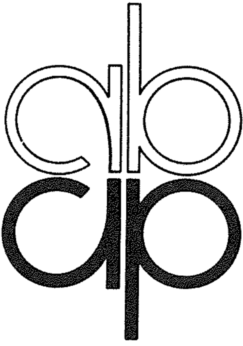
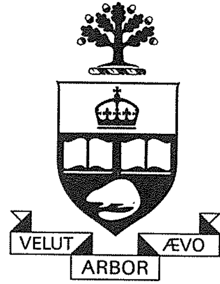


CLARKE INSTITUTE OF PSYCHIATRY

250 College Street

Toronto, Ontario M5T 1R8

(416) 979-2221



B R O C H U R E

GENDER IDENTITY CLINIC

INDEX

	Page
Gender Identity Clinic Staff................	1
Introduction................................	2
History of the Clinic.......................	3
Aims and Functions of the Clinic............	4
Method of Patient Assessment................	5
Diagnosis of Transsexualism and Establishment of Cross Gender Identity......	6
Legal Implications..........................	9
-Change of documentation	
-Marriage	
-Children	

METAMORPHOSIS MEDICAL
RESEARCH FOUNDATION
P.O. BOX 5963, STATION A
TORONTO, ONTARIO M5W 1P4

GENDER IDENTITY CLINIC STAFF

Psychiatrist-in-Charge:	Dr. Betty W. Steiner
Associate Psychiatrist:	Dr. Stephen J. Hucker
Associate Psychiatrist:	Dr. John Thornton
Research Coordinator:	~~Mr. Neville Case~~ Julie Martz
Senior Research Psychologist:	Dr. Ray Blanchard
Research Consultant:	Dr. Ron Langevin
Administrative Assistant:	Mrs. Krystyna Lewis

CONSULTANTS:

Dr. Walter J. Hannah	Head, Dept. of Obstetrics & Gynaecology Women's College Hospital
Dr. David Shaul	Head, Dept. of Obstetrics & Gynaecology, New Mount Sinai Hospital
Dr. Ann Kenshole	Internist, Women's College Hospital
Dr. Nicholas Forbath	Endocrinologist, Toronto General Hospital
Dr. Joseph Berg	Geneticist, Surrey Place Centre
Dr. William R.N. Lindsay	Plastic Surgeon, Wellesley Hospital

INTRODUCTION

Through history, some men have desired to become women, some women have wished to become men. Many fascinating examples of cross gender identity can be found in literature. The first well published case of transsexualism is that of the now famous Christine Jorgenson who in 1953, underwent surgical sex reassignment in Denmark. Since that time there have been an increasing number of patients presenting with transsexualism and other related disorders of gender idenity. As a result a number of specialized clinics have been established across the world, particularly in North America. One of the first began in 1966 at Johns Hopkins Hospital in Baltimore. Many others followed, some to die overnight, the more reputable ones to continue and flourish.

Gender identity refers to the feeling, "I am a man" or "I am a woman." It is undifferentiated at birth but is said to be firmly established

by the age of 36 months. The best known disorder of gender identity is transsexualism, defined as the belief held by a biologically normal individual, that he/she is a member of the opposite sex.

The causes of gender disorders are unknown. Various theories have been postulated such as a particular family constellation. Recent work has shown that some patients demonstate biochemical disturbance, but this has not yet been replicated. Certainly there are patients who, under stress, demonstrate a shift in their gender identity. These are perhaps better classified as "secondary transsexuals" as compared to the more classical "primary transsexual."

HISTORY OF THE CLINIC

In 1968 patients were presenting at various psychiatric teachingc enters in Toronto, claiming to be transsexual and demanding

surgical sex reassignment. At that time no facilities were available in Canada to evaluate patients with disorders of gender identity. A pilot study was undertaken at the Clarke Institute in 1969 and within six months 88 patients had been referred. At that time the waiting list was closed. A protocol outline was designed, seven stage multidisciplinary process whereby patients were evaluated. Following completion of the pilot project, patients were still requesting surgery. A Demonstration Model grant was obtained from the Ministry of Health of the Province of Ontario which ran for the maximum period of three years, from 1 September 1975 to 31 August 1978. Since that time the Clinic has been funded independently by the Ministry of Health and has become integrated into the Clarke's budget as a specialized clinic. To date, 522 patients have been referred. As a result of the number of children (between five and fifteen years of age) referred for evaluation of gender disorders, the Child and Adolescent Gender

Identity Clinic was established, under the direction of Dr. Susan Bradley.

AIMS AND FUNCTIONS OF THE CLINIC

1) Clinical Services

These involve evaluation of patients referred to the Clinic, the management and/or treatment of many patients, and a consultation service to other professionals throughout the province.

2) Education

This includes programmes aimed at professionals in the allied mental health fields such as psychiatrists, social workers, public health nurses. In addition, numerous interviews are given to print and radio and television journalists. Talks are given as well to interested groups, eg. Public Health Nurses, Family Service Association, Metropolitan Police, etc.

general practitioners
? lawyers
police

3) Research

This is an important component of the Clinic and has resulted in the appearance of numerous publications in both nationally and internationally-recognized journals, together with numerous presentations at national and international meetings.

METHOD OF PATIENT ASSESSMENT

All patients must be referred by a practising physician. It is important that someone in the community - namely, a professional - be aware of the patient's gender problem as the Clinic's facilities are not available on a 24-hour basis.

Upon receipt of the letter of referral, the patient is contacted by the administrative assistant. Completion of a general information questionnaire is requested, the patient's life story in his/her own words, and photographs (both dressed and crossdressed). Upon

completion of this information, a series of interviews are booked, with two psychiatrists, a social worker, internist, and/or an endocrinologist. A standardized psychological test battery and laboratory tests are also carried out, usually taking approximately four days to complete on an outpatient basis. At times additional tests are administered, e.g. chromosonal examination, electroencephalograph (EEG), phallometric tests, etc. When possible, the patient's partner/spouse and family are interviewed for a comprehensive social history and relatives are requested to complete a psychological test battery.

Once all the pertinent information from the assessment has been collected, a conference is arranged with the Clinic staff to which the patient is invited. The referring physician is asked to participate as well as the patient's partner and/or family if he/she so desires. After an extensive discussion the patient is informed of the Clinic member's diagnostic

impression and necessary recommendations for the future management of the case are made. An annual re-evaluation of the patient and a revised psychological test battery is completed every 12 months. This annual re-assessment and follow-up continues for a period of five to ten years.

It should be noted that surgical sex reassignment is not performed on any patient who is currently married at the time he/she is recommended to undergo such a procedure owing to the legal complications which could ensure, nor to anyone who is under the age of 21.

Diagnosis of Transsexualism

After the diagnosis of transsexualism is made the following expectations are placed on the patient:

1) The biological male (who believes he is a female) is expected to a) establish "her" cross gender identity and live and function

in society as a woman.

b) find employment as a female while being helped in obtaining documentation to this end, e.g. change of social security card, health insurance card, driver's licence, credit cards, etc.

c) establish her cross gender identity for a period of one year, to be followed by a re-evaluation. If she has shown sufficient emotional stability she is placed on female hormone therapy, e.g. - estrogen. As a result of the estrogen therapy the patient will experience a redistribuiton of body fat around the hips, shoulders and neck as well as a slight decrease in the growth of face and body hair with some redistribution in the female contour. Mild to moderate enlargement of the breasts (gynaecomastia) occurs and in addition, there is quite a marked decrease of sexual drive, the patient perhaps no longer being able to maintain penile erections.

d) Once the patient has established her

cross gender identity for a minimum period of two years, she is re-evaluated with a view to possible surgical sex reassignment (bilateral orchidectomy as well as penectomy and creation of an artificial vagina - bilateral removal of testes, amputation of penis).

2) The biological female (who believes she is a male) is expected to a) establish "his" cross gender identity and live and function in society as a man.

b) to find employment as a man and is helped in obtaining documentation to support his, e.g. change of social security card, health insurance card, driver's licence, etc.

c) to establish his cross gender identity for one year after which time the patient is re-evaluated. If he has shown sufficient emotional stability he is placed on male hormone therapy. This consists of monthly injections, resulting in a redistribution of body fat with the

thickening in the neck and shoulder girdle, as well as an increased growth of body and facial hair and an enlargement of the clitoris which produces an increased sexual drive. Over a period of weeks there is a deepening of voice into the male range.

d) to be considered after a further period of twelve months, for surgical sex re-assignment. This consists of bilateral amputation of the breasts (breast oblation), followed by the total removal of both ovaries, tubes and uterus (total panhysterectomy and bilateral salpingo oophorectomy).

One of the main difficulties in the management of the transsexual patient is the length of time involved from the initial evaluation to the final surgical sex reassignment. All patients are anxious to rush through this period, while on the other hand, the Clinic encourages a slow but steady and prolonged progress over a minimum period of two years,

in order that the patient adapt to living in his/her chosen gender, before undergoing irrevocable surgical procedure. This "real life" experience is the most important and most meaningful part of establishing his/her chosen role in society. All patients who have undergone surgical sex reassignment agree, adding that, from their point of view the most important but most difficult period is waiting for surgery. All patients agree however, that once having successfully established their cross gender identity, surgical sex reassignment is an anticlimax! The time is important, too, for those patients who are not really sure of their cross gender desire, allowing those who feel that they are not transsexual to resume their biologiclaly normal sex role without having undergone an irreversible surgical procedure. All the changes of feminisation brought about by estrogen (female hormone) therapy are completely reversible, as are the masculinisation which occurs with testosterone (male hormone) therapy. In the

case of the biological female, however, the deeper voice change will remain permanently.

LEGAL IMPLICATIONS

Change of Documentation

Patients are encouraged to change their documentation to their chosen gender, e.g. social security card, credid cards, driver's licence, once they have been diagnosed as transsexual. This presents no problem but those individuals who encounter obstacles are given a note by the Clinic stating that they are to establish their cross gender identity and to live and function in their chosen sex role. This enables some patients to undergo rehabilitation training, where necessary, so their identifying documents are in the appropriate sex. Following surgical sex reassignment, patients are then able to undergo a legal name change which is heard "in camera." It is recommended that the patient maintain the same initials in order to avoid possible future

complications. A passport is easy to obtain at this stage simply by filling out a routine application form. The ability to change a birth certificate varies from province to province and so depends on where the patient was born. Legislation has been passed to allow a change of the designates sex on the birth certificate in - Ontario, British Columbia, Alberta, New Brunswick, Manitoba and Saskatchewan.

Marriage

The question of the legality of a transsexual marrying has not yet been decided in Canada. British law has not recognized "the union between two members of the same sex" since the Corbett vs. Corbett case in 1963, where the definition of "sex" is based solely on chromosonal sex and does not take into account the other variables which are involved in sexual identity, e.g. hormonal sex, gonodal sex, internal and external morphology, and the

assigned sex at birth and sex at rearing. In Canada, where most of the laws are based on the British legal system, it is interesting to note that there is no "definition of sex" in Canadian law. Hence, the validity of a marriage contract between (a male-to-female transsexual with a biological male, or a female-to-male transsexual with a biological female) has not been defined and as yet no precedent has been set.

Children

Though the surgically reassigned transsexual is unable to conceive and procreate following surgical sex reassignment, a number of patients have had children of their own prior to surgery or have lived in a union where the partner has had children. In most cases these children appear to be normal, healthy individuals seeming not to suffer any emotional side effects as a result of being raised by a transsexual parent and his/her partner.

Some of the female-to-male transsexual patients living with biological females have raised the issue of artificial insemination or adoption. Once again, Canadian law is not clear on the legality of these issues. Most of the legal problems raised by transsexualism have not as yet produced answers and there will be no answers until a precedent has been set.

Non-Transsexual Patients

For those patients who have other types of gender disorder, various forms of therapy are recommended, e.g. marital therapy, assertive training, intensive exploratory psychotherapy, etc. These patients are also seen for annual consultation for re-assessment. The period of follow-up for the Clinic patients as a whole is a minimum of 5 and preferably up to 10 years.