

**HARRY BENJAMIN INTERNATIONAL GENDER DYSPHORIA ASSOCIATION'S
THE STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS:¹**

Committee Members:

Stephen B. Levine MD (Chairperson), George Brown MD, Eli Coleman PhD., Peggy Cohen-Kettenis PhD, J. Joris Hage MD, Judy Van Maasdam MA, Maxine Petersen MA, Friedemann Pfafflin, MD, Leah C. Schaefer EDD.

Consultants: Dallas Denny MA, Domineco DiCeglie MD, Wolf Eicher MD, Jamison Green, Richard Green MD, Louis Gooren MD, Donald Laub MD, Anne Lawrence MD, Walter Meyer III MD, C. Christine Wheeler PhD

TABLE OF CONTENTS

PART ONE–Introductory Concepts	page 2-3
PART TWO–Brief Reference Guide to the Standards of Care	pages 3-10
PART THREE--The Full Text of the Standards of Care	pages 10-29
Epidemiological Considerations-----	pages 10
Diagnostic Nomenclatures-----	pages 10-14
The Mental Health Professional-----	pages 14-16
The Treatment of Children-----	page 16-17
The Treatment of Adolescents-----	pages 17-18
Psychotherapy with Adults-----	pages 18-21
The Real Life Experience-----	page 21-22
Requirements for Hormone Therapy for Adults-----	pages 22
Hormone Therapy for Adults-----	pages 23-26
Requirements for Genital Reconstructive and Breast Surgery-----	page 26-27
Surgery-----	pages 27-29

¹This is the fifth version of the Standards of Care since the original 1979 document. Previous revisions were accepted in 1980, 1981, and 1990.

PART ONE--INTRODUCTORY CONCEPTS

The Purpose of the Standards of Care. The major purpose of the Standards of Care (SOC) is to articulate this international organization's professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders. Professionals may use this document to understand the parameters within which they may offer assistance to those with these problems. Persons with gender identity disorders, their families, and social institutions may use the SOC as a means to understand the current thinking of professionals. All readers should be aware of the limitations of knowledge in this area and of the hope that some of the clinical uncertainties will be resolved in the future through scientific investigation.

The Overarching Treatment Goal. The general goal of the specific psychotherapeutic, endocrine, or surgical therapies for people with gender identity disorders is lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment.

The Standards of Care Are Clinical Guidelines. The SOC are intended to provide flexible directions for the treatment of gender identity disorders. When eligibility requirements are stated they are meant to be minimum requirements. Individual professionals and organized programs may raise them. Clinical departures from these guidelines may come about because of a patient's unique anatomic, social, or psychological situation, an experienced professional's evolving method of handling a common situation, or a research protocol. These departures should be recognized as such, explained to the patient, documented both for legal protection and so that the short and long term results can be retrieved to help the field to evolve.

The Clinical Threshold. A clinical threshold is passed when concerns, uncertainties, and questions about gender identity persist in development, become so intense as to seem to be the most important aspect of a person's life, or prevent the establishment of a relatively unconflicted gender identity. The person's struggles are then variously informally referred to as a gender identity problem, gender dysphoria, a gender problem, a gender concern, gender distress, or transsexualism. Such struggles are known to be manifested from the preschool years to old age and have many alternate forms. These forms come about by various degrees of personal dissatisfaction with sexual anatomy, gender demarcating body characteristics, gender roles, gender identity, and perceptions of others. When dissatisfied individuals meet specified criteria in one of two official nomenclatures--the International Classification of Diseases-10 (ICD-10) or the Diagnostic and Statistical Manual of Mental Disorders--Fourth Edition (DSM-IV)--they are formally designated as suffering from a gender identity disorder (GID). Some persons with GID exceed another threshold--they persistently possess a wish for surgical transformation of their bodies.

Two Primary Populations with GID Exist--Biological Males and Biological Females. The sex of a patient always is a significant factor in the management of GID. Clinicians need to separately consider the biological, social, psychological, and economic dilemmas of each sex. For example, when first requesting professional assistance, the typical biological female seems to be further along in consolidating a male gender identity than does the typical biological male in his quest for a comfortable female gender identity. This often enables the sequences of therapy to proceed more rapidly for male-identified persons. All patients, however, must follow the SOC.

PART TWO

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

- 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.

PART THREE

THE FULL TEXT OF THE STANDARDS OF CARE

Introduction. This section provides an in depth understanding of the Standards of Care. It supplies comprehensive information about the matters either not contained in The Brief Reference Guide or listed there only in an abbreviated fashion. This explication of the SOC is intended for all readers--professionals, patients, family members, and institutional personnel who have to make decisions about those with gender identity disorders.

I. EPIDEMIOLOGICAL CONSIDERATIONS

Prevalence. When the gender identity disorders first came to professional attention, clinical perspectives were largely focused on how to identify candidates for sex reassignment surgery. As the field matured, professionals recognized that some persons with bona fide gender identity disorders neither desired nor were candidates for sex reassignment surgery. The earliest estimates

of prevalence for adults were stated as 1 in 37,000 males and 1 in 107,000 females. The most recent information of the transsexual end of the gender identity disorder spectrum from Holland is 1 in 11,900 males and 1 in 30,400 females. Four observations, not yet firmly supported by systematic study, increase the likelihood of a higher prevalence: 1) unrecognized gender problems are occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, other sexual disorders and intersexed conditions; 2) some nonpatient male transvestites, female impersonators, and male and female homosexuals may have a form of gender identity disorder; 3) the intensity of some persons' gender identity disorders fluctuates below and above a clinical threshold; 4) gender variant behavior among female-bodied individuals tends to be relatively invisible to the culture, particularly to mental health professionals and scientists.

Natural History of Gender Identity Disorders. In the past, so much attention had been paid to the therapeutic sequence of cross-gender living, administration of cross-sex hormones, and genital (and other) surgeries that some made the erroneous assumption that a diagnosis of GID inevitably should lead to this sequence. A diagnosis of GID actually only creates a serious consideration of an array of complex options, only one of which is medical support for this triadic therapeutic sequence. Ideally, prospective data about the natural history of gender identity struggles would inform all treatment decisions. These are lacking except for the demonstration that most boys with gender identity disorder outgrow their wish to become a girl without therapy. Five less firmly scientifically established factors prevent clinicians from prescribing the triadic therapeutic sequence based on diagnosis alone: 1) some carefully diagnosed persons spontaneously change their aspirations; 2) others make more comfortable accommodations to their gender identities without medical interventions; 3) others give up their wish to follow the triadic sequence during psychotherapy; 4) some gender identity clinics have an unexplained high drop out rate; and 5) the percentage of persons who are not benefited from the triadic sequence varies significantly from study to study.

Cultural Differences in Gender Identity Disorders Throughout the World. Even if epidemiologic studies established that a similar base rate of gender identity disorders existed all over the world, it is likely that cultural differences from one country to another would alter the behavioral expressions of the disorder. Moreover, access to treatment, cost of treatment, the therapies offered and the social attitudes towards the afflicted and the professionals who deliver care differ broadly from place to place. While in most countries, crossing gender boundaries more reliably generates moral outrage rather than compassion, there are striking examples in certain cultures how the cross-gendered behaviors of spiritual leaders are not stigmatized.

II. DIAGNOSTIC NOMENCLATURES

The Five Elements of Clinical Work. Professional involvement with patients with gender identity disorders involves any of the following: diagnostic assessment, psychotherapy, real life experience, hormonal therapy, and surgical therapy. This section provides a background on the first stage--diagnostic assessment.

The Development of a Nomenclature. The term 'transsexual' emerged into professional and public usage in the 1950s as a means of designating a person who aspired to or actually lived in the anatomically contrary gender role, whether or not hormones had been administered or surgery had been performed. During the 1960s and 1970s, clinicians used the term “true transsexual.” The true transsexual was thought to be a person with a characteristic path of atypical gender identity development that predicted an improved life from a treatment sequence that culminated in genital surgery. They were thought to have: 1) cross-gender identifications that were consistently expressed behaviorally in childhood, adolescence, and adulthood; 2) minimal or no sexual arousal to cross-dressing; and no heterosexual interest (relative to their anatomic sex). True transsexuals could be of either sex. “True transsexual” males were distinguished from males who arrived at the desire to change their gender via a reasonably masculine behavioral developmental pathway. Belief in the true transsexual concept for males dissipated when it was realized that: 1) such patients were rarely encountered; 2) those who requested genital reconstructive surgery more commonly had adolescent histories of fetishistic cross-dressing or autogynephilic fantasies without cross-dressing; 3) some of the original true transsexuals had falsified their histories to make their stories match the earliest theories about the disorder. The concept of “true transsexual” females never created diagnostic uncertainties, largely because patient histories were relatively consistent and gender variant behaviors, such as, female cross-dressing, remained unseen by clinicians. The term ‘gender dysphoria syndrome’ was then adopted to designate the presence of a gender problem in either sex until psychiatry developed an official nomenclature.

The diagnosis of Transsexualism was introduced in the DSM-III in 1980 for gender dysphoric individuals who demonstrated at least two years of continuous interest in removing their sexual anatomy and transforming their bodies and social roles. Others with gender dysphoria could be either diagnosed as Gender Identity Disorder of Adolescence or Adulthood Nontranssexual Type or Gender Identity Disorder Not Otherwise Specified (GIDNOS). These diagnostic terms were ignored by the media who used the term transsexual for any person who wanted to change or had changed sex.

THE DSM-IV. In 1994, the DSM-IV committee replaced the diagnosis of Transsexualism with Gender Identity Disorder. Depending on their age, those with a strong and persistent cross-gender identification and a persistent discomfort with his or her sex or a sense of inappropriateness in the gender role of that sex were to be diagnosed as Gender Identity Disorder of Childhood (302.6), Adolescence, or Adulthood (302.85). For persons who did not meet the criteria, Gender Identity Disorder Not Otherwise Specified (GIDNOS)(302.6) was to be used. This category included a variety of individuals--those who desire only castration or penectomy without a concomitant desire to develop breasts; those with a congenital intersex condition; those with transient stress-related cross-dressing; those with considerable ambivalence about giving up their gender roles. Patients with GID and GIDNOS were to be subclassified according to the sex of attraction: attracted to males; attracted to females; attracted to both; attracted to neither. This subclassification on the basis of orientation was intended to assist in determining over time whether individuals of one orientation or another fared better in particular approaches; it was **not**

intended to guide treatment decisions.

Between the publication of DSM-III and DSM-IV, the term "transgendered" began to be used in various ways. Some employ it to refer to those with unusual gender identities in a value free manner that is, without a connotation of psychopathology. Some professionals informally use the term to refer to any person with any type of gender problem. Transgendered is not a diagnosis, but professionals find it easier to informally use than GIDNOS, which is.

ICD-10. The ICD-10 now provides five diagnoses for the gender identity disorders (F64):

Transsexualism (F64.0) has three criteria:

1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment
2. The transsexual identity has been present persistently for at least two years
3. The disorder is not a symptom of another mental disorder or a chromosomal abnormality

Dual-role Transvestism (F64.1) has three criteria:

1. The individual wears clothes of the opposite sex in order to experience temporary membership in the opposite sex
2. There is no sexual motivation for the cross-dressing
3. The individual has no desire for a permanent change to the opposite sex

Gender Identity Disorder of Childhood (64.2) has separate criteria for girls and for boys. For girls:

1. The individual shows persistent and intense distress about being a girl, and has a stated desire to be a boy (not merely a desire for any perceived cultural advantages to being a boy) or insists that she is a boy.
2. Either of the following must be present:
 - a. persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing
 - b. persistent repudiation of female anatomical structures, as evidenced by at least one of the following:
 - (1. an assertion that she has, or will grow, a penis
 - (2. rejection of urination in a sitting position
 - (3. assertion that she does not want to grow breasts or menstruate
3. The girl has not yet reached puberty
4. The disorder must have been present for at least 6 months

For boys:

1. The individual shows persistent and intense distress about being a boy, and has a desire to be a girl, or, more rarely, insists that he is a girl
2. Either of the following must be present:
 - a. preoccupation with stereotypic female activities, as shown by a preference for either cross-dressing or simulating female attire, or by an intense desire to participate in the games and pastimes of girls and rejection of stereotypical male

toys, games, and activities

b. persistent repudiation of male anatomical structures, as evidenced by at least one of the following repeated assertions:

(1. that he will grow up to become a woman (not merely in the role)

(2. that his penis or testes are disgusting or will disappear

(3. that it would be better not to have a penis or testes

3. The boy has not yet reached puberty

4. The disorder must have been present for at least 6 months

Other Gender Identity Disorders (F64.8) has no specific criteria

Gender Identity Disorder, Unspecified has no specific criteria.

Either of the previous two diagnoses could be used for those with an intersexed condition.

The purpose of the DSM-IV and ICD-10 is to organize and guide treatment and research. These nomenclatures were created at different times and driven by different professional groups through a consensus process. There is an expectation that the differences between the systems will be eliminated by the year 2000. At this point, the specific diagnoses are based to a larger extent on clinical reasoning than on scientific investigation. It has not been sufficiently studied, for instance, whether sexual attraction patterns predict whether or not a patient will be a mentally healthier person in five years with or without the triadic sequence.

The Gender Identity Disorders are Mental Disorders. To qualify as a mental disorder, any behavioral pattern must result in a significant adaptive disadvantage to the person and cause personal mental suffering. The DSM-IV and ICD-10 have defined hundreds of mental illnesses which vary in onset, duration, pathogenesis, functional disability, and treatability. The designation of Gender Identity Disorders as mental disorders is not a license for stigmatization or for the deprivation of gender patients' civil rights. The use of a formal diagnosis is an important step in offering relief, providing health insurance coverage, and generating research to provide more effective future treatments.

III. THE MENTAL HEALTH PROFESSIONAL

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

1. to accurately diagnose the individual's gender disorder;
2. to accurately diagnose any co-morbid psychiatric conditions and see to their appropriate treatment;
3. to counsel the individual about the range of treatment options and their implications;
4. to engage in psychotherapy
5. to ascertain eligibility and readiness for hormone and surgical therapy;
6. to make formal recommendations to medical and surgical colleagues;
7. to document their patient's relevant history in a letter of recommendation;

8. to be a colleague on a team of professionals with interest in the gender identity disorders;
9. to educate family members, employers, and institutions about gender identity disorders;
10. to be available for follow-up of previously seen gender patients.

The Training of Mental Health Professionals.

The Adult-Specialist. The education of the mental health professional who specializes in adult gender identity disorders rests upon basic general clinical competence in diagnosis and treatment of mental or emotional disorders. The basic clinical training may occur within any formally credentialing discipline--for example, psychology, psychiatry, social work, counseling, or nursing. The following are the recommended minimal credentials for special competence with the gender identity disorders:

1. A master's degree or its equivalent in a clinical behavioral science field. This or a more advanced degree should be granted by an institution accredited by a recognized national or regional accrediting board. The mental health professional should have written credentials from a proper training facility and a licensing board.
2. Specialized training and competence in the assessment of the DSM-IV/ICD-10 Sexual Disorders (not simply gender identity disorders).
3. Documented supervised training and competence in psychotherapy.
4. Continuing education in the treatment of gender identity disorders which may include attendance at professional meetings, workshops, or seminars or participating in research related to gender identity issues.

The Child-Specialist. The professional who evaluates and offers therapy for a child or early adolescent with GID should have been trained in childhood and adolescent developmental psychopathology. The professional should be competent in diagnosing and treating the ordinary problems of children and adolescents.

The Differences between Eligibility and Readiness. The SOC provides eligibility requirements for hormones and surgery. Without first meeting eligibility requirements, the patient and the therapist should not request hormones or surgery. An example of an eligibility requirement is: a person must live full time in the preferred gender for twelve months prior to genital reconstructive surgery. To meet this criterion, the professional needs to document that the real life experience has occurred for this duration. Meeting readiness criteria--further consolidation of the evolving gender identity or improving mental health in the new or confirmed gender role--is more complicated because it rests upon the clinician's judgment. The clinician might think that the person is not yet ready because his behavior frequently contradicts his stated needs and goals.

The Mental Health Professional's Relationship to the Endocrinologist and Surgeon. Mental health professionals who recommend hormonal and surgical therapy share the legal and ethical responsibility for that decision with the physician who undertakes the treatment. Hormonal treatment can often alleviate anxiety and depression in people without the use of additional psychotropic medications. Some individuals, however, need psychotropic medication prior to, or concurrent with, taking hormones or having surgery. The mental health professional is expected to make these decisions and see to it that the appropriate psychotropic medications are offered to

the patient. The presence of psychiatric co-morbidities does not necessarily preclude hormonal or surgical treatment, but some diagnoses pose difficult treatment dilemmas and may delay or preclude the use of either treatment.

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

1. The patient's general identifying characteristics
2. The initial and evolving gender, sexual, and other psychiatric diagnoses
3. The duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent
4. The eligibility criteria that have been met and the MHP's rationale for hormones or surgery
5. The patient's ability to follow the Standards of Care to date and the likelihood of future compliance
6. Whether the author of the report is part of a gender team or is working without benefit of an organized team approach
7. That the sender welcomes a phone call to verify the fact that the mental health professional actually wrote the letter as described in this document.

The organization and completeness of these letters provide the hormone-prescribing physician and the surgeon an important degree of assurance that mental health professional is knowledgeable about gender issues and is competent in conducting the roles of the mental health professional.

One Letter is Required for Instituting Hormone Therapy. One letter from a mental health professional, including the above seven points, written to the medical professional who will be responsible for the patient's endocrine treatments is sufficient.

Two-Letters are Generally Required for Surgery. It is ideal if mental health professionals conduct their tasks and periodically report on these processes to a team of other mental health professionals and nonpsychiatric physicians. Letters of recommendation to physicians or surgeons written after discussion with a gender team then reflect the influence of the entire team. One letter to the physician performing surgery will generally suffice as long as it is signed by two mental health professionals.

More commonly, however, letters of recommendation are from mental health professionals who work alone without colleagues experienced with gender identity disorders. Because professionals working independently may not have the benefit of ongoing professional consultation on gender cases, two letters of recommendation are required prior to initiating hormonal therapy or surgery. 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 with doctoral degrees who can be expected to adequately evaluate co-morbid psychiatric conditions. 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 topics. At least one of the letters should be an extensive report. The second letter writer, having read the first letter, may choose to offer a briefer summary and an agreement with the

recommendation.

IV. TREATMENT OF CHILDREN

The initial task of the child-specialist mental health professional is to provide careful diagnostic assessments of gender-disturbed children. This means that the individual 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. Since many gender-disturbed children do not meet formal criteria for GID of Childhood and many that do will not continue to do so later in childhood, hormonal and surgical therapies should never be undertaken with this age group. Treatment for these children, however, should be offered based on the clinician's assessment. Over time, this may involve family therapy, marital therapy, parent guidance, individual therapy of the child, or various combinations. Treatment should be extended to all forms of psychopathology, not simply the gender disturbance. Effort should be made, even with mild forms of gender identity struggles, to follow the family. This allows the child and the family to benefit from continuing services as the gender identity problem evolves and allows the clinician to rethink the validity of the initial assessment.

V. TREATMENT OF ADOLESCENTS

Adolescents should be dealt with conservatively because gender identity development can rapidly and unexpectedly evolve. They 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. Because an adolescent shift toward gender conformity can occur primarily to please the family, it may not persist or reflect a permanent change in gender identity. Clinical follow-up is encouraged.

Adolescents may be eligible for beginning triadic therapy as early as age 18, preferably with parental consent. 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. In many European countries 16 to 18 year-olds are legal adults for medical decision-making, and do not require parental consent.

The age at which adolescents who consistently maintain an unwavering desire to live permanently in the opposite gender role should be permitted to begin the real life experience or hormonal therapy is 18 years.

Hormonal Therapy for Adolescents. Hormonal treatment should be conducted in two phases only after puberty is well established. In the initial phase biological males should be provided an antiandrogen (which neutralize testosterone effects only) or an LHRH agonist (which stops the production of testosterone only), and biological females should be administered sufficient androgens, progestins, or LHRH agonists (which stops the production of estradiol, estrone, and progesterone) to stop menstruation. After these changes have occurred and the adolescent's mental health remains stable, biologic males may be given estrogenic agents and biologic females may be given higher masculinizing doses of androgens. Medications used in the second

phase, estrogenic agents for biologic males and high dose androgens for biologic females, produce irreversible changes.

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. These 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. Two goals justify this intervention: a) to gain time to further explore the gender and other developmental issues in psychotherapy; b) make passing easier if the adolescent continues to pursue gender change. In order to provide puberty delaying hormones to a person less than age 18, the following criteria must be met:

- (1) throughout childhood they have demonstrated an intense pattern of cross-gender identity and aversion to expected gender role behaviors;
- (2) gender discomfort has significantly increased with the onset of puberty;
- (3) their social, intellectual, psychological, and interpersonal development are limited as a consequence of their GID;
- (4) serious psychopathology, except as a consequence of the GID, is absent;
- (5) the family consents and participates in the triadic therapy.

Prior to Age 16. Second phase hormones those which induce opposite sex body should not be given prior to age 16 years.

Mental Health Professional Involvement is an Eligibility Requirement for Triadic Therapy During Adolescence. 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. 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. While the number of sessions during these six and eighteen month periods rests upon the clinician's judgment, the intent is that hormones and surgery be thoughtfully and recurrently considered over time.

School-aged persons 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. 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.

VI. PSYCHOTHERAPY WITH ADULTS

A Basic Observation. Many adults with gender identity disorder find comfortable, effective ways of identifying themselves that do not involve all the components of the triadic treatment

sequence. While some individuals manage to do this on their own, psychotherapy can be very helpful in bringing about the discovery and maturational processes that enable self-comfort.

Psychotherapy is Not an Absolute Requirement for Triadic Therapy. Every adult gender patient does not require psychotherapy in order to precede with the real life experience, hormones, or surgery. Individual programs vary to the extent that they perceive the need for psychotherapy. 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. The SOC committee is wary of insistence on some minimum number of psychotherapy sessions prior to the real life experience, hormones, or surgery for three reasons: 1.) patients differ widely in their abilities to attain similar goals in a specified time; 2.) minimum number of sessions tend to be construed as a hurdle which tends to be devoid of the genuine opportunity for personal growth; 3.) the committee would like to encourage the use of the mental health professional as an important support to the patient throughout all phases of gender transition. Individual programs may set eligibility criteria to some minimum number of sessions or months of psychotherapy.

The mental health professional who conducts the initial evaluation need not be the psychotherapist. 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 proceed with the next phase of rehabilitation.

Goals of Psychotherapy. Psychotherapy often provides education about a range of options not previously seriously considered by the patient. It emphasizes the need to set realistic life goals for work and relationships. And it seeks to define and alleviate the patient's conflicts that may have undermined a stable lifestyle.

The Therapeutic Relationship. The establishment of a reliable trusting relationship with the patient is the first step toward successful work as a mental health professional. This is usually accomplished by competent nonjudgmental exploration of the gender issue with the patient during the initial diagnostic evaluation. Other issues may be better dealt with later, after the person feels that the clinician is interested in and understands the gender problem. Ideally, the clinician's work is with the whole of the person's complexity, not merely a narrow definition of gender. The goal of therapy, to help the person to live more comfortably with in a gender role and body, also means to deal effectively with nongender issues. The clinician often attempts to facilitate the capacity to work and to establish or maintain supportive relationships. The clinician understands a broader definition of gender--an aspect of identity that is inextricably related to all aspects of living. Even when these initial goals are attained, mental health professionals should discuss the likelihood that no educational, psychotherapeutic, medical, or surgical therapy can permanently eradicate all vestiges of the person's original sex assignment.

Processes of Psychotherapy. Psychotherapy is a series of highly refined interactive communications between a person who is knowledgeable about how people emotionally suffer and how this may be alleviated and one who is experiencing gender distress. The psychotherapy

sessions initiate a developmental process. They enable the person's: history to be appreciated, current dilemmas to be understood, and unrealistic ideas and maladaptive behaviors to be identified. Psychotherapy is not a specific technology, informed by a specific ideology, delivered to the patient to cure the gender identity disorder. Its usual goal is a long-term stable life style with realistic chances for success in relationships, education, work, and gender identity and role. Gender distress often intensifies relationship, work, and educational dilemmas. Typically, psychotherapy consists regularly held 50-minute sessions.

The therapist should make clear that it is the patient's right to choose among many options. The patient can experiment over time with alternative approaches. Since most patients have tried unsuccessfully to suppress their cross-gender aspirations prior to seeing the psychotherapist, this recommendation is not realistic.

Ideally, psychotherapy is a collaborative effort. The therapist must be certain that the patient understands the concepts of eligibility and readiness because they must cooperate in defining the patient's problems and in assessing progress in dealing with them. Collaboration prevents stalemates between a therapist who seems needlessly withholding of a recommendation and a patient who seems too profoundly distrusting to freely share thoughts, feelings, events, and relationship.

Benefit from psychotherapy may be attained at every stage of gender evolution. This includes the post-surgical period when the anatomic obstacles to gender comfort have been removed and the person continues to feel a lack of genuine comfort and skill in living in the new gender role.

Options for Gender Adaptation. The activities and processes that are listed below have, in various combinations, helped people to find more personal ease. These adaptations may evolve spontaneously and during psychotherapy. Finding a new adequate gender adaptation does not mean that the person may not in the future elect to pursue the real life experience, hormones, and genital reconstruction. These activities and processes are focused on matters other than real life experience, hormones, and surgery.

Activities-

Biological Males

1. cross-dressing: unobtrusively with undergarments; unisexually; or in a feminine fashion
2. changing the body through: hair removal through electrolysis or body waxing; minor plastic cosmetic surgical procedures
3. increasing grooming, wardrobe, and vocal expression skills

Biological Females

1. cross-dressing: unobtrusively with undergarments, unisexually, or in a masculine fashion
2. changing the body through breast binding, weight lifting, applying theatrical facial hair
3. padding underpants or wearing a penile prosthesis

Both genders

1. learning about transgender phenomena from: support groups and gender networks; communication with peers via the Internet; studying these Standards of Care; relevant lay and professional literatures about legal rights pertaining to work,

- relationships, and public cross-dressing
- 2. involvement in recreational activities of the desired gender
- 3. episodic cross-gender living

Processes

1. acceptance of personal homosexual or bisexual fantasies and behaviors (orientation) as distinct from gender role aspirations
2. acceptance of the need to maintain a job, provide for the emotional needs of children, honor a spousal commitment, or not to distress a family member as currently having a higher priority than the personal wish for constant cross-gender expression
3. integration of male and female gender awareness into daily living
4. identification of the triggers for increased cross-gender yearnings and effectively attend to them; for instance, develop better self-protective, self-assertive, and vocational skills to advance at work and resolve interpersonal struggles to strengthen key relationships
5. seeking spiritual comfort

VII. THE REAL-LIFE EXPERIENCE

The act of fully adopting a new or evolving gender role for the events and processes of everyday life is known as the real-life experience. The real-life experience is essential to the transition process to the gender role that confirms with personal gender identity. 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 the familial, vocational, interpersonal, educational, economic, and legal consequences are likely to be. Professionals have a responsibility to discuss these predictable consequences. These represent external reality issues that must be confronted for success in the new gender role. This may be quite different from the personal happiness in the new gender role that was imagined prior to the real life experience.

Parameters of the Real Life Experience. 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.

Real-Life Experience versus Real Life Test. Although professionals may recommend living in the desired gender as a step toward surgical assistance, the decision as to when and how to begin the real-life experience remains the person's responsibility. Some begin the

real-life experience and decide that this often imagined life direction is not in their best interest. Professionals sometimes construe the real-life experience as the real life *test* of the ultimate diagnosis. If patients prospered in the aspired-to gender, they were confirmed as "transsexual," if they decided against continuing, they "must not have been." This reasoning is a confusion of the forces that enable successful adaptation with the presence of a gender identity disorder. The real-life experience tests the person's resolve, capacity to function in the aspired to gender, and the alignment of social, economic, and psychological supports. It assists both the patient and the mental health professional in their judgments how to proceed. Diagnosis, although always open for reconsideration, precedes a recommendation for patients to embark on the real life experience. When the patient is successful in the real life experience, both the MHP and the patient gain confidence in the original decision to embark on the path to the irreversible further steps.

Beard Removal for the Male to Female Patient. Beard density is a genetically determined secondary sex characteristic whose growth is not significantly slowed by cross-sex hormone administration. Facial hair removal via electrolysis is a generally safe, time-consuming process that often facilitates the real life experience for biologic males. Side effects are often discomfort during and immediately after the procedure, and, less frequently, hypo-or hyper pigmentation, scarring, and folliculitis. Formal medical approval for hair removal is not necessary; electrolysis may be begun whenever the patient deems it prudent. It is usually recommended prior to commencing the real life experience because the beard must be grown out to visible lengths so that it can be most easily removed. Many patients will require two years of regular treatments to effectively eradicate their facial hair. Hair removal by laser is a new alternative approach, but experience with it is limited.

VIII. REQUIREMENTS FOR HORMONE THERAPY FOR ADULTS

Eligibility Criteria The administration of hormones is not to be lightly undertaken because of their medical and social dangers. Three 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 a person be provided hormones who has neither fulfilled criteria #3 or #4.

Readiness Criteria. Three 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 (this implies an absence of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance);
3. hormones are likely to be taken in a responsible manner.

Can Hormones Be Given For Those Who Do Not Initially Want Surgery or a Real Life Experience? Yes, but after diagnosis and psychotherapy with a qualified mental health professional following minimal standards listed above. These cases often are deeply controversial and require particular caution.

IX. HORMONE THERAPY FOR ADULTS

Reasons for Hormone Therapy. Cross-sex hormonal treatments play an important role in the anatomical and psychological gender transition process for properly selected adults with gender identity disorders. These hormones are medically necessary for rehabilitation in the new gender. They improve the quality of life and limit psychiatric co-morbidity which often accompanies lack of treatment. When physicians administer androgens to biologic females and estrogens, progesterone, and/or testosterone-blocking agents to biologic males, patients feel and appear more like members of their aspired-to sex.

The Desired Effects of Hormones. Biologic males treated with cross-sex hormones can realistically expect treatment to result in: breast growth, some redistribution of body fat to approximate a female body habitus, decreased upper body strength, softening of skin, decrease in body hair, slowing or stopping the loss of scalp hair, decreased fertility and testicular size, and less frequent, less firm erections. Most of these changes are reversible, although breast enlargement will not completely reverse after discontinuation of treatment.

Biologic females treated with cross-sex hormones can expect: a permanent deepening of the voice, permanent clitoral enlargement, mild breast atrophy, increased upper body strength, weight gain, facial and body hair growth, male-pattern baldness, increased social and sexual interest and arousability, and decreased hip fat.

The degree of desired effects actually attained varies from patient to patient. The maximum physical effects of hormones may not be evident until two years of continuous treatment. Heredity limits the tissue response to hormones and cannot be overcome by increasing dosage.

Medical Side Effects. Side effects in biologic males treated with estrogens may include increased propensity to blood clotting (venous thrombosis with a risk of fatal pulmonary embolism), development of benign pituitary prolactinomas, infertility, weight gain, emotional lability and liver disease. Side effects in biologic females treated with testosterone may include infertility, acne, emotional lability (including the potential for major depression), increases in sexual desire, shift of lipid profiles to male patterns which increase the risk of cardiovascular disease, and the potential to develop benign and malignant liver tumors and hepatic dysfunction. Patients with medical problems or otherwise at risk for cardiovascular disease may be more likely to experience serious or fatal consequences of cross-sex hormonal treatments. For

example, cigarette smoking, obesity, advanced age, heart disease, hypertension, clotting abnormalities, malignancy, and some endocrine abnormalities are relative contraindications for the use of hormonal treatment. Therefore, some patients may not be able to tolerate cross-sex hormones. However, risk-benefit ratios should be considered collaboratively between the patient and prescribing physician.

Social Side Effects. There are often important social effects from taking hormones which the patient must consider. These include relationship changes with family members, friends, and employers. Hormone use may be an important factor in job discrimination, loss of employment, divorce and marriage decisions, and the restriction or loss of visitation rights for children. The social effects of hormones, however, can be positive as well.

The Prescribing Physician's Responsibilities. Hormones are to be prescribed by a physician. Hormones are not to be administered simply because patients demand them. Adequate psychological and medical assessment are required before and during treatment. Patients who do not understand the eligibility and readiness requirements and who are unaware of the SOC should be informed of them. This may be a good indication for a referral to a mental health professional experienced with gender identity disorders.

The physician providing hormonal treatment and medical monitoring need not be a specialist in endocrinology, but should become well-versed in the relevant medical and psychological aspects of treating persons with gender identity disorders.

After a thorough medical history, physical examination, and laboratory examination, the physician should again review the likely effects and side effects of this treatment, including the potential for serious, life-threatening consequences. The patient must have the cognitive capacity to appreciate the risks and benefits of treatment, have his/her questions answered, and agree to medical monitoring of treatment. The medical record must contain a written informed consent document reflecting a discussion of the risks and benefits of hormone therapy.

Physicians have a wide latitude in what hormone preparations they may prescribe and what routes of administration they may select for individual patients. As therapeutic options rapidly evolve, it is the responsibility of the prescribing physician to make these decisions. Viable options include oral, injectable, and transdermal delivery systems. Topically applied hormonal creams have not been shown to produce adequate cross-sex effects. The use of transdermal estrogen patches should be considered for males over 40 years of age or those with clotting abnormalities or a history of venous thrombosis.

In the absence of any other medical, surgical, or psychiatric conditions, basic medical monitoring should include: serial physical examinations relevant to treatment effects and side effects, vital sign measurements before and during treatment, weight measurements, and laboratory assessment. For those receiving estrogens, the minimum laboratory assessment should consist of a pretreatment free testosterone level, fasting glucose, liver function tests, and complete blood count with reassessment at 6 and 12 months and annually thereafter. A pretreatment prolactin level should be obtained and repeated at 1, 2, and 3 years. If hyperprolactemia does not occur during this time, no further measurements are necessary.

For those receiving androgens, the minimum laboratory assessment should consist of

pretreatment liver function tests and complete blood count with reassessment at 6 months, 12 months, and yearly thereafter. Yearly palpation of the liver should be considered. Patients should be screened for glucose intolerance and gall bladder disease.

Biological males undergoing estrogen treatment should be monitored for breast cancer and encourage in engage in routine self-examination. As they age, they should be monitored for prostatic cancer. Females who have undergone mastectomies who have a family history of breast cancer should be monitored for the disease. Gender patients, whether on hormones or not, should be screened for pelvic malignancies as are other persons.

Physicians should provide their patients with a brief written statement indicating that this person is under medical supervision which includes cross-sex hormone therapy. During the early phases of hormone treatment, the patient should be encouraged to carry this statement at all times to help prevent difficulties with the police.

Reductions in Hormone Doses After Gonadectomy. Estrogen doses in post-orchietomy patients can often be reduced by 1/3 to 1/2 and still maintain feminization. Reductions in testosterone doses post-oophorectomy should be considered, taking into account the risks of osteoporosis. Lifelong maintenance treatment is usually required in both sexes.

The Misuse of Hormones. Some individuals obtain hormones from nonmedical sources, such as friends, family members, and pharmacies in other countries. These treatments are often excessive in dose, produce more side effects, are medically unmonitored, and expose the person to greater medical risk. Persons taking medically monitored hormones have been known to take additional doses of illicitly obtained hormones without their physician's knowledge. Mental health professionals and prescribing physicians should inquire whether their patients have increased their doses and make a reasonable effort to enhance compliance in order to limit medical and psychiatric morbidity from treatment. It is ethical for physicians to discontinue taking medical and legal responsibility for patients who place themselves at higher risk by noncompliance with the prescribed hormonal regimen. Patient pressure is not a sufficient reason to deliver substandard medical care.

Other Potential Benefits of Hormones. Hormonal treatment, when medically tolerated, should precede any genital surgical interventions. Satisfaction with the hormone's effects consolidates the person's identity as a member of the aspired-to gender and further adds to the conviction to proceed. Dissatisfaction with hormonal effects may signal ambivalence about proceeding to surgical interventions. Hormones alone often generate adequate breast development, precluding the need for augmentation mammoplasty. Some patients who receive hormonal treatment will not desire surgical interventions.

The Use of Antiandrogens and Sequential Therapy. Antiandrogens can be used as adjunctive treatments in biologic males receiving estrogens, even though they are not always necessary to achieve feminization. In some patients, antiandrogens may offer assistance by more profoundly suppressing the production of testosterone and enabling a lower dose of estrogen to be used when adverse estrogen side effects are anticipated.

Feminization does not require sequential therapy. Attempts to mimic the menstrual cycle by prescribing interrupted estrogen therapy or substituting progesterone for estrogen during part of the month are not necessary to achieve feminization.

Informed Consent. Hormonal treatments should be provided only to those who are legally able to provide informed consent. This includes persons who have been declared by a court to be emancipated minors and incarcerated persons who are considered competent to participate in their medical decisions. For adolescents, informed consent needs to include the minor patient's assent and the written informed consent of a parent or legal guardian. Informed consent implies that the patient understands that hormone administration limits fertility and the removal of sexual organs prevents the capacity to reproduce.

Hormonal Treatment of Prisoners. Patients who are receiving hormonal treatments as part of a medically monitored program of gender transition should continue to receive such treatment while incarcerated to prevent emotional lability, reversibility of physical effects, and the sense of desperation that may include depression and suicidality.

X. REQUIREMENTS FOR GENITAL RECONSTRUCTIVE AND BREAST SURGERY

Eligibility Criteria. These minimum eligibility criteria for various surgeries equally apply to biological males seeking genital reconstruction and biological females seeking mastectomy and phalloplasty. They are:

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. if required by the mental health professional, regular responsible participation in a psychotherapy throughout the real life experience at a frequency determined by the mental health professional. Psychotherapy, per se, is not an absolute eligibility criterion for surgery.
5. demonstrable 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

Readiness Criteria. The readiness criteria include:

1. demonstrable progress in consolidating the evolving gender identity
2. demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health (this implies an absence of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance).

Can Surgery Be Provided Without Hormones and the Real Life Experience? Individuals who "just" want mastectomy, penectomy, or genital reconstructive therapy without meeting the

eligibility criteria can not be provided bodily alterations because they are "special cases." Organ removal or remodeling is a surgical treatment for a gender disorder. The surgery occurs after many careful steps. Such surgery is not a patient right that once demanded has to be granted. The SOC contains provisions for an individual approach for every patient, but this does not mean that the general guidelines for the sequence of psychiatric evaluation, possible psychotherapy, hormones, and real life experience can be ignored because a person desires just one surgical procedure.

If a person has lived convincingly as a member of the opposite sex for a long period of time and is assessed to be a psychologically healthy person after a requisite period of psychotherapy, there is no inherent reason that he or she must take hormones prior to having a desired breast or genital surgery.

XI. SURGERY

Conditions under which Surgery May Occur. Surgical treatment for a person with a gender identity disorder is not merely another elective procedure. Typical elective procedures only involve a private mutually consenting contract between a suffering person and a technically competent surgeon. Surgeries for GID are to be undertaken only after a comprehensive evaluation by a qualified mental health professional. Surgery may be performed once written documentation testifies that a comprehensive evaluation has occurred and that the person has met the eligibility and readiness criteria. By following this procedure, the mental health professional, the physician prescribing hormones, the surgeon and the patient share in the responsibility of the decision to make irreversible changes to the body. The patient who has decided to undergo genital or breast operations, however, tends to view the surgery as the most important and effective treatment to correct the underlying problem.

Requirements for the Surgeon Performing Genital Reconstruction. The surgeon should be a urologist, gynecologist, plastic surgeon or general surgeon, and Board-Certified as such by a nationally known and reputable association. The surgeon should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons in this field must be willing to have their therapeutic skills reviewed by their peers. Willingness and cooperation with peer review are essential. This includes attendance at professional meetings where new ideas about techniques are presented.

Ideally, the surgeon should be knowledgeable about more than one of the surgical techniques for genital reconstruction so that the surgeon will be able to choose the ideal technique for the individual patient's anatomy and medical history. When surgeons are skilled in a single technique, they should so inform their patients and refer those who do not want or are unsuitable for this procedure to another surgeon.

Prior to performing any surgical procedures, the surgeon should have all medical conditions appropriately monitored and the effects of the hormonal treatment upon the liver and other organ systems investigated. This can be done alone or in conjunction with medical colleagues. Since pre-existing conditions may complicate genital reconstructive surgeries,

surgeons must also be competent in urological diagnosis. The medical record should contain written informed consent for the particular surgery to be performed.

How to Deal with the Ethical Question Concerning Sex Reassignment (Gender Confirming)

Surgeries. Many persons, including medical professionals, object on ethical grounds to surgery for GID. In ordinary surgical practice, pathological tissues are removed in order to restore disturbed functions or corrections are made to disfiguring body features to improve the patient's self image. These specific conditions are not present when surgery is performed for gender identity disorders. In order to understand how surgery is able to alleviate the psychological discomfort of the patient with a gender identity disorder, professionals who are inexperienced with severe gender identity disorders need to listen to these patients discuss their symptoms, dilemmas, and life histories. It is important that the professionals dealing with gender patients feel comfortable about altering anatomically normal structures.

The resistance against performing surgery on the ethical bases of "above all do no harm" should be respected, discussed, and met with the opportunity to learn about the psychological distress of having a gender identity disorder from the patients themselves.

Genital, Breast, and Other Surgery for the Male to Female Patient. Surgical procedures may include orchiectomy, penectomy, vaginoplasty and augmentation mammoplasty. Vaginoplasty requires both skilled surgery and postoperative treatment. The three techniques are: penile skin inversion, pedicled rectosigmoid transplant, or free skin graft to line the neovagina.

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, suction-assisted lipoplasty of the waist, rhinoplasty, facial bone reduction, face-lift, and blephoroplasty. These do not require letters of recommendation from mental health professionals as does genital reconstruction therapy. The committee is concerned about the safety and effectiveness of voice modification surgery and urges more follow-up research prior to widespread use of this procedure. Patients who elect this procedure should do so after all other surgeries requiring general anesthesia with intubation are completed to protect their vocal cords.

Breast and Genital Surgery for the Female to Male Patient. Surgical procedures may include mastectomy (chest reconstruction), hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, and phalloplasty. 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, sexual sensation, 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. Even the metoidioplasty technique, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one surgery. The plethora of techniques for penis construction indicate that further technical development is necessary. Patients may undergo hysterectomy and salpingo-oophorectomy prior to phalloplasty.

The mastectomy procedure is usually the first surgery performed for ease in passing in the preferred gender role, but for some patients it is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient is informed.

Genital surgeries often combine more than one of the above operations, but typically genital surgery requires several separate operative procedures.

The Surgeon's Relationship with the Physician Prescribing Hormones and Mental Health Professional. The surgeon is not merely an interchangeable technician hired to perform a procedure. The surgeon is part of the team of clinicians participating in a long rehabilitation process. The patient often feels an immense positive regard for (transference) and trusting bond to the surgeon, which ideally will enable long-term follow-up care. Because of the significance of the surgeon to the patient, these physicians are responsible for awareness of the diagnosis that has led to the recommendation for genital reconstruction. Surgeons should have a chance to speak at length with their patients to satisfy themselves that the patient is likely to benefit from the procedures apart from the letters recommending surgery. Ideally, the surgeon should have a close working relationship with the other professionals who have been actively involved in the patient's psychological and endocrinological care. This is usually best accomplished by belonging to an interdisciplinary team of professionals who specialize in gender identity disorders. Such gender teams do not exist everywhere, however. At the very least, the surgeon needs to be reassured that the mental health professional and physician prescribing hormones are reputable professionals with specialized experience with the gender identity disorders. This is often reflected in the quality of the documentation letters. Since factitious and falsified letters have occasionally been presented, surgeons should personally communicate with at least one of the mental health professionals to verify the authenticity of their letters.

Surgery for Persons with Psychotic Conditions and Other Serious Mental Illnesses.

Surgical therapies are undertaken only for the treatment of the patient's gender identity disorder. When severe psychiatric disorders with impaired reality testing--such as, schizophrenia, dissociative identity disorder, borderline personality disorder, are present as well, a significant effort must be made to improve these conditions with state-of-the-art psychiatric treatments before hormones and surgery are contemplated. A reevaluation by a Ph.D clinical psychologist or psychiatrist should be conducted within two weeks of surgery describing the patient's mental status and readiness for surgery. It is preferable if the clinician has previously evaluated the patient. No surgery should be performed while the patient is actively psychotic.

Postsurgical Follow-up by Professionals. In general, long-term postoperative follow-up is encouraging in that it is one of the factors associated with a good psychosocial outcome. Follow-up is also essential to the patient's subsequent anatomic and medical health and to the surgeon's knowledge about the benefits and limitations of surgery.

Long-term follow-up with the surgeon is recommended in all patients to ensure an optimal surgical outcome. Surgeons who are operating on patients who are coming from long distances should include personal follow-up in their care plan and then ensure affordable, local, long-term aftercare in the patient's geographic region. Postoperative patients may also

incorrectly exclude themselves from follow-up with the physician prescribing hormones, not recognizing that these physicians are best able to prevent, diagnose and treat possible long term medical conditions that are unique to the hormonally and surgically treated. Postoperative patients also have general health concerns and should undergo regular medical screening according to recommended guidelines.

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.