



**Gender Identity Research and Education Society**

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## **EARLY MEDICAL TREATMENT FOR TRANSEXUAL PEOPLE**

Bernard Reed - 2006

Gender discomfort may be detected, albeit rarely, in children aged as young as three or four. Usually, transsexual people describe feelings of gender discomfort that date back to their early childhood. They often regret that they were not treated at the onset of puberty, when they experienced intense stress as their bodies began to develop in conflict with their core gender identities – their inner sense of being boys or girls. During puberty, transsexual boys develop breasts, start to menstruate and sometimes become frustrated by their small stature. Transsexual girls' voices deepen, they grow beards and prominent Adam's apples, experience erections and become taller than most other women.

Young transsexual people have to overcome many obstacles in obtaining medical help to deal with their difficulties. The first obstacle is learning to how to describe their feelings with a child's limited vocabulary. Then, expressing their feelings within their families often seems impossible. What they see is a family, and the world beyond it, neatly divided into two gender expressions: boys and girls, in strict accordance with genital appearance and with no tolerance for any variation from that norm. Boys who behave in feminine ways are labelled sissies. Girls showing tomboy traits experience more tolerance but not complete acceptance.

Despite the pressure to conform, some children feel such acute discomfort with the gender roles assigned to them that they try to express their core gender identities in their behaviour and dress. Usually, this is discouraged by other family members, often strongly. Expressing gender variance at school frequently leads to bullying.

Too often, when families seek medical help to deal with the gender variant behaviour of a child, the professionals respond unhelpfully. They may predict that the child will grow out of it and that, meanwhile, conformity can be achieved by rewarding gender congruent behaviour and punishing gender variant behaviour.

Some families are referred to the specialised gender identity development unit (GIDU) for children and adolescents, which is currently part of the Tavistock and Portman NHS Trust in London. Ten years ago, it was receiving about 15 cases per annum. That number has grown to 60 in more recent years. The reasons for that increase are not known. It is possible that there is a real increase in atypical gender identity development among children generally. Some fear that might be due to environmental pollution, which does appear to affect other species. It may just be that these children and their families now feel more able to be open about the condition. Certainly, there is greater awareness of gender variance and less stigma attached to it, as a result of its being discussed in television programmes. Also, the enactment of legislation that protects adult transsexual people, as well as the provision for them of medical treatment within the NHS (albeit often less than satisfactory) provides real evidence of society's greater tolerance towards them.

The GIDU found that in 80% of the cases involving children, they did not progress to become transsexual people, i.e. those who have undergone or who intend to undergo transition to live full-time in the gender role that accords with the core gender identity. Many eventually became gay or lesbian people. Others remained heterosexual people. However, in the absence of long-term follow-up, it is unknown whether some of this latter group do continue experiencing a degree of gender discomfort but are able to conceal it or deal with it by occasional cross dressing, as transgendered, rather than transsexual people. It is also unknown to what extent some of this group are referred later to the gender identity clinics for adults.

In children it is sometimes difficult to distinguish potentially atypical sexual orientation from atypical gender identity development. Nonetheless, in a small number of children the distinction can often be made, and will become more apparent as pubertal changes increase the transsexual adolescent's disgust with the developing secondary sex characteristics. No such revulsion will occur in those who are destined to be gay or lesbian. Within the 20 % of the Portman Clinic's users who did become transsexual people there was a clear pattern that, if they had still been experiencing severe gender discomfort in adolescence, they were highly likely to go on to experience transsexualism in adulthood. This means that a differential diagnosis, made in early puberty, is likely to be accurate, and that has important implications for the way that these young people should be treated.

Medical treatment is provided in a series of phases that include:

- 1 - careful psychological assessment
- 2 - fully reversible intervention: medication to block the production of the natural hormones that feminise or masculinise the body during puberty
- 3 - partially reversible intervention: prescribing hormones to masculinise or feminise the body in accordance with the core gender identity
- 4 - irreversible intervention: surgery to alter the body to conform as nearly as possible to the core gender identity, which is not carried out before the age of 18.

The first stage of treatment, psychological assessment, may start well before puberty. It will include helping the family to live with the uncertainty that must necessarily be occasioned by the known variability in outcomes. Families should be supported in maintaining a respectful acceptance of gender variant expression and, if necessary, the co-operation of the school should be sought. Teachers need to be educated and they and the parents need to be alert to the likelihood of bullying. Strategies to protect the child should be put in place.

In making the decision to proceed to the second phase, fully reversible intervention, clinicians must rely on the young person's own account of his or her feelings, the obvious behaviour and presentation of the young person, information from the parents (and sometimes teachers) and psychological tests. Although there is persuasive evidence that the brains of transsexual people are programmed before birth to develop, in small but highly significant ways, inconsistently with the rest of the body, this difference is, and is likely to remain, undetectable in living subjects. No physical test is available. Nonetheless, some clinical teams are confidently diagnosing transsexualism in young people in the early stages of puberty.

In The Netherlands, and in some of the major American and Australian treatment centres, the clinicians have developed extensive expertise in psychological assessment leading to a diagnosis of transsexualism. They therefore feel confident enough to provide hormone blockers just after the start of puberty in carefully selected cases, but only with the fully informed consent of the adolescent and the parents or guardians. In Australia, the consent of the Court is also required (although this is currently being challenged in the courts). By this early stage of puberty, before the young person has developed unwanted secondary sex characteristics, he or she has, nonetheless, been able to experience the initial effects of naturally produced hormones. This is regarded as diagnostically important. This intervention provides the adolescent, and the clinicians, with an extended, additional period of time to examine thoroughly his or her own sense of gender identity whilst being spared the stress of full puberty. Improved psychological and social function is reported in young people helped in this way.

During this process, the adolescent's bone density, ratio of leg length to body length and overall height are carefully monitored and controlled. In the case of adolescents contemplating an eventual transition from male to female, they need to be aware that the administration of blockers prevents the production of sperm, which might otherwise be stored and thus enable them to have children of their own. However, spermatogenesis will be re-established if they choose to stop hormone blockers for a short period in order to regain reproductive capacity. They also need to be aware that the underdevelopment of their genitals provides less material for the surgeons to use later in the construction of a vagina, although there are techniques for dealing with this problem. Reproductive capacity is not lost in the case of young female to male individuals.

Following a substantial period – up to two or even three years of reversible intervention, adolescents who are confirmed as transsexual, may then be prescribed cross-sex hormones (testosterone for a trans boy; estrogen for a trans girl) This third phase of treatment produces changes which are only partially reversible, and is not usually undertaken before the age of 16. Surgery can be offered later, generally not before 18, to align the body as closely as possible to the confirmed gender identity.

The hormone blocking treatment, introduced in early puberty, as described above, accords with the Standards of Care published by the Harry Benjamin International Gender Dysphoria Association (now being renamed as the World Professional Association for Transgendered Health – WPATH), the recognised world authority in this field, and the Guidance published by the UK's Royal College of Psychiatrists (which stipulates that it should be based on a second psychiatric opinion). If the adolescent did decide to revert to the gender role assigned at birth, the hormone blockers would be discontinued and the previous pubertal pathway would be resumed automatically. So far, none of the Dutch adolescents treated in the above way has chosen to revert to the original gender role and none has expressed any subsequent regret.

In the UK, the principal clinicians responsible for prescribing blockers for such adolescents argue that to interrupt or interfere with the normal pubertal process may result in unsatisfactory physical development and significant psychopathology. They therefore insist that no such intervention should be initiated until all the pubertal body changes are complete. Of course, in transsexual people, those changes cause intense

stress and even suicidal feelings and then require significantly greater invasive and costly surgical and other procedures than is the case if puberty is blocked in the early stages. Nonetheless, these British clinicians insist that the adolescents have to accept changes that they consider “foreign” and undesirable. In 2004, these clinicians wrote Guidelines, which embodied their own protocols, and obtained endorsement for them from the British Society for Paediatric Endocrinology and Diabetes (BSPED). BSPED then published these Guidelines, which are a deterrent to any other clinician in the UK who might wish to follow the Dutch approach.

The suffering of these British adolescents is poignantly illustrated by the following extract from a letter written by a 16½ year old individual, who has commenced the transition from a male to a female gender role. It was addressed to the female paediatric endocrinologist who has been responsible for the adolescent’s care.

- The last two and a half years have been horrendous for me, with my body becoming so disgustingly adult male that I cannot bear it. Imagine how you would feel if, tomorrow morning, you were to wake up to find yourself in a male body, with a man’s voice and a man’s face looking back at you from the mirror, with early morning beard and moustache stubble, with no breasts, an adam’s apple, large male feet and hands, a body covered in thick, black hair and a penis and testicles.
- Would your brain be screaming out, in protest, that you are female, not male? Living in a male body hurts beyond belief. I sometimes feel as if I will go crazy with the sadness and desperateness of it.
- My body will never, ever be as I would like it to be and now, unfortunately, it is really a case of damage limitation.

GIRES, in collaboration with Mermaids, administered a symposium in London in May 2005, attended by a multi-disciplinary team of medical specialists from around the world. Its aim was to resolve the differences in practice and establish an agreed protocol for use worldwide. However, the main authors of the BSPED Guidelines, who were both members of the team, remain unwilling to change their practice. Consequently, the team could only agree to establish a research programme to compare the outcomes of the British and Dutch approaches, in which the clinics in Amsterdam, London and Boston would participate. There is likely to be a five-year wait for the results of the comparative research, even if it gets underway.

The Dutch clinicians have published their view that requiring full puberty to be completed is unnecessary. Two American team members have published articles that endorse the Dutch approach. The team member who is a medical ethicist is publishing an article that states the BSPED approach ‘risks being incongruent with English legislation and with the ethical principles that such legislation incorporates’. However, the process of using these opinions to mount a legal challenge to British practice would, even if successful, be too slow to help those transsexual adolescents living in the UK whose puberty has already begun. The Dutch clinicians are not permitted to treat them. British families who wish to choose the Dutch approach have to seek it in the USA, if they can afford to do so.

Meanwhile, GIRES and Mermaids will continue to press for an alternative British approach. GIRES has provided BSPED with a critique of its Guidelines and informed it that early suspension of puberty is offered in Australia, Belgium, Canada, Germany, The Netherlands and the USA. So far, BSPED has removed its approval from the

previously published Guidelines and agreed to convene a meeting to review them, including overseas clinicians and user representatives.