1:00 p.m. - 4:00 p.m. (3 CE credits)

S7 "Assessment and Treatment of the Gender Dysphoric Patient" presented by Sallie Hunt, LMFT, FAPA and Thomas S. Satterwhite, MD

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Treatment of Gender Dysphoria in Patients

Presented by Sallie Hunt, LMFT, FAPA
And Dr. Thomas Satterwhite, MD

My Story with Carol Beecroft

- Carol Beecroft (1926-2006) was one of the first persons in the Central Valley to disclose her Transgendered condition.
- Closely aligned with Virginia Prince, who lived full time as a woman, although she never sought GRS.
- She, along with Ms. Prince, created the TRI-ESS society, which was a sorority for the heterosexual cross-dressers (which was how most Gender-Dysphoric males identified at the time.

Gender Dysphoria

- Dysphoria is defined as "being unwell or unhappy." From the greek word *Dysphoros,* which means "hard to bear" (Webster's, 2015)
- Gender Dysphoria is a persistent sadness which is on a continuum from mild to severe centralized on one's biological gender.
- The onset is typically in very early childhood or puberty, but it some cases is not actualized until adulthood.

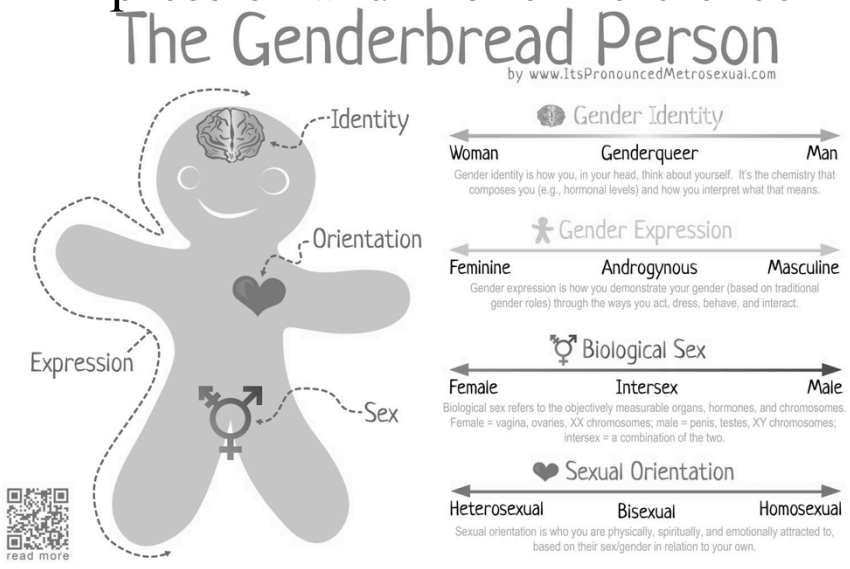
Prevalance of Gender Dysphoria

- The number of Transgender Individuals is as high as .05% of the General Population.
  - 3/4 of a million people
- This number is increasing as younger cases are emerging.
  - LA Adolescent Physician Johanna Olson, M.D. reported an increase of 330% since 2013 in her practice alone (Olson, 2015).

Two Primary Populations of GD

- Taken from the Standards of Care (SOC):
  - Biological Males and Biological Females
  - Biological sex is always a significant factor when managing GD.
    - different social, psychological and economic dilemmas.

Varients of Identification, Self-Expression and Erotic Preference



Gender Spectrum

- Because of the variations of gender expression, for which there are many different names, one of the most important challenges for the Gender Therapist is to determine where on the continuum the patient falls. This leads to the determination of the conclusive diagnosis.
  - E.g. Fetish disorder vs. Gender Dysphoria

Causes

"It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theorems instead of theories to suit facts."

- Sherlock Holmes [In Arthur Conan Doyle's "A Scandal in Bohemia" (1891)]

Reimer Twins- Tragedy due to Emphasis on Nurture in the Formation of Gender Identity

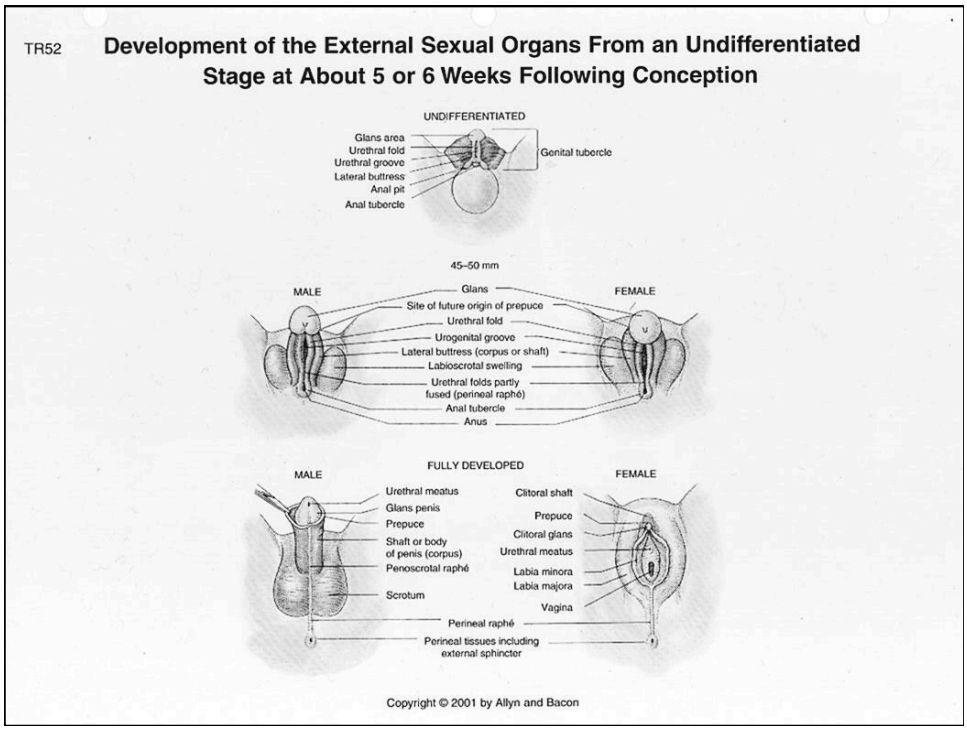
- Twins born David and Brian, both with phimosis which required circumcision.
  - During procedure, David's penis was cauterized (burned) beyond surgical repair.
  - Dr. John Money suggested to parents that David be reassigned to the female gender and raised as a female.
    - At puberty, David (now Brenda) was given female hormones to force secondary sex characteristics.
  - Scientifically, this was an ideal case study as both children shared genes, family environments and intrauterine environments.
  - Tragically, Brenda could did not accept the forced assignment of the female gender and, after years of depression, committed suicide (following the suicide of her twin brother Brian).

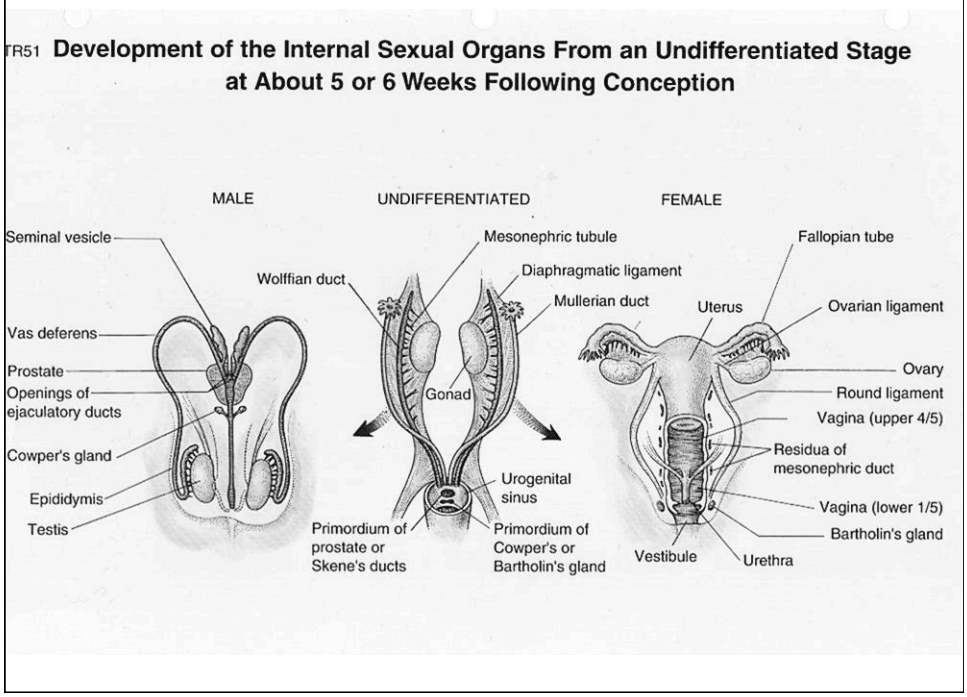
Findings and Results of this Case Study

- Forced tighter ethical controls regarding scientific research.
- Changed focus from Nurture to Nature regarding the origins of Gender Identity.
- Also, many (but not enough) pediatric surgeons are currently considering waiting for intersex children to self-identify before performing surgery.
- Please refer to the internet for more information.
  - Several articles and published journals exist regarding this case.

Prenatal Development

- We all start off with female brains.
  - Genitals develop within the first 6-12 weeks of pregnancy. However, brain development does not occur at a significant rate until the second trimester.
  - The presence of male hormones results in a brain which has subtle, but critical physical differences from the female brain (Gooren 2006).
- "The fact that the brain and the genitals develop at different times in the womb mean that a misalignment between the genitals and brain may develop, leading to either an intersex condition, or a transgender individual" (transascity.org).





Additional Influences While in the Womb

- Women with Complete Androgen Insensitivity Syndrome (CAIS) develop as female despite having XY chromosomes (Gooren).
- Phenobarbital or diphantoin administered to pregnant women as anticonvulsants can increase the chance of giving birth to a transsexual child (Dessens 1999).
  - the belief is that these chemicals disrupt the influence of testosterone on the brain in the womb.
- DHT deficient Male (Genetic Defect that prevents prenatal conversion of DHT, baby presents as female) (Bao, 2011).
- Boys (XY) born with a partial or complete lack of a penis, treated with female hormones. 50% eventually identify as males (Gooren).

Influences Cont.

- XX girls born with Congenital Adrenal Hyperplasia (CAH)
  - exposed to high levels of testosterone within the womb, develop male personality features. 100-300% more likely to identify as transgender (Gooren).
- Kallmann's Syndrome, which leads to a deficiency of gonadotropine-releasing hormone. Adult does not develop secondary sex characteristics. Very few of these individuals identify as transgender (Meyenburg, 2001).
- It is also possible that there are other compounding factors that will lead to a masculinized or feminized brain.

WPATH Standards of Care

16

WPATH Standards of Care (Formerly Harry Benjamin Standards of Care)

- Currently also referred to as the WPATH (World Professional Assiciation for Transgender Health) Standards of Care (SOC).
- Originally developed by Dr. Harry Benjamin after treating a MtF child per request of Alfred Kinsey.
  - Designed to maximize positive outcomes.
  - Officially outlined in 1979.
- Currently on it's seventh revision and is still sometimes known as the International Standards of Care (ISOC) due to it's worldwide adoption.

The Benjamin Continuum

- Pseudo Transvestite
  - Fetishistic Transvestite
    - True Transvestite
      - Transsexual Type IV
        - True Transsexual Type V
          - True Transsexual Type VI

My note: Today we recognize that gender is fluid

Purpose of the Standards of Care

- "To create a professional consensus about the psychiatric, psychologic, medical and surgical management of Gender Identity Disorders" (Standards of Care, 2012).
- Clinical guidelines for the professional
  - What does this mean?
    - The professional who performs a service to a Transgendered patient or client must be aware that the SOC are the minimal requirements that are needed to promote an accurate assessment, safe transition and (if needed) improved hormonal and surgical outcomes.

The Ten Tasks of Mental Health Professionals for Treating Transgender Patients (Covered in the SOC)

1. Create a Supportive Environment and Determine Purpose of the Visit
2. Assessment of Gender Identity Concerns
3. Assessment of Mental Stability
4. Education Regarding Treatment Options and Advocating for Support
5. Responsibility for Integrated Services for Family Members

The Ten Tasks of Mental Health Professionals for Treating (Cont.) Transgender Patients

6. Determine Eligibility and Readiness for Referral to Medical Treatment
7. Completion of Psychosocial Assessment
8. Documentation Letter for Hormone Therapy or Surgery
9. Provision of Collaborative Services
10. Be Available to Educate or Train Employers, Schools, and Institutions

Wide Variance Among the Transgendered Population

- A component practitioner must be able to discern the exact course of treatment that is necessary for a successful adjustment.
- There are times when comorbidities and/or life events may either alter the course of treatment or force a departure from treatment until resolution is accomplished.
- Make sure to document the change in your protocol to protect yourself and the patient.

Requirements of Professional Involvement

- Professional involvement with patients with GD involve:
  - Diagnostic Assessment
  - Psychotherapy
  - Real Life Experience
  - Hormonal Therapy
  - Surgical Therapy

Diagnostic Assessment

- Mental Status Exam (MSE)
- Patient History
  - Developmental Milestones
  - Hx of Presenting Problem
  - Hx of events that led to conclusion of Gender Dysphoric status
  - Any Comorbidities or Prior Psychiatric Treatment.
- Family System Dynamics, Interpersonal Relationship Statuses and Intrapersonal Status (Self-Perception).
- Physiological Assessment and Medical Hx
  - Records, if available with written consent

Psychotherapy

- The Therapeutic process should focus on treating any comorbidities or life stressors that would prevent a successful outcome.
- Also focuses on preparing the patient for the transition process, monitoring transition and following up with the patient during their post-hormonal and/or post-operation phase.
- I would like to stress the importance of having a team of professionals who are well-versed in the SOC and that communicate the patient's progress, development and potential issues/risks on an ongoing basis.
  - My team consists of a Forensic Psychologist, and Endocrinologist, A PA, and a selection of competent surgeons who are well known for treating GD and having positive outcomes.

Psychometric Testing

- Highly stress importance of Psychometric testing to rule out any significant psychopathology, which may mimic Gender Dysphoria or interfere with the therapeutic process and eventual transition.
  - Testing could also pinpoint comorbidity that may be developing (such as Bipolar Disorder) which needs to be treated and stabilized prior to hormonal or surgical intervention.
- Refer patient to a qualified Psychologist or Forensic Psychologist for this portion of the treatment process.

Controversy With Testing

- Testing has recently become highly controversial recently as both it and psychotherapy in general are not absolute requirements.
  - However, in my practice I deem it a necessity to maximize positive results, so I now have subjective findings plus objective findings to finalize my diagnostic impression of Gender Dysphoria that requires continuance of care (Hormones and/or Surgery).
  - Most physicians and surgeons who render the physiological treatments feel more confident knowing that the patient demonstrates this level of commitment.

Real Life Experience

- Patient must proceed with a Real Life Experience prior to hormonal support.
  - Real Life Experience is defined as living as the desired gender,
  - This experience must last for a total of one year and must involve both in the home and in the outside world scenarios.
    - Required so that the patient gains an understanding of the stressors involved in living as their desired gender.
  - Point of Interest- Until recently, the patient had to pass the real-life test (be identified as their desired gender by members of their community) prior to

Hormonal Therapy

- Person must be deemed eligible and ready for Hormone Therapy.
  - Eligibility- Possible psychopathologies have been ruled out and chronological/developmental age milestones have been met. (Now controversial due to Harm Reduction theory).
  - Readiness- The Clinician's judgement on whether the patient is stable and will benefit from benefit from starting hormone therapy.
- A letter from the Clinician recommending hormone therapy based on the above criteria is required before instituting hormonal treatment.
  - In my opinion, an in-depth, substantive letter is beneficial at this point to best prepare the MD for the patient and their specific needs before starting a hormonal treatment

Hormonal Testing (Cont.)

- Controversy with the treatment of Transgendered Children and Adolescents
  - Age Limitations versus Harm Reduction.

Case Example- Harm Reduction

- 14 year old FtM patient has been in therapy for a year and completed the necessary psychometric testing and has been found to be a suitable candidate for hormones. However, his parents have recently made the decision to separate which is causing increase familial stress.
- Your subjective findings of this patient is that he is emotionally mature and developmentally capable to commence hormonal treatment.
- This is an example of a deviation of treatment when it it decided that, although it will create an enormous impact on his emotional and physiological system. You must now make the decision whether to commence hormonal treatment to alleviate some of his dysphoria or to put aside the focus on transition and ameliorate the emotion impact he is experiencing from his parents' separation.

Example Continued- Harm Reduction

- As a therapist, what would you do?
- Would it be better to minimize the Gender Dysphoria or switch therapeutic focus to facilitate adjustment to his parents' separation and the family stress?
- Goals must be flexible enough to cope with new or ongoing life stressors such as these

Surgical Therapy

- Includes Facial Feminization Surgery and GRS (both MtF and FtM)
  - To be discussed in additional detail by Dr. Thomas Satterwhite.

Conclusion

Outcomes of Treatment

- 80% of individuals with GID report significant improvement in gender dysphoria after some treatment.
  - MtF individuals typically suffer worse outcome
    - Due to problems with "Passing"
  - Individuals whose symptoms manifested at a younger age had better adjustment to the new gender role.
- 2/3rds of individuals reported improvement in Quality of Life (Murad et. al., 2010).

Importance of Aftercare

- A study in Sweden found that Transgender individuals have higher rates of mortality from cardiovascular disease and suicide, suicide attempts and psychiatric hospitalizations compared to the healthy control population.
  - This highlights that post-surgical transsexuals are a risk group that need long term psychiatric and somatic follow-up care (Dhejne et. all, 2011).

36

"As we've seen, transsexualism is most likely a neurological condition of as yet unknown origin and not a "mental illness". There are many other intense neurological conditions conditions such as pain, depression and bipolar disorders for which we do not know the underlying causes but suspect biological causes. We know that these other conditions are real because we see people in distress, and we treat those people medically and with compassion to relieve their suffering. Why should it be any different with transsexualism?"

- Lynn Conway

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Questions?