(Note: If anyone has a copy of the 1st-3rd Versions of the Standards of Care, and wouldn't mind contributing them to the site, please email me. Thanks.)

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Harry Benjamin Standards of Care for Gender Dysphoric Persons

Revised Draft (1/90)

STANDARDS OF CARE

The Hormonal and Surgical Sex Reassignment
of Gender Dysphoric Persons

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Standards of Care: The Hormonal and Surgical Sex Reassignment of Gender Dysphoric Persons

1. Introduction

As of the beginning of 1979, an undocumentable estimate of the number of adult Americans hormonally and surgically sex-reassigned ranged from 3,000 to 6,000. Also undocumentable is the estimate that between 30,000 and 60,000 U.S.A. citizens consider themselves to be valid candidates for sex reassignment. World estimates are not available. As of mid-1978, approximately 40 centers in the Western hemisphere offered surgical sex reassignment to persons having a multiplicity of behavioral diagnoses applied under a multiplicity of criteria.

In recent decades, the demand for sex-reassignment has increased as have the number and variety of possible psychologic, hormonal and surgical treatments. The rationale upon which such treatments are offered have become more and more complex. Varied philosophies of appropriate care have been suggested by various professionals identified as experts on the topic of gender identity. However, until the present, no statement of the standard of care to be offered to dysphoric patients (sex reassignment applicants) has received official sanction by any identifiable professional group. The present document is designed to fill that void.

2. Statement of Purpose

Harry Benjamin International Gender Dysphoria Association, Inc., presents the following as its explicit statement of the appropriate standards of care to be offered to applicants for hormonal and surgical sex reassignment.

3. Definitions

3.1 _Standard of care_. The standards of care, as listed below, are _minimal_ requirements and are not to be construed as standards of care. It is recommended that professionals involved in the management of sex reassignment cases use the following as _minimal_ criteria for the evaluation of their work. It should be noted that some experts on gender identity recommend that the time parameters listed below be doubled, or tripled. It is recommended that the reasons for any exceptions to these standards, in the management of any individual case, be carefully documented. Professional opinions differ regarding the permissibility of, and the circumstances warranting, any such exception.

3.2 _Hormonal sex reassignment_. Hormonal sex reassignment refers to the administration of androgens to genotypic and phenotypic females, and the administration of estrogens and/or progesterones to genotypic and phenotypic males, for the purpose of effecting somatic changes in order for the patient to more closely approximate the physical appearance of the genotypically-other sex. Hormonal sex reassignment does not refer to the administration of hormones for the purpose of medical care and/or research conducted for the treatment of non-gender dysphoric medical conditions (e.g., aplastic anemia, impotence, cancer, etc.).

3.3 _Surgical sex reassignment_. Genital surgical sex reassignment refers to surgery of the genitalia and/or breasts performed for the purpose of altering the morphology in order to approximate the physical appearance of the genetically-other sex in persons diagnosed as gender dysphoric. Such surgical procedures as mastectomy, reduction mammoplasty, augmentation mammoplasty, castration, orchiectomy, penectomy, vaginoplasty, hysterectomy, salpingectomy, vaginectomy, oophorectomy, and phalloplasty -- in the absence of any diagnosable birth defect or other medically defined pathology, except gender dysphoria, are included in this category labeled surgical sex reassignment.

Non-genital surgical sex reassignment refers to any and all other surgical procedures of non-genital, or non-breast, sites (nose, throat, chin, cheeks, hips, etc.) conducted for the purpose of effecting a more masculine appearance in a genetic female or for the purpose of effecting a more feminine appearance in a genetic male, in the absence of identifiable pathology which would warrant such surgery regardless of the

patient's genetic sex (facial injuries, hermaphroditism, etc.).

3.4 _Gender dysphoria_. Gender dysphoria herein refers to that psychological state whereby a person demonstrates dissatisfaction with their sex of birth and the sex role, as socially defined, which applies to that sex, and who requests hormonal and surgical sex reassignment. Gender dysphoria, herein, does not refer to cases of infant sex reassignment or reannouncement. Gender dysphoria, therefore, is the primary working diagnosis applied to any and all persons requesting surgical and hormonal sex reassignment.

3.5 _Clinical behavioral scientist_.

[1] Possession of an academic degree in a behavioral science does not necessarily attest to the possession of sufficient training or competence to conduct psychotherapy, psychologic counseling, nor diagnosis of gender identity problems. Persons recommending sex reassignment surgery or hormone therapy should have documented training and experience in the diagnosis and treatment of a broad range of psychologic conditions. Licensure or certification as a psychological therapist or counselor does not necessarily attest to competence in sex therapy. Persons recommending sex reassignment surgery or hormone therapy should have the documented training and to diagnose and treat a broad range of sexual conditions. Certification in sex therapy or counseling does not necessarily attest to competence in the diagnosis and treatment of gender identity conditions or disorders. Persons recommending sex reassignment surgery or hormone therapy should have proven competence in general psychotherapy, sex therapy, and gender counseling/therapy.

Any and all recommendations for sex reassignment surgery and hormone therapy should be made only by clinical behavioral scientists possessing the following minimal documentable credentials and expertise:

3.5.1 A minimum of a Masters Degree in a clinical behavioral science, granted by an institution of education accredited by a national or regional accrediting board.

3.5.2 One recommendation, of the two required for sex reassignment surgery, must be made by a person possessing a doctoral degree (e.g. Ph.D., Ed.D., D.Sc., D.S.W., Psy.D., or M.D.) in a clinical behavioral science,

granted by an institution of education accredited by a national or regional accrediting board.

3.5.3 Demonstrated competence in psychotherapy as indicated by a license to practice medicine, psychotherapy, clinical social work, marriage and family counseling, or social psychotherapy, etc., granted by the state of residence. In states where no such appropriate license board exists, persons recommending sex reassignment surgery or hormone therapy should have been certified by a nationally-known and reputable association, based on education and experience criteria and, preferably, some form of testing (and not simply on membership received for dues paid) as an accredited or certified therapist/counselor (e.g. American Board of Psychiatry and Neurology, Diplomate in Psychology from the American Board of Professional Psychologists, Certified Clinical Social Workers, American Association of Marriage and Family Therapists, American Professional Guidance Association, etc.).

3.5.4 Demonstrated specialized competence in sex therapy and theory as indicated by documentable training and supervised clinical experience in sex therapy (in some states professional licensure requires training in human sexuality; also, persons should have approximately the training and experience required for certification as a Sex Therapist or Sex Counselor by the American Association of Sex Educators, Counselors and Therapists, or as required for membership in the Society for Sex Therapy and Research). Continuing education in human sexuality and sex therapy should also be demonstrable.

3.5.5 Demonstrated and specialized competence in therapy, counseling, and diagnosis of gender identity disorders as documentable by training and supervised clinical experience, along with continuing education.

The behavioral scientists recommending sex reassignment surgery and hormone therapy and the physician and surgeon(s) who accept those recommendations share the responsibility for certifying that the recommendations are made based on competency indicators as described above.

4. Principles and Standards

Introduction

4.1.1 Principle 1. Hormonal and surgical sex reassignment is extensive in its effects, is invasive to the integrity of the human body, has effects and consequences which are not, or are not readily, reversible, and may be requested by persons experiencing short-termed delusions or beliefs which may later be changed and reversed.

4.1.2 Principle 2. Hormonal and surgical sex reassignment are procedures requiring justification and are not of such minor consequence as to be performed on an elective basis.

4.1.3 Principle 3. Published and unpublished case histories are known in which the decision to undergo hormonal and surgical sex reassignment was, after the fact, regretted and the final result of such procedures proved to be psychologically dehabilitating to the patients.

4.1.4 Standard 1. Hormonal and/or surgical[2] sex reassignment on demand (i.e., justified simply because the patient has requested such procedures) is contraindicated. It is herein declared to be professionally improper to conduct, offer, administer or perform hormonal sex reassignment and/or surgical sex reassignment without careful evaluation of the patient's reasons for requesting such services and evaluation of the beliefs and attitudes upon which such reasons are based.

4.2.1 Principle 4. The analysis or evaluation of reasons, motives, attitudes, purposes, etc., requires skills not usually associated with the professional training of persons other than clinical behavioral scientists.

4.2.2 Principle 5. Hormonal and/or surgical sex reassignment is performed for the purpose of improving the quality of life as subsequently experienced and such experiences are most properly studied and evaluated by the clinical behavioral scientist.

4.2.3 Principle 6. Hormonal and surgical sex reassignment are usually offered to persons, in part, because a psychiatric/psychologic diagnosis of transsexualism (see _DSM-III_, Section 302.5X), or some related diagnosis, has been made. Such diagnoses are properly made only by clinical behavioral scientists.

4.2.4 Principle 7. Clinical behavioral scientists, in deciding to make the recommendation in favor of hormonal and/or surgical sex reassignment share the moral responsibility for that decision with the physician and/or surgeon who accepts that recommendation.

4.2.5 Standard 2. Hormonal and surgical (genital and breast) sex reassignment must be made by a firm written recommendation for such procedures made by a clinical behavioral scientist who can justify making such a recommendation by appeal to training or professional experience in dealing with sexual disorders, especially the disorders of gender identity and role.

4.3.1 Principle 8. The clinical behavioral scientist's recommendation for hormonal and/or surgical sex reassignment should, in part, be based upon an evaluation of how well the patient fits the diagnostic criteria for transsexualism as listed in the DSM-III-R category 302.50 to wit:[3]

A. Persistent discomfort and sense of inappropriateness about one's assigned sex.

B. Persistent preoccupation for at least two years with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex.

C. The person has reached puberty.

This definition of transsexualism is herein interpreted not to exclude persons who meet the above criteria but who otherwise may, on the basis of their past behavioral histories, be conceptualized and classified as transvestites and/or effeminate male homosexuals or masculine female homosexuals.

4.3.2 Principle 9. The intersexed patient (with a documented hormonal or genetic abnormality) should first be treated by procedures commonly accepted as appropriate for such medical conditions.

4.3.3 Principle 10. The patient having a psychiatric diagnosis (i.e., schizophrenia) in addition to a diagnosis of transsexualism should first be treated by procedures commonly accepted as appropriate for such non-transsexual psychiatric diagnoses.

4.3.4 Standard 3. Hormonal and surgical sex reassignment may be made available to intersexed patients and to patients having non-transsexual psychiatric/psychological diagnoses if the patient and therapist have fulfilled the requirements of the herein listed standards; if the patient can be reasonably expected to be habilitated or rehabilitated, in part, by such hormonal and surgical sex reassignment procedures; and if all other commonly accepted therapeutic approaches to such intersexed or non-transsexual psychiatrically/psychologically diagnosed patients have been either attempted, or considered for use prior to the decision not to use such alternative therapies. The diagnosis of schizophrenia, therefore, does not necessarily preclude surgical and hormonal sex reassignment.

Hormonal Sex Reassignment

4.4.1 Principle 11. Hormonal sex reassignment is both therapeutic and diagnostic in that the patient requesting such therapy either reports satisfaction or dissatisfaction regarding the results of such therapy.

4.4.2 Principle 12. Hormonal sex reassignment may have some irreversible effects (infertility, hair growth, voice deepening, and clitoral enlargement in the female-to-male patient and infertility and breast growth in the male-to-female patient) and, therefore, such therapy must be offered only under the guidelines proposed in the present standards.

4.4.3 Principle 13. Hormonal sex reassignment should precede surgical sex reassignment as its effects (patient satisfaction or dissatisfaction) may indicate or contraindicate later surgical sex reassignment.

4.4.4 Standard 4.[4] The initiation of hormonal sex reassignment shall be preceded by recommendation for such hormonal therapy made by a clinical behavioral scientist.

4.5.1 Principle 14. The administration of androgens to females and of estrogens and/or progesterones to males may lead to mild or serious health-threatening complications.

4.5.2 Principle 15. Persons who are in poor physical health, or

who have identifiable abnormalities in blood chemistry, may be at above average risk to develop complications should they receive hormonal medication.

4.5.3 Standard 5. The physician prescribing hormonal medication to a person for the purpose of effecting hormonal sex reassignment must warn the patient of possible negative complications which may arise and that physician should also make available to the patient (or refer the patient to a facility offering) monitoring of relevant blood chemistries and routine physical examinations including, but not limited to, the measurement of SGPT in persons receiving testosterone and the measurement of SGPT, bilirubin, triglycerides and fasting glucose in persons receiving estrogens.

4.6.1 Principle 16. The diagnostic evidence for transsexualism (see 4.3.1 above) requires that the clinical behavioral scientist have knowledge, independent of the patient's verbal claim, that the dysphoria, discomfort, sense of inappropriateness and wish to be rid of one's own genitals, have existed for at least two years. This evidence may be obtained by interview of the patient's appointed informant (friend or relative) or it may best be obtained by the fact that the clinical behavioral scientist has professionally known the patient for an extended period of time.

Surgical (Genital and/or Breast) Sex Reassignment

4.7.1 Principle 17. Peer review is a commonly accepted procedure in most branches of science and is used primarily to ensure maximal efficiency and correctness of scientific decisions and procedures.

4.7.2 Principle 18. Clinical behavioral scientists must often rely on possibly unreliable or invalid sources of information (patient's verbal reports or the verbal reports of the patient's families and friends) in making clinical decisions and in judging whether or not a patient has fulfilled the requirements of the herein listed standards.

4.7.3 Principle 19. Clinical behavioral scientists given the burden of deciding who to recommend for hormonal and surgical sex reassignment and for whom to refuse such recommendations are subject to extreme social pressure

and possible manipulation as to create an atmosphere in which charges of laxity, favoritism, sexism, financial gain, etc., may be made.

4.7.4 Principle 20. A plethora of theories exist regarding the etiology of gender dysphoria and the purposes or goals of hormonal and/or surgical sex reassignment such that the clinical behavioral scientist making the decision to recommend such reassignment for a patient does not enjoy the comfort or security of knowing that his or her decision would be supported by the majority of his or her peers.

4.7.8 Standard 7. The clinical behavioral scientist recommending that a patient receive surgical (genital and breast) sex reassignment must obtain peer review, in the format of a clinical behavioral scientist peer who will personally examine the patient applicant, on at least one occasion, and who will, in writing, state that he or she concurs with the decision of the original clinical behavioral scientist. Peer review (a second opinion) is not required for hormonal sex reassignment. Non-genital/breast surgical sex reassignment does not require the recommendation of a behavioral scientist. At least one of the two behavioral scientists making the favorable recommendation for surgical (genital and breast) sex reassignment must be a doctoral level clinical behavioral scientist.[5]

4.8.1 Standard 8. The clinical behavioral scientist making the primary recommendation in favor of genital (surgical) sex reassignment shall have known the patient in a psychotherapeutic relationship for at least 6 months prior to making said recommendation. That clinical behavioral scientist should have access to the results of psychometric testing (including IQ testing of the patient) when such testing is clinically indicated.

4.9.1 Standard 9. Genital sex reassignment shall be preceded by a period of at least 12 months during which time the patient lives full-time in the social role of the genetically-other sex.

4.10.1 Principle 21. Genital surgical sex reassignment includes the invasion of, and the alteration of, the genitourinary tract. Undiagnosed pre-existing genitourinary disorders may complicate later genital surgical sex reassignment.

4.10.2 Standard 10.[6] Prior to genital surgical sex reassignment a urological examination should be conducted for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract.

4.11.1 Standard 11. The physician administering or performing surgical (genital) sex reassignment is guilty of professional misconduct if he or she does not receive written recommendations in favor of such procedures from at least two clinical behavioral scientists; at least one of which is a doctoral level clinical behavioral scientist and one of whom has known the patient in a professional relationship for at least 6 months.

Miscellaneous

4.12.1 Principle 22. The care and treatment of sex reassignment applicants or patients often causes special problems for the professionals offering such care and treatment. These special problems include, but are not limited to: the need for the professional to cooperate with the education of the public to justify his or her work, the need to document the case history perhaps more completely than is customary in general patient care, the need to respond to multiple, nonpaying, service applicants and the need to be receptive and responsive to the extra demands for services and assistance often made by sex reassignment applicants as compared to other patient groups.

4.12.2 Principle 23. Sex reassignment applicants often have need for post-therapy (psychologic, hormonal and surgical) follow-up care for which they are unable or unwilling to pay.

4.12.3 Principle 24. Sex reassignment applicants are often in a financial status which does not permit them to pay excessive professional fees.

4.12.4 Standard 12. It is unethical for professionals to charge sex reassignment applicants "whatever the traffic will bear" or excessive fees far beyond the normal fees changed for similar services by the professional. It is permissible to charge sex reassignment applicants for services in advance of the tendering of such services even if such an advance fee arrangement is not typical of the professional's practice. It is permissible to charge

patients, in advance, for expected services such as post-therapy follow-up care and/or counseling. It is unethical to charge patients for services which are essentially research and which services do not directly benefit the patient.

4.13.1 Principle 25. Sex reassignment applicants often experience social, legal and financial discrimination not known, at present, to be prohibited by federal or state law.

4.13.2 Principle 26. Sex reassignment applicants often must conduct formal or semiformal legal proceedings (i.e., in-court appearances against insurance companies or in pursuit of having legal documents changed to reflect their new sexual and genderal status, etc.).

4.13.3 Principle 27. Sex reassignment applicants, in pursuit of what are assumed to be their civil rights as citizens, are often in need of assistance (in the form of copies of records, letters of endorsement, court testimony, etc.) from the professionals involved in their case.

4.13.4 Standard 13. It is permissible for a professional to charge only the normal fee for services needed by a patient in pursuit of his or her civil rights. Fees should not be charged for services for which, for other patient groups, such fees are not normally charged.

4.14.1 Principle 28. Hormonal and surgical sex reassignment has been demonstrated to be a rehabilitative, or habilitative, experience for properly selected adult patients.

4.14.2 Principle 29. Hormonal and surgical sex reassignment are procedures which must be requested by, and performed only with the agreement of, the patient having informed consent. Sex reannouncement or sex reassignment procedures conducted on infantile or early childhood intersexed patients are common medical practices and are not included in or affected by the present discussions.

4.14.3 Principle 30. Sex reassignment applicants often, in their pursuit of sex reassignment, believe that hormonal and surgical sex reassignment have fewer risks than such procedures are known to have.

4.14.4 Standard 14. Hormonal and surgical sex reassignment may be conducted or administered only to persons obtaining their legal majority (as defined by state law) or to persons declared by the courts as legal adults (emancipated minors).

4.15.1 Standard 15. Hormonal and surgical sex reassignment may be conducted or administered only after the patient has received full and complete explanations, preferably in writing, in words understood by the patient applicant, of all risks inherent in the requested procedures.

4.16.1 Principle 31. Gender dysphoric sex reassignment applicants and patients enjoy the same rights to medical privacy as does any other patient group.

4.16.2 Standard 16. The privacy of the medical records of the sex reassignment patient shall be safeguarded according to the procedures in use to safeguard the privacy of any other patient group.

5. Explication

5.1 Prior to the initiation of hormonal sex reassignment:

5.1.1 The patient must demonstrate that the sense of discomfort with the self and the urge to rid the self of the genitalia and the wish to live in the genetically-other sex role have existed for at least 2 years.

5.1.2 The patient must be known to a clinical behavioral scientist for at least 3 months and that clinical behavioral scientist must endorse the patient's request for hormone therapy.

5.1.3 Prospective patients should receive a complete physical examination which includes, but is not limited to, the measurement of SGPT in persons to receive testosterone and the measurement of SGPT, bilirubin, triglycerides and fasting glucose in persons to receive estrogens.

5.2 Prior to the initiation of genital or breast sex reassignment (penectomy, orchiectomy, castration, vaginoplasty, mastectomy, hysterectomy, oophorectomy, salpingectomy, vaginectomy, phalloplasty, reduction mammoplasty, breast amputation):

5.2.1 See 5.1.1, above.

5.2.2 The patient must be known to a clinical behavioral scientist for at least 3 months and that clinical behavioral scientist must endorse the patient's request for genital surgical sex reassignment.

5.2.3 The patient must be evaluated at least once by a clinical behavioral scientist other than the clinical behavioral scientist specified in 5.2.2 above and that second clinical behavioral scientist must endorse the patient's request for genital sex reassignment. At least one of the clinical behavioral scientists making the recommendation for genital sex reassignment must be a doctoral level clinical behavioral scientist.

5.2.4 The patient must have been living in the genetically-other sex role for at least one year.

5.3 During and after services are provided:

5.3.1 The patient's right to privacy should be honored.

5.3.2 The patient must be charged only appropriate fees and these fees may be levied in advance of services.

Notes:

[1] The drafts of these Standards of Care dated 2/79 and 1/80 required that all recommendations for hormonal and/or surgical sex reassignment be made by licensed psychologists or psychiatrists. That requirement was rescinded, and replaced by the definition in section 3.5, in 3/81.

[2] The present standards provide no guidelines for the granting of non-genital/breast cosmetic or reconstructive surgery. The decision to perform such surgery is left to the patient and surgeon. The original draft of this document did recommend the following however (rescinded 1/80):

"Non-genital sex reassignment (facial, hip, limb, etc.) shall be preceded by a period of at least 6 months during which time the patient lives full-time in the social role of the genetically other sex."

[3] _DSM-III-R Diagnostic and Statistical Manual of Mental Disorders_ (Third Edition-Revised). Washington, D.C. The

American Psychiatric Association, 1987.

[4] This standard, in the original draft, recommended that the patient must have lived successfully in the social/gender role of the genetically-other sex for at least 3 months prior to the initiation of hormonal sex reassignment. This requirement was rescinded 1/80.

[5] In the original and 1/80 version of these standards, one of the clinical behavioral scientists was required to be a psychiatrist. That requirement was rescinded in 3/81.

[6] This requirement was rescinded 1/90.

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HARRY BENJAMIN INTERNATIONAL GENDER DYSPHORIA ASSOCIATION'S

STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS
(Fifth Version)

This is the fifth version (June 15, 1998) of the Standards of Care since the original 1979 document. Previous revisions were in 1980, 1981, and 1990.
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.

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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 froma 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.

Professional involvement with patients with gender identity disorders involves any of the following:
Diagnostic assessment
Psychotherapy
Real life experience
Hormonal therapy
Surgical therapy.

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

The Training of Mental Health Professionals
The Adult-Specialist
basic 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.
recommended minimal credentials for special competence with the gender identity disorders:
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
specialized training and competence in the assessment of theDSM-IV/ICD-10 Sexual Disorders (not simply gender identity disorders)
documented supervised training and competence in psychotherapy
continuing education in the treatment of gender identity disorders
The Child-Specialist
training in childhood and adolescent developmental psychopathology.
competence in diagnosing and treating the ordinary problems of children and adolescents

The Differences between Eligibility and Readiness Criteria for Hormones or Surgery.
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)
Readiness -- the specified criteria that rest upon the clinician's judgment prior to taking the next step in a triadic therapeutic sequence

The Mental Health Professional's Documentation Letters for Hormones or Surgery Should Succinctly Specify:
The patient's general identifying characteristics
The initial and evolving gender, sexual, and other psychiatric diagnoses
The duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent
The eligibility criteria that have been met and the MHP's rationale for hormones or surgery
The patient's ability to follow the Standards of Care to date and the likelihood of future compliance
Whether the author of the report is part of a gender team or is working without benefit of an organized team approach
The offer of receiving a phone call to verify that the documentation letter is authentic

One-Letter is Required for Instituting Hormone Treatment;Two-Letters are Required for Surgery

Two separate letters of recommendation from mental health professionals who work alone without colleagues experienced with gender identity disorders are required for surgery and
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. 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
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.

Children with Gender Identity Disorders
The initial task of the child-specialist mental health professional is to provide careful diagnostic assessments of gender-disturbed children.
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.
hormonal and surgical therapies should never be undertaken with this age group.
treatment over time 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.

Treatment of Adolescents
In typical cases the treatment is conservative becausegender 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.
They 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 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.
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 administered an antiandrogen (which neutralize testosterone effects only) or an LHRH agonist (which stops the production of testosterone only)
biological females should be administered sufficient androgens, progestins, or LHRH agonists (which stops the production of estradiol, estrone, and progesterone) to stop menstruation.
second phase treatments--after these changes have occurred and the adolescent's mental health remains stable
biologic males may be given estrogenic agents
biologic females may be given higher masculinizing doses of androgens
second phase medications 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.
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
to gain time to further explore the gender and other developmental issues in psychotherapy
to 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
throughout childhood they have demonstrated an intense pattern of cross-gender identity and aversion to expected gender role behaviors
gender discomfort has significantly increased with the onset of puberty
social, intellectual, psychological, and interpersonal development are limited as a consequence of their GID
serious psychopathology, except as a consequence of the GID, is absent
the family consents and participates in the triadic therapy
Prior to Age 16. Second phase hormones, those which induce opposite sex characteristics 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.
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.
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.

Psychotherapy with Adults
Many adults with gender identity disorder find comfortable, effective ways of identifying themselves without the triadic treatment sequence, with or without psychotherapy
Psychotherapy is not an absolute requirement for triadic therapy.
Individual programs vary to the extent that they perceive the need for psychotherapy.
When the mental health professional's initial assessmentleads 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 but expects individual programs to set these

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.
Psychotherapy often provides education about a range of options not previously seriously considered by the patient. Its goals are:
to be realistic about work and relationships
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
to find a comfortable way to live within a gender role and body
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

The Real-Life Experience
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.
When clinicians assess the quality of a person's real-life experience in the new gender role, the following abilities are reviewed
to maintain full or part-time employment
to function as a student
to function in community-based volunteer activity
to undertake some combination of items 1-3
to acquire a new (legal) first or last name
to provide documentation that persons other than the therapist know that the patient functions in the new gender role.

Eligibility and Readiness Criteria for Hormone Therapy for Adults
Three eligibility criteria exist.
age 18 years
demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks
Either a documented real life experience should be undertaken for at least three months prior to the administration of hormones Or
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
under no circumstances should an person be provided hormones who has neither fulfilled criteria #3 or #4.
Three readiness criteria exist:
the patient has had further consolidation of gender identity during the real-life experience or psychotherapy
the patient has made some progress in mastering other identified problems leading to improving or continuing stable mental health
hormones are likely to be taken in a responsible manner
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.

Requirements for Genital Reconstructive and Breast Surgery
Six eligibility criteria for various surgeries exist and equally apply to biological males and biological females
legal age of majority in the patient's nation

12 months of continuous hormonal therapy for those without a medical contraindication
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
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.
knowledge of the cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches.
awareness of different competent surgeons
Two readiness criteria exist
demonstrable progress in consolidating the new gender identity
demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better or at least a stable state of mental health.

Surgery
Genital, Breast, and Other Surgery for the Male to Female Patient
Surgical procedures may include orchiectomy, penectomy, vaginoplasty, augmentation mammaplasty, and vocal cord surgery.
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
Augmentation mammaplasty 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 blepharoplasty.
Genital and Breast Surgery for the Female to Male Patient.
Surgical procedures may include mastectomy, 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, 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.
Reduction mammaplasty may be necessary as an early procedure for some large breasted individuals to make the real life experience feasible.
Liposuction may be necessary for final body contouring
Postsurgical Follow-up by Professionals.
Long term postoperative follow-up is one of the factors associated with a good psychosocial outcome.
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
Postoperative patients may incorrectly exclude themselves from follow-up with the physician prescribing hormones as well as their surgeon and mental health professional.
These clinicians are best able to prevent, diagnose and treat possible long-term medical conditions that are unique to the hormonally and surgically treated.
Surgeons who are operating on patients who are coming from long distances should include personal follow-up in their care plan.
Continuing long-term follow-up has to be affordable and available in the patient's geographic region.
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.

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 30,400females. 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 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 1960sand 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. Toqualify 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. TheSOC 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:

The patient's general identifying characteristics
The initial and evolving gender, sexual, and other psychiatric diagnoses
The duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent
The eligibility criteria that have been met and the MHP's rationale for hormones or surgery
The patient's ability to follow the Standards of Care to date and the likelihood of future compliance
Whether the author of the report is part of a gender team or is working without benefit of an organized team approach
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. Oneletter 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 to18 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 maybe 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 procede 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 over40 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 at1, 2, and 3 years. If hyperprolactinemia 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. Estrogendoses in post-orchiectomy 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. Hormonaltreatment, 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 mammaplasty. 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 experiencecan 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 mammaplasty. 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 mammaplasty 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 blepharoplasty. 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.

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The Harry Benjamin International Gender Dysphoria Association's
Standards of Care for Gender Identity Disorders, Sixth Version

February, 2001
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This is the sixth version of the Standards of Care since the original 1979 document. Previous revisions were in 1980, 1981, 1990, and 1998.

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I. 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 conditions. Persons with gender identity disorders, their families, and social institutions may use the SOC 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 psychotherapeutic, endocrine, or surgical therapy for persons 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 persons with gender identity disorders. When eligibility requirements are stated they are meant to be minimum requirements. Individual professionals and organized programs may modify 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, and 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 during a person's 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, gender conflict, or transsexualism. Such struggles are known to occur from the preschool years to old age and have many alternate forms. These reflect various degrees of personal dissatisfaction with sexual identity, sex and gender demarcating body characteristics, gender roles, gender identity, and the 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 biologic, social, psychological, and economic dilemmas of each sex. All patients, however, should follow the SOC.

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II. 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 transsexualism in adults were 1 in 37,000 males and 1 in 107,000 females. The most recent prevalence information from the Netherlands for the transsexual end of the gender identity disorder spectrum 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 an even higher prevalence: 1) unrecognized gender problems are occasionally diagnosed when patients are seen with anxiety, depression, bipolar disorder, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, other sexual disorders and intersexed conditions; 2) some nonpatient male transvestites, female impersonators, transgender people, 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 variance 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. Ideally, prospective data about the natural history of gender identity struggles would inform all treatment decisions. These are lacking, except for the demonstration that, without therapy, most boys and girls with gender identity disorders outgrow their wish to change sex and gender. After the diagnosis of GID is made the therapeutic approach usually includes three elements or phases (sometimes labeled triadic therapy): a real-life experience in the desired role, hormones of the desired gender, and surgery to change the genitalia and other sex characteristics. Five less firmly scientifically established observations prevent clinicians from prescribing the triadic therapy 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 therapy varies significantly from study to study. Many persons with GID will desire all three elements of triadic therapy. Typically, triadic therapy takes place in the order of hormones ==> real-life experience ==> surgery, or sometimes: real-life experience ==> hormones ==> surgery. For some biologic females, the preferred sequence may be hormones ==> breast surgery ==> real-life experience. However, the diagnosis of GID invites the consideration of a variety of therapeutic options, only one of which is the complete therapeutic triad. Clinicians have increasingly become aware that not all persons with gender identity disorders need or want all three elements of triadic therapy.

Cultural Differences in Gender Identity Variance throughout the World. Even if epidemiological 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 these conditions. Moreover, access to treatment, cost of treatment, the therapies offered and the social attitudes towards gender variant people and the professionals who deliver care differ broadly from place to place. While in most countries, crossing gender boundaries usually generates moral censure rather than compassion, there are striking examples in certain cultures of cross- gendered behaviors (e.g., in spiritual leaders) that are not stigmatized.

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III. Diagnostic Nomenclature

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, hormone therapy, and surgical therapy. This section provides a background on diagnostic assessment.

The Development of a Nomenclature. The term transexxual 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. True transsexuals 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 3) 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 sex and gender via a reasonably masculine behavioral developmental pathway. Belief in the true transsexual concept for males dissipated when it was realized that such patients were rarely encountered, and that 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 later 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 transforming the sex of their bodies and their social gender status. Others with gender dysphoria could be diagnosed as Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type; or Gender Identity Disorder Not Otherwise Specified (GIDNOS). These diagnostic terms were usually ignored by the media, which used the term transsexual for any person who wanted to change his/her sex and gender.

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 their 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 these criteria, Gender Identity Disorder Not Otherwise Specified (GIDNOS)(302.6) was to be used. This category included a variety of individuals, including those who desired only castration or penectomy without a desire to develop breasts, those who wished hormone therapy and mastectomy without genital reconstruction, those with a congenital intersex condition, those with transient stress-related cross-dressing, and those with considerable ambivalence about giving up their gender status. Patients diagnosed with GID and GIDNOS were to be subclassified according to the sexual orientation: attracted to males; attracted to females; attracted to both; or attracted to neither. This subclassification was intended to assist in determining, over time, whether individuals of one sexual orientation or another experienced better outcomes using particular therapeutic approaches; it was not intended to guide treatment decisions.

Between the publication of DSM-III and DSM-IV, the term "transgender" began to be used in various ways. Some employed it to refer to those with unusual gender identities in a value-free manner -- that is, without a connotation of psychopathology. Some people informally used the term to refer to any person with any type of gender identity issues. Transgender is not a formal diagnosis, but many professionals and members of the public found it easier to use informally than GIDNOS, which is a formal diagnosis.

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

Transsexualism (F64.0) has three criteria:
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;
The transsexual identity has been present persistently for at least two years;
The disorder is not a symptom of another mental disorder or a chromosomal abnormality.
Dual-role Transvestism (F64.1) has three criteria:

The individual wears clothes of the opposite sex in order to experience temporary membership in the opposite sex;
There is no sexual motivation for the cross-dressing;
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:

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;
Either of the following must be present:
Persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing;
Persistent repudiation of female anatomical structures, as evidenced by at least one of the following:
An assertion that she has, or will grow, a penis;
Rejection of urination in a sitting position;
Assertion that she does not want to grow breasts or menstruate.
The girl has not yet reached puberty;
The disorder must have been present for at least 6 months.
For boys:
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.
Either of the following must be present:
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;
Persistent repudiation of male anatomical structures, as evidenced by at least one of the following repeated assertions:
That he will grow up to become a woman (not merely in the role);
That his penis or testes are disgusting or will disappear;
That it would be better not to have a penis or testes.
The boy has not yet reached puberty;
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 guide treatment and research. Different professional groups created these nomenclatures through consensus processes at different times. There is an expectation that the differences between the systems will be eliminated in the future. At this point, the specific diagnoses are based more on clinical reasoning than on scientific investigation.

Are Gender Identity Disorders Mental Disorders? To qualify as a mental disorder, a behavioral pattern must result in a significant adaptive disadvantage to the person or cause personal mental suffering. The DSM-IV and ICD-10 have defined hundreds of mental disorders 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 often important in offering relief, providing health insurance coverage, and guiding research to provide more effective future treatments.

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

To accurately diagnose the individual's gender disorder;
To accurately diagnose any co-morbid psychiatric conditions and see to their appropriate treatment;
To counsel the individual about the range of treatment options and their implications;
To engage in psychotherapy;
To ascertain eligibility and readiness for hormone and surgical therapy;
To make formal recommendations to medical and surgical colleagues;
To document their patient's relevant history in a letter of recommendation;
To be a colleague on a team of professionals with an interest in the gender identity disorders;
To educate family members, employers, and institutions about gender identity disorders;
To be available for follow-up of previously seen gender patients.
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. 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:

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 documented credentials from a proper training facility and a licensing board.
Specialized training and competence in the assessment of the DSM-IV/ICD-10 Sexual Disorders (not simply gender identity disorders).
Documented supervised training and competence in psychotherapy.
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. These requirements are in addition to the adult-specialist requirement.

The Differences between Eligibility and Readiness. The SOC provide recommendations for eligibility requirements for hormones and surgery. Without first meeting these recommended 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 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 and the patient's judgment.

The Mental Health Professional's Relationship to the Prescribing Physician 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 this assessment, and see 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 Letter for Hormone Therapy or Surgery Should Succinctly Specify:

The patient's general identifying characteristics;
The initial and evolving gender, sexual, and other psychiatric diagnoses;
The duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent;
The eligibility criteria that have been met and the mental health professional's rationale for hormone therapy or surgery;
The degree to which the patient has followed the Standards of Care to date and the likelihood of future compliance;
Whether the author of the report is part of a gender team;
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 and competent concerning gender identity disorders.

One Letter is Required for Instituting Hormone Therapy, or for Breast Surgery. One letter from a mental health professional, including the above seven points, written to the physician who will be responsible for the patient's medical treatment, is sufficient for instituting hormone therapy or for a referral for breast surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

Two Letters are Generally Required for Genital Surgery. Genital surgery for biologic males may include orchiectomy, penectomy, clitoroplasty, labiaplasty or creation of a neovagina; for biologic females it may include hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, or creation of a neophallus.

It is ideal if mental health professionals conduct their tasks and periodically report on these processes as part of a team of other mental health professionals and nonpsychiatric physicians. One letter to the physician performing genital surgery will generally suffice as long as two mental health professionals sign it.

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 genital surgery. If the first letter is from a person with a master's degree, the second letter should be from a psychiatrist or a Ph.D. clinical psychologist, 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, 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.

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V. Assessment and Treatment of Children and Adolescents
Phenomenology. Gender identity disorders in children and adolescents are different from those seen in adults, in that a rapid and dramatic developmental process (physical, psychological and sexual) is involved. Gender identity disorders in children and adolescents are complex conditions. The young person may experience his or her phenotype sex as inconsistent with his or her own sense of gender identity. Intense distress is often experienced, particularly in adolescence, and there are frequently associated emotional and behavioral difficulties. There is greater fluidity and variability in outcomes, especially in pre-pubertal children. Only a few gender variant youths become transsexual, although many eventually develop a homosexual orientation.

Commonly seen features of gender identity conflicts in children and adolescents include a stated desire to be the other sex; cross dressing; play with games and toys usually associated with the gender with which the child identifies; avoidance of the clothing, demeanor and play normally associated with the child's sex and gender of assignment; preference for playmates or friends of the sex and gender with which the child identifies; and dislike of bodily sex characteristics and functions. Gender identity disorders are more often diagnosed in boys.

Phenomenologically, there is a qualitative difference between the way children and adolescents present their sex and gender predicaments, from and the presentation of delusions or other psychotic symptoms. Delusional beliefs about their body or gender can occur in psychotic conditions but they can be distinguished from the phenomenon of a gender identity disorder. Gender identity disorders in childhood are not equivalent to those in adulthood and the former do not inevitably lead to the latter. The younger the child the less certain and perhaps more malleable the outcome.

Psychological and Social Interventions. The task of the child-specialist mental health professional is to provide assessment and treatment that broadly conforms to the following guidelines:

The professional should recognize and accept the gender identity problem. Acceptance and removal of secrecy can bring considerable relief.
The assessment should explore the nature and characteristics of the child's or adolescent's gender identity. A complete psychodiagnostic and psychiatric assessment should be performed. A complete assessment should include a family evaluation, because other emotional and behavioral problems are very common, and unresolved issues in the child's environment are often present.
Therapy should focus on ameliorating any comorbid problems in the child's life, and on reducing distress the child experiences from his or her gender identity problem and other difficulties. The child and family should be supported in making difficult decisions regarding the extent to which to allow the child to assume a gender role consistent with his or her gender identity. This includes issues of whether to inform others of the child's

situation, and how others in the child's life should respond; for example, whether the child should attend school using a name and clothing opposite to his or her sex of assignment. They should also be supported in tolerating uncertainty and anxiety in relation to the child's gender expression and how best to manage it. Professional network meetings can be very useful in finding appropriate solutions to these problems.
Physical Interventions. Before any physical intervention is considered, extensive exploration of psychological, family and social issues should be undertaken. Physical interventions should be addressed in the context of adolescent development. Adolescents' gender identity development can rapidly and unexpectedly evolve. An adolescent shift toward gender conformity can occur primarily to please the family, and may not persist or reflect a permanent change in gender identity. Identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility; more fluidity may return at a later stage. For these reasons, irreversible physical interventions should be delayed as long as is clinically appropriate. Pressure for physical interventions because of an adolescent's level of distress can be great and in such circumstances a referral to a child and adolescent multi- disciplinary specialty service should be considered, in locations where these exist.

Physical interventions fall into three categories or stages:

Fully reversible interventions. These involve the use of LHRH agonists or medroxyprogesterone to suppress estrogen or testosterone production, and consequently to delay the physical changes of puberty.
Partially reversible interventions. These include hormonal interventions that masculinize or feminize the body, such as administration of testosterone to biologic females and estrogen to biologic males. Reversal may involve surgical intervention.
Irreversible interventions. These are surgical procedures.
A staged process is recommended to keep options open through the first two stages. Moving from one state to another should not occur until there has been adequate time for the young person and his/her family to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions. Adolescents may be eligible for puberty-delaying hormones as soon as pubertal changes have begun. In order for the adolescent and his or her parents to make an informed decision about pubertal delay, it is recommended that the adolescent experience the onset of puberty in his or her biologic sex, at least to Tanner Stage Two. If for clinical reasons it is thought to be in the patient's interest to intervene earlier, this must be managed with pediatric endocrinological advice and more than one psychiatric opinion.

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

throughout childhood the adolescent has demonstrated an intense pattern of cross-sex and cross-gender identity and aversion to expected gender role behaviors;
sex and gender discomfort has significantly increased with the onset of puberty;
the family consents and participates in the therapy.
Biologic males should be treated with LHRH agonists (which stop LH secretion and therefore testosterone secretion), or with progestins or antiandrogens (which block testosterone secretion or neutralize testosterone action). Biologic females should be treated with LHRH agonists or with sufficient progestins (which stop the production of estrogens and progesterone) to stop menstruation.

Partially Reversible Interventions. Adolescents may be eligible to begin masculinizing or feminizing hormone therapy, as early as age 16, preferably with parental consent. In many countries 16-year olds are legal adults for medical decision making, and do not require parental consent.

Mental health professional involvement is an eligibility requirement for triadic therapy during adolescence. 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. While the number of sessions during this six-month period rests upon the clinician's judgment, the intent is that hormones and the real-life experience be thoughtfully and recurrently considered over time. In those patients who have already begun the real-life experience prior to being seen, the professional should work closely with them and their families with the thoughtful recurrent consideration of what is happening over time.

Irreversible Interventions. Any surgical intervention should not be carried out prior to adulthood, or prior to a real-life experience of at least two years in the gender role of the sex with which the adolescent identifies. The threshold of 18 should be seen as an eligibility criterion and not an indication in itself for active intervention.

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VI. Psychotherapy with Adults
A Basic Observation. Many adults with gender identity disorder find comfortable, effective ways of living 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. Not every adult gender patient requires psychotherapy in order to proceed with hormone therapy, the real-life experience, hormones, or surgery. Individual programs vary to the extent that they perceive a 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, and estimate its frequency and duration. There is no required minimum number of psychotherapy sessions prior to hormone therapy, the real-life experience, or surgery, for three reasons: 1) patients differ widely in their abilities to attain similar goals in a specified time; 2) a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth; 3) the mental health professional can be 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 members of a gender team do not do psychotherapy, the psychotherapist should be informed that a letter describing the patient's therapy might be requested so the patient can proceed with the next phase of treatment.

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 issues 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 their gender identity concerns. Ideally, the clinician's work is with the whole of the person's complexity. The goals of therapy are to help the person to live more comfortably within a gender identity and to deal effectively with non-gender issues. The clinician often attempts to facilitate the capacity to work and to establish or maintain supportive relationships. 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 and previous gendered experience.

Processes of Psychotherapy. Psychotherapy is a series of interactive communications between a therapist who is knowledgeable about how people suffer emotionally and how this may be alleviated, and a patient who is experiencing distress. Typically, psychotherapy consists of regularly held 50 minute sessions. The psychotherapy sessions initiate a developmental process. They enable the patient's history to be appreciated current dilemmas to be understood, and unrealistic ideas and maladaptive behaviors to be identified. Psychotherapy is not intended 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 expression. Gender distress often intensifies relationship, work, and educational dilemmas.

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. Ideally, psychotherapy is a collaborative effort. The therapist must be certain that the patient understands the concepts of eligibility and readiness, because the therapist and patient must cooperate in defining the patient's problems, and in assessing progress in dealing with them. Collaboration can prevent a stalemate 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 relationships.

Patients may benefit from psychotherapy at every stage of gender evolution. This includes the post-surgical period, when the anatomic obstacles to gender comfort have been removed, but the person may continue 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 comfort. These adaptations may evolve spontaneously and during psychotherapy. Finding new gender adaptations does not mean that the person may not in the future elect to pursue hormone therapy, the real-life experience, or genital surgery.

Activities:
Biological Males:
Cross-dressing: unobtrusively with undergarments; unisexually; or in a feminine fashion;
Changing the body through: hair removal through electrolysis or body waxing; minor plastic cosmetic surgical procedures;
Increasing grooming, wardrobe, and vocal expression skills.
Biological Females:
Cross-dressing: unobtrusively with undergarments, unisexually, or in a masculine fashion;

Changing the body through breast binding, weight lifting, applying theatrical facial hair;
Padding underpants or wearing a penile prosthesis.
Both Genders:
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;
Involvement in recreational activities of the desired gender;
Episodic cross-gender living.
Processes:
Acceptance of personal homosexual or bisexual fantasies and behaviors (orientation) as distinct from gender identity and gender role aspirations;
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;
Integration of male and female gender awareness into daily living;
Identification of the triggers for increased cross-gender yearnings and effectively attending to them; for instance, developing better self-protective, self-assertive, and vocational skills to advance at work and resolve interpersonal struggles to strengthen key relationships.
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VII. Requirements for 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. Hormones are often medically necessary for successful living 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 testosterone-blocking agents to biologic males, patients feel and appear more like members of their preferred gender.

Eligibility Criteria. The administration of hormones is not to be lightly undertaken because of their medical and social risks. Three criteria exist.

Age 18 years;
Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks;
Either:
a documented real-life experience of at least three months prior to the administration of hormones; or
a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).
In selected circumstances, it can be acceptable to provide hormones to patients who have not fulfilled criterion 3 - for example, to facilitate the provision of monitored therapy using hormones of known quality, as an alternative to black-market or unsupervised hormone use.

Readiness Criteria. Three criteria exist:

The patient has had further consolidation of gender identity during the real-life experience or psychotherapy;
The patient has made some progress in mastering other identified problems leading to improving or continuing stable mental health (this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis and suicidality;

The patient is likely to take hormones in a responsible manner.
Can Hormones Be Given To Those Who Do Not Want Surgery or a Real-life Experience? Yes, but after diagnosis and psychotherapy with a qualified mental health professional following minimal standards listed above. Hormone therapy can provide significant comfort to gender patients who do not wish to cross live or undergo surgery, or who are unable to do so. In some patients, hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross living or surgery.

Hormone Therapy and Medical Care for Incarcerated Persons. Persons who are receiving treatment for gender identity disorders should continue to receive appropriate treatment following these Standards of Care after incarceration. For example, those who are receiving psychotherapy and/or cross-sex hormonal treatments should be allowed to continue this medically necessary treatment to prevent or limit emotional lability, undesired regression of hormonally-induced physical effects and the sense of desperation that may lead to depression, anxiety and suicidality. Prisoners who are subject to rapid withdrawal of cross- sex hormones are particularly at risk for psychiatric symptoms and self- injurious behaviors. Medical monitoring of hormonal treatment as described in these Standards should also be provided. Housing for transgendered prisoners should take into account their transition status and their personal safety.

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

Desired Effects of Hormones. Biologic males treated with estrogens 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 testosterone can expect the following permanent changes: a deepening of the voice, clitoral enlargement, mild breast atrophy, increased facial and body hair and male pattern baldness. Reversible changes include increased upper body strength, weight gain, increased social and sexual interest and arousability, and decreased hip fat.

Potential Negative Medical Side Effects. 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 may increase side effects and risks for hormonal treatment. Therefore, some patients may not be able to tolerate cross-sex hormones. However, hormones can provide health benefits as well as risks. Risk-benefit ratios should be considered collaboratively by the patient and prescribing physician.

Side effects in biologic males treated with estrogens and progestins 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, liver disease, gallstone formation, somnolence, hypertension, and diabetes mellitus.

Side effects in biologic females treated with testosterone may include infertility, acne, emotional lability, 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.

The Prescribing Physician's Responsibilities. Hormones are to be prescribed by a physician, and should not be administered without adequate psychological and medical assessment 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 hormone treatment, including the potential for serious, life-threatening consequences. The patient must have the 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. Viable options include oral, injectable, and transdermal delivery systems. 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. Transdermal testosterone is useful in females who do not want to take injections. 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. Gender patients, whether on hormones or not, should be screened for pelvic malignancies as are other persons.

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. Biologic males undergoing estrogen treatment should be monitored for breast cancer and encouraged to engage in routine self-examination. As they age, they should be monitored for prostatic cancer.

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. Females who have undergone mastectomies and who have a family history of breast cancer should be monitored for this disease.

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

the police and other authorities.

Reductions in Hormone Doses After Gonadectomy. Estrogen doses in post-orchiectomy 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 all gender patients.

The Misuse of Hormones. Some individuals obtain hormones without prescription from friends, family members, and pharmacies in other countries. Medically unmonitored hormone use can 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 make an effort to encourage compliance with recommended dosages, in order to limit morbidity. It is ethical for physicians to discontinue treatment of patients who do not comply with prescribed treatment regimens.

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 preferred sex and gender and further adds to the conviction to proceed. Dissatisfaction with hormonal effects may signal ambivalence about proceeding to surgical interventions. In biologic males, hormones alone often generate adequate breast development, precluding the need for augmentation mammaplasty. Some patients who receive hormonal treatment will not desire genital or other surgical interventions.

The Use of Antiandrogens and Sequential Therapy. Antiandrogens can be used as adjunctive treatments in biologic males receiving estrogens, though they are not always necessary to achieve feminization. In some patients, antiandrogens may more profoundly suppress the production of testosterone, 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 treatment 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.

Reproductive Options. Informed consent implies that the patient understands that hormone administration limits fertility and that the removal of sexual organs prevents the capacity to reproduce. Cases are known of persons who have received hormone therapy and sex reassignment surgery who later regretted their inability to parent genetically related children. The mental health professional recommending hormone therapy, and the physician prescribing such therapy, should discuss reproductive options with the patient prior to starting hormone therapy. Biologic males, especially those who have not already reproduced, should be informed about sperm preservation options, and encouraged to consider banking sperm prior to hormone therapy. Biologic females do not presently have readily available options for gamete preservation, other than cryopreservation of fertilized embryos. However, they should be informed about reproductive issues,

including this option. As other options become available, these should be presented.

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IX. The Real-Life Experience

The act of fully adopting a new or evolving gender role or gender presentation in everyday life is known as the real-life experience. The real- life experience is essential to the transition to the gender role that is congruent with the patient's gender identity. Since changing one's gender presentation 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 with their patients. Change of gender role and presentation can be an important factor in employment discrimination, divorce, marital problems, and the restriction or loss of visitation rights with children. These represent external reality issues that must be confronted for success in the new gender presentation. These consequences may be quite different from what the patient imagined prior to undertaking the real-life experiences. However, not all changes are negative.

Parameters of the Real-Life Experience. When clinicians assess the quality of a person's real-life experience in the desired gender, the following abilities are reviewed:

To maintain full or part-time employment;
To function as a student;
To function in community-based volunteer activity;
To undertake some combination of items 1-3;
To acquire a (legal) gender-identity-appropriate first name;
To provide documentation that persons other than the therapist know that the patient functions in the desired gender role.

Real-Life Experience versus Real-Life Test. Although professionals may recommend living in the desired gender, 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 prosper in the preferred gender, they are confirmed as "transsexual," but 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, the capacity to function in the preferred gender, and the adequacy of social, economic, and psychological supports. It assists both the patient and the mental health professional in their judgments about 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 mental health professional and the patient gain confidence about undertaking further steps.

Removal of Beard and other Unwanted Hair for the Male to Female Patient. Beard density 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 include 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 grow out to visible lengths to be 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.

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X. Surgery

Sex Reassignment is Effective and Medically Indicated in Severe GID. In persons diagnosed with transsexualism or profound GID, sex reassignment surgery, along with hormone therapy and real-life experience, is a treatment that has proven to be effective. Such a therapeutic regimen, when prescribed or recommended by qualified practitioners, is medically indicated and medically necessary. Sex reassignment is not "experimental," "investigational," "elective," "cosmetic," or optional in any meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound GID.

How to Deal with Ethical Questions Concerning Sex Reassignment Surgery. Many persons, including some 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 alterations are made to body features to improve the patient's self image. Among those who object to sex reassignment surgery, these conditions are not thought to present when surgery is performed for persons with gender identity disorders. It is important that professionals dealing with patients with gender identity disorders feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort of patients diagnosed with gender identity disorders, professionals need to listen to these patients discuss their life histories, and dilemmas. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having profound gender identity disorder.

It is unethical to deny availability or eligibility for sex reassignment surgeries or hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV, or hepatitis B or C, etc.

The Surgeon's Relationship with the Physician Prescribing Hormones and the Mental Health Professional. The surgeon is not merely a technician hired to perform a procedure. The surgeon is part of the team of clinicians participating in a long-term treatment process. The patient often feels an immense positive regard for the surgeon, which ideally will enable long-term follow-up care. Because of his or her responsibility to the patient, the surgeon must understand the diagnosis that has led to the recommendation for genital surgery. 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. Ideally, the surgeon should have a close working relationship with the other professionals who have been actively involved in the patient's psychological and medical care. This is 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 assured that the mental health professional and physician prescribing hormones are reputable professionals with specialized experience with gender identity disorders. This is often reflected in the quality of the documentation letters. Since fictitious 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.

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.

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XI. Breast Surgery
Breast augmentation and removal are common operations, easily obtainable by the general public for a variety of indications. Reasons for these operations range from cosmetic indications to cancer. Although breast appearance is definitely important as a secondary sex characteristic, breast size or presence are not involved in the legal definitions of sex and gender and are not important for reproduction. The performance of breast operations should be considered with the same reservations as beginning hormonal therapy. Both produce relatively irreversible changes to the body.

The approach for male-to-female patients is different than for female-to-male patients. For female-to-male patients, a mastectomy procedure is usually the first surgery performed for success in gender presentation as a man; and for some patients it is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Female-to-male patients might may have surgery at the same time they begin hormones. For male-to-female patients, augmentation mammoplasty may be performed if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social gender role.

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XII. Genital Surgery
Eligibility Criteria. These minimum eligibility criteria for various genital surgeries equally apply to biologic males and females seeking genital surgery. They are:

Legal age of majority in the patient's nation;
Usually 12 months of continuous hormonal therapy for those without a medical contraindication (see below, "Can Surgery Be Performed Without Hormones and the Real-life Experience");
12 months of successful continuous full time real-life experience. Periods of returning to the original gender may indicate ambivalence about proceeding and generally should not be used to fulfill this criterion;
If required by the mental health professional, regular responsible participation in psychotherapy throughout the real-life experience at a frequency determined jointly by the patient and the mental health professional. Psychotherapy per se is not an absolute eligibility criterion for surgery;
Demonstrable knowledge of the cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches;
Awareness of different competent surgeons.
Readiness Criteria. The readiness criteria include:

Demonstrable progress in consolidating one's gender identity;
Demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health (this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance).
Can Surgery Be Provided Without Hormones and the Real-Life Experience? Individuals cannot receive genital surgery without meeting the eligibility criteria. Genital surgery is a treatment for a diagnosed gender

identity disorder, and should undertaken only after careful evaluation. Genital surgery is not a right that must be granted upon request. The SOC provide for an individual approach for every patient; but this does not mean that the general guidelines, which specify treatment consisting of diagnostic evaluation, possible psychotherapy, hormones, and real-life experience, can be ignored. However, if a person has lived convincingly as a member of the preferred gender for a long period of time and is assessed to be a psychologically healthy after a requisite period of psychotherapy, there is no inherent reason that he or she must take hormones prior to genital surgery.

Conditions under which Surgery May Occur. Genital surgical treatments for persons with a diagnosis of gender identity disorder are not merely another set of elective procedures. Typical elective procedures only involve a private mutually consenting contract between a patient and a surgeon. Genital surgeries for individuals diagnosed as having GID are to be undertaken only after a comprehensive evaluation by a qualified mental health professional. Genital surgery may be performed once written documentation 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 surgeon and the patient share responsibility of the decision to make irreversible changes to the body.

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. Surgeons should attend professional meetings where new techniques are presented.

Ideally, the surgeon should be knowledgeable about more than one of the surgical techniques for genital reconstruction so that he or she, in consultation with the patient, will be able to choose the ideal technique for the individual patient. 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.

Genital Surgery for the Male-to-Female Patient. Genital surgical procedures may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. These procedures require skilled surgery and postoperative care. Techniques include penile skin inversion, pedicled rectosigmoid transplant, or free skin graft to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Other Surgery for the Male-to-Female Patient. 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 blepharoplasty. These do not require letters of recommendation from mental health professionals.

There are concerns about the safety and effectiveness of voice modification surgery and more follow-up research should be done prior to widespread use of this procedure. In order to protect their vocal cords, patients who elect this procedure should do so after all other surgeries requiring general anesthesia with intubation are completed.

Genital Surgery for the Female-to-Male Patient. Genital surgical procedures may include hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular

prostheses, 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 several separate stages of surgery and frequent technical difficulties which may require additional operations. Even metoidioplasty, 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 indicates that further technical development is necessary.

Other Surgery for the Female-to-Male Patient. Other surgeries that may be performed to assist masculinization include liposuction to reduce fat in hips, thighs and buttocks.

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XIII. Post-Transition Follow-up
Long-term postoperative follow-up is encouraged in that it is one of the factors associated with a good psychosocial outcome. Follow-up is important 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 operate on patients who are coming from long distances should include personal follow-up in their care plan and attempt to ensure affordable, local, long-term aftercare in the patient's geographic region. Postoperative patients may also sometimes 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 hormonally and surgically treated patients. Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. The need for follow-up extends 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.

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