

Editorial

Disorders of gender identity:
what to do and who should do it?[†]

James Barrett

**Summary**

Transsexualism is not usually indicative of psychopathology. In carefully selected individuals, with multidisciplinary support, a change of social gender role and cross-sex hormone treatment greatly improves the psychological and social state. Sustained improvement merits gender reassignment surgery. The key is early referral with

subsequent primary care cooperation in the treatment plan.

Declaration of interest

J.B. works as a full-time National Health Service Consultant in a large gender identity clinic.

James Barrett (pictured) is a consultant psychiatrist and the lead clinician in the Charing Cross Gender Identity Clinic. Over the past 20 years he has assessed over 5000 people with disorders of gender identity.

Disorders of gender identity are uncommon and there is a public, and to some extent a general psychiatric, perception that transsexualism is the only or at least the main disorder of gender identity. This is illusory, but the illusion persists in part because most dual-role transvestites do not come to the attention of psychiatric services. The prevalence of transsexualism has been estimated at 1:7440 males and 1:31 153 females¹ and the rate of referrals to gender identity clinics continues to increase.

Defining disorders of gender identity

Currently, transsexualism, childhood disorder of gender identity and dual-role transvestism are listed in ICD-10² as disorders of personality and behaviour (significantly, *not* illnesses) and DSM-5 abandons a psychopathological model,³ instead deploying the looser term 'gender dysphoria'. It seems likely that ICD-11 will move in the same direction.

Whether transvestism is contiguous with transsexualism or distinct from it is a debate that has endured over the decades and the diagnostic position reflects this uncertainty. The current diagnostic criteria imply that there is never a genetic or hormonal element in transsexualism and that any such abnormality, if present, would always account for the cross-gender identity. It should be noted that either or both of these implications may well be without foundation. Further, the experience of gender dysphoria arising as a result of a proven disorder of sexual differentiation requires a therapeutic approach that additionally addresses the associated endocrine and metabolic aspects of that disorder.

Whether gender identity issues should be viewed as psychiatric disorders, intersex disorders or any sort of disorder at all is currently something of an ideological battleground. There are some parallels with the psychiatric declassification of homosexuality but crucially people with gender identity issues seek medical and surgical intervention whereas homosexual people do not and the providers of those interventions are obliged only to act if they believe it to be in the patients' interests. The field is highly politicised, attracting much public fascination and arousing opinions so loud⁴ that sometimes it gets forgotten that medical

interventions in this setting can dramatically improve quality of life at very little cost.

Recent clinic-based studies have generally supported the view that transsexualism is usually an isolated diagnosis and not part of any general psychopathological disorder.⁵ Similar results are suggested in adolescents, supporting the idea that major psychopathology is not required for the development of transsexualism. It seems that the earlier findings suggesting otherwise⁶ might have represented a sampling bias or illnesses caused by minority stress.

On the other hand, though, the inference of the current and earlier diagnostic classifications that other psychiatric disorders should be excluded may have meant that the populations actually referred to gender identity clinics were filtered, causing an artificially lower rate of psychopathology in these clinic populations and thus suggesting the low rate of psychiatric comorbidity. It is also, of course, possible for transsexualism to be coincidental with a mental illness (including one caused by minority stress) and yet not caused by it. Teasing the two apart is difficult and requires much experience.

Important differential diagnoses include fetishistic transvestism, dysmorphophobia, autogynaephilia and some of the other disorders of personality or sexuality. Occasionally, psychoses may present in such a way as to resemble a gender identity disorder and, increasingly rarely, gay or lesbian people, particularly in non-Western societies, may present as transsexual.⁷

Role of the multidisciplinary team

Disorders of gender identity are of obscure origin. Psychological, social and biological hypotheses abound but there is still no accepted theory. Treatment requires a more multidisciplinary input than almost any other in psychiatry or any other branch of medicine. Psychiatrists, psychologists, endocrinologists, speech and language therapists and surgeons (ear, nose and throat, breast, plastic, gynaecological and urological) are routinely involved. Because most of the differential diagnoses are psychiatric arguably a professional group with a good skill set to diagnose and thereafter coordinate care is liaison psychiatry, regardless of precise diagnostic categorisation, although additional training and experience will certainly be required.

The US-based World Professional Association for Transgender Health (www.wpath.org) promulgates treatment guidelines, making it clear that implementation will vary in different national healthcare and legislative circumstances. Intercollegiate guidelines apply in the UK.⁸

[†]See pp. 151–156, this issue.

Treatment

The treatment of disorders of gender identity is drastic and irreversible, so it should only be undertaken in a setting of diagnostic certainty. Just as the clinical team cannot compel the patient to undertake treatment, so the patient cannot compel the team to provide it. Honesty on all sides and a concordance of views underpins successful treatment in this field, as it does in most medical practice. It seems generally recognised that the safest and most effective treatment is that delivered by an experienced multidisciplinary gender identity clinic or network. In such a setting it is a general principle that reversible changes should precede irreversible ones and that no step should be undertaken unless the preceding steps have been accompanied by psychological and social improvement. Early and prompt treatment seems to be associated with better outcomes, in part because delayed referral is associated with an increased rate of self-medication – this having been demonstrated to cause suboptimal eventual outcomes.⁹

Almost always a clear change of gender role precedes or accompanies any hormone treatment. Although bilateral mastectomy might be considered slightly earlier (after androgen treatment is well under way and the patient established in a male role), to be considered as candidates for genital surgery patients are verified as having thrived in their new gender role for at the very least a year and have to seem resilient enough to do so in the future. It is very worrying if patients are hanging on to a life in their new gender role by only a whisker and have no plausible plan for how they will manage after gender reassignment surgery. Patients who have thrived in the very long term describe, looking back, gender reassignment surgery as having been ‘the icing on the cake’ and emphasise how important it was to have a good quality cake to add that icing to.

Although it is inappropriate for hormone treatment to start without the assessment and approval of a competent expert service, it is best for prescription and administration to occur in a primary care setting because such treatment will be lifelong and is not challenging or hazardous, the standardised mortality ratio being reassuring. The lack of a licence for all treatments except Sustanon reflects not danger but the prohibitive costs of seeking licences for low-volume treatments. It is safe and sensible for general practitioners, working in concert with gender identity clinics, to prescribe cross-sex hormones from the outset and to continue to do so after patients are discharged from those clinics.

The technical sophistication of gender reassignment surgery is now such that born-male patients enjoy surgery of such high quality that the results very closely mimic born-female genitals.¹⁰ Genital surgery for female patients is a very much more technically challenging procedure, much less studied and reported upon.¹¹ The results are such that no born-female patient can conceal the truth from a sexual partner in the context of close physical intimacy and it is strongly suspected that much greater psychological and social benefit to born-female patients is conferred by a bilateral mastectomy than by phalloplasty. Such genital surgery is undertaken by only about a third of born-female patients.

Quality of life

With prompt and competent treatment the improvement in quality of life seen in people with disorders of gender identity

can be quite extraordinary and is sustained in the very long term. Around 4000 people have used the Gender Recognition Act 2004 to change the sex on their UK birth certificate (K. Williamson, Ministry of Justice, personal communication, 2013). Many underwent treatment decades earlier and continue to thrive (the oldest applicant I am aware of was 92). Even greater numbers have changed the sex on their passport, suggesting a sustained change of social gender role and good enough function and earning power to be travelling abroad. Considered purely in terms of quality-adjusted life-years per pound spent, a gender identity clinic would rank very highly. It seems odd that such an effective treatment should ever be considered ‘low priority’ or that access to it should be delayed or made administratively more complex than access to less efficacious therapies.

Service provision

For UK residents the most pressing issue is probably now one of adequate service provision for a well-proven and successful treatment regimen. Primary and secondary care sometimes delays access to treatment, primary care conservatism often complicates and delays access to hormone therapy and in the past inconsistent state funding combined with cumbersome administration unnecessarily stalled some surgical aspects of treatment. None of these things requires further evidence or additional funding to be remedied – better awareness, speedier referrals, wholehearted primary care cooperation and a greater sense of determination in administrative minds are all that are required.

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