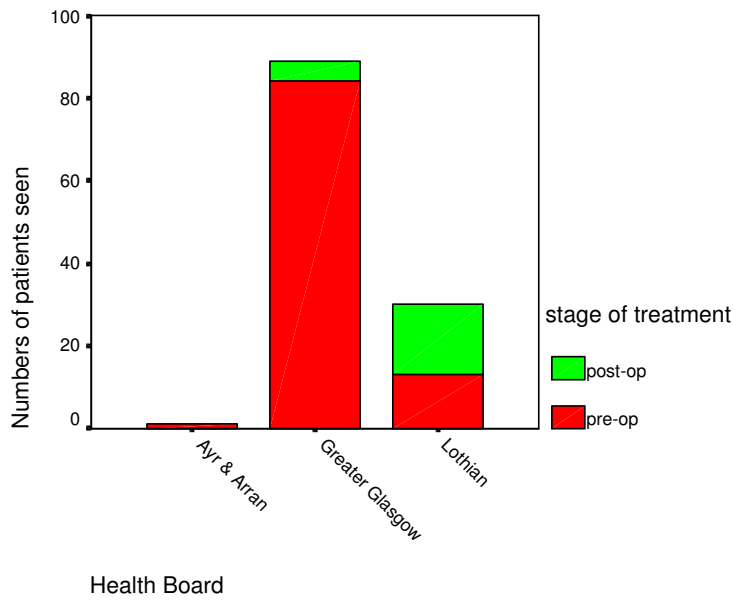
Number of patients seen by Psychiatrists by Health Board



Number of patients seen in Speech & Language Therapy Units by Health Board



Number of patients seen in Family Planning Services by Health Board



The only health boards where family planning services were dealing with transsexual patients were Ayrshire and Arran, Greater Glasgow and Lothian.

Numbers of gender patients seen by specialty in Scotland

