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Mental Health Care and Assessment of Transgender Adults

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UCSF Alliance Health Project • UCSF Transgender Surgery Program

Castro Mission Health Center Transgender Life Care and Dimensions Clinics

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Continuing Medical Education Disclosure

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- Disclosure: No relevant financial relationships. Presentation does not include discussion of off-label products.

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Transgender surgeries are now covered for San Francisco residents on Medi-Cal or without insurance.

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Edmund G. Brown Jr.
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Department of Managed Health Care

DATE: April 9, 2013

LETTER No. 12-K

GENDER NONDISCRIMINATION REQUIREMENTS

The purpose of this letter is to remind health care service plans (health plans) of their obligations under the Insurance Gender Nondiscrimination Act (IGNA), codified in Health and Safety Code section 1365.5.¹ IGNA prohibits health plans from discriminating against individuals because of the individual's gender, including gender identity or gender expression. This prohibition extends to the availability of health coverage and the provision of benefits.²

Background

IGNA prohibits health plans from denying a person a contract (health coverage), or from limiting benefits, because of the individual's sex.³ IGNA defines "sex" to include "gender," "gender identity," and "gender expression."⁴ IGNA requires health plans to provide transgender individuals with the same contracts and coverage benefits that are available to non-transgender individuals.

IGNA does not prohibit health plans from applying nondiscriminatory exclusions or limitations, conducting medical necessity determinations or applying appropriate utilization management criteria on a case-by-case basis with respect to specific requests for transgender services. However, if a health plan denies an individual's request for services on the basis that the services are not medically necessary or that the services do not meet the health plan's utilization

¹ AB 1586 (Koretz – Chap. 421, Stats. 2005).

² IGNA also amends Insurance Code section 10140.

³ Health and Safety Code section 1365.5.

⁴ "Gender" means sex, and includes a person's gender identity and gender expression. "Gender expression" means a person's gender-related appearance and behavior whether or not stereotypically associated with the person's assigned sex at birth. Penal Code section 422.56, subd. (c).

**Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division**

NCD 140.3, Transsexual Surgery
Docket No. A-13-87
Decision No. 2576
May 30, 2014

DECISION

The Board has determined that the National Coverage Determination (NCD) denying Medicare coverage of all transsexual surgery as a treatment for transsexualism is not valid under the “reasonableness standard” the Board applies. The NCD was based on information compiled in 1981. The record developed before the Board in response to a complaint filed by the aggrieved party (AP), a Medicare beneficiary denied coverage, shows that even assuming the NCD’s exclusion of coverage at the time the NCD was adopted was reasonable, that coverage exclusion is no longer reasonable. This record includes expert medical testimony and studies published in the years after publication of the NCD. The Centers for Medicare & Medicaid Services (CMS), which is responsible for issuing and revising NCDs, did not defend the NCD or the NCD record in this proceeding and did not challenge any of the new evidence submitted to the Board.

Effect of this decision

Since the NCD is no longer valid, its provisions are no longer a valid basis for denying claims for Medicare coverage of transsexual surgery, and local coverage determinations (LCDs) used to adjudicate such claims may not rely on the provisions of the NCD. The decision does not bar CMS or its contractors from denying individual claims for payment for transsexual surgery for other reasons permitted by law. Nor does the decision address treatments for transsexualism other than transsexual surgery. The decision does not require CMS to revise the NCD or issue a new NCD, although CMS, of course, may choose to do so. CMS may not reinstate the invalidated NCD unless it has a different basis than that evaluated by the Board. 42 C.F.R. § 426.563.

CMS must implement this Board decision within 30 days and apply any resulting policy changes to claims or service requests made by Medicare beneficiaries other than the AP for any dates of service after that implementation. With respect to the AP’s claim in



Challenges with Expanding Access to Surgery

- Co-occurring mental health and substance use disorders
- History of trauma, societal discrimination, negative experiences in medical and mental health care settings may interfere with engagement in care
- Unstable living situations and lack of social support
- Lack of resources in health care and mental health care settings

What Psychiatrists and Other Mental Health Practitioners Can Contribute

- Providing care to stabilize co-occurring mental health and substance abuse disorders with transition and across the lifespan.
- Principles of cultural humility and patient centered care.
- Emphasis on psychosocial functioning and support.

What Psychiatrists and Other Mental Health Practitioners Can Contribute

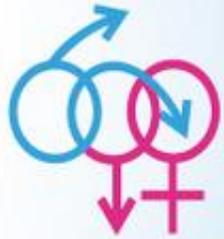
- Principles of psychiatric consultation in evaluating for surgery
- Training mental health teams
- Advocacy in health systems

Roles in Gender Teams

- **UCSF Alliance Health Project:** Formed new Gender Team, trained staff, set protocols, monthly supervision meetings, second letters
- **Castro Mission Health Center:** Longstanding gender teams: Dimensions and Transgender Life Care Program. Hired additional staff. Added monthly supervision meeting. Structured interview form for mental health assessments.
- **Women's HIV Clinic at SFGH:** Strong existing multidisciplinary team. Patients with high rates of co-occurring psychiatric illness and substance abuse, and psychosocial challenges. Training staff, setting protocols.
- **UCSF Medical Center Transgender Surgery Program:** Building institutional support, setting protocols, reviewing letters, evaluations for second letters, research agenda

There are More Trans People Than Once Thought

- Massachusetts phone survey: 0.5% identified as transgender (N=28,000+). (Conron, et al 2012)
- Netherlands: 0.8%-1.1% (N=8000+) identified as gender incongruent (Kuyper and Wijsen, 2014)
- New Zealand: 1.2% of 8,000+ high school students identify as transgender. (Clark TC et al 2014)
- Numbers seeking binary transition at gender centers is much smaller, but growing rapidly. (Dhejne et al 2013)



WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH



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Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People

The World Professional Association for Transgender Health

www.wpath.org

Version 7

2016 **WPATH** SYMPOSIUM AMSTERDAM



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Psychiatric Assessments for Hormone Therapy and WPATH SOC 7

- Elimination of 12 weeks of psychotherapy or 12 weeks living in role of “opposite sex”
- Presence of persistent gender dysphoria and ability to give informed consent is basis for hormonal treatment
- Hormonal therapy indicated for gender dysphoria across the gender spectrum
- Mental illness should be “reasonably well-controlled” per SOC 7
 - Concurrent treatment of Gender Dysphoria with co-occurring mental illness often is necessary

SOC 7: Access to Care

- WPATH SOC 7 brings “informed consent” clinics under SOC.
- These clinics do not require a letter from a mental health professional to start hormones, which lowers barriers to care.
- However “informed consent” clinics are expected by SOC to refer those with mental health issues for treatment.

Closing the Gap: WPATH SOC 7 and the “Informed Consent” Model

- Community clinics, often using a team approach, are providing hormonal therapy without a letter from a mental health professional
- Assessment is more than just having the capacity to understand risks/benefits: experienced medical providers use clinical judgment that hormonal therapy is indicated
- Clinics often have mental health providers for referral when indicated by intake staff or medical provider

Care for Trans Patients with Co-occurring Mental Illness

- Simultaneously addressing mental illness, substance abuse, and gender dysphoria is often necessary, while working to optimize functioning in trans people with co-occurring psychiatric illness

Hormone Therapy and Co-occurring Mental Illness

- Hormone therapy is safe and effective for gender dysphoria in patients with severe mental illness, though mood symptoms can occur.
- Hypomania/mania with testosterone is uncommon, even with supraphysiologic doses, though bipolar patients should be followed closely at time of initiation.
 - Occurred in 2/50 cis men given 600mg/week testosterone. (Pope, et al, Arch Gen Psychiatry 2000)
- Reduced mental health symptoms overall in trans men with testosterone treatment; weekly injections better tolerated than every 2 weeks. (Davis& Meier, 2013)
- Risk/benefits must be weighed, including mental health improvement with relief of gender dysphoria, and harm from withholding care.

SOC 7 Criteria for Surgery

- Persistent, well-documented gender dysphoria
- Capacity for informed consent, and of age to consent
- If significant medical or mental health concerns are present, they must be well-controlled.

SOC 7 and Social Transition

- Social transition is not a requirement for hormones, chest/breast surgery, hysterectomy/salpingo-oophorectomy, or orchiectomy
- For vaginoplasty, metoidioplasty, phalloplasty: 12 continuous months of living in a gender role congruent with gender identity

SOC 7 and Surgery: Hormones

- Chest surgery for trans men: Hormone therapy not a prerequisite
- Breast augmentation in trans women: Hormone therapy recommended for at least 12 months (for better outcome)
- Genital surgery: 12 continuous months of hormone therapy (unless not clinically indicated)

SOC 7 and Surgery: wpath.org

- SOC 7 requires one mental health assessment for chest surgery and two for genital surgery
- From 2 licensed, knowledgeable mental health professionals.

Mental Health Assessments and Letters for Surgery

- Letter is the consultation report to the surgeon and necessary documentation for insurance coverage
- Letter should provide necessary information for surgeon's own assessment and care of patient
- Assessor should be a resource for the surgeon after the consultation is written
- Assessment process can aid in patient education and preparation for surgery

What's in a Letter?

- Dated and addressed to surgeon
- Name and date of birth of patient
- Who the assessor is, and the assessor's relationship with the patient.
 - E.g.: "I am a licensed clinical social worker, and saw AB weekly from July-December, 2014, for psychotherapy and for an assessment for genital surgery."

What's in a Letter? (2)

- The history of the patient's gender dysphoria, and what treatment (e.g. psychotherapy, hormones, other surgeries) the patient has already undergone.
- The patient's social transition, with pertinent details. (e.g., when the patient started living in full time their current gender role, relationships and functioning in current gender role, legal name/gender change.)
- For genital surgery, specify length of time on hormones and in current gender role, meeting SOC 7 one year requirement.

What's in a Letter? (3)

- History of mental illness and substance abuse
- Current medical or mental health conditions, current medications, and level of stability of these conditions.
- Capacity for informed consent, and patient's understanding of the risks and benefits of the planned surgery.
- Fertility discussion, when appropriate.
- Psychosocial stability: Housing, support, plan for post-operative period.

What's in a Letter? (4)

- Diagnosis: Gender Dysphoria, Co-occurring conditions
- A statement that the patient meets SOC 7 criteria for the surgery.
- A request that the surgeon contact you (at 415-XXX-XXXX) if further information is needed.

The Second Assessment and Letter

- Typically scheduled after first assessment is complete.
- Letter from first assessment reviewed, and case discussed with first assessor, when necessary, before second assessment.
- First assessment letter reviewed with patient
- Independent assessment of patient, including diagnosis, co-occurring conditions, ability for informed consent and understanding of risks/benefits of planned surgery, and current psychosocial stability and aftercare plan.
- Availability to speak with the surgeon, if necessary

ASSESSMENT FOR GENDER AFFIRMING SURGERY

Name _____ DOB _____

Primary Language _____ Race/Ethnicity _____

Gender _____ Pronoun _____

Insurance Coverage _____

Basic Eligibility for Surgery

- 18 or over
- Engaged with medical provider in SF Health Network for at least 1 year

Other Steps

- eReferral Sent
- Medical Evaluation Form Completed
- Patient Education Form Reviewed

Assessment Process Explained

Surgery Referral Process Explained

DECISION-MAKING ABOUT SURGERY

1) Which surgery or surgeries are you interested in?

2) What makes you interested in surgery at this time?

3) If you have the option, have you thought about which surgeon you would like to work with? If so, what makes you interested in that particular surgeon?

Client Name _____

4) What has your planning process about this surgery been like? (Which surgery, when, how to prepare) What kind of research have you done about this particular surgery? What do you know about the post-operative care needs for this surgery?

5) What are your expectations about what will change in your life as a result of surgery?

6) If applicable, are you aware of the impact of surgery on long-term reproductive capacity? If you want children or think there's a possibility you want children in the future, have you thought about how to plan for that? What kind of support and resources do you need in thinking about or planning for it?

7) How do you generally make major life decisions? How have you made major life decisions in the past? Has there been anything different about this decision-making process?

8) How do you generally cope with difficult or challenging situations? What are your external and internal supports or coping strategies?

GENDER IDENTITY AND GENDER DYSPHORIA

9) How do you identify in terms of gender?

10) Was there a time when you began to notice a difference between your internal sense of gender and your assigned gender? If so how was that for you?

11) What do others in your life (family, friends, co-workers) know about your gender identity? How have others responded to your gender expression or gender identity?

12) What is your relationship like with your body? Do you experience distress related to your body? How has any distress affected your functioning (for example: activities, relationships, work, school, daily self-care)?

13) Any steps taken to manage gender dysphoria? What have their outcomes been?

- Social transition? (Expression of gender that feels aligned with internal sense of gender identity? Across different settings?)

- Hormone therapy? (when, how long, from whom, impact)

- Other gender-related surgeries?

Client Name _____

Castro Mission Health Center & Dimensions Youth Clinic
Revised 9/14

- Changing name or legal documents?

- Other

SEXUAL AND RELATIONSHIP HISTORY

14) Who are you sexually attracted to? Who do you have sex with?

15) Are you dating or in a relationship now? If so, have you discussed plans for surgery with your partner or partners?

16) What kind of role or how important a role does sex play in your life now? Do you experience any body image issues that get in the way expressing yourself sexually?

17) How might surgery affect or change sex for you? How might it affect relationship with romantic or sexual partners?

18) If you have had sex in exchange for money/a place to stay/ to support yourself, do you anticipate any changes in income/ability to work following surgery?

MEDICAL HISTORY

19) Do you have any major medical issues? Do you take any medications? Do you know if medical conditions (eg diabetes, HIV, high blood pressure, BMI \geq 40) are well-controlled? Have you talked to your primary care provider about the impact of any medical conditions on surgery? If medical conditions are not well-controlled are you engaged in planning with your primary care provider about how to manage them?

20) Have you ever had surgery? What was it like? How did you manage it?

MENTAL HEALTH (Based on comprehensive mental health assessment)

21) Do you have a history of mental health treatment? Are you taking or have you taken psychiatric medications? Have you experienced symptoms recently (and if so, are you currently having symptoms)?

22) If mental health symptoms are or have been present, what triggers symptoms? How might the process of surgery (preparing for surgery, having surgery, healing from surgery) affect symptoms? What kind of support will you need in the process of surgery to manage these symptoms?

23) Are there other mental health supports you have in place (such as groups, alternative treatments)?

CURRENT AND PAST SUBSTANCE USE (Based on comprehensive substance use assessment)

24) Are you currently using substances (including alcohol and tobacco), or do you have a history of use? (If yes, do a comprehensive assessment of substance use, if not already done by you.) If you are currently using substances what is your understanding of how these may impact surgery?

25) If you are currently using substances (including alcohol and tobacco) do you have a plan to cut down or discontinue use? What kinds of supports might you need?

STABILITY, SUPPORTS AND AFTERCARE

26) What is your current housing situation? Where will you recover from surgery? If not permanently/stably housed, do you have a plan for shelter post-surgery? Do you have a private area and access to clean water for post-surgery recovery?

27) What is your current source of income? How will surgery and recovery from surgery affect your income? Do you have a plan to manage this? Do you have a plan for how to pay for food, rent, necessary medical supplies, and other expenses during that period?

28) How will you get to and from surgery? To and from follow-up appointments? Who will provide help with basic care? Who will provide emotional/social support?

Client Name _____

PLAN

What are next steps for both clinician and client, what is plan for support and ongoing treatment if assessed to be necessary?

OTHER RELEVANT CLINICAL INFORMATION (Clinician observations, client concerns or questions, areas that still need to be addressed)

CLINICIAN TASKS

- Education about procedure and outcomes provided as appropriate**
- Client assessed to have adequate information about the surgery and to have ability to make informed consent**
- Client assessed to meet WPATH SOC 7**

Date

Clinician Name

Co-Signer (if applicable)

Clinician Signature

Co-Signature (if applicable)

Case Vignette #1: Assessment for Vaginoplasty in Patient with Diagnosis of Borderline Personality Disorder

Psychiatry resident requests supervision on case:

- 61 yo trans F, seeing UCSF residents serially for several years, has been seeing this resident in psychotherapy for almost 2 years.
- H/o multiple suicide attempts, but none in last several years
- On hormone therapy and living as female for decades
- S/P orchiectomy many years ago for testicular cancer.
- Learns that vaginoplasty is now available; seeking “letter” immediately to get in queue.

Considerations in this patient

1. The patient meets SOC 7 criteria of persistent gender dysphoria, one year social transition and on hormones, and (likely) capacity for informed consent.
2. Is the patient stable for surgery: medically, mentally, and psychosocially?
3. Does she have realistic expectations for surgery?
4. Can concerns about stability and realistic expectations be addressed in therapy? Is there any reason to delay for a better outcome?
5. How does one maintain a therapeutic alliance while acting as a gatekeeper?

National Transgender Discrimination Survey: Survey of 7000 Trans People

- Refusal of health care: 19% of our sample reported being refused care due to their transgender or gender non-conforming status
- Harassment and violence in medical settings: 28% of respondents were subjected to harassment in medical settings and 2% were victims of violence in doctor's offices
- Lack of provider knowledge: 50% of the sample reported having to teach their medical providers about transgender care

Table 2. Risk of various outcomes among sex-reassigned subjects in Sweden (N=324) compared to population controls matched for birth year and birth sex.

	Number of events cases/ controls 1973–2003	Outcome incidence rate per 1000 person-years 1973–2003 (95% CI)		Crude hazard ratio (95% CI) 1973–2003	Adjusted* hazard ratio (95% CI) 1973–2003	Adjusted* hazard ratio (95% CI) 1973–1988	Adjusted* hazard ratio (95% CI) 1989–2003
		Cases	Controls				
Any death	27/99	7.3 (5.0–10.6)	2.5 (2.0–3.0)	2.9 (1.9–4.5)	2.8 (1.8–4.3)	3.1 (1.9–5.0)	1.9 (0.7–5.0)
Death by suicide	10/5	2.7 (1.5–5.0)	0.1 (0.1–0.3)	19.1 (6.5–55.9)	19.1 (5.8–62.9)	N/A	N/A
Death by cardiovascular disease	9/42	2.4 (1.3–4.7)	1.1 (0.8–1.4)	2.6 (1.2–5.4)	2.5 (1.2–5.3)	N/A	N/A
Death by neoplasm	8/38	2.2 (1.1–4.3)	1.0 (0.7–1.3)	2.1 (1.0–4.6)	2.1 (1.0–4.6)	N/A	N/A
Any psychiatric hospitalisation‡	64/173	19.0 (14.8–24.2)	4.2 (3.6–4.9)	4.2 (3.1–5.6)	2.8 (2.0–3.9)	3.0 (1.9–4.6)	2.5 (1.4–4.2)
Substance misuse	22/78	5.9 (3.9–8.9)	1.8 (1.5–2.3)	3.0 (1.9–4.9)	1.7 (1.0–3.1)	N/A	N/A
Suicide attempt	29/44	7.9 (5.5–11.4)	1.0 (0.8–1.4)	7.6 (4.7–12.4)	4.9 (2.9–8.5)	7.9 (4.1–15.3)	2.0 (0.7–5.3)
Any accident	32/233	9.0 (6.3–12.7)	5.7 (5.0–6.5)	1.6 (1.1–2.3)	1.4 (1.0–2.1)	1.6 (1.0–2.5)	1.1 (0.5–2.2)
Any crime	60/350	18.5 (14.3–23.8)	9.0 (8.1–10.0)	1.9 (1.4–2.5)	1.3 (1.0–1.8)	1.6 (1.1–2.4)	0.9 (0.6–1.5)
Violent crime	14/61	3.6 (2.1–6.1)	1.4 (1.1–1.8)	2.7 (1.5–4.9)	1.5 (0.8–3.0)	N/A	N/A

Notes:

*Adjusted for psychiatric morbidity prior to baseline and immigrant status.

‡Hospitalisations for gender identity disorder were excluded.

N/A Not applicable due to sparse data.

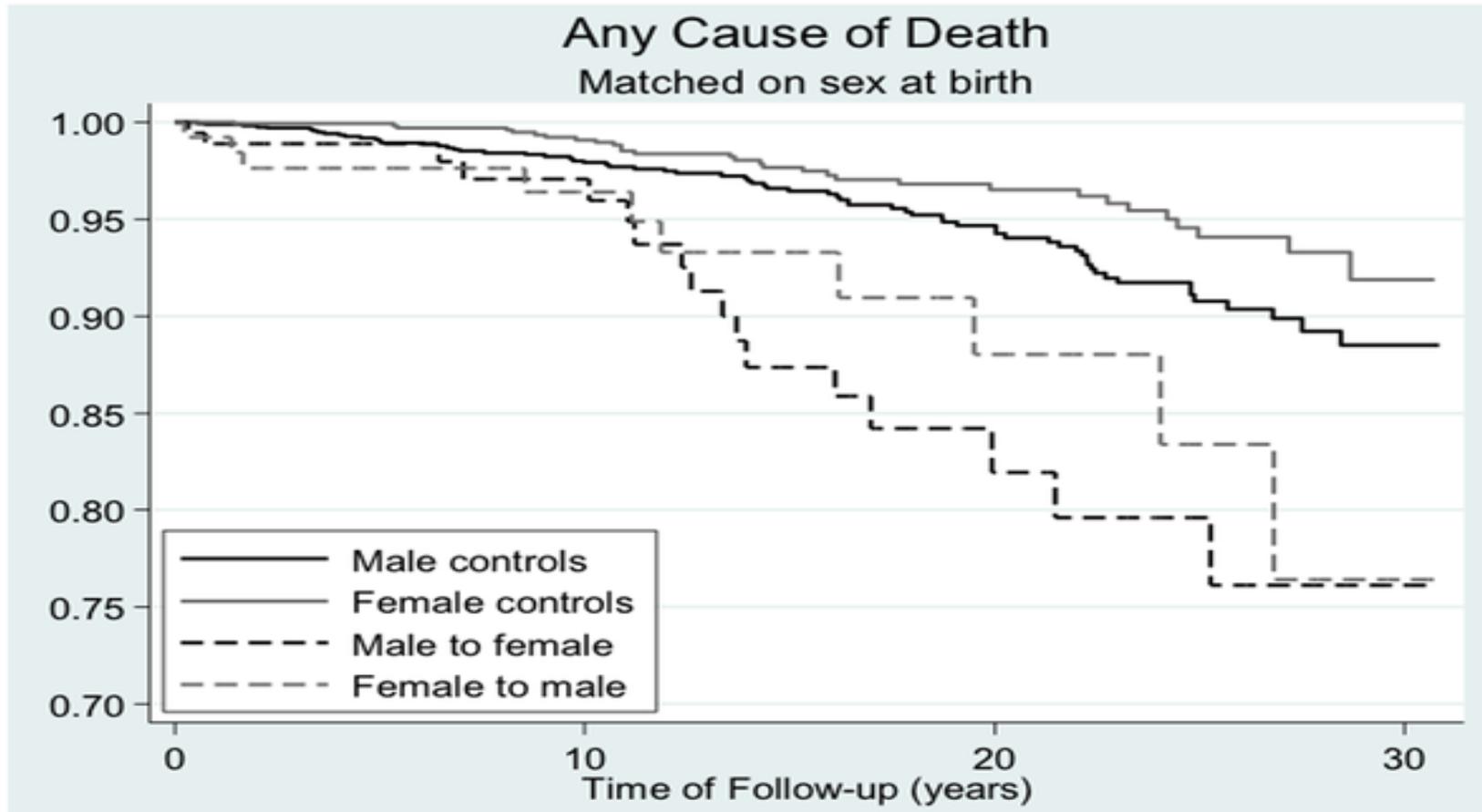
doi:10.1371/journal.pone.0016885.t002

Dhejne C, Lichtenstein P, Boman M, Johansson ALV, et al. (2011) Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. *PLoS ONE* 6(2): e16885.

doi:10.1371/journal.pone.0016885

<http://www.plosone.org/article/info:doi/10.1371/journal.pone.0016885>

Figure 1. Death from any cause as a function of time after sex reassignment among 324 transsexual persons in Sweden (male-to-female: N=191, female-to-male: N=133), and population controls matched on birth year



Dhejne C, Lichtenstein P, Boman M, Johansson ALV, et al. (2011) Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. PLoS ONE 6(2): e16885.

doi:10.1371/journal.pone.0016885

<http://www.plosone.org/article/info:doi/10.1371/journal.pone.0016885>

Regret Rate by Decade, Sweden

- **1960–1971** 4/15 (27 %) 0
- **1972–1980** 6/103 (5.8 %) 5
- **1981–1990** 1/76 (1.3 %) 3
- **1991–2000** 3/127 (2.4 %) 3
- **2001–2010** 1/360 (0.3 %) 4
- **1960–2010** 15/681 (2.2 %) 15

Case Vignette #2: Trans Man with Depression, Seeking Chest Surgery

- 20 yo assigned female at birth, now identifies as trans male.
- Referred by chest surgeon for mental health assessment for surgery.
- Reports being a “tomboy,” but only recognizing trans identity in past two years.
- Out to family; has used male name and pronoun only with online communities. Socially isolated and uncomfortable leaving home.
- Started testosterone 7 months ago, with lowered voice and some body hair.
- Sees psychologist weekly (depression CBT) and psychiatrist monthly (antidepressants) with little improvement, since being brought in for psychiatric evaluation after online friend called 911, concerned about suicidality. Neither psychologist nor psychiatrist felt comfortable doing the one necessary evaluation for chest surgery.
- Pt feels persistent discomfort with breasts, and with being perceived as female.

Trans Man Seeking Chest Surgery: WPATH SOC 7

- Pt has persistent gender dysphoria.
- Pt has capacity to understand risks and benefits of surgery.
- SOC 7 allows for chest surgery early in transition, including before testosterone or social transition.
- Has family support post-operatively.

Is mental illness “stable”? Should the criteria be instead that the mental illness does not affect capacity or judgment, and that the mental health benefits of surgery outweigh the risks?

Case vignette #3: Genderqueer Youth Seeking Unconventional Surgery

- A. is an African American genderqueer youth seen at Dimensions Clinic, in early 20's, followed for last 4 years at Dimensions Clinic.
- Gender identity neither male nor female, but they had strong gender dysphoria about penis, masculine features.
- Presented with untreated bipolar disorder, Type II, and alcohol use disorder
- Gender dysphoria treated concomitantly with addressing mood disorder and alcohol use.
- Treated first with spironolactone, then estradiol added; presentation gradually became more feminine.
- Peer support and culturally sensitive clinical environment helped maintain therapeutic alliance
- Now presents seeking “genital nullification.”

Genderqueer Youth: Considerations for Surgery

Considerations:

- A. has capacity for informed consent and longstanding documented gender dysphoria
- Has only moderate preference for “nullification” over conventional vaginoplasty
- A.’s husband is supportive of A.’s choice, but would prefer vaginoplasty
- Could A.’s wishes change with time?
 - Gradual drift towards female presentation and identity
 - Could desire to have loss of sensation be due to discomfort with penis, and change post-operatively
 - Discussion with surgeon

Gender Spectrum Recognized in DSM 5

- Gender Dysphoria (in Adolescents or Adults)
 - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by 2 or more of the following indicators:
 1. 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)
 2. 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 the anticipated secondary sex characteristics)
 3. A strong desire for the primary and/or secondary sex characteristics of the other gender
 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
 6. 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)

Gender Dysphoria in DSM 5 (2):

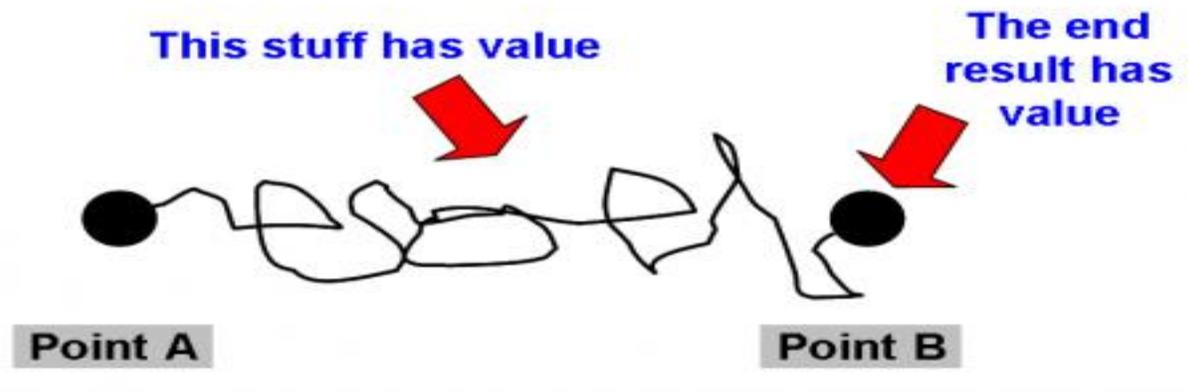
- B. The condition is associated with *clinically significant distress* or *impairment in social, occupational, or other important areas of functioning*.
- **Subtypes**
 - With or without *disorder of sex development*
- **Specifier**
 - *Post-transition*, i.e., the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and is undergoing (or 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, phalloplasty in a natal female).

Transition across the gender spectrum

- Pts present with discomfort with incongruity of physical body and/or expected social gender role with their gender identity and/or preferred gender expression.
- Social, medical and/or surgical transition interventions can help relieve this discomfort and/or bring more life satisfaction
- Intermediate place on gender spectrum for some fits better with sense of self and/or life circumstances.

Approach

- Rather than impose a given narrative on patient, assist patient in finding own path.



Mental Health Assessments for Hormones and Surgery

- WPATH SOC 7 provides guidance for assessments: wpath.org
- Assessment for hormones includes the presence of persistent gender dysphoria, the ability to give informed consent, and the absence of contraindications
- Hormone therapy and treatment of co-occurring conditions often must happen concurrently
- Assessments for surgery include presence of persistent gender dysphoria, stability in mental health, ability to give informed consent, plus consideration of psychosocial and other health factors for good outcomes.
- Clear communication between mental health, medical, and surgical members of treatment team is necessary.

Clinical Manual of
**Cultural
Psychiatry**

SECOND EDITION



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