Chapter 12
Care for Adults with Gender Dysphoria

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Abstract This chapter gives an overview of the care for adults with gender dysphoria from the last decades of 1900 until recently, with a short vision for the future. The view on the care of individuals with gender issues has changed tremendously. This evolution is described here: from a psychotic illness, through a rather strict definition of "transsexualism," towards a broader description of gender-variant individuals. Also, the treatment has evolved simultaneously: from antipsychotic drugs, through medical treatment (hormones and surgery) of the "true transsexual" and the psychotherapeutic approach with the adult with "secondary transsexualism," towards a variety of possible treatments and transitions (social and/or physical), determined by the preference of the individual in consultation with the mental healthcare provider. In the most recent years, the focus has been on de-psychopathologization of gender variance; on the human rights of gender-variant people; on the effect of stigmatization, discrimination, and victimization; and on ways to prevent these negative social experiences.

Although the care of individuals with gender dysphoria has improved significantly over the past 50 years, more work needs to be done. Twenty-first-century gender care described in this volume should also be more readily available in the Southern Hemisphere and the Asia-Pacific Region. In the meantime, research evaluating treatment with the continuous aim of improving the care of individuals with gender dysphoria remains an important focus.

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12.1 Introduction

Although the phenomenon of incongruence between body-sex and soul-sex (gender) has been addressed in the scientific literature since the first half of the twentieth century, it was Harry Benjamin (1885–1986), a German endocrinologist working in the USA, who started to treat gender-dysphoric persons systematically in the 1960s with hormones and recommended surgery to end their suffering. He became interested in the subject after being introduced to a young man with gender dysphoria by Alfred Kinsey (1894–1956), who did not know how to help this patient. This young anatomical man adopted the social role of a woman. It was in 1954 that Harry Benjamin, for the first time, applied the term "transsexualism" to this phenomenon, a term that still remains popular. Psychologists and psychiatrists in those days had extreme disagreements among themselves and were mostly reluctant to give consent to medical interventions promoting transition, because many of them thought these individuals were suffering from a psychotic condition. Benjamin's book "The Transsexual Phenomenon" appeared in 1966 (Benjamin, 1966), and therein the author gave the history of 100 transsexual patients he had treated, providing details about diagnosis and medical treatment. In the meantime, Green and Money published their book "Transsexualism and Sex Reassignment" in 1969 (Green & Money, 1969). Researching history, mythology, and cultural anthropology, they concluded that the transsexual phenomenon was long-standing, widespread, and pervasive. Another important professional helping persons with gender problems was Stoller, the first psychoanalyst supportive of sex reassignment and who established criteria for this medical approach. He introduced the word "gender identity," a word that remains essential in the discourse about gender diversity. Next to infant–parent relationship and the child's perception of its external genitalia, he attributed a biologic force to explain its origin (Stoller, 1968).

In the Netherlands, the first sex operation was performed in 1959. But the surgeon was brought into court! The accusation was about performing surgery on a delusional person, because transsexualism was considered a delusion. Although the surgeon was acquitted, this incident delayed systematic help and care for transsexuals in the Netherlands until the end of the 1960s (Cohen-Kettenis, 1986).

12.2 Care of Transsexuals 1968–1995

12.2.1 History

In the period after the publication of the above-mentioned books and concurrently with the sexual revolution (1968), the view of "transsexualism" started to change, although slowly. Medical treatment via hormones and "sex reassignment surgery" remained controversial. First, in the 1970s and 1980s psychiatry, certainly in southern Europe, was dominated by the psychoanalytic "discourse," and so was "transsexualism" or "gender dysphoria" (Cohen-Kettenis & Wålinder, 1987). "For human beings, it is as impossible to change sexes as to become a pure spirit and the mutilating operation will only lead into a dead end." This sentence was published in the Summary of a paper written by Caire in 1989 in the "Annales Psychiatriques." Although transsexualism was no longer considered a delusion by most of the Anglo-Saxon professionals, it was still presumed by many to reflect an intrapsychic conflict for which psychotherapy was "the" solution. The aim of this psychotherapeutic approach was to cure the cross-gender identity feelings and to help the person accept his/her sex of birth. Nowadays, this is called "gender reparative therapy" (Byne et al., 2012).

Secondly, evidence for the effectiveness of a medical treatment approach was nearly nonexistent. Only case reports and retrospective studies consisting of small samples were published. A good example is the publication of Wålinder and Thuwe (1975), who concluded, on the basis of the follow-up investigation of 24 sex-reassigned transsexuals, that 2 out of the 11 biological men and none of the biological women regretted the measures that had been taken. Negative predictive factors detected were unstable personality, excessive geographical distance between patient and therapist, and long interruptions of hormone treatment. Even in 2003, a Dutch survey (A Campo, Nijman, Merckelback, & Evers, 2003) demonstrated that most psychiatrists thought that transsexualism was merely an epiphenomenon, a symptom of other psychiatric illnesses, and therapy options proposed to patients depended on their personal view on gender identity disorder. For example, some psychiatrists considered these patients as having a kind of body dysmorphic disorder comparable to anorexia and thus did not need to be treated by surgery.

Third, the world view in those days was still very dichotomized as a woman and a man's world, with little acceptance of diversity. Masculine matched up with man and feminine matched up with woman. As mentioned in the DSM-III, gender identity was seen as the private experience of gender role, and gender role as the public expression of gender identity. All these factors contributed to how transsexualism was conceptualized and the concept was clinically utilized. The diagnosis of "transsexualism" in the DSM-III (the diagnosis "gender identity disorder" for adults was only introduced in 1994 with the fourth edition of the DSM) was therefore rather narrowly defined, with a direct link to therapy. Providing hormonal and surgical sex reassignment surgery was only meant for those persons with extreme gender dysphoria. Clinicians, also influenced by public opinion, were scared to do harm to their patients and were very careful regarding hormonal and surgical sex reassignment therapy. Services were often denied if someone was not considered a "true" transsexual (being the person who wants to live in the other gender than assigned at birth, with a true conviction that he or she was born in the wrong sex, and wants a complete bodily adaptation to the other sex) because only those individuals were thought to be good candidates for sex reassignment therapy, in order to avoid postoperative regret (Cohen-Kettenis & Pfäfflin, 2010).

12.2.2 Diagnosis: Clinical Features

Before 1995, the DSM-III (1980) and the DSM-III-R (1985) were used to diagnose transsexualism, but more importantly it was the pre-Internet period. Online searches for symptoms were not existent and individuals with gender issues and gender dysphoria sought psycho-medical help in very different ways than they do nowadays. Most individuals had difficulty finding their way to the scarcely existing gender teams (Cohen-Kettenis & Wålinder, 1987) and were often held back by general practitioners, psychiatrists, psychotherapists, or other health professionals. Hormones were often bought under the counter. In the late 1960s and 1970s, some chose to undergo sex reassignment in Casablanca where Dr. Burou, a gynecologist, specialized in performing vaginoplasties (Hage, Karim, & Laub, 2007). No psychological evaluation was needed to receive surgery, as no standards of care for transsexuals existed at that time. However, many individuals suffered in silence and tried to cope with their cross-gender feelings without coming out at all.

Individuals who were able to find and contact competent mental health professionals for their gender issues could mainly be divided into two categories: those who had decided on sex reassignment therapy and those who just wanted help with their gender issues, with the knowledge that sex reassignment therapy was one of the therapeutic options, but that comfortable accommodation to their cross-gender identity without medical interventions was another option (Bockting, Knudson, & Goldberg, 2006).

Mental health professionals (psychiatrists, psychologists, or social workers with a specific interest in gender issues) working in private or as part of a multidisciplinary team were very cautious in their diagnostic work. Their first goal was to prevent patient regret of the transition, and they took the whole responsibility on their own shoulders for the decision to allow patients to undergo sex reassignment therapy. Because the diagnosis of transsexualism was based on nonobjective criteria and no psychometric instruments were developed to measure gender-dysphoric symptoms, the diagnosis was lengthy in time (mostly 1 year for the observational phase; see below), divided into two phases, and often information was examined by interviewing a third party (Cohen-Kettenis & Gooren, 1999).

12.2.2.1 First Diagnostic Phase

In the first phase, the observational phase, diagnostic criteria of ICD-9 or the DSM-III (APA, 1980) and later on the DSM-III-R (APA, 1987) for transsexualism were checked by means of a clinical interview. In addition to the criteria concerning the wish to belong to the other gender and to change their bodies, one of the criteria of DSM-III was "absence of physical or genetic abnormality," and another "not due to another mental disorder, such as schizophrenia," but both criteria were skipped in the DSM-III-R diagnosis. DSM-III as well as DSM-III-R asked for an enduring gender dysphoria of more than 2 years before the diagnosis could be proposed.

This was a useful criterion for clinicians to determine if a person was eligible for sex reassignment surgery (SRS) or not. Besides the DSM diagnoses, a thorough psychological/psychiatric assessment was performed to evaluate the psychological and social functioning of the applicant, his/her intellectual and emotional coping mechanisms, as well as possible concomitant psychopathology. The first aim of this evaluation was to be sure that the applicant had no major psychiatric problem or personality disorder that was underlying the diagnosis of "transsexualism" and that could impair the outcome of sex reassignment therapy. Second, a differential diagnosis was established to exclude applicants with the following diagnoses from medical treatment: patients with "transvestism"—but these individuals do not have the wish to be rid of their own genitals—or patients with "atypical gender identity disorder," individuals with a disturbed gender identity who only in isolated periods of stress wish to belong to the other sex and to be rid of their own genitals, or individuals who only seek a partial sex reassignment. Another third aim was to evaluate the already documented negative prognostic factors for postoperative failure (Wålinder, Lundström, & Thuwe, 1978), including psychiatric comorbidity, poor support of the applicant's family, dissatisfaction with secondary characteristics at initial assessment, and inadequate social functioning.

12.2.2.2 Second Diagnostic Phase

The second diagnostic phase is meant to evaluate the applicant during the "real-life test"; this is the period during which the clinician asks the applicant to live permanently in the desired gender role, a requirement mentioned for the first time in the first version of the Standards of Care (Cohen-Kettenis & Gooren, 1999). The applicant can experiment by experiencing "in vivo" how to live in the other gender and by coping with the consequences of this change. In this period, the applicant discloses his gender dysphoria and wish for transitioning to family, friends, and work. A new name is chosen. The aim of this test is also to check if, by living in the opposite gender role, the gender dysphoria will disappear, and thus the need for gender role change. Most clinicians and gender identity clinics in the 1970s and 1980s were expected to request this "real-life test" without hormones. Only after approximately 2 years, when the patient persisted in his/her transgender wish and was happy with the results of the hormonal treatment, he or she was considered ready to undergo surgery.

12.2.2.3 Typology

For clinical purposes, most clinicians recognized a subdivision in types of transsexualism, primary versus secondary transsexualism (in male-to-female transsexuals) (Person & Ovesey, 1974a, 1974b). This classification was made on the basis of the resolution of an ambiguous core gender. Person and Ovesey presumed that primary (true) transsexuals are asexual and have lifelong cross-gender wishes, but do not cross-dress as children and show no fetishistic arousal in adolescence related to their choice of clothing, while secondary transsexuals evolve from effeminate homosexuality or heterosexual transvestitism and experience cross-gender wishes only after puberty. The transsexual wish can follow a stressful period, can be episodic, or can evolve into a long-term identity (Lawrence & Zucker, 2012). These authors, together with others (e.g., Dolan, 1987; Levine & Lothstein, 1981; Meyer, 1982; Stoller, 1968), recommended that all individuals with secondary transsexualism should first undergo psychotherapy (supportive, insight oriented, or a combination of both) before undergoing sex reassignment therapy, to consider their wish for sex change as thoroughly and as objectively as possible (Dolan, 1987).

Blanchard's typology of male-to-female individuals was similar: "homosexual transsexuals" (gender-dysphoric individuals who are sexually attracted to individuals of the same natal sex) and "nonhomosexual transsexuals" (Blanchard, 1985; Blanchard, Clemmensen, & Steiner, 1987). According to Blanchard, the etiology of these categories is different. Nonhomosexual transsexuals experience autogynephilia (Blanchard, 1989), the male's proneness to be sexually aroused by thoughts or images of themselves as women, which can be considered a paraphilia. These individuals were assumed to seek SRS to actualize their autogynephilic desires. In this group, more postoperative regret was noticed (Blanchard, Steiner, Clemmensen, & Dickey, 1989; Lundström, Pauly, & Wålinder, 1984), as these individuals tried to live longer in the male gender role, sought sex reassignment later in life, and dealt with more loss (marriage, family, work) when transitioning. Therefore, clinicians emphasized an extra evaluation during the second phase of the diagnosis. More recent outcome studies though have not found more regret in these individuals with late-onset gender dysphoria, but rather found that they have more difficulties with social acceptance in the new role after transitioning (Lawrence, 2003).

Female applicants were (and still are) considered a more homogeneous group, with most sexually orientated towards women, searching for therapy at a younger age, having fewer psychological disturbances or postoperative regrets (Dolan, 1987; Levine & Lothstein, 1981).

12.2.3 Therapy

Therapeutic options for individuals with gender dysphoria were and remain diverse: psychotherapy (individual therapy, marital or family therapy, or group therapy), hormonal therapy, social transition into the desired gender role, and/or sex reassignment surgery.

In the 1970s and 1980s there was the conviction among professionals that gender-dysphoric persons, with the exception of the "true" transsexual, were probably more accurately treated by psychotherapy. The purpose of this psychotherapy was to improve the understanding of gender issues, to try to cope with them, and to search for alternative solutions to gender problems (Cohen-Kettenis & Gooren, 1999), such as part-time transitioning. In those days, numerous published papers reported successful outcomes of treating adolescents or adults by psychotherapy alone (Barlow, Abel, & Blanchard, 1979; Barlow, Reynolds, & Agras, 1973; Davenport & Harrison, 1977; Kirkpatrick & Friedmann, 1976; Lothstein, 1980). These papers were about psychodynamic and behavioral psychotherapy with the aim of accepting the natal sex and preventing social and physical transition to "the other sex." But conclusions from these (mostly) case studies were difficult to draw: Who were these gender-dysphoric individuals, did they suffer from one of the less severe forms of gender dysphoria, what were the criteria of a successful outcome, was the outcome long-lasting, and was a successful outcome (renouncing SRS) due to therapy or an effect of other determinants (Cohen-Kettenis & Kuiper, 1984; Cohen-Kettenis & Wålinder, 1987)?

For those who were eligible for SRS, supportive psychotherapy, not having the purpose to "cure" the gender dysphoria but to explore the evolving gender identity and the anxieties and ambivalences, to help with "coming out," and to cope with the losses a transition encompasses, was strongly encouraged. These sessions started in the diagnostic phases and continued while the patients were taking hormones in preparation for decisions about surgery. This psychotherapy was mostly individual, but patients could also benefit from group therapy (Stermac, Blanchard, Clemmensen, & Dickey, 1991), reducing the feelings of isolation, providing support in exploring their gender issues, and even providing practical advice on clothing, makeup, and other aspects of gender presentation. Marital or family therapy could help in the resolution of conflicts between spouses or between family members. It was well known from the literature examining prognostic factors for successful SRS that good family support was very important for a positive outcome. From that moment on, some mental health professionals involved the loved ones (partners, parents, children, other family member, etc.) in the counseling of the gender-dysphoric patient.

12.2.4 Standards of Care (SOC): Versions 1, 2, 3, and 4

The World Professional Association for Transgender Health (WPATH), formerly (from 1979 until 2007) called the Harry Benjamin International Gender Dysphoria Association (HBIGDA), is a multidisciplinary professional association devoted to the understanding and treatment of gender identity disorder. In 1979, for the first time, HBIGDA presented an explicit statement on the appropriate standards of care for hormonal and surgical sex reassignment (Walker et al., 1979). Being endorsed by an identifiable professional group, this original statement on the standards of care was expected to provide more clinical guidelines for professionals and improve the care for gender-dysphoric patients. It was recommended that professionals involved in the management of sex reassignment cases use these standards as the minimal criteria for the evaluation of their work. A quote in the introduction of this document demonstrated that carefulness and cautiousness were of primary concern:

> "*It should be noted that some experts on gender identity recommend that the time parameters listed in these standards should be doubled, or tripled* (p. 2)".

These standards were revised by the same members of the founding committee of the HBIGDA in 1980 (version 2), in 1981 (version 3), and in 1990 (version 4) always chaired by Dr. Paul Walker (Walker et al., 1980, 1981, 1990). The different versions all contained 32 principles and 16 standards but were adapted in a slightly more liberal way across each revision. In the first version, the Standards of Care recommended that the applicant eligible for sex reassignment treatment meet the DSM-III criteria of transsexualism (category 302.5x). Preceding the hormonal therapy, the patient should live for 3 months full-time in the social role of the desired gender and should have a psychotherapeutic interaction of a minimum of 3 months with the psychologist or psychiatrist making the recommendation in favor of treatment. For genital surgery, the requirements were professional relationship for at least 6 months with a psychologist or psychiatrist and full-time living in the desired gender for 12 months. Hormonal sex reassignment should precede SRS. Two different clinical behavioral scientists must give their approval for genital surgery. Instead of being considered a counselor, the behavioral scientist held more of a gatekeeper's role, controlling who was eligible for sex reassignment therapy and who was not, without sharing the responsibility of the decision for medical therapy with the patient.

Already in version 2, the requirement that the patient had to live successfully in the desired gender role at least 3 months prior to the hormonal treatment was rescinded. In version 3, the requirement that one of the clinical behavioral scientists giving the written recommendation for genital surgery be a psychiatrist was eliminated. Minimal documentable credentials and expertise of the clinical behavioral scientists who could give written approval for sex reassignment therapy were adopted in version 4.

Most gender identity clinics, as well as private practitioners treating gender-dysphoric individuals in Europe and North America, adhered to the SOC (Petersen & Dickey, 1995). Although these standards, seen through the eye of the professional in 2012, patronized the individual with gender dysphoria, they were also a big step forward in the appropriate care for these patients, preventing them from maltreatment or from being a victim of abuse and unethical practices.

12.3 Care of Individuals with the Diagnosis of Gender Identity Disorder: 1995–2010

12.3.1 History: Terminology

With the introduction of DSM-IV (APA, 1994) and DSM-IV TR (APA, 2000), the diagnosis of transsexualism disappeared and the diagnostic label changed to Gender Identity Disorder. After 1995, more and more papers about GID were published with mainly two foci: follow-up studies of larger cohorts of individuals who underwent sex reassignment therapy and a second focus on etiological issues, with emphasis on the biological brain aspects (e.g., Garcia-Falgueras & Swaab, 2008; Hare et al., 2009; Zhou, Hofman, Gooren, & Swaab, 1995). These papers provided more insight into what gender identity is and presented more evidence for the effectiveness of the medical treatment of gender identity disorder in adults (Byne et al., 2012).

The 1995–2010 period involved the development of the Internet and social networking. Transgender people started to connect with each other in ways that were previously not possible. Consumer organizations emerged and influenced professionals about how to conceptualize, to diagnose, and to treat gender dysphoria. They also influenced the terminology. The term male transsexual was first replaced by male-to-female transsexual and afterwards by trans-woman, and a female transsexual became first a female-to-male transsexual person and afterwards a trans-man. Sexual orientation is now more frequently defined by gender identity and not by natal sex; the terms gynephilic or androphilic became more common. The name "real-life test" was changed into "real-life experience" and is, since the launch of the SOC—version 7, replaced by the paraphrase "living in a gender role that is congruent with the gender identity."

After 1995, more attention was also paid to individuals who do not wish to undergo genital surgery for diverse reasons such as keeping their fertility, or sexual reasons, as well for those who do not want to or cannot transition. Hormonal therapy only, without any surgery, became more acceptable.

12.3.2 Diagnostics

12.3.2.1 Diagnostic Criteria

From 1994 on, the applicant for sex reassignment had to fulfill the diagnosis "Gender Identity Disorder" (GID) according the DSM-IV criteria (APA, 1994) or DSM-IV-TR (APA, 2000) (same criteria). In the GID diagnosis, the same two components as in the earlier versions were present: (a) There is a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is of the other sex (not merely a desire for any perceived cultural advantages of being the other sex); (b) there must be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex. Also in the DSM-IV and the DSM-IV-TR manual, the diagnosis cannot be concurrent with a physical intersex condition (criterion c), those individuals with an intersex condition with gender dysphoria are coded GID Not Otherwise Specified (NOS), and to the diagnosis requires evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning (criterion d) (APA, 1994, 2000). In contrast with the DSM-III diagnosis, the criterion "a strong and persistent cross-gender identification" does not mention any duration of the symptoms in the DSM-IV diagnosis, which gives the clinicians less guidance regarding medical therapy, but gives them more freedom in their interpretation of who is eligible for SRS (Cohen-Kettenis & Gooren, 1999). In DSM-IV and DSM-IV-TR (already in DSM-III-R), comorbidity (such as schizophrenia) is no longer an exclusion as such. The following specifiers may be noted based on the individual's sexual orientation, namely, sexually attracted to males, to females, to both, or to neither. For clinical reasons though, the subdivision made on the basis of sexual orientation, as well as the subdivision in primary and secondary transsexualism, has been abandoned and replaced by the categories early onset versus late onset, which has turned out to be more useful and pragmatic. This subdivision, although not used in the DSM-IV or DSM-IV-TR, is made based on the onset of gender dysphoria. Individuals with early onset have a history of lifelong gender-dysphoric feelings and fulfill retrospectively the diagnosis of GID in childhood; individuals with late onset had no GID in childhood and start having gender-dysphoric feelings later in life, after puberty. Besides the clinical reasons, this subdivision is less stigmatizing and considered more useful for future research purposes (Doorn, Gooren, & Verschoor, 1994; Nieder et al., 2011).

A new phenomenon that has to be considered as a differential diagnostic category, in addition to those already mentioned, is the recently described phenomenon of the "Modern Eunuch." These are men who voluntarily want to be castrated (chemically or physically). The majority identify as male or view themselves as in an alternate non-male, non-female, gender space. Only very few identify as male-to-female transsexuals. Johnson, Brett, Roberts, and Wassersug (2007) suggest that male-to-eunuch is a valid transgender identity. This category is still a clinical description without a formal diagnosis and without well-established therapy.

12.3.2.2 Assessment

To assess more objectively the degree of gender dysphoria, existing gender-related subscales of well-known questionnaires (MMPI-2, Minnesota Multiphasic Personality Inventory-2, Gómez-Gil et al., 2008) were more frequently used, and new scales evaluating gender-dysphoric symptoms were developed. The Utrecht Gender Dysphoria Scale (Cohen-Kettenis & van Goozen, 1997) has been widely used for clinical and research purposes and has now been validated (Kreukels et al., 2012; Steensma et al., 2013). Deogracias developed a Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults (Deogracias et al., 2007) with good sensitivity and specificity, which also has been cross-validated (Singh et al., 2010).

The diagnostic phase is performed as in former years (evaluation of the gender dysphoria as well as a thorough psychological evaluation) but with other priorities and foci and a less lengthy time frame (depending on the individual case, sometimes a few evaluation sessions are sufficient). Mental health professionals have become more acquainted with Gender Identity Disorders and gender incongruence and are more guided and backed by outcome studies supporting the effectiveness of sex reassignment surgery. Consumer organizations pushed hard to reduce the time required before hormonal treatment could start, as well as the period of real-life experience, because they considered these diagnostic procedures as needlessly lengthy, stressful, and expensive (Cohen-Kettenis & Gooren, 1999). In an evaluation of more than 200 postoperative MtF individuals, Lawrence (2003) reached the conclusion that the duration of preoperative real-life experience in the desired gender role showed a significant association with "happiness with result" but not with any other outcome measures. In general, in most gender identity clinics, the real-life experience has mostly lost its value as a diagnostic guide and is no longer a requirement for hormonal treatment (see SOC version 7). Living in the preferred/experienced gender could begin even after the hormonal treatment has started. Although requested for genital surgery, the real-life experience was mostly reduced to 1 year before surgery was authorized.

The task of the mental health professional has evolved in fundamental ways. The gatekeeper's role became obsolete, and a working alliance with the patient based on trust and respect became essential. The diagnosis shifted to an evaluation. During these evaluation sessions, the mental health professional together with the patient is expected to discuss all the relevant (gender) issues, the consequences, and the planning of care, in an atmosphere wherein the responsibilities are shared and the decisions are made collaboratively (Pfäfflin, 2007). Sometimes, there is a lack of confidence between the mental health professional and the patient and the work alliance remains strained. In these cases, a separation between assessment and psychotherapy is advised (Bockting et al., 2006).

12.3.3 Therapy

From the 1990s onwards, in contrast with the former period, therapy and, more specifically, psychotherapy for gender-dysphoric individuals became more pragmatic and symptom-based. The etiological vision on the origin of transsexualism (be it somatic and/or psychosocial) is not relevant anymore in the therapeutic approach towards the patient. Patients with early-onset GID or with late-onset GID are receiving the same sex reassignment treatment, if they so wish. Hormonal therapy and sex reassignment surgery is accepted as the best available treatment for individuals with gender dysphoria. The focus of the therapy has become the present distress and its alleviation. Gender reparative therapy has been largely abandoned and is typically judged as unethical (Coleman et al., 2011).

This is also the decade that mental health professionals became more convinced that not all individuals with gender dysphoria need both hormones and surgery to alleviate their gender dysphoria, but that some need only one or neither of these treatment options. Gender transition is nowadays considered to encompass separate social and bodily transitions; not all individuals want both. More individualized treatment has become the rule (Coleman et al., 2011).

In their psychotherapeutic approach, most clinicians and mental health professionals have two parallel foci: first is the gender-related care and second is the care for (if present) other mental health problems. During the general counseling sessions, diverse gender-related issues and concerns can be addressed depending on the individual's needs such as body image (masculinity–femininity), implications of the process of coming out, grief and loss, sexual concerns, fertility concerns, social isolation, spiritual concerns, and violence and abuse (Bockting et al., 2006). As gender identity problems, untreated gender dysphoria, and above all social stigma causing minority stress affect the mental health and the psychosocial functioning of the transgender individual, sometimes more focused care is needed. By treating solely the gender dysphoria, the mental health problems are not always solved (through counseling, hormones, and/or social transition). In other more complex cases with more comorbidity, a specific treatment is needed, for example, by pharmacotherapy in the case of major depression, anxiety disorder, or concomitant psychosis or by more specific psychotherapy (in individuals with eating disorders and/or personality disorders). Sometimes the clinician has to refer his patient to a more specialized clinician or psychiatrist for the treatment of comorbid mental health concerns.

Not all individuals want and need a mental health professional to guide them in the gender transition and ask only for an assessment to get approval for hormones and surgery. They consider that by interacting with a mental health professional, they could be stigmatized. It is well emphasized in the sixth version of the SOC of WPATH though that the present inclusion of GID as a mental disorder in the DSM-IV-TR is not a license for stigmatization. Anyway, in the turmoil of a gender transition, moments of reflection together with a mental health professional can always be beneficial. All versions of the SOC strongly support psychotherapy throughout the transition. On the other hand, the mental health professional enables the gender-dysphoric individual to have access to care and can be helpful in achieving health insurance coverage (Pfäfflin, 2007).

In fact, methodologically well-grounded research to evaluate the requirements for sex reassignment surgery that support better outcomes (better psychosocial functioning and less regret) is still not available. Pfäfflin and Junge (1998) published a 30-year review of follow-up studies between 1961 and 1991, and more than 15 years later Gijs and Brewaeys (2007) stated that there is no scientific consensus about how long the contact with the treatment center, real-life experience, hormonal treatment, and counseling ought to last in order to obtain the best results (De Cuypere & Vercruysse, 2009). Nevertheless, a predictor that has been found to be important for a successful SRS outcome is the criterion described as "an adequate understanding of what surgery can and cannot do." This means that individuals who want to undergo sex reassignment surgery must have a realistic view about what can be achieved through surgical interventions, because surgery removes or damages "healthy" organs irreversibly (Rächlin, 1999). In this light, information sessions during counseling are very useful. The gender-dysphoric individual should have the knowledge of different surgical possibilities, their results, and their implications, including reproductive (im)possibilities, complications, postsurgical rehabilitation requirements, and costs, a requirement that has been addressed in different versions of the SOC since version 5.

Although it is well known that lifelong hormonal treatment guided by an endocrinologist or hormone-prescribing physician is needed and that follow-up by the surgeon is associated with good surgical outcomes, less is known about postoperative follow-up by mental health professionals. Only Rehman, Lazer, Benet, Schaeffer, and Melman (1999) especially stressed the need for additional postoperative psychotherapy, an advice that has been inserted in the SOC version 7.

Recently, the Board of Trustees (BOT) of the American Psychiatric Association (APA) approved the report of the Task Force on Treatment of Gender Identity Disorder (Byne et al., 2012). The primary aim of this report was to answer the question as to whether or not there is sufficient credible literature to support development by the APA of treatment recommendations for GID. With subjective improvement as the primary outcome measure, the current evidence base combined with clinical consensus was judged sufficient to support recommendations for adults in the form of an evidence-based APA Practice Guideline. While other guidelines, policy statements, and Standards of Care exist and are available for mental health professionals in providing care to individuals with GID, the report identified several reasons that recommendations specifically targeted to psychiatrists would be desirable. This could likely have a positive impact on the number of psychiatrists willing to help transgender patients. The report also recommends that additional steps pertaining to gender variance (individuals with any degree of cross-gender identification) be taken by the APA beyond drafting treatment recommendations for GID. These include issuing a policy statement to clarify the APA's position regarding the medical necessity of treatments for GID, the ethical bounds of treatments for minors with GID or gender variance, and the rights of persons of any age who are gender variant, transgender, or transsexual (Byne et al., 2012). This report calls for a variety of measures that would greatly benefit the transgender patients and is therefore well accepted. However, the APA did not reach consensus regarding the question of whether or not persistent cross-gender identification sufficient to motivate an individual to seek SRS, per se, is a form of psychopathology in the absence of clinically significant distress or impairment.

12.3.4 More Recent Versions of the SOC: Versions 5 and 6

12.3.4.1 SOC Version 5: 1998

In 1998 version 5 of the SOC was issued, composed by other committee members than the four editions before, and chaired by Dr. Stephen Levine (Levine et al., 1998). SOC 5 differed significantly from the former editions, not only by its length (33 pages instead of 10) but also by the rather detailed guidelines, with specific attention to subgroups. In this version, as well as in version 6, Gender Identity Disorder is still considered a mental disorder.

The "triadic therapeutic sequence" is a new concept in these SOC, and it works to standardize the medical treatment. If the GID diagnosis according to the DSM-IV is made and the patient meets the requirements for medical therapy, the triadic therapeutic sequence of cross-gender living, administration of cross-sex hormones, and genital (and other) surgeries as medical treatment is put forward. Psychotherapy is not a requirement for the triadic therapy. According to version 5 of the SOC,

> The Mental Health Professional who recommends hormonal and surgical therapy shares the legal and ethical responsibility for that decision with the physician who undertakes the treatment.

In this version of the SOC, the issue concerning the patient's legal and ethical responsibility in the decision for SRS is not addressed.

The SOC—fifth edition distinguishes between eligibility and readiness criteria for hormonal therapy and surgery. These eligibility criteria are set out in the section "Requirements for Hormone Therapy for Adults" and "Requirements for Genital Reconstructive and Breast Surgery." The eligibility criteria are those specified criteria that must be documented before moving to a next step in a triadic therapeutic sequence. Without first meeting eligibility requirements, the patient and the therapist should not request hormones or surgery. The readiness criteria are fulfilled if there is further consolidation of the evolving gender identity and if the patient has made progress in mastering interpersonal issues or in dealing with work and family leading to improving or continuing stable mental health. These readiness criteria are rather subjective and rest upon the clinician's judgment. This sometimes can compromise the relationship between the counselor and patient.

For the first time in the history of care for individuals with gender dysphoria, in this edition there is also attention to adolescents with gender dysphoria. The possibility of treating them with puberty blockers is discussed, and guidelines are given.

In complement to the focus on hormonal treatment and genital and breast surgery, there are also paragraphs on the tasks and training of mental health professionals, on psychotherapy (where emphasis is placed on the benefit of psychotherapy, although not an absolute requirement), and on the real-life experience.

In comparison with the previous versions of the SOC, version 5 gives much more guidance to caregivers but is still mainly focused on the prerequisites that patients need to fulfill.

12.3.4.2 SOC Version 6: 2001

Three years after SOC version 5, a next version was issued and chaired by Walter Meyer (Meyer et al., 2001) and included new Committee Members, except Peggy Cohen-Kettenis and Eli Coleman who were already involved in the fifth version of the SOC. These standards were nearly identical to the former version, but with more nuances and some other highlights.

The therapeutic triadic sequence, according to this version, can be handled in a flexible way and is not necessarily in the sequence of real-life experience → hormones → surgery but could also be hormones → real-life experience → surgery or for biologic females, hormones → breast surgery → real-life experience. This version emphasizes that the complete therapeutic triad of the diagnosis of GID is only one of the variety of therapeutic options and that not all persons with GID need or want all three elements of triadic therapy. The SOC advocate that hormones can also be given to those who do not want surgery or a real-life experience and that hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross living or surgery.

In this version of the SOC, there is a paragraph added concerning the reproductive needs and rights of persons after a sex transition, reflecting a more public debate. The standards encourage patients to consider and discuss fertility issues prior to starting hormonal treatment. Hormonal therapy leads to decreased spermatogenesis (production of spermatozoa) and eventually to azoospermia (absence of sperm in semen) in trans-women (Wierckx et al., 2012).

Also, more attention has been given to the hormone therapy and medical care for incarcerated persons, advising that housing for transgendered prisoners should take into account their transition status and their personal safety.

Although, at first sight, there are no major differences with the former version of the SOC, this version already put more emphasis on the individual needs of the person with gender dysphoria to engage, for example, in a partial transition and on the human rights every single person with gender dysphoria has, young or old, free or incarcerated, with reproductive wishes or not.

12.4 Care of Persons with Gender Dysphoria from 2010 Onwards

12.4.1 SOC, Seventh Version, 2011

The ambition of the newly revised seventh version of the SOC, named as "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People," issued during the WPATH symposium in Atlanta 2011, was huge (Coleman et al., 2011). In the new spirit of de-psychopathologization of gender variance since the first decade of 2000 and in contrast with the former versions, this version of the SOC includes a statement concerning gender nonconformity, namely, "Gender nonconformity *should not be judged as inherently pathological or negative, yet gender dysphoria is a specific distress that can be alleviated through medically necessary treatment*." Concerning the question if "gender dysphoria" is a mental disorder or not, the seventh version of the SOC is rather diplomatic and uses the following wording: *"Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder."*

The new SOC wanted to be more evidence-based and succeeded, for the first time, to cite a lot of background, review, and research literature providing as much evidence as possible for these standards. The clinical guidelines are very detailed (from pages 33–122) and extend beyond providing hormones and surgery. They are about achieving overall health, well-being, and self-fulfillment. These standards have been revised by an International Advisory group of individuals who identify as transsexual and/or transgender to address critiques from former issues of the SOC, which were criticized for creating barriers to care by imposing strict criteria for therapy.

Although the general purpose and use of the standards of care roughly remain the same as in previous editions, to provide safe and effective pathways to achieving lasting personal comfort with the gendered selves of our patients, the tone of the new standards is rather different. The emphasis is on what professionals need to do, rather than what the client needs to do, to have the best suitable therapy. These standards are very flexible and recognize the uniqueness of each patient. There are also several new sections such as E-therapy, Voice and Communication, and considerations for persons with DSD. In this version, the concept of the therapeutic triadic sequence is left behind.

Briefly, the changes are as follows. There is no longer a distinction between eligibility and readiness criteria; these are mostly merged under the criterion: "If significant medical or mental health concerns are present, they must be reasonably well controlled." Concerning the requirements for hormonal therapy, the same criteria are handled, except that the criterion of real-life experience or psychotherapy for a minimum of 3 months is deleted. The requirements for breast surgery in trans-men remain the same; in trans-women the 18 months of female hormones are no longer a prerequisite to undergo breast surgery; the SOC only strongly recommend taking female hormones for at least 12 months prior to breast augmentation, to maximize breast growth and in order to obtain better esthetic results. Concerning the criteria for genital surgery, 12 months of hormone therapy is still required. Another requirement is "12 months of living in a gender role that is congruent with the gender identity," but this is no longer mandatory when only gonadectomy (surgical removal of ovaries or testes) is performed. Trans-women, for example, can undergo oophorectomy (removal of ovaries) without having lived in the male role for 12 months. The other prerequisites remain the same, but are worded in slightly different ways.

12.4.2 De-psychopathologization: DSM-5 and ICD-11

The diagnostic labeling of gender-variant individuals with a mental illness by using the diagnosis Gender Identity Disorder became a topic of growing controversy in consumer, professional, and human rights organizations (Lev, 2006). The debate as to whether or not a diagnosis of gender identity disorder is valid, needed, or wanted for adult gender-dysphoric individuals can be considered fundamental, as the new DSM-5 is going to be published in 2013 and the ICD-11 in 2015. One of the major arguments put forth by consumer groups for removal of the diagnosis in the DSM-5 is that gender variance is not, in and of itself, pathological and that having a cross-gender or transgender identity does not constitute a psychiatric disorder (Knudson, De Cuypere, & Bockting, 2010). Classifying gender variance as such perpetuates stigma attached to gender nonconformity. Some authors even mention a stigma-sickness slope. The daily experience of stigma, prejudice, discrimination, harassment, and abuse commonly drives trans-people to the social, economic, and legal margins of society, impacts on their mental and physical health, and edges many of them into situations and patterns of behavior that leave them vulnerable to HIV infection and AIDS-related illnesses (Winter, 2012a). Meanwhile, in 2010, WPATH released a statement urging the de-psychopathologization of gender variance worldwide:

> …The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon which should not be judged as inherently pathological or negative. The psychopathologisation of gender characteristics and identities reinforces or can prompt stigma, making prejudice and discrimination more likely, rendering transgender and transsexual people more vulnerable to social and legal marginalization and exclusion, and increasing risks to mental and physical well-being. WPATH urges governmental and medical professional organizations to review their policies and practices to eliminate stigma toward gender-variant people.

The DSM-5 Workgroup on Sexual and Gender Identity Disorders of the American Psychiatric Association received a lot of input from professionals and consumers regarding their work in the revision of the diagnosis of Gender Identity Disorder, including recommendations from WPATH (De Cuypere, Knudson, & Bockting, 2010, 2011). In the discussion concerning the pros and the cons of retaining the GID in DSM-5, the workgroup decided to retain the diagnosis, but to replace the name of the diagnosis by Gender Dysphoria, which implies that the identity is no longer considered disordered, but that a diagnosis is needed for those transgender individuals who, at some point in their lives, experience clinically significant distress associated with their gender variance. Greater access to care was one of the major arguments to maintain a diagnosis of gender dysphoria in the DSM-5.

Whether ICD-11 should have a diagnosis of gender dysphoria is another discussion, since ICD is not a manual of mental disorders but a "classification of diseases and related health problems" with a chapter on "Mental and Behavioural [sic] Disorders." At this moment transsexualism and dual-role transvestism are still categorized in this chapter. The provisional proposal from the Working Group on Sexual Disorders and Sexual Health is to remove the diagnoses from Chap. 5 and to place it in a separate chapter under a new name: Gender Incongruence (Winter, 2012b).

It is obvious from the already published SOC version 7, the new proposals for DSM-5 and ICD-11, that in the coming years more efforts will be made by activists, consumers, professionals, and human rights organizations to continue to destigmatize gender variance and gender diversity to prevent individuals with a gender incongruence from being marginalized, stigmatized, and becoming ill. Efforts will also be made to give these individuals easier access worldwide to professional care in their wish for transition, in the way and the extent to which they want it.

12.4.3 Future

The implications of the de-psychopathologization of gender variance, the new SOCs, the more broadly defined diagnosis “Gender dysphoria” in the DSM-5, and the proposed elimination of the diagnosis “transsexualism” from the Mental Disorder chapter in the ICD-11 for the care of the transgender individual can only be predicted from what is already known at this moment. The intention of these changes is that transgender individuals will feel more respected, less stigmatized, and less imprisoned in the dichotomy of man–woman. There may be more respect for different therapeutic options that give the transgender individual more opportunity to align their transgender wishes and their reality. As the whole spectrum of gender variance becomes a focus of diagnosis and treatment, more people with gender issues may feel that their issues are addressed. Transgender individuals may get a greater opportunity to make decisions about their own lives, yielding more self-confidence and fewer mental health problems. This is of course only an expert opinion. I doubt that in this new era of more autonomy for the patient, there will be more individuals who regret their therapeutic choice. But as scientists we should evaluate this evolution, making it more evidence-based. Therefore, more follow-up research that is methodologically well grounded is still needed.

12.5 Vignette: Illustration of Different Approaches in Different Time Frames

Michael came to visit the Gender Identity Clinic of the University Hospital in Ghent for the first time in 1993; he was 21 years old. At that time he was hospitalized in the psychiatric department of the hospital for suicidality. He had tried to commit suicide by hanging. During the interview with the psychiatrist, he revealed that he felt depressed because his mother did not allow him to dress himself and to go out as a woman.

Michael is the youngest of a family with four boys. Soon after his birth, it became clear that he had psychomotoric retardation. An etiological diagnosis for this retardation has never been established. The mother and father had opposing views about his education and argued a lot about it. The father had also an alcohol problem. When Michael was 7, the parents split. He blamed his father for having left the family and felt abandoned by him. The mother was overprotective towards Michael during his childhood and adolescence. As a child, Michael showed no feminine behavior, chose neutral play options, and preferred boys as peers. His cross-dressing started at 12, from puberty onwards, and included the purpose of sexual excitement when he experienced himself as a woman. From then on, he periodically wanted to be a woman but also had periods during which he felt like a man. When he cross-dressed at home, there was bullying from his elder brother. When Michael first attended the gender identity clinic, he was a rather shy young man, not very feminine in his appearance, difficult in contact, and very silent. He was not always consistent in his complaints. Sometimes he said he wanted a total social and physical transition, sometimes he said he wanted only a social transition helped by hormones, and no genital surgery. During the consultation with his mother, she commented negatively on her ex-husband in the presence of Michael. Michael admired women and disapproved of men. There was a negative identification with the father. An IQ test revealed that Michael had borderline intellectual functioning (IQ: 70–75).

Our advice after several evaluation sessions was to stimulate him to further explore his feminine identity by giving him the opportunity to live as a woman on the weekends and to live as a man during the week. We made some agreements concerning these cross-dressing sessions with the mother and brother, but were not supportive for female hormonal treatment to begin. We also advised him to follow some more intensive therapeutic sessions to cope more easily with the loss of his father. The rationale for our treatment proposal was as follows: Michael suffers from the loss of his father, there is no consistency in his wish to change sex, and he does not want to go through a full physical transition. Our diagnosis was Gender Identity Disorder of Adolescence or Adulthood Non-transsexual Type (302.85) with parent–child problem and borderline intellectual functioning. According the DSM-III-R, Michael was considered not to be eligible for hormonal therapy.

Fourteen years later, in 2007, Michael attended the gender identity clinic again. He presented himself as Michelle, a good-looking girl, and told us he had continuously lived as a woman for 10 years, but still did not take female hormones. In the meantime, she lived apart from her family, under supervision, but was not able to work. She had no partner. She defined herself as being bisexual. The mother was still a supportive figure for Michelle. During the 14 years we did not have contact, Michelle went through some psychotic episodes (approximately five times), always provoked by stress. Antipsychotic medication had now stabilized her mental illness. It was very important for Michelle to be considered a woman; there were no hesitations about that anymore. She wanted female hormones and breast augmentation, without genital surgery. By taking hormones and having breasts, she would obtain the secondary characteristics of a woman, would suffer less from beard growth, and would feel more like a woman. Primary male organs were not so important for her, she was not disgusted by them, and she was very afraid of sex reassignment surgery.

After four evaluation sessions, the psychiatrist of the gender identity clinic gave approval for hormonal therapy. A clear-cut DSM-IV-TR diagnosis was difficult to make, Gender Identity Disorder or Gender Identity Disorder Not Otherwise Specified, but was not so important for our therapeutic plan, as Michelle's wish was taken at face value. Although she had a low IQ, she had the capacity to make a fully informed decision and to consent for treatment. Michelle was very pleased with this decision: With the growth of her breasts, not having erections anymore, and less hair growth over her body, she nevertheless had a relapse of a psychotic period, but it was very short, and she was quickly under control.

After 18 months of female hormones, the gender team consisting of a psychiatrist, endocrinologist, and surgeon agreed to breast augmentation. There was no doubt about her female gender identity, and we agreed on her request for partial bodily transition. One year later, she enjoys her physical transition and thanked the gender team for agreeing to give her hormonal treatment and breast surgery. She functions well and feels much happier than before.

The most impressive change of vision of the gender team over the years was that we now agreed upon a partial physical transition and that we are convinced this decision is in the best interest of Michelle. Also, the low IQ and the periodic psychotic episodes were not anymore absolute contraindications, but only a focus of attention.

12.6 Discussion and Conclusions

When we review more than 50 years of gender care, we can conclude that the view of care for persons with gender dysphoria has changed tremendously. Before the 1970s, transsexualism was viewed as a symptom of major psychopathology, a psychotic illness that had to be treated by antipsychotics or through an intensive (psychodynamic) psychotherapy, helping the patient to accept his or her sex of birth. From the 1970s onwards, more and more psychiatrists and psychologists became convinced that, in some patients, gender dysphoria was an authentic complaint, best treated by medical treatment (hormones and surgery), and not a delusion. These patients needed to be carefully selected and to follow a rather strict procedure of triadic sequence. Only patients with a lifelong cross-gender identity were considered good candidates for sex reassignment surgery.

At that time, secondary transsexualism still needed to be treated by psychotherapy. Later on, mental health professionals agreed that even individuals with late-onset gender dysphoria could benefit from sex reassignment (treatment). Until the end of the previous century, the role of the mental health professional was the role of a stern evaluator, a firm/tough gatekeeper. Their approach was dichotomous, male–female, without allowing partial treatment. The concept of gender variance or gender nonconformity has only become accepted in the last 10 years. The idea is that only some gender nonconforming people experience gender dysphoria at some point in their lives (Coleman et al., 2011), gender dysphoria referring to the distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). Treatment is meant to help people with such distress to explore their gender identity and find the gender role and bodily adaptation that fits them. The mental health professional is no longer a gatekeeper. Psychiatrists have a role only in treating those individuals with severe psychiatric morbidity hampering the gender care. More attention has been drawn in recent years to the human rights of gender-variant people; to the effect of stigmatization, discrimination, and victimization; and to ways of preventing these.

Although in many countries and regions of the world gender care succeeded in treating gender-variant and gender-dysphoric individuals with dignity and respect, improving their quality of life, still many individuals do not have access to this high quality of care for diverse reasons, e.g., geographical, financial, social, religious, and familial or other reasons. This will be one of the foci or challenges in the upcoming years. Research on etiology and treatment with the aim of continuously improving the care of gender-dysphoric individuals (taking into account the newer concept of gender dysphoria) remains another focus.

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