Gender
DYSPHORIA

A STRUGGLE WITHIN...

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MIRROR MIRROR , CAN'T YOU SEE? WHAT YOU SHOW IS KILLLING ME !!

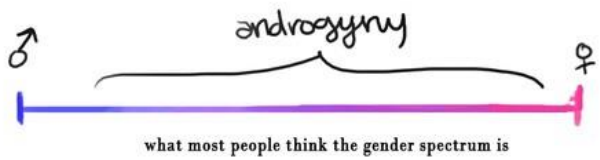
- Expand knowledge regarding sexual orientation, gender identity
- Learn LGBTQ+ definitions
- Understand the concept of Gender Dysphoria
- Manage it
- Identify your unconscious biases and work towards over-coming them.

Sex

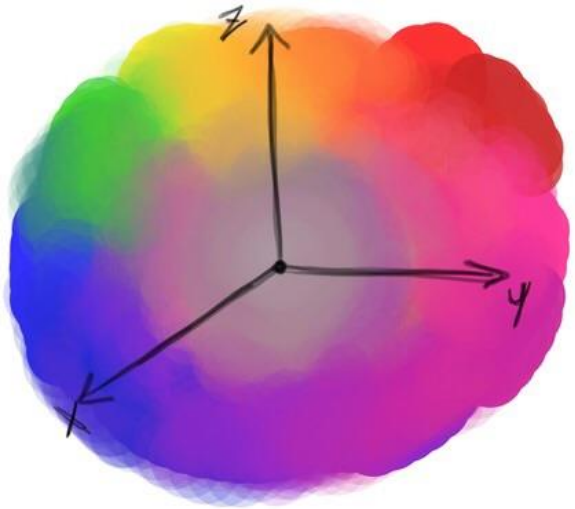
- Assigned at birth, based on the appearance of external genitalia.
- When the external genitalia are ambiguous, other indicators (e.g., internal genitalia, chromosomal and hormonal sex)
- It is the physical, biological and chemical makeup of an individual and simply refers to the biological differences between men and women.

Gender

- Attitudes, feelings, and behaviours that a given culture associates with a person's biological sex.
- Gender is complex!
- There are people that feel they fit in anywhere in between the two or with neither.



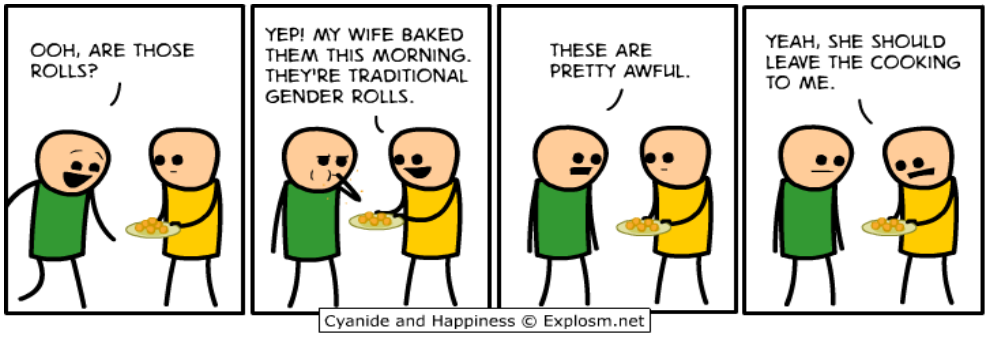
what most people think the gender spectrum is



what the gender spectrum actually is

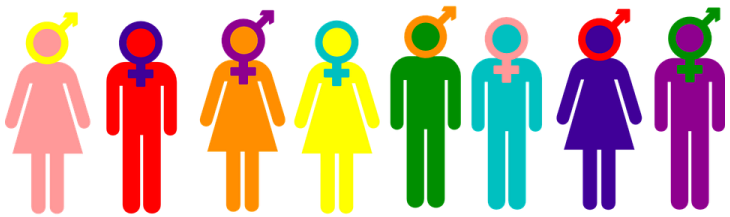
Difference between gender & sex

- Sex
  - Biological
  - From Nature
  - Constant
  - Based on chromosomes, internal and external sex organs, and the hormonal activities within the body
- Gender
  - Socio – cultural context
  - From Society
  - Variable
  - Changes with time and culture

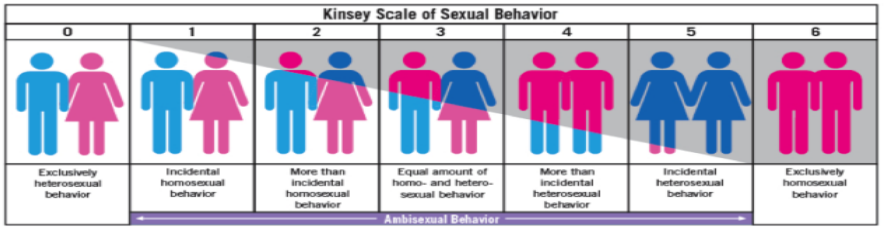


Gender Identity

- A person's deeply-felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender nonconforming, gender neutral)
- It may not correspond to sex assigned at birth or to primary or secondary sex characteristics.
- Since gender identity is internal, it is not necessarily visible to others.



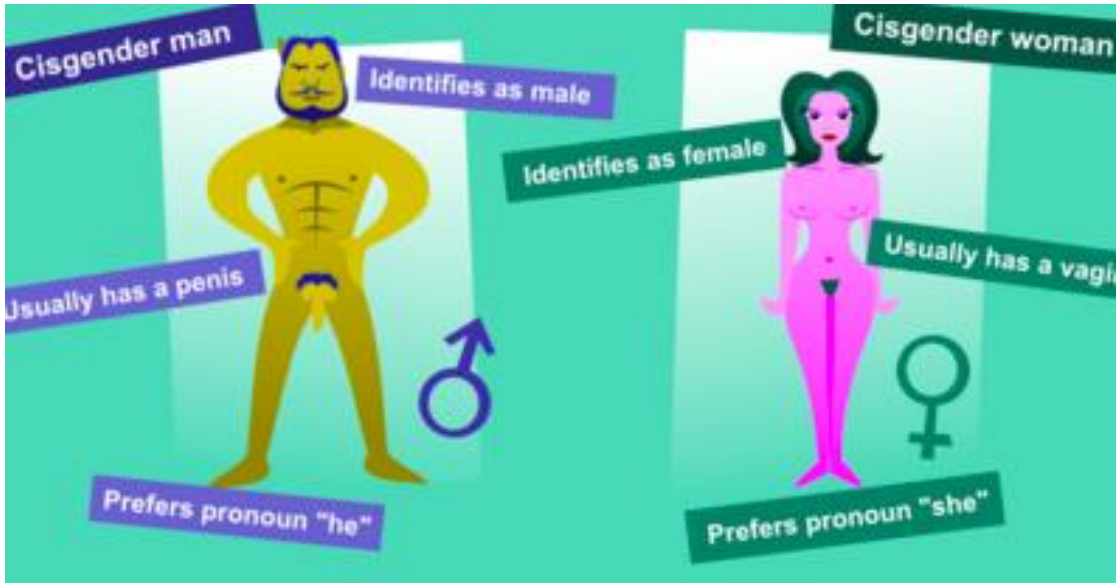
Sexual orientation



- A component of identity that includes a person's sexual and emotional attraction to another person and the behavior and/or social affiliation that may result from this attraction.
- A person may be attracted to men, women, both, neither, or to people who are gender queer, androgynous, or have other gender identities.
- Individuals may identify as lesbian, gay, heterosexual, bisexual, queer, pansexual, or asexual, among others.

Cisgender

- An adjective used to describe a person whose gender identity and gender expression align with sex assigned at birth.

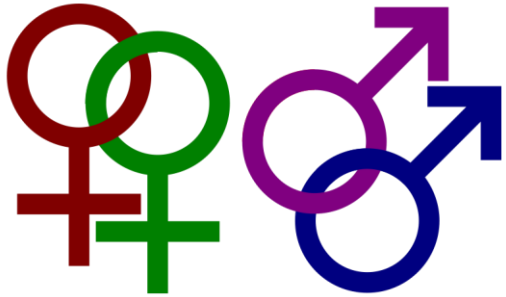


Heterosexual

- Person primarily emotionally, physically, and/or sexually attracted to members of the opposite sex. Also known as straight.

Homosexual

- Person primarily emotionally, physically, and/or sexually attracted to members of the same sex/gender.
- This [medical] term is considered stigmatizing due to its history as a category of mental illness, and is discouraged for common use (use gay or lesbian instead).



Gay

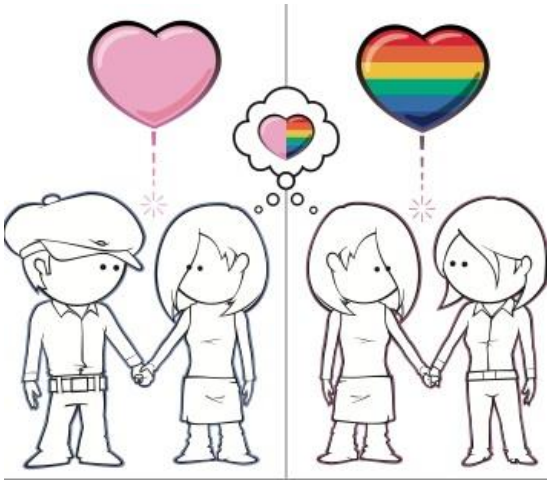
- Individuals who are primarily emotionally, physically, and/or sexually attracted to members of the same sex and/or gender.
- Commonly refers to men who are attracted to other men, but can be applied to women as well.

Lesbian

- Women who are primarily emotionally, physically, and/or sexually attracted to women.

Bisexual

- A person who is emotionally, physically, and/or sexually attracted to people of their gender and another gender
- This attraction does not have to be equally split or indicate a level of interest that is the same across the genders or sexes

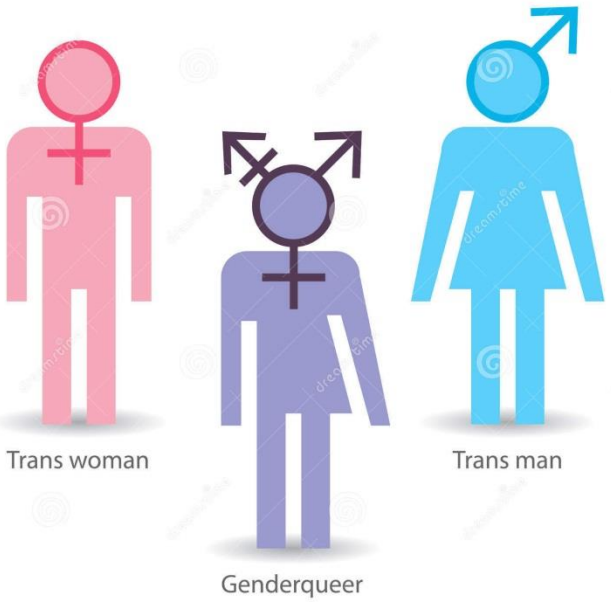


Trans* (spelt with an asterisk) is an umbrella term referring to all non-cisgender identities including :

- Transsexual
- Transvestite
- Genderqueer
- Genderfluid
- Genderless
- Nongendered
- Third Gender
- And Many Others.

Transgender

- Gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth.



Trans man

- Female-to-male transgender people or transsexuals signify that they are men while still affirming their history as assigned female sex at birth. (sometimes referred to as transguy)

Trans woman

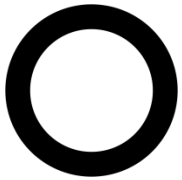
- Male-to-female transsexuals or transgender people to signify that they are women while still affirming their history as assigned male sex at birth.

Bi-curious

- A curiosity about having attraction to people of the same gender/sex (similar to questioning).

Asexual

- Experiencing little or no sexual attraction to others and/or a lack of interest in sexual relationships/behavior.
- Continuum from people who experience no sexual attraction or have any desire for sex, to those who experience low levels, or sexual attraction only under specific conditions, and many of these different places on the continuum have their own identity labels (see demisexual).
- Asexuality is different from celibacy in that it is a sexual orientation whereas celibacy is an abstaining from a certain action.
- Not all asexual people are aromantic.

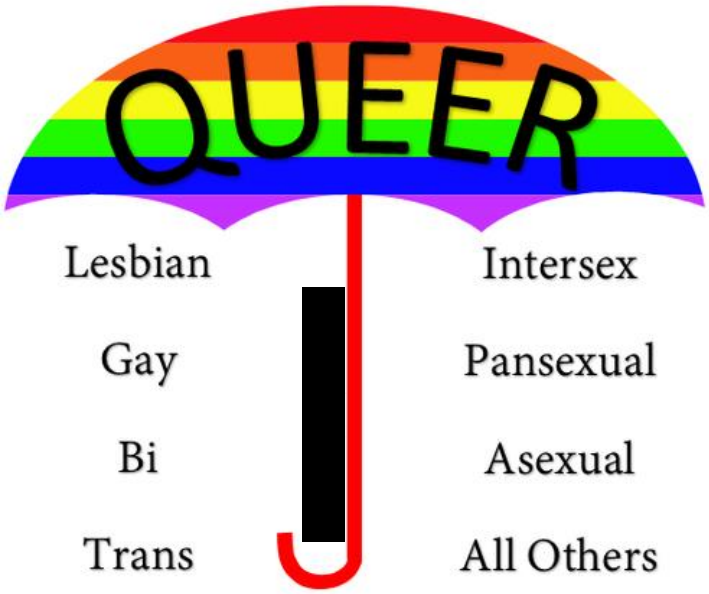


Questioning

- An individual who, or a period of time when, someone is unsure about, or exploring their own sexual orientation or gender identity.

Queer

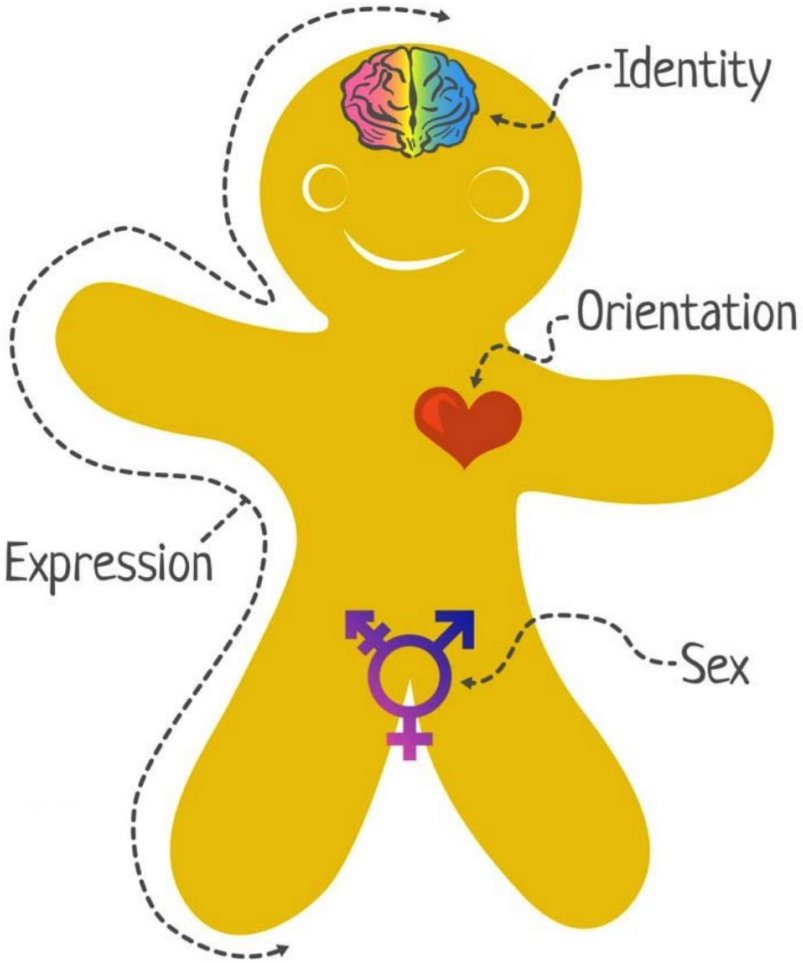
- Umbrella term
- Individuals who don't identify as straight
- Non-normative gender identity
- Use interchangeably with LGBTQ
- Historically derogatory term
- Not all people are comfortable with use of term Queer



Gender queer

- Does not align with a binary understanding of gender
- Does not identify fully as either a man or a woman
- May redefine gender or decline to define themselves as gendered altogether
- Both man and woman (bigender, pangender, androgyne)
- Neither man nor woman (genderless, gender neutral, neutrois, agender)
- Moving between genders (genderfluid) or embodying a third gender

The Genderbread Person



Gender Identity

Woman — Genderqueer — Man

Gender identity is how you, in your head, think about yourself.

Gender Expression

Feminine — Androgynous — Masculine

Gender expression is how you demonstrate your gender (based on traditional gender roles) through the ways you act, dress, behave, and interact.

Biological Sex

Female — Intersex — Male

Biological sex refers to the objectively measurable organs, hormones, and chromosomes.

Sexual Orientation

Heterosexual — Bisexual — Homosexual

Sexual orientation is who you are physically, spiritually, and emotionally attracted to, based on their sex/gender in relation to your own.

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- Throughout history men and women have experienced confusion and anguish resulting from rigid, forced conformity to sexual dimorphism
- In the 19th and early 20th century, Karl Ulrichs recognized ‘urnings’ as a group of men born with a woman’s spirit inside
- Magnus Hirschfeld coined the term “transsexual” in 1923 to describe people who want to live a life that corresponds with their experienced gender rather than their designated gender

GENDER NONCONFORMITY

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex .

GENDER DYSPHORIA

Gender Dysphoria is defined as a condition with marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, that is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning

Only some gender nonconforming people experience gender dysphoria at some point in their lives.

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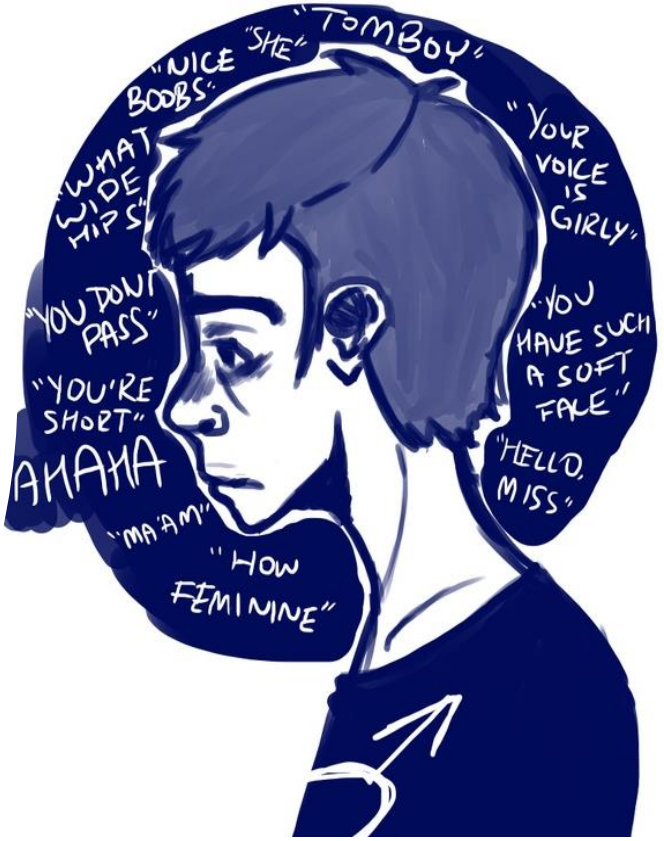
- Non-conformity may lead to psychological distress when confronted by social prejudice and non-acceptance.
- This distress is not inherent in being transsexual, transgender or gender non-conforming
- Gender variant people and gender non-conforming people do not necessarily have Gender Dysphoria.



Kuchh to log kahenge . . .

- Stigma attached to gender nonconformity leads to prejudice and discrimination, resulting in “minority stress” (I. H. Meyer, 2003).
- Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011).

The category, "Gender Identity Disorder" in DSM-IV-TR has been replaced by "Gender Dysphoria" in DSM-5.

"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 that should not be judged as inherently pathological or negative."

The current version of the World Health Organization's ICD-11 has adopted the nomenclature of 'gender incongruence' (15). ICD- 10 used the term trans sexualism when diagnosing adolescents and adults

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- **Diagnostic criteria: DSM-5 Gender Dysphoria in Adolescents and Adults 302.85 (F64.1)** A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:
  - **A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).**
  - **A strong desire to be rid of one's primary and/or secondary sex characteristics** because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of anticipated secondary sex characteristics).
  - **A strong desire for the primary and/or secondary sex characteristics of the other gender.**
  - **A strong desire to be of the other gender** (or some alternative gender different from one's assigned gender).
  - **A strong desire to be treated as the other gender** (or some alternative gender different from one's assigned gender).
  - **A strong conviction that one has the typical feelings and reactions of the other gender** (or some alternative gender different from one's assigned gender)

- The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if:

  - **With a disorder of sex development** (e.g. a congenital adrenogenital disorder such as 255.2[E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome) Specify if:

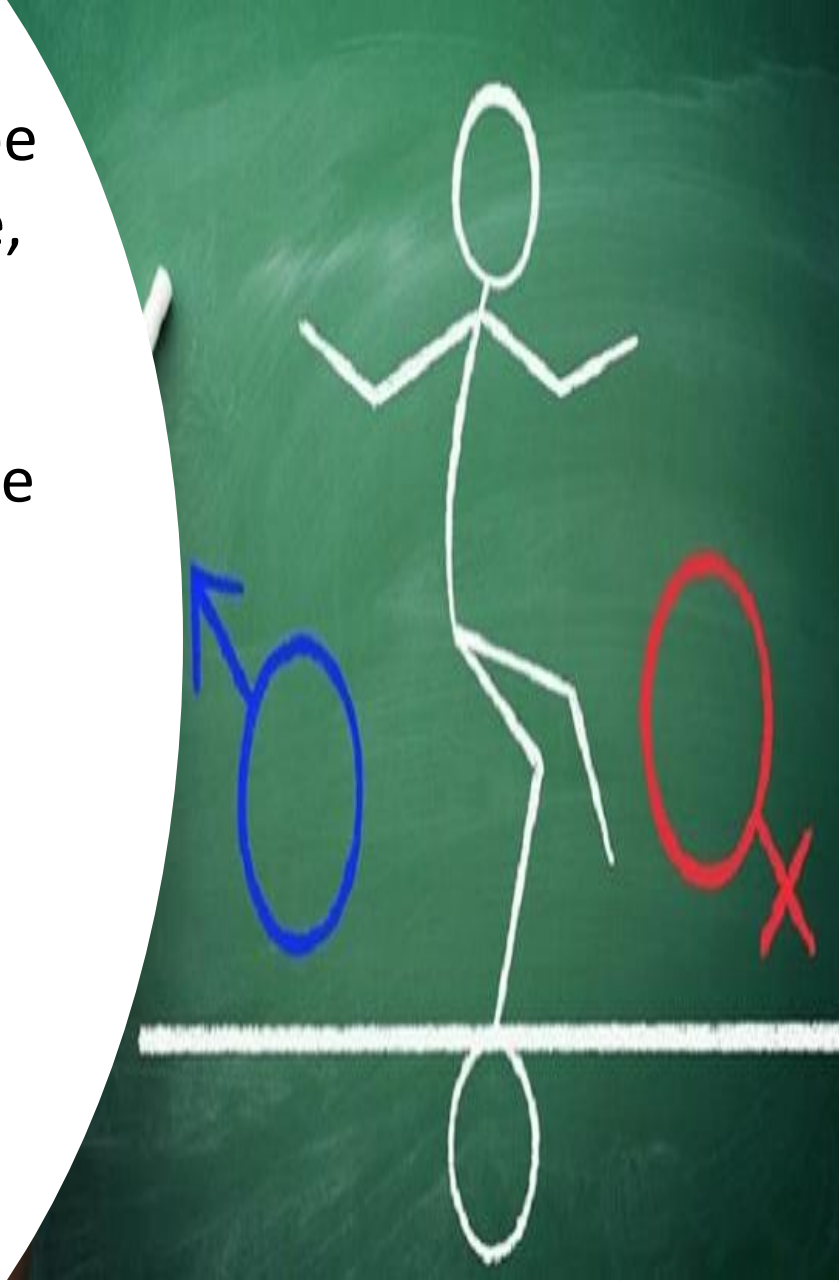
  - **Post-transition:** the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen - namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

Do they need your help?

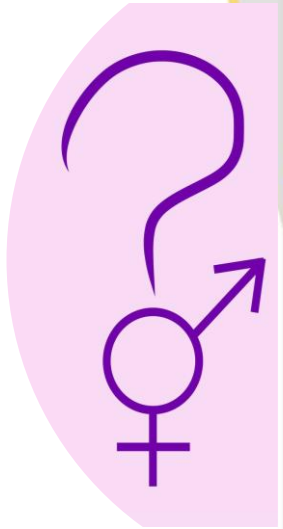
The distress of Gender Dysphoria, when present, might give rise to an individual seeking clinical consultation. Transsexual, transgender, and gender non-conforming people might seek the assistance of a mental health professional (MHP) for various reasons.

- For psychotherapeutic assistance to explore gender identity and expression.
- To facilitate a coming-out process.
- Assessment and referral for feminizing/masculinizing medical interventions.
- Psychological support for family members (partners, children, extended family).
- Psychotherapy unrelated to gender concerns; or other professional services.

Gender dysphoria can in large part be alleviated through treatment. Hence, while transsexual, transgender, and gender nonconforming people may experience gender dysphoria at some point in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.



- Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them.
- Treatment is individualized.
- This process may or may not involve a change in gender expression or body modifications.



Create a welcoming atmosphere

- Often scan office
- Provide visual cues
  - Non-discrimination posters
  - Brochures/ educational materials
  - Helpline information
  - Information about non-profits
- Availability of unisex restrooms
- Educate support staff

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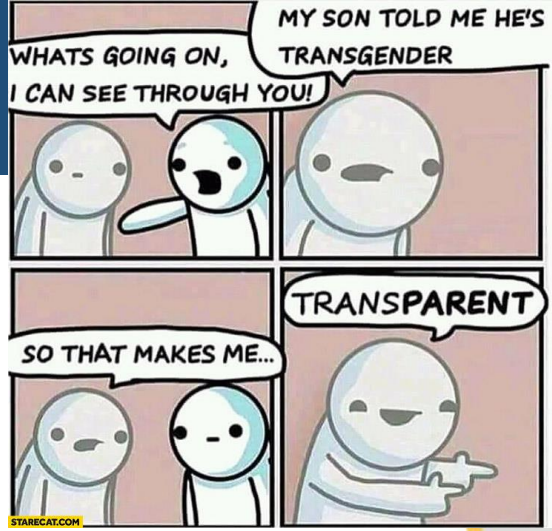
Communication



- ANY PATIENT CAN BE LGBTQ+.
- Avoid making assumptions about patient's sexuality.
- Use gender-neutral language.
- Echo language- both with patient and informant.
- Assure confidentiality.
- Explain to patients that a sexual history is standard practice.
- Apologize if you inadvertently use an offensive term.
- Ask open-ended questions.
- Don't use the patient to educate you on LGBT+ issues.
- No awkward pauses- keep eye contact, consider facial expressions.
- Be prepared to refer if you cant help.
- Thank the patient for trusting you.

Sexual History

- Can only be taken smoothly if a sexual history is taken of ALL patients
- Focus on sexual behavior and not orientation
  - Are you sexually active? Have you been sexually active in the past?
  - Have you had sex with men/women/both?
  - Types of sexual activities
  - Do you use protection? What type? Regularly?
  - Have you been screened for STIs/HIV?
  - Any past h/o STI?
- Substance history
- Sexual Abuse/Violence

DON’T USE EXTRA PRECAUTIONS FOR EXAMINATION ONCE A PATIENT COMES OUT TO YOU!!!

Assessment/ Rating scales

- Child Behaviour Checklist (CBCL), the Teacher's Report Form (TRF) and the Youth Self-Report (YSR) form
- The gender identity / gender dysphoria questionnaire for adolescents and adults is one particular useful measure
- Questionnaires may reduce reluctance to disclose. Male respondents were more likely to admit engaging in sexually coercive behavior on a questionnaire than in an interview

Phenomenology in Children

- Children as young as age two may show features
- They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers.
- Heterogeneity in these features: Some children demonstrate extremely gender nonconforming behaviour and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present .
- Comobidity with internalizing disorders such as anxiety and depression .
- The prevalence of autistic spectrum disorders seems to be higher

Phenomenology in Adolescents

Phenomenology in Adolescents

- In most children, gender dysphoria will disappear before or early in puberty.
- However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop.
- Therefore, it may come as a surprise to others when a youth's gender dysphoria first becomes evident in adolescence.
- Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery.
- Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4.
- The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

BE AWARE !!

- Inexperienced clinicians may mistake indications of gender dysphoria for delusions.
- Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms but not suffering from underlying severe psychiatric illness such as psychotic disorders.
- It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder.

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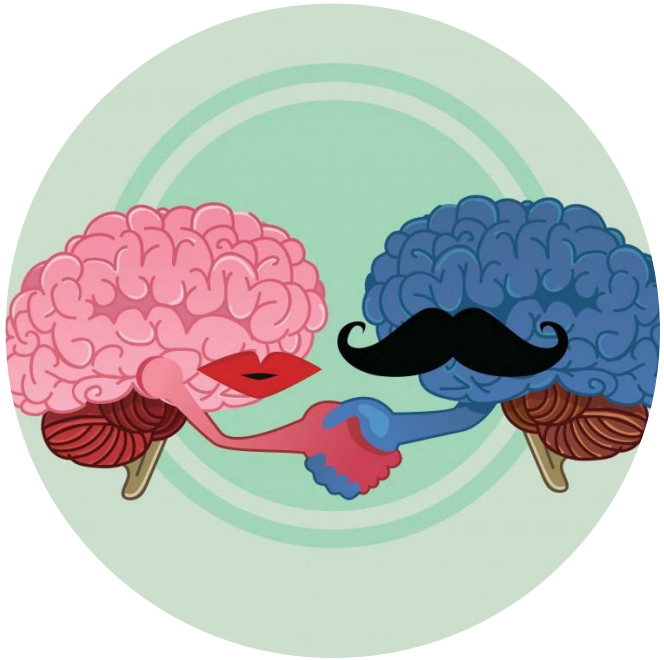
Therapeutic Approaches - An Overview

Approach in prepubescent children: 3 approaches

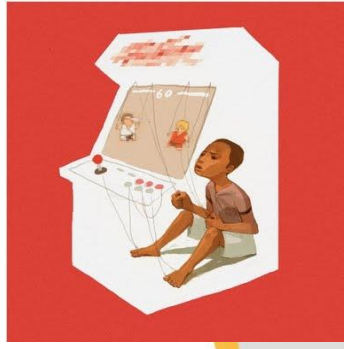
- Working with child and caregivers to lessen gender dysphoria, decrease cross gender behavior and identification - likened to sexual orientation conversion efforts or reparative therapies of homosexuality, thereby forcing the societal norms on individuals
- Dutch approach: remain neutral, allow developmental trajectory of gender identity to unfold naturally
- Affirmation of child's cross gender identification; support in transitioning in cross- gendered role

Options for Psychological and Medical Treatment of Gender Dysphoria



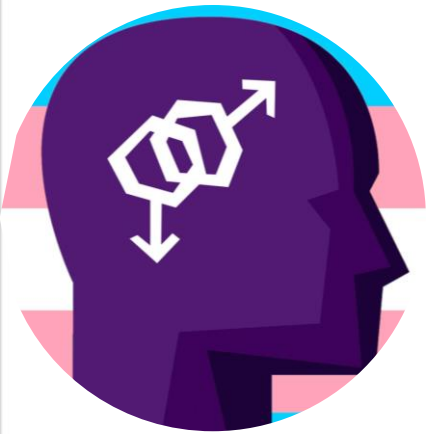
For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person.

Treatments options include the following:



- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity)
- Hormone therapy to feminize or masculinize the body
- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring)
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Other Options



- Offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy
- Offline and online support resources for families and friends
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity
- Hair removal through electrolysis, laser treatment, or waxing
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks
- Changes in name and gender marker on identity documents.

Gender Affirmative Therapy

It's holistic and should include input from multiple disciplines such as Psychiatry, Psychology, Endocrinology, Surgery, Urology, Gynaecology, Voice Surgery and Therapy, Occupational Therapy, Nursing, Social Work and other related professions. The multidisciplinary collaborative work with peer review and supervision are of paramount importance.

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

- Meet the competency requirements for mental health professionals working with adults.
- Trained in childhood and adolescent developmental psychopathology.
- Competent in diagnosing and treating the ordinary problems of children and adolescents.

Approach in prepubescent children: 3 approaches

- Working with child and caregivers to lessen gender dysphoria, decrease cross gender behavior and identification - likened to sexual orientation conversion efforts or reparative therapies of homosexuality, thereby forcing the societal norms on individuals
- Dutch approach: remain neutral, allow developmental trajectory of gender identity to unfold naturally
- Affirmation of child's cross gender identification; support in transitioning in cross-gendered role

The roles of mental health professionals working with gender dysphoric children and adolescents

- Directly assess gender dysphoria.
- Provide family counselling and supportive psychotherapy to assist children and adolescents.
- Assess and treat any co-existing mental health concerns.
- Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria.
- Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations).
- Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children.

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Psychological Assessment of Children and Adolescents

- Do not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria.
- Offer a thorough assessment any co-existing mental health concerns; and educate clients and their families about therapeutic options.
- A psychodiagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed.

Assessment of gender identity and gender dysphoria,

the impact of stigma attached to gender nonconformity on mental health

the availability of support from family, friends, and peers

history and development of gender dysphoric feelings

- The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment.
- For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment, and can be diagnostically informative.

Provide information regarding options for gender identity and expression and possible medical interventions

- Educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria
- Facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions
- This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support
- The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical
- interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal

Assess, diagnose, and discuss treatment options for co-existing mental health concerns

- Clients presenting with gender dysphoria may struggle with a range of mental health concerns
- Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders
- These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

- Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success, particularly in the long term. Such treatment is no longer considered ethical.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

- Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. This also applies to peers and mentors from the community, who can be another source of social support.

Cont.

- Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.
- Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression.
- Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition.
- Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

- Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties.
- For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described.

Physical Interventions

For adolescents

Physical interventions for adolescents fall into 3 categories or stages

1. Fully reversible interventions.
2. Partially reversible interventions.
3. Irreversible interventions.

Fully reversible interventions.

These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

Criteria for puberty suppressing hormones

In order for adolescents to receive puberty suppressing hormones, the following minimum criteria in the left must be met.

- The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
- Gender dysphoria emerged or worsened with the onset of puberty;
- Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;
- The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

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Partially reversible interventions.

These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

Partially Reversible Interventions

- Adolescents may be eligible to begin feminizing/ masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.
- Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults. The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence.

Criteria for Feminizing/Masculinizing Hormone Therapy

- Persistent, well-documented Gender Dysphoria;
- Capacity to make a fully informed decision and to give consent for treatment;
- Age of majority(18 years) is reached;
- If significant medical or mental concerns are present, they must be reasonably well controlled.

- Referral for Feminizing/Masculinizing Hormone Therapy
  Hormone therapy can be initiated with referral from two qualified MHPs
- One of the two MHPs should be a qualified Psychiatrist. It is also preferable, if the first referral is from the client's psychotherapist/Psychiatrist, the second referral be from an MHP who has only had an evaluative role with the client.
- Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent.
- MHPs who refer for hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service, but should not be held responsible for any physical complication arising out of hormone therapy.

Content of the referral letter for feminizing/masculinizing hormone therapy

- The client's general identifying characteristics
- Results of the client's psychosocial assessment, including any diagnoses
- The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counselling to date
- An explanation that the criteria for hormone therapy (See Annexure 2) have been met and a brief description of the clinical rationale for supporting the client's request for hormone therapy
- A statement that informed consent has been obtained from the client
- A statement that the referring professional is available for coordination of care and welcomes a phone call to establish this.

Regimens for Feminizing Hormone Therapy (MtoF)

- FIRST LINE THERAPY

  Androgen-Reducing Medications (Anti-Androgens)
  - Cyproterone acetate (50–100 mg per day)
  - GnRH agonists (triptorelin depot 3.75mg monthly or 11.25mg 3 monthly)
  - Spironolactone (100–200 mg per day)
  - 5-alpha reductase inhibitors (finasteride 5mg per day or dutasteride 0.5mg per day)
- SECOND LINE THERAPY

  Estrogen
  - Oral ethinylestradiol (2.0–6.0 mg per day)
  - Conjugated estrogens
  - Transdermal estradiol patch (0.1– 0.4 mg twice weekly)
  - Parenteral: Estradiol valerate (2–10 mg IM injection every week)
- THIRD LINE THERAPY

  Progestins

Regimens for Masculinizing Hormone Therapy (FtoM)

- FIRST LINE THERAPY

  Testosterone
  - Oral testosterone undecanoate (160–240 mg per day).
  - Intramuscular testosterone cypionate or enanthate (100–200 mg IM)
  - Intramuscular testosterone undecanoate (1000 mg).
  - Daily transdermal preparation (Testosterone gel 1% 2.5–10 g per day or Testosterone patch 2.5 – 7.5 mg per day) currently not readily available in India.
  - Transdermal and intramuscular testosterone achieve similar masculinizing results and the goal is to use the lowest dose needed to maintain the desired clinical result.
- SECOND LINE THERAPY
  - GnRH Agonists GnRH agonists
    (Triptorelin depot 3.75mg monthly or 11.25mg 3monthly)
- THIRD LINE THERAPY
  - Progestins Medroxyprogesterone to assist with menstrual cessation early in hormone therapy

Physical Effects of Hormone Therapy

- In FtoM Individuals:
  - Skin oiliness/acne
  - Facial/body hair growth
  - Scalp hair loss
  - Increased muscle mass & strength
  - Body fat redistribution with atrophy of breast tissue
  - Cessation of menstruation
  - Clitoral enlargement
  - Vaginal atrophy
  - Deepened voice .

Physical Effects of Hormone Therapy

- In MtoF Individuals:
  - Breast growth
  - Thinning and slowed growth of body and facial hair
  - Male pattern baldness
  - Decreased erectile function
  - Decreased libido
  - Male sexual dysfunction and decreased sperm production
  - Decreased testicular size
  - Increased percentage of body fat
  - Decreased muscle mass & strength
  - Softening of skin.

Hormone Therapy Risks

Risk level	MtF	FtM
Likely increased	Venous thromboembolism Gallstones Elevated Liver Enzymes Hypertriglyceridemia	Polycythemia Weight gain Acne Balding Sleep apnea
Likely increased in the presence of risk factors	Cardiovascular disease	
Possible increased	Hypertension Hyperprolactinemia / prolactinoma	Elevated liver enzyme Hyperlipidemia
Possible increased in presence of risk factors	Type 2 Diabetes	Destabilization of psychiatric disorders Cardiovascular disease Hypertension Type 2 Diabetes
Not increased or inconclusive	Breast Cancer	Bone density loss Breast cancer Cervical cancer Ovarian cancer Uterine cancer

Irreversible interventions

These are sexual reassessment surgeries (SRS).

Referral for surgery

- One referral –
  - From a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).
- Two referrals –
  - From qualified mental health professionals who have independently assessed the patient – are needed for genital surgery.

    If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent.

The recommended content of the referral letters for surgery is as follows

- The client's general identifying characteristics
- Results of the client's psychosocial assessment, including any diagnoses
- The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counselling to date
- An explanation that the criteria for surgery have been met, and a brief description of the rationale for supporting the client's request for surgery
- A statement that informed consent has been obtained from the client
- A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

Genital surgery should not be carried out until

- Patients reach the legal age of majority in a given country, and
- Patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Sex Reassignment Surgery
(WPATH SOC)

	MtF	FtM
Breast/chest	Breast augmentation	Mastectomy
Genital	Penectomy Orchidectomy Vaginoplasty Clitoroplasty Vulvoplasty	Hysterectomy/salpingectomy Oophorectomy Metoidioplasty Phalloplasty Vaginectomy Srotoplasty Penile prosthesis Testicular prosthesis
Non-genital/ non-breast	Facial feminization Liposuction/Lipofilling Voice surgery Thyroid cartilage reduction Gluteal augmentation	Voice surgery (rare) Liposuction/lipofilling Pectoral implants

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Criteria for Breast/Chest Surgery

- Mastectomy and Creation of a Male Chest in FtoM Persons:
  - Persistent, well-documented Gender Dysphoria;
  - Capacity to make a fully informed decision and to give consent for treatment;
  - Age of majority (18 years) is reached;
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
- Although not an explicit criterion, it is recommended that MtoF persons undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for Genital Surgery

- Hysterectomy and Salpingo-Oophorectomy in FtoM Persons and Orchiectomy in MtoF Persons:
  - Persistent, well documented Gender Dysphoria;
  - Capacity to make a fully informed decision and to give consent for treatment;
  - Age of majority (18 years) is reached;
  - If significant medical or mental health concerns are present, they must be well controlled;
  - 12 continuous months of hormone therapy as appropriate to the person's gender goals(unless hormones are not clinically indicated for the individual).
- The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a person undergoes irreversible surgical intervention.
- These criteria do not apply to patients who are having these surgical procedures for medical indications other than Gender Dysphoria.

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Criteria for Genital Surgery

- Metoidioplasty or Phalloplasty in FtoM Persons and Vaginoplasty in MtoF Persons:
  - Persistent, well documented Gender Dysphoria;
  - Capacity to make a fully informed decision and to give consent for treatment;
  - Age of majority(18 years) is reached;
  - If significant medical or mental health concerns are present, they must be well controlled;
  - 12 continuous months of hormone therapy as appropriate to the person's gender goals (unless hormones are not clinically indicated for the individual);
  - 12 continuous months of living in a gender role that is congruent with their gender identity.

Pre-Surgical Screening and Precautions

- Psychologically prepared have realistic goals and expectations of the surgery
- Good understanding of the surgical intervention to be performed, its cost, required length of hospitalization, likely complications.
- Should be informed of, and understand, any alternative procedures, and risks and complications of the interventions
- If the MtoF individual is on female hormone therapy, it should be discontinued three weeks prior to surgery and not resumed at least for two weeks after surgery to prevent thrombosis in major arteries.
- Androgen (testosterone) hormones need not be stopped pre-operatively in case of FtoM individual and should be continued for life if there are no contraindications.

- HIV-positive alone is not a contraindication for genital reassignment surgery, but the general medical condition of the HIV-positive patient should be taken into consideration.
- Urological examination identifying and perhaps treating abnormalities of the genitourinary tract.
- Psychotherapy is not an absolute requirement for surgery unless the initial assessment by MHP leads to a recommendation for psychotherapy.
- There is a need to be continually under care of mental health professional at every stage of gender transition to ensure better outcome.

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Postoperative Care and Follow-Up

- Long-term postoperative care and follow-up after surgical treatments for Gender Dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009).
- Positive outcomes have been reported in areas of cosmetic appearance, sexual functioning, self-esteem, body image, socioeconomic adjustment, family life, relationships, psychological status and satisfaction.
- Health professionals should emphasize on continuity of care with the hormone-prescribing physician (for clients receiving hormones) and the treating mental health professional.

Surgery for Persons with Psychotic Conditions and Other Serious Mental Illnesses

- For severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder),

Psychotropic medications
and/or
Psychotherapy before surgery

- Re-evaluation by a mental health professional qualified to assess and manage psychotic conditions should be conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic.

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Challenges related to access and use of gender transition services in the public hospitals

- Individual (self-stigma, poverty),
- Institutional (registration policies)
- Structural levels (societal stigma).

At the individual level:

Lack of support for travel expenses pertaining to SRS procedures.

At the institutional level, some of the stigma and discrimination experiences

- Lack of hospital policies on whether transgender people can get registered as ‘man’ or ‘woman’ in the outpatient department; and in which ward (male or female ward) they get admitted.
- Access is not easy to psychological assessment which is still assumed to be important by psychiatrists preceding surgeries and hormone treatment, and harassment (physical, psychological and sexual) is faced in certain instances during the medical assessment.
- Lack of adequate training of psychiatrists, surgeons and endocrinologists regarding assessment and treatment relating to SRS further increases the vulnerability of this population.
- Insensitivity on the part of physicians, counsellors, nurses and paramedical workers.
- Harassment from the relatives of the co-patients
- Lack of information and adequate safeguards from the side of the hospital authorities is the cause of such harassment.
- Lack of accessibility to institutions which offer SRS services- either due to the miniscule number of hospitals offering SRS or the exorbitant costs

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At the structural level:

- Societal stigma against people who transgress gender norms, especially against transgender people, is internalized by the HCPs themselves.
- MtoF transgender people → face intersecting stigmas – stigma related to being a transgender person, being a sex worker, and being a person suspected to be at high risk for HIV.
- FtoM transgender persons → face complete invisibilisation and immobility due to their location within a patriarchal society that does not confer any rights to the female bodied person.
- Lack of awareness and general stigma surrounding transgender persons in the society, media as well as medical professionals, despite the widely publicized NALSA judgement is a challenge.

Gender Affirmative voice Transformation

Speech and Language therapy

Therapy with Women (male to female)	Therapy with Men (female to male)
The introduction of female hormones will have no effect on the male voice. Therefore, other factors known to mark the difference between male and female voices have to be enhanced to give the individual a more feminine voice. Key communication areas where males and females differ, for example voice quality, pitch, intonation, prosody, rate, articulation, resonance, language and non-verbal communication are to be focused.	The introduction of male hormones in women will lower the pitch of the voice, although the degree and rate of change is variable . Therapy may be offered at this time to help stabilise the voice and laryngeal support musculature that will have been physically altered by the male hormones. However, it is not simply lowering the pitch that will make the voice appear more masculine.

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Surgical intervention for changing voice

Male to Female	Female to Male
• Cricothyroid approximation • Anterior commissure webbing and shortening of vocal folds with or without LASER. • Thyroid chondroplasty may also be offered to reduce the prominence of the thyroid cartilage for cosmetic appearance.	• Pitch-changing surgery for this population is not as well developed. • There have been attempts to lower the pitch further with surgery e.g. Isshiki type III thyroplasty.

INDIAN LAW, TRANSGENDER IDENTITY AND GENDER TRANSITION

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Certificates Related to SRS

- After gender affirmative surgery, the surgeon should provide a certificate to the individual stating the nature of surgery/ies done. This certificate will work as a valid medical document that might facilitate in legal procedures of change of name and gender in identity documents, if opted for after SRS.

Issues Pertaining to Legal Status of People Seeking SRS

- Legal status to Sex Reassignment Surgery has been given
- A person who has undergone SRS can definitely avail all rights due to that gender. However, it is unclear whether a trans person can avail all legal rights before undergoing SRS.
- In the absence of a uniform process of changing one's gender identity in documents in all states, documents of an SRS seems to be the most definite document warranting gender identity change. In some cases surgeons insist on family consent before SRS to avoid future litigations.
- Affidavits are needed for a change in name and gender by paying the appropriate court or notary fee and getting these signed by a magistrate.

- A person can, at any point during the course of SRS (and even without it as well), go to a lawyer in case they want to change their name and gender in their official documents. The process involves the following steps. However there is no clarity about the process and requirements differ from place to place, case to case, and is often dictated by individual bureaucratic specificities.
  - Getting an affidavit notarised at the court: Such affidavit should mention the change in gender identity (male to female, female to male, or male/female to transgender).
  - An official gazette notification must be done to notify the change.
  - Two newspaper advertisements need to be published that include age, date of birth, place of residence, previous official name, and current gender and name.
  - Filing an application before employer: This application must request for relevant changes in the employee identity card and attach copies of the gender-change affidavit, newspaper advertisements and/or gazette notification.
  - Pursuant to this, applications can be filed before relevant authorities for changes to Voter‟s ID Card, PAN Card, Bank documents including Debit/Credit Card, Driving License, Passport, Ration Card, etc. These applications must include copies of the affidavit, advertisements and the fresh employee identity card.
  - Renewal of passport is not yet possible without SRS certificate, contrary to provisions given in the NALSA judgement.

Need for comprehensive Legislation regarding SRS in India

- Ensure specific legal protections for transgender people seeking gender affirmation procedures in this country.
- Ensures safety, dignity, accessibility and convenience of transgender persons in every state of the country who wish to undergo SRS.
- Ensure that medical professionals in charge of implementing SRS are sufficiently sensitized and trained, and protected from harassment due to litigation arising from criminal laws which may be used against them in various instances, e.g. for emasculating an MtoF person during an SRS process.

Challenges Faced vis a vis Gender Transition

- Lack of clarity or official records regarding the medical procedure that needs to be followed, and is followed, in India.
- Insufficient awareness regarding the concept of self-identification of gender and Gender Dysphoria
- Criminalisation of emasculation under S. 325 of the IPC without clarification about exception provided under S. 88;
- Equation of „transgender" to people from groups with specific socio-cultural connotations such as hijra, kothi, aravani, etc.
- Taboo surrounding the transgenders since colonial times;
- Lack of training within the medical profession regarding related procedures

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Remember!

- Above all they need acceptance, affection, support of family, peer group, teachers, and all those who are in their social circle