



The Gender Centre Inc. Fact Sheet
Transsexualism
The Current Medical Viewpoint

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Summary

Purpose

This document provides an overview of current best practice in providing effective health care for persons with the transsexual syndrome. It describes the nature of the syndrome, its diagnosis, treatment and outcomes; recognises its biological aetiology; and makes recommendations for the legal status of people experiencing transsexualism. It updates a similar document produced for the Forum on 14 February 1995.

The syndrome

Transsexualism is a Gender Identity Disorder in which there is a strong and on-going cross-gender identification, i.e. a desire to live and be accepted as a member of the opposite sex. There is a persistent discomfort with his or her anatomical sex and a sense of inappropriateness in the gender role of that sex. There is a wish to have hormonal treatment and surgery to make one's body as congruent as possible with one's psychological sex.

Treatment

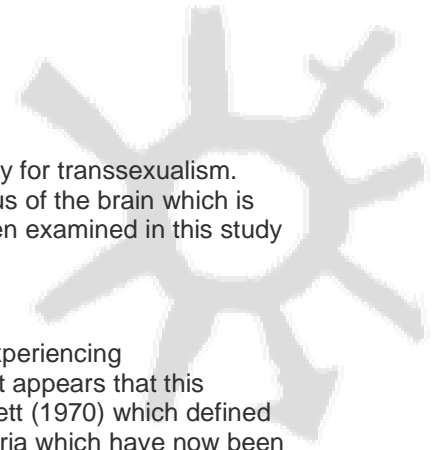
The currently accepted and effective model of treatment utilises hormone therapy and surgical reconstruction and may include counselling and other psychotherapeutic approaches; electrolysis; and speech therapy. In all cases, the length and kind of treatment provided will depend on the individual needs of the patient and will be subject to negotiation between the Consultants involved, the patient's General Practitioner and the patient.

Outcomes

Studies which have been carried out into long-term outcomes indicate that a treatment model using the principles described above is highly successful, with some suggesting up to a 97% success rate. This compares extremely favourably with the outcomes of treatment for other chronic conditions.

Aetiology

Dr. Harry Benjamin, who introduced the syndrome to the general medical community in the early 1950s, favoured a biological explanation of the syndrome, believing that the genetic and endocrine systems must provide a "fertile soil" for environmental influences. The weight of current



scientific evidence suggests a biologically-based, multi-factorial aetiology for transsexualism. Most recently, for example, a study identified a region in the hypothalamus of the brain which is markedly smaller in women than in men. The brains of transsexual women examined in this study show a similar brain development to that of other women.

Legal position

The present legal position is that people who have been diagnosed as experiencing transsexualism immediately lose a substantial part of their civil liberties. It appears that this situation was decided by the decision in the case of Corbett versus Corbett (1970) which defined the legal sex of the plaintiff as male, using genital and chromosomal criteria which have now been superseded. Medically, there is no reason why people receiving treatment for transsexualism and who have permanently changed gender role should be given any lesser legal status than that of any other person.

1. Aims and Objectives of this Document

1.1 The aim of this document is to provide an overview of current best practice in providing effective health care for persons with the transsexual syndrome.

1.2 Its objectives are to:

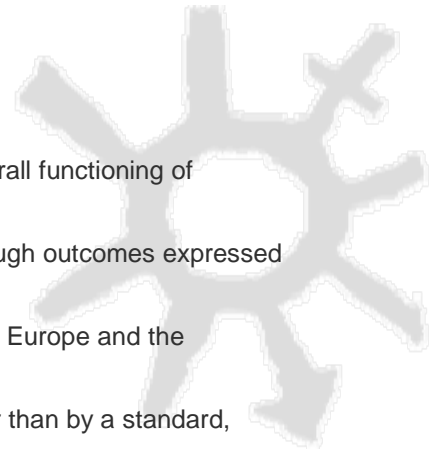
- describe the nature of the medical evidence;
- identify appropriate diagnostic criteria for transsexualism;
- indicate the main features of appropriate models of treatment;
- identify outcomes and measures in terms of improved quality of life;
- describe the case for a biological aetiology; and
- make recommendations for the legal status of people experiencing transsexualism.

2. The Nature of the Medical Evidence

2.1 Following the general move away from a mechanistic base of thought by the scientific community at large, new views of medicine, health and disease have arisen¹. In the United Kingdom (U.K.), these have been accompanied by a government policy which identifies patient care as the main expected outcome of medical research and development². An important response of the medical profession to these changes has been its growing recognition that the application of quantitative, empirically-based methodologies to the social phenomenon of health does not necessarily produce results which can usefully inform the practice of medicine in its lived social and cultural contexts³. Instead, there has been an increasing emphasis on the quality of life for patients as the measure of the effectiveness of healthcare⁴.

2.2 One result of this has been that in the process model of aetiology – diagnosis – treatment – outcome, expectations of proving causality are now less significant. Instead, interest in aetiology has focused increasingly on its usefulness in informing treatment and contributing to successful outcomes. This trend reflects the fact that the aetiology of many of the chronic conditions for which medicine provides treatment is unknown. It also recognises that the growing complexity of scientific and social theories and their interrelationship makes causality increasingly difficult to define.

2.3 Thus, in the case of transsexualism, current medical practice considers it from the viewpoints of:



its socio–biological context, that is, its relationship to the overall functioning of individuals in their social contexts;

- measuring the effectiveness of diagnosis and treatment through outcomes expressed as improvements in the patient's quality of life;
- relating U.K. practices to comparative practices elsewhere in Europe and the developed western world;
- treating each patient according to their individual need rather than by a standard, prescriptive regimen of healthcare;
- having an aetiology which is unproven and which does not, therefore, provide appropriate evidence for an adversarial court–room setting; and
- increasing concern that an inappropriate focus on aetiology rather than an appropriate focus on the outcomes of treatment could operate to the disadvantage of patients.

3. Diagnostic Criteria

3.1 Two main diagnostic systems for transsexualism are in operation, International Classification of Diseases 10th Edition (I.C.D. 10)⁵ and Diagnostic and Statistical Manual of Mental Disorders 4th Edition (D.S.M. IV)⁶. Diagnostic criteria which combine features of both systems are as follows:

- Transsexualism is a Gender Identity Disorder in which there is a strong and ongoing cross–gender identification, and a desire to live and be accepted as a member of the opposite sex. There is a persistent discomfort with his or her anatomical sex and a sense of inappropriateness in the gender role of that sex. There is a wish to have hormonal treatment and surgery to make one's body as congruent as possible with one's psychological sex;
- The diagnosis of transsexualism is confirmed when gender dysphoria has been present for at least two years and has been alleviated by cross–gender identification; and
- Transsexualism is linked with, but distinct from:
 - Intersex conditions (e.g. androgen insensitivity syndrome or congenital adrenal hyperplasia) and accompanying gender dysphoria;
 - Transient, stress related cross–dressing behaviour; and
 - Persistent pre–occupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex.

4. Treatment

4.1 There is no single model of treatment: rather, variety in approach is both supported and sought as part of the continuing professional discussion of the syndrome. Typically, however, an effective model of treatment will utilise hormone therapy and surgical reconstruction, and also include:⁷

- counselling;



psychotherapeutic approaches;

- electrolysis; and
- speech therapy.

4.2 Assessment of the patient's progress is likely to take place at approximately three monthly intervals and at the appropriate point surgery will be used. Depending on the physicality and the overall health of the patient, surgery may include, for male to female transsexuals:

- vaginoplasty (construction of a vagina);
- penectomy (removal of penis);
- orchidectomy (removal of testes);
- clitoroplasty (construction of a clitoris);
- and possibly breast augmentation (enlargement of the breasts);
- rhinoplasty (reshaping the nose);
- cosmetic surgery such as hair transplants or facial remodelling;
- thyroid chondroplasty (shaving of the Adam's apple); and
- crico–thyroid approximation and anterior commissure advancement (for raising the pitch of the voice),

and for female to male transsexuals:

- hysterectomy & oophorectomy (removal of uterus and ovaries);
- bilateral mastectomy (breast removal); and
- possibly phalloplasty (construction of a penis).

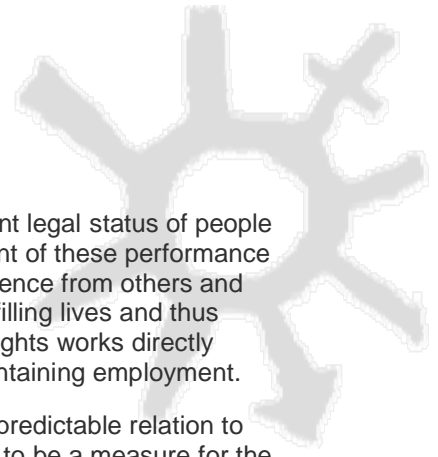
4.3 As medical and surgical techniques and knowledge increases, other or additional treatments may be used. In all cases, the length and kind of treatment provided will depend upon the individual needs of the patient and will be subject to negotiation between the Consultants involved, the patient's General Practitioner, and the patient. Involving the patient (and, in the case of minors, the parents or guardians of patients) in the management of their own programme of care is considered to be extremely important.

5. Outcomes and measures

5.1 There is a paucity of research into the long–term outcomes of treatment for transsexualism. However, the studies which have been carried out indicate that a treatment model using the principles described above is highly successful, with some suggesting up to a 97% success rate⁸. This compares extremely favourably with the outcomes of treatment for other chronic conditions.

5.2 Using a "Quality of Life" model for measuring the effectiveness of patient care, outcomes of this kind may be measured in terms of expressed patient satisfaction with their ability to:

- find employment;
- make relationships;
- integrate with the larger community; and



live fulfilling lives.

5.3 It is a matter of concern to the U.K. medical community that the current legal status of people who have been treated for Transsexualism works against the achievement of these performance indicators. That status marginalises individuals who have no visible difference from others and prevents them from being able to integrate, make relationships or live fulfilling lives and thus impairs quality of life⁹. In particular, the lack of substantive employment rights works directly against the important economic performance indicator of finding and maintaining employment.

5.4 The heterosexual or homosexual partnership of the patient bears no predictable relation to outcomes of treatment for Transsexualism and should not be considered to be a measure for the effectiveness of treatment.

6. Aetiology

6.1 Dr. Harry Benjamin introduced the syndrome to the general medical community in the early 1950s and advocated the compassionate treatment of it¹⁰. Benjamin favoured a biological explanation to the syndrome, believing that the genetic and endocrine systems must provide a "fertile soil" for environmental influences¹¹.

6.2 In their work on plastic surgery techniques four years later, Gillies and Millard echoed Benjamin's point of view and suggested that transsexualism should be classified as an intersex condition¹².

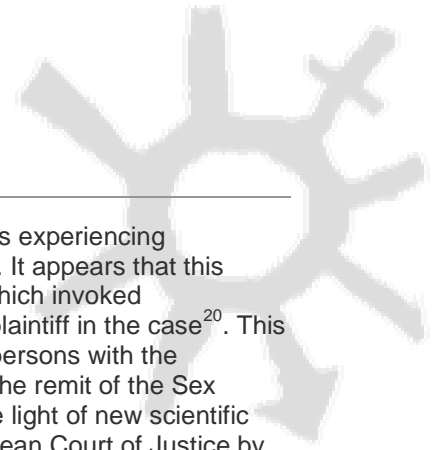
6.3 In an authoritative review of research in this field in 1985, Hoenig follows Benjamin in ultimately depending on a biological force or forces to account for transsexualism¹³. Summarising and commenting on this and other medical viewpoints three years later, in 1988, Doctor indicates that the overall weight of evidence is that there is "the formation of some kind of gender system within the brain that is fundamental to ultimate gender identity and gender–role development"¹⁴.

6.4 It is a viewpoint of this kind that Money suggests in an authoritative paper "The Concept of Gender Identity Disorder in Childhood and Adolescence after 37 years" where he states "causality with respect to gender identity disorder is divisible into genetic, prenatal hormonal, postnatal social, and post–pubertal hormonal determinants" and suggests "there is no one cause of a gender role ... Nature alone is not responsible, nor is nurture, alone. They work together, hand in glove."¹⁵

6.5 More recently, in a paper given to the Council of Europe's XXIII Colloquy on European Law, Gooren has suggested that "there is now evidence to believe that in transsexuals the differentiation process of the brain taking place in the first years after birth has not followed the course anticipated of the preceding criteria of sex (chromosomal, gonadal, and genital)"¹⁶. Thus, although sex assignment at birth by the criterion of the external genitalia is statistically reliable, in people experiencing transsexualism it is not: they are exceptions to the statistical rule.

6.6 Most recently, a study has been carried out of a region in the hypothalamus of the brain which is smaller in women than in men. Strikingly, the region was of female size or smaller in six male–to–female transsexuals, regardless of hormone treatment. This result supports the hypothesis that gender identity stems from an interaction between the developing brain and sex hormones¹⁷.

6.7 This view that the weight of current scientific evidence suggests a biologically–based, multi–factorial aetiology¹⁸ for transsexualism is supported by articles in journals, the press and popular scientific works.



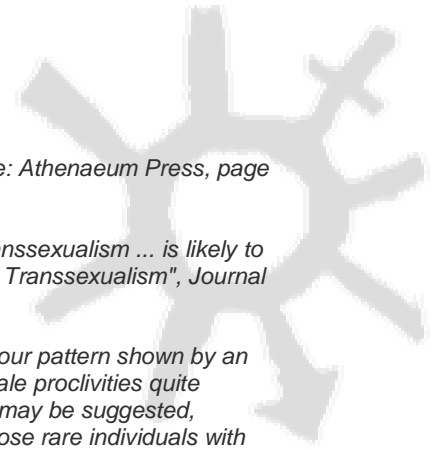
7. Recommendations for Legal Status

7.1 The present legal position is that people who have been diagnosed as experiencing transsexualism immediately lose a substantial part of their civil liberties¹⁹. It appears that this situation was decided by the decision in *Corbett versus Corbett* (1970) which invoked "chromosomal, gonadal, and genital" tests to define the legal sex of the plaintiff in the case²⁰. This definition has since been applied to employment to the disadvantage of persons with the transsexual syndrome, for example, by placing them apparently outside the remit of the Sex Discrimination Act²¹. These tests must be considered obsolete now in the light of new scientific information and the legal view has recently been challenged in the European Court of Justice by the case of *P versus S and Cornwall County Council* where the Advocate General has declared that the Equal Treatment Directive "must be interpreted as precluding the dismissal of a transsexual on account of a change of sex".²²

7.2 Current medical knowledge recognises that an absolute aetiology for transsexualism is not available although the present weight of evidence is in favour of a biologically-based, multi-factorial causality. It is considered, therefore, that scientific knowledge of transsexualism has progressed considerably since *Corbett versus Corbett* and that the evidence presented there is no longer reliable. From the point of view of medical ethics, the imperatives of respect for autonomy, beneficence, non-maleficence and justice²³ mean that medicine would not support any legal interpretation of its research into transsexualism that would operate against the health, well-being or advantage of patients. Medically, there is no reason why people receiving treatment for transsexualism and who have permanently changed gender role²⁴ should be given any lesser legal status than that of any other person.

References

1. 1 More general works such as Lupton, D. (1992) *Medicine and Culture*, London: Sage and Seedhouse, D. (1991) *Liberating Medicine*, Chichester: Wiley, provide a useful overview and synthesis of the major work in this field, including that of, for example, Illich; Foucault; and Ian Kennedy.
2. See, for example, NHS (1994) *Supporting Research and Development in the N.H.S.*, London: H.M.S.O., *Working for Patients, Managing the New, the Calman Report*.
3. See, for example, Colquhoun, D. and Kelleher, A., eds. (1993) *Health Research in Practice: Political, Ethical and Methodological Issues*, (London, Chapman and Hall).
4. See, for example, Fallowfield, L. (1990) *The Quality of Life: The Missing Measurement in Health Care*, London, Souvenir Press.
5. World Health Organisation (1992) *International Classification of Disorders*, Geneva, W.H.O.
6. American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* Washington: A.P.A.
7. See, for example, Reid, R. (1992) "Working with Gender Dysphoria", *Counselling Gender Dysphoria*, Ed. Z.J. Playdon, Devon: ATC.
8. Green, R. and Fleming D.T. (1990) "Transsexual Surgery Follow-Up: Status in the 1990s", *Annual Review of Sex Research*, Ed. J. Bancroft, volume 1, 1990, pages 163 – 174. Of the 130 F.T.M.'s reported in the study, 97% of the outcomes were considered to be satisfactory; of the 220 M.T.F.'s 87% of the outcomes were considered to be satisfactory. See also Pfafflin, F. & Junge, A. (1992) *Geschlechtumwandlung Schattauer, Stuttgart/New York for an extensive survey on outcome*.
9. For a general discussion of the medical effects of social stigmatisation see Scambler, G. (1991) "Deviance, sick role and stigma", *Sociology As Applied to Medicine*, Ed. G. Scambler, 3rd edition, London: Balliere Tindall, pages 185 – 196.



10. King, D. (1993) *The Transvestite and the Transsexual*, Newcastle upon Tyne: Athenaeum Press, page 46.
11. Benjamin stated the "if the soma is healthy and normal no severe case of transsexualism ... is likely to develop in spite of all provocations". Benjamin, H. (1953) "Transvestism and Transsexualism", *Journal of Sex Research*, 5:2, page 13.
12. "The physical sex picture does not always bear a fixed relation to the behaviour pattern shown by an individual. One or other hormone may determine an individual's male or female proclivities quite independently of the absence of some of the appropriate physical organs. It may be suggested, therefore, that the definition of hermaphroditism should not be confined to those rare individuals with proved testes and ovaries but extended to include all those with indefinite sex attitudes." Gillies, H. and Millard D.R. (1957) *The Principles and Art of Plastic Surgery*, Volume 1, London, Butterworth, page 370–1.
13. Hoenig, J. (1985) "The Origin of Gender Identity" *Gender Dysphoria*, Ed. Steiner, B.W., New York: Plenum Press.
14. Docter, R.F. (1988) *Transvestites and Transsexuals, Towards a Theory of Cross–Gender Behaviour*, New York: Plenum Press, page 63.
15. Money, J. (1994) "The Concept of Gender Identity Disorder in Childhood and Adolescence After 39 Years", *Journal of Sex and Marital Therapy*, 20 (3: 163–177).
16. Gooren L.G.J. (1993) "Biological Aspects of Transsexualism and their relevance to its legal aspects", *Proceedings of the XXIII Colloquy on European Law: Transsexualism, Medicine and the Law*, Strasbourg; Council of Europe.
17. J.N. Zhou, M.A. Hoffman, L. Gooren and D.F. Swaab, "A sex difference in the human brain and its relation to transsexuality", *Nature*, 2 November 1995, volume 378:6552, pages 68–70
18. For example, Moir, A. and Jessel, D. (1989) *Brainsex* London: Michael Joseph; Gorman, C. (1992) "Sizing up the Sexes", *Time*, 20 January 1992, pages 38–45; "Sex is all in the Brain", *Times* 12 September 1992.
19. McMullen, M. & Whittle, S. (1994) *Transvestism, Transsexualism and the Law*, (London, Gender Trust).
20. *All England Law Reports* (1970) Volume 2 pages 32 – 51 *Corbett v Corbett otherwise Ashley*.
21. *Industrial Tribunal Case No. 16132/93* (1993) *Interim Decision of the Industrial Tribunal P v S and Cornwall County Council*.
22. *Court of Justice of the European Communities, Opinion of the Advocate General in the case of P v S and Cornwall County Council* (1995) case C–13/94, paragraph 25.
23. Gillon, R. (1994) "Medical Ethics; four principles plus attention to scope" *British Medical Journal*, volume 309 (16 July 1994) pages 184–188.
24. *The point of permanent change of gender role is decided by the consultant psychiatrist in negotiation with the patient and is usually the commencement of the "life test"*.

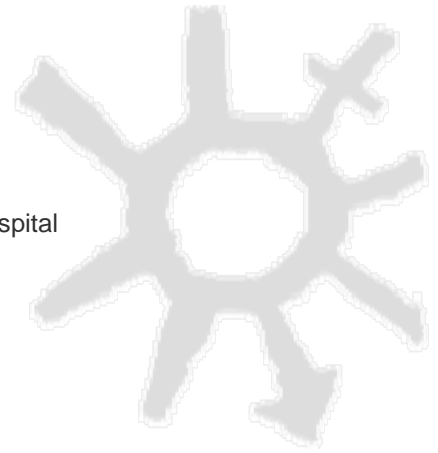
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