

Minefields and Pitfalls in Gender Identity Disorder, for both Patient and Doctor

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"So long as we run away from a preparedness to have people look closer at failures they will continue to be a stick to beat us with. Though if instead we stop ... if we probe ... and if we are then able to explain why (rare as it is) people sometimes come down this road for the wrong reasons and fail ... then we are paradoxically in a better position to understand and emphasize why the vast majority of people benefit from the treatment." Christine Burns - Press for change

Introduction.

Diagnosis and Management.

Self diagnosis is fundamental. Transsexuals invariably diagnose themselves because it is usually so obvious to them. The analogy is with gay men and women who also diagnose themselves because of the subjectivity of their sexuality. For would-be Transsexuals, going to the Doctor (i.e. their General Practitioner) will be a different experience from almost any other patient seeking treatment because the Transsexual person will be asking for help, usually knowing more about their condition than the GP. The role of the GP in this situation is to be aware of his/her own limitations and prejudices and refer on to a Gender Specialist, usually a psychiatrist. In an ideal world the GP would be familiar with the condition and well able to respond appropriately.

The role of the Gender Specialist is to make a careful diagnostic assessment to either confirm or refute the diagnosis of 'Gender Dysphoria' and to exclude the possibility that the person may be mentally ill, by which I mean suffering from Schizophrenia or Bipolar Affective Disorder (also known as 'Manic Depressive Psychosis'), where symptoms of Gender Dysphoria may mask mental illness. Likewise other psychiatric conditions such as Borderline Personality Disorder must be considered, because these suggest emotional instability. There is evidence to suggest that such co-morbid psychopathology is associated with poor outcome.

The Gender Specialist will continue to monitor the patient's progress every few months and judge when hormones should be started - if indeed the patient wants hormones. The Doctor must be careful to remain neutral and objective in his opinions particularly regarding suitability for treatment and prognosis in both the short and long term. Experience suggests that the most unlikely would-be Transsexuals often do well, whereas others who seem to be passable and stable and well adjusted, sometimes fall by the wayside. Clearly this has to do with the subjectivity of one's Gender Dysphoria and factors such as the intensity, drive and determination to overcome problems regardless, not to mention social variables including family support or opposition etc.

For the Gender Dysphoric patient the management of their own treatment process is crucial. They must take an active role alongside the Gender Specialist in formulating their treatment plan. This includes setting out their own timetable, goals and means of achieving these in terms of when and if they start hormones, transition and in due course undergo Gender Reassignment Surgery (GRS). The Gender Specialist will look to the Harry Benjamin (International Gender Dysphoria

Association - HBIQDA) Guidelines, and combine this with his own clinical judgment. By assuming a lead role in their own treatment, the patient accepts primary responsibility, albeit shared with the Gender Specialist, for what they are doing together with the consequences in both the short and long term. So the patient must have the right to put the brakes on and halt the process at any time during their journey. Clearly the HBIQDA Guidelines are intended to be flexible, multiple-pathways and not a rigid sequence, so there is scope for choice in the route one adopts and the pace one takes to achieve the desired goal.

The causes of Gender Dysphoria in Transsexual people are multifactorial. Current thinking includes factors which are both biological - 'Nature' - (genetic and hormonal from conception on), as well as social and environmental - 'Nurture'. Alternatively, Gender Dysphoria could be, as some argue, merely a normal variation in human behaviour.

Legally the situation for 'Trans-people' in UK has improved radically over the last 15 years, with employment protection, and recently, the right to have one's birth certificate changed, and some of the legal rights of a woman including the right to marry.

Pitfalls and minefields in this process.

'Sod's law' invariably applies i.e. if anything can go wrong it will go wrong, Transsexual treatment is no exception. Pitfalls and minefields occur in the management of patients in much the same way as many other fields of mental health care, such as, for example, substance misuse. However I believe that Transsexualism is especially fraught with problems, and difficulties because it is a condition with such a varied history and uncertain aetiology and associated with so much social stigma, and to a degree continues to be tainted with concepts of sin, degeneracy and criminality.

For the patient the key phase in this process is facing up to and coming to terms with one's true sense of self in terms of gender. This is such a fundamental aspect of one's personality that it is essential to sort it out as soon as possible. Failure to do so may be disastrous.

Pitfalls for Doctors

Ignorance and Dismissal.

In this case the pitfall for the Doctor is likely to stem from his own ignorance of the condition and dismissing it as a phase, especially in younger or teenage patients. Even worse is to regard it as some sort of personality aberration to be cured by marriage, or joining the army. Or that it is a mental illness, in other words a psychosis in which one's wrong sense of gender is considered a delusion. The father of one of my patients, a Transman, discussed his "daughter's" condition with his GP who informed the father that any girl who thinks she's a boy is psychotic and any doctor who colluded with this is equally psychotic. As recently as the 1970's Trans-people were 'treated' with Electro-Convulsive Therapy (ECT) and Aversion Therapy, as it turned out, with no success whatsoever. (Ref: Dr. John Randall 1970)

Prescribing Hormones.

This comes with risks which must be clearly spelt out to patients. The Doctor is obliged to obtain informed consent from the patient that he/she understands the effects, side-effects and risks of any medication prescribed. The Harry Benjamin guidelines require three months counselling or psychotherapy, and/or three months cross gender living, prior to starting feminizing hormones. The hormones are given on a trial basis as a diagnostic test designed to confirm or refute the patient's self diagnosis as transsexual, because transsexuals don't usually mind that their libido is reduced and their breasts develop. In my experience, non-transsexuals object strongly to being made impotent and sprouting breasts.

Baseline blood checks are recommended before hormones are prescribed. Anti-androgens such as Androcur, may be prescribed to reduce hirsutism, but may sometimes cause lethargy and depression. This needs to be explained before it is prescribed. Other risks include deep vein thrombosis and pulmonary embolus.

In Female-to-Male Transsexuals, testosterone, usually given by injection, is recommended following at least three months psychotherapy or counselling, and/or three months cross gender living, together with baseline blood checks. Again the effects side-effects and risks are spelled out carefully beforehand. Failure to follow these simple rules can be disastrous for both patient and doctor.

Failure to Monitor RLE.

Three monthly visits to both G.P. and the Gender Specialist are recommended, and liaison usually by letter between Gender Specialist and GP is expected. It is assumed, not necessarily always correctly, that transsexual patients are honest about whether or not they are fulfilling their 'real-life experience' requirements. Dishonest patients do exist and may pay dearly for deceiving both themselves and their Doctor. Failures do occur rarely, and are latched onto by the media and blown up out of all proportion compared to the vast majority who are successful. However, as Christine Burns of Press for Change says, such failures are salutary and need to be drawn attention to despite the possible harm done to the Transsexual Community, and to the reputations of those who treat them. We learn from our mistakes.

The importance of Clinical Judgment over Standards of Care.

Patients are all different, and must be treated as individuals. There is no uniform, standard and correct treatment plan which is applicable to every Transsexual going through the process of self-actualization. Clearly it must be the trans-person who determines just how they go about achieving their goals, facilitated by the Gender Specialist, who must be sensitive enough to do this according to the specific needs and requirements of his patient. Encouragement by the Doctor, or anyone else for that matter, to hurry up or slow down the process takes away responsibility from the patient for decisions made, so if things go wrong it is not the patient but rather the adviser who must then take the blame. In other words, the trans-person, should be sure enough in him or herself to set the pace and say how they wish to go about transitioning. The Doctor is merely the facilitator.

Standards of Care as set out in the Harry Benjamin Association are not rules but rather a set of guidelines. They are written by a committee of experts in Gender Identity Disorders, and revised every two or three years. More recently there has been some input by Trans-people and Self-Help Groups to try to vary the more restrictive and paternalistic hoops and hurdles, previously required prior to starting hormones and recommending GRS. Currently, within the NHS it is standard practice across mental health care to involve service users in the development and operation of guidelines.

The evidence base for the Harry Benjamin Standards of Care/guidelines is tenuous to say the least. Further research on factors predicting outcome, including particular treatment protocols and their success/failure rates are essential. To date, neither the NHS – nor anyone else – has provided this information, meaning that evidence concerning the pro's and con's of different treatment protocols is sadly lacking.

Working with patient disappointment.

Disappointment, mainly about delays for evaluation and treatment, especially with regard to initiating hormones, in my experience leads to frustration, depression and anger which increases as each month goes by. No wonder there is a thriving industry for the Internet provision of hormones and antiandrogens. It's easy and convenient to shop online.

Disappointment may also occur because hormones don't always produce the expected feminising effects. The effects of hormones are often very slow and subtle. Sometimes no breast growth occurs whatsoever, and facial features remain stubbornly masculine. Face and body hair may persist despite dozens of sessions of laser or electrolysis or both, even when this is combined with Androcur.

According to Gender Expert, Anne Lawrence the best predictor of a good treatment outcome, subjectively, has less to do with the duration of one's Real-Life-Experience (RLE) but rather the success or otherwise of GRS. If the operation produces congruity between body image and mirror image and produces a functional and sensitive neo-vagina, regardless of whether it is used in sexual relations, a good outcome can be expected. Having said this, many post-op Trans-women adjust satisfactorily following cosmetic surgery.

Transsexual patients having GRS from Dr Suporn in Thailand are required to submit themselves to a rigorous regime of dilating for at least two hours, twice daily for six months postoperatively to produce a satisfactory outcome. Dr. Suporn's operation is not for the fainthearted.

Appreciating the Patient's Drive and Intelligence.

Traps for the unwary Doctor include failing to take into account the power and intensity of the Transsexual person's gender dysphoria. Unsurprisingly, the intensity of one's Gender Dysphoria, like pain, is subjective and therefore unable to be quantified/measured. As often as not there is no consistent link between the Gender Dysphoric person's feelings and their appearance. The person with the most unlikely 'super-masculine' physical characteristics, may have a 'super-feminine' sense of self as 'she'.

One former director of a Gender Identity Clinic in the North of England, dealt with this particular problem by asking his nursing colleagues to observe patients attending his Clinic. Like the Roman Emperors of old, his nurses gave the Transsexual patients the legendary 'thumbs up' or 'thumbs down' for being either worthy of treatment or not, depending on how they looked. Those who were refused treatment were then fed to the lions. There is no record of patient satisfaction or suicide statistics for this clinic. Clearly, good practice should not involve the Doctor delegating clinical decisions to anyone else.

Colluding with Patients.

This is different from responding to their reasonable needs for hormones etc. It is quite appropriate to raise difficulties with patients as well as to assess their strengths and recognise and discuss other psychopathology. Colluding with patients means ignoring their denial of very real problems of social acceptance, as well as glossing over the need to be employed and self-supporting wherever possible. It means failing to recognize 'Masked' Depression, or Borderline Personality Disorders, or even Asperger's syndrome. It means giving in to patients' unrealistic demands for prescribing numerous different hormones and anti-androgens, known as 'polypharmacy'.

These days, colluding with patients demands for GRS prior to the completion of at least one year RLE is tantamount to asking to be sued or complained about. Guidelines which are intended to be flexible, can and occasionally are used to criticize a particular doctor's practice. This is not new in medicine – just look at the debate about children's vaccinations. Many advances in medicine have been initiated by doctors who have been prepared to defy convention by sticking their necks out for their patients.

Minefields for Patients

Incorrect self-diagnosis.

This may occur on the basis of any number of misconceptions of oneself in terms of one's identity as male or female. Books have been written on the subject of personality development, including gender identity, involving separation-individuation from one's parents. Until one reaches adolescence, one is very much a product of parental and peer influences. At this age and stage we are programmed to regard ourselves very much as how others view us, and for the most part, at the time we accept this. From adolescence and about 10 years after we revise our sense of self, and consciously or unconsciously face up to our real selves; i.e. who we really are, male or female, straight, gay, introverted or extroverted, caring or selfish, conforming or rebellious, career-minded or not, religious or atheist. Some are inherent while others are life-style choices.

Sex-role conformity,

in which the denial of one's sexual preference as gay is masked as Transsexualism in order to sanction sexual relations with other men. This may be associated with homophobic programming during one's early life. Sometimes there is culturally acquired ignorance. Sometimes it is a failure to appreciate the distinction between Gender Identity Disorder (Transsexualism), and Sexuality (Fetishistic Transvestism, or even Effeminate Homosexuality). Sometimes there's overlap and confusion between these categories.

Interestingly the 'lady boys' of Thailand and the Philippines all start off defining themselves as Gay, because they discover during their teens that they enjoy sex with other boys/men. After a few years their feminine personae develop, they put the gay scene behind them, and regard themselves as heterosexual women. During this process, they feminize themselves with hormones and continue living as woman indefinitely. However many do not proceed with gender reassignment surgery. Are they Transsexual? Probably they are TS despite not fitting exactly the ICD 10 criteria that to be Transsexual one must abhor one's genitals, and want them surgically removed.

The Journey and Failure to Anticipate the Consequences.

The process of coming to terms with one's gender dysphoria may be phasic and can be stunted or blocked at any stage. The first phase is often the most important and includes fond and often guilt-laden memories of feeling girlish as a child and identifying with girls and expressing this through cross-dressing as well as liking the company of girls and envying girls. Later on these earlier fond memories reemerge, sometimes obsessively, and the germ of one's Transsexualism emerges. This leads to the phase of 'coming out' as Transsexual to oneself, often the hardest part, and in due course facing up to one's inner feelings and dealing with them by 'coming out' openly to others as Transsexual.

This is the stage where befriending or 'Buddying' by another Transsexual is important and can be as helpful as Counselling for a Trans-person who has recently 'come out' and is in need of guidance support and a sympathetic ear.

This phase usually involves medical/psychiatric treatment, planning to transition, and then starting an official 'real-life experience' for one or two years before undergoing GRS (or not, if GRS is not desired). Obviously the process doesn't end here. By far the most important phase of this journey, and in my view the 'Holy Grail' of the process, is to achieve a fulfilling, happy, purposeful socially integrated and rewarding life. Usually these people are those who are happy and content within themselves – "being happy in one's skin and inner self, regardless of 'pass-ability'". They are the successes. Sadly 'living happily ever after' doesn't always happen, but for many Transsexual people it does. The failures are not because they are Transsexual, but because they haven't coped with their lives.

Misconceptions abound about the relative importance of hormonal treatment and surgery as opposed to the importance of succeeding socially as a woman, including amongst one's peers and family.

The success rate for Transsexuals who are properly evaluated and treated is around 95%. The other 5% are socially isolated and/or chronically depressed. (Very few commit suicide). This also includes those who change their minds and revert back to their former gender role. Note that 'changing back' does not necessarily equate with 'failure' since they may be happy to have 'exorcised their gender demons'.

Family pressure to conform

where family especially parents and siblings, or even wife and children, put enormous pressure on the potential Transsexual to maintain the status quo. This leads to 'defense mechanisms' of denial, suppression and distraction as a means of dealing with the Gender Dysphoria. These in turn lead to increasing depression, self-hatred and aggression, and all in all makes for an extremely unhappy, frustrated and sometimes suicidal person.

Importance of doctor-patient relationship.

Fooling the doctor is not at all difficult. My view is that the doctor-patient relationship is one of trust and confidence and I like to assume that this is reciprocated.

Transgender feelings in some persons may be associated with the belief that they are Transsexual and will only function as a woman after surgery and so demand GRS as a first step, and refuse to go through the process required to adjust i.e. the 'Real-Life-Experience'. As a result, they usually fail to anticipate subsequent problems of social integration and acceptance.

Some, but certainly not all Transsexuals who bypass, shorten or completely avoid their RLE come to grief. I have seen a number of high-achieving Transsexuals, including professionals whose circumstances were such that RLE prior to surgery was simply not possible. Their pre- and post-operative treatment was carefully monitored by a Gender Specialist, and they have continued living successfully afterwards.

Unfortunately some potential Transsexuals start off as victims from their school days onwards. They are bullied for liking girls and being labelled 'sissy's', and it is from these early experiences that the sense of being different develops. They feel persecuted for this and a pattern is established which becomes an ongoing theme for the remainder of their lives. Their persecutors progress from the school bully to teachers, possibly parents, and later others in authority, including sometimes the very doctors and counsellors who are trying to help them.

Pseudo-Transsexualism

or 'Conspiratorial' Transsexualism, is where your friends convince you that you are Transsexual, in the same way that someone who has recently been tattooed tries to convince others of the benefits of being tattooed. This is not dissimilar to a religious conversion experience in which a potential, vulnerable, transgender person becomes a 'born-again' Transsexual with all the enthusiasm of a new convert, only to regret their decision with some embarrassment a few years later. God forbid they had GRS in the meantime.

Obviously the Internet, with its virtual world of fantasy feelings and identities often plays a large part in this process. The process goes something like this: A lonely isolated closet transvestite can transform their life if they imagine themselves and then project themselves in Internet chat-rooms as a confident girl/woman who then becomes a target for predatory men who flatter and encourage them in their 'feminine fantasy world', somehow reinforcing their sense of self, or ego, as an attractive young girl wanted and loved by a man – their Prince Charming. In reality they have made themselves vulnerable to exploitation, usually by older men who then take advantage of them.

The fantasy of being an attractive girl is obviously very appealing, and in a situation where the heart rules the head, even some smart people with mild Gender Dysphoria fool themselves into believing they are essentially female and therefore Transsexual.

Summary.

Being Transsexual brings with it certain assumptions including the need to face up to it and do something about it. Early on there is a need to find others – soul-mates – with similar feelings about themselves and to 'compare notes', either face to face or through the internet. In this regard the Self-Help Groups are important to gain basic information about the available resources, and also to have the opportunity to meet like-minded persons who are valuable in helping potential Transsexuals to avoid the pitfalls and minefields of the treatment process.

Certain expectations follow regarding this 'treatment process'. After all it is labelled a medical condition so there is a protocol to be followed, so the next port of call is usually the GP and from there to a Gender Specialist, usually a Psychiatrist. These are the key people whose role is to facilitate progress towards achieving the goal of finding one's true self with regard to the gender one feels oneself to be.

Conclusion.

The journey is not easy, and may be fraught with difficulty from the outset. Often it seems that only those with thick skins and strong personalities come through unscathed. It's all very well feeling female, but establishing oneself as female and integrating into the real world, and having a social life, a job and a purpose comes at a price. Sadly, this is not always achieved. Both nature and society are cruel taskmasters.

Sometimes treatment works, and when it does it's a joy.

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