

## THE TREATMENT OF TRANSSEXUALITY: THE DUTCH MODEL

The Netherlands is a small country in Western Europe not only famous for its windmills, wooden shoes and tulips, but also for its tolerance.

Tolerance of abortion, soft drugs, euthanasia, gay people and transsexualism.

Transsexualism can be best defined as an extreme form of gender dysphoria.

Gender dysphoria is a discrepancy between gender identity on the one hand and the physical characteristics of the body on the other. Transsexuals feel trapped in their bodies: "I felt my body was a prison cell. There were no windows. I could not breathe: I could not get out, I didn't have the key". To the non-transsexual this problem is so alien and unimaginable that it is difficult to sympathize with the transsexual's problems.

On medical evaluation of transsexuals, no objective signs of intersexuality can be found with the existing techniques of assessing biological parameters of sex.

Therefore in traditional medical practice a transsexual will be advised to undergo psychotherapy to achieve that his/her body concept will occur with the actual physical body. The transsexual will view such an advice as improper since it is totally at odds with how he/she perceives and knows his/her problem. The body is not "me"; the gender identity is the true "me". This intimate and trusted knowledge of the self is, in fact, not different from what we, nontranssexuals, experience in our selfreflection with the cardinal difference that in our case it "happens" to agree with our physical body. One transsexual after having undergone sex reassignment treatment, phrased his situation as follows: "before this treatment I had/was no - body, now I am somebody.

To the biomedical sciences it has been very puzzling how a normally as man or woman differentiated person could maintain that he/she is a member of the opposite sex. How can the mind, the head be in such discord, in such a clash with the undeniable given of the reality of one's genitalia.

But from the beginning of this century on it has become apparent from studies in rats and other lower mammals that their sexual differentiation was not completed with the differentiation of the external genitalia into either male or female, the criterion to label them as male or female.

It has become accepted that, similar to the situation in lower mammals, also the human species undergoes a differentiation of the brain as a part of the differentiation process of becoming a man or a woman. Sex differences in size and shape of certain nuclei in the hypothalamus have been described in the human. Also the human species undergoes a differentiation of the brain as an integral part of the differentiation process of becoming man or woman.

Recent research on brains of MF's transsexuals in the Dutch Brain Research Institute could demonstrate that one of the brain nuclei that is sexdimorphic in the human, the bed nucleus of the stria terminalis in the hypothalamus, shows all characteristics of a female differentiation.

Very recently we found a male differentiation of this nucleus in a FM.

Transsexualism can be conceptualized as a sexual differentiation disorder wherein the sexual differentiation of the brain has not followed the course set of the chromosomes, the gonads and external genitalia.

The observations over the years that psychotherapy is not helpful in altering a crystallized cross-gender identity and that most transsexuals do not show severe psychopathology has led clinicians to adopt sex reassignment as an important treatment option.

In the Netherlands the first case of surgical gender reassignment was recorded in 1959.

This gave rise to a storm of disapproval.

Nevertheless, some physicians continued to treat transsexual individuals with hormones and surgical gender reassignment. In 1972 The Netherlands Gender Foundation was founded. It has provided psychological care and advice for Dutch transsexuals.

For hormonal treatment and sex reassignment surgery the foundation referred transsexual individuals to the Vrije University in Amsterdam.

In 1975 the Gender Clinic in Amsterdam was founded.

The successful outcome of gender reassignment therapy in most transsexuals and the change of societal standards resulted in a more liberal attitude by the health authorities.

In 1977 the Dutch Health Council published a new report that stated:

“The physical adaptation (gender reassignment) of subjects with gender problems is a therapeutic procedure with a reasonable probability of success and is an essential part of the management, that offers the greatest likelihood to alleviate their existential distress”.

The Gender Clinic in Amsterdam is part of the Academic Hospital of the Vrije University.

In the beginning there was a lot of prejudice in the medical field. It was difficult to gain respect in our hospital just as it proved to be difficult to function normally in medical science.

Not to mention the outside world: the society as a whole.

In the seventies and eighties we started to engage in many educational activities in the media (radio, tv, papers, magazines) to explain the phenomenon of transsexualism to the public.

In general one could say that this has had its effect: transsexuals have met with wider understanding, respect and support in the Netherlands.

In 1982 the Dutch health insurance's decided to fully cover the costs of the sex reassignment therapy. Not only the costs of hormones and surgery are reimbursed but also in most of the cases speech therapy and the costs of laser hair removal or electrolysis in male-to-female transsexuals.

Another important change was the legal status of the transsexual that was introduced in 1985: by law it was made possible to change the birth certificate. So a transsexual person who had undergone sex reassignment surgery could officially be registered as a member of the desired sex.

When in 1988 Louis Gooren was made the first professor in transsexuology the medical field had to acknowledge the status of this medical treatment.

Over the last 25 years the Amsterdam Gender Team has treated more than 2200 transsexuals.

In the Netherlands, a country with 16 million inhabitants the prevalence of transsexualism is: 1:13 –15.000 M-V and 1:30-35.000 V-M.

The sex ratio is 3 males vs 1 female. Figures are very similar to these of Singapore reported by Tsoi et al.

Every year about 150 new patients apply in our clinic for a sex reassignment treatment.

80 – 100 actually undergo sex reassignment therapy, others receive psychotherapy.

Transsexuals are a reliable and representative sample of the general population. All social layers are represented: for example in our group 8 medical doctors, 7 religious ministers.

From unskilled labourers to a university professor.

Transsexualism occurs in all cultures and nations.

The care provided by the Amsterdam team is in agreement with the Standards of Care of the International Harry Benjamin Gender Dysphoria Association, an international professional organisation in the field of transsexualism.

The Amsterdam Gender Team is a multidisciplinary team. It provides the full treatment plan: diagnosis, hormonal treatment and surgery.

We work together with several self helpgroups (MF and FM).

The treatment is in accordance with a medical model based on a strict protocol drawn up together with the Dutch Ministry of Health.

Before the applicant is referred to a psychologist/psychiatrist for the diagnosis some basic information about the procedure is given.

The Amsterdam Gender Team considers transsexualism not as a psychiatric problem.

Most of the applicants are referred for the diagnosis to one of the psychologists of the team.

Only in case of addiction to alcohol/drugs or in case of a psychiatric history the applicant will be referred to a psychiatrist.

Presently, it is impossible to diagnose transsexualism on the basis of objective criteria.

One is dependent on the subjective information given by the applicant for the diagnosis.

Like other teams the Amsterdam Gender Team uses psychodiagnostic assessment to appraise the intellectual and emotional coping mechanisms of the person and to detect psychopathology.

During this diagnostic phase it is important to inform the applicant about the possibilities and limitations of sex reassignment to prevent unrealistic high expectations in regard to their future lives.

If the diagnosis is positive the decision to start the SRT is discussed in a meeting of the Gender Team. Before the applicant can start the hormonal treatment it must be sure that he or she can stay in the Netherlands for the duration of the treatment.

Every year about 10 –20 patients from countries with an extremely intolerant attitude to transsexualism (Iran, Russia Rumania) ask for asylum in the Netherlands.

In most of the cases the Dutch Government grant asylum to undergo SRT.

During the hormonal treatment one has to live permanently in the role of the desired sex, the “real-life” test. Before the hormonal therapy is started a medical examination is performed to exclude physical problems and to prevent complications as a result of the hormonal treatment.

Feelings of dysphoria usually decline as a result of both the bodily changes and the possibility to live in the new social role. During the “real-life” test regular contact with the psychologist/psychiatrist of the Gender Team is required. In their sessions the social transformation is a major focus of the discussion, because this transformation stage is almost always turbulent.

The Amsterdam Gender Team urges transsexuals strongly not to give up their job in this stage of the treatment. It is important to live and to work as a member of the desired sex.

The Dutch trade unions have drawn up a document for employers how to handle in case of a transsexual employee.

When the “real-life” test has resulted in a satisfactory social role change the applicant is referred for surgery.

Not all transsexuals wish to have surgery, because of physical or social problems.

In MF’s vaginoplasty and, in most cases (80%) breast enlargement are performed.

In FM's breast reduction and hysterectomy are performed. A phalloplasty is still in an experimental phase. In the Netherlands most of the FM's prefer to have a neoscrotum with testicular prosthesis and a metoidioplasty which transforms the hypertrophic clitoris in to a microphallus.

In our new protocol there will be the possibility for FM's to have a mastectomy before starting the androgens.

After surgery the patients have to continue the hormonal treatment to prevent hot flushes and to stop osteoporosis. Patients visit our clinic once a year to evaluate the hormone therapy.

In the Netherlands it is possible to change the legal sex after SRS upon condition that the transsexual cannot procreate in the original sex. Since this year it is not necessary anymore that the patient must divorce before a legal sex change because of the legal gay marriage in the Netherlands.

Strong feelings of belonging to the opposite sex and corresponding manifestations of behaviour have been reported as beginning as early as 4 to 5 years of age.

Not all children with gender identity disorders will turn out to be transsexuals after puberty.

In the Netherlands we have special clinic for adolescents with gender problems.

The diagnostic procedure for adolescents is essentially the same as for older applicants, but is more extensive and therefore more time consuming. Applicants must have shown a life-long extreme and complete cross-gender identity. Around puberty these feelings and behaviours must become rather than less pronounced.

Serious psychopathology must be absent, with exception of problems that are a consequence of their living in the unwanted gender role. Applicants must function socially without significant problems (have a supportive family, do well at school).

One could argue that adolescents should never be allowed to start sex reassignment, which is present policy in many countries. The other side of the coin is that early treatment might be beneficial in adolescents in whom secondary sex characteristics have not developed.

Young MF's will pass much more easily as females if they do not grow a full beard and do not develop a low voice. When treated several years later their voice will always keep a male-like quality and many years of painful and expensive laser or electrolysis are needed to remove facial hair.

In FM's when the breasts are still small, breast reduction will be an easier intervention, with less scar tissue.

The Amsterdam gender clinic starts the hormonal treatment in adolescents just before puberty (about 20 patients a year).

Such therapy blocks the development of unwanted sex characteristics without the induction of the cross-gender characteristics (such as breasts/menstruation in boys and a beard/deep voice in girls). This treatment with LHRH agonists is fully reversible.

Only after it has become clear that patients benefit from treatment estrogens are administered to MF's and androgens to FM's.

Parents are always to be involved in the treatment of their children and they are required to give their formal approval before the start of any SRT phases.

Transsexuals who have been treated early in the Amsterdam gender clinic pass very easily as a member of the opposite gender.

During the last decades we have done a lot of research in our clinic.

Because the clinic is part of an Academic Hospital all facilities to do research are available.

The department of Endocrinology of the Vrije University in Amsterdam plays a prominent role in research of hormonal treatment of transsexuals.

A retrospective study in 816 MF's and 293 FM's showed that in both MF and FM total mortality was not higher than in the general population and that the observed mortality could not be related to hormonal treatment.

Thromboembolism was the major complication in MF's transsexuals treated with oral estrogens. No serious morbidity was observed which could be related to androgen treatment in FM's.

It became also clear that the androgen treatment in FM's increases the amount of visceral fat. Visceral fat is an important determinant of disturbances in lipid metabolism, which can cause higher cholesterol levels.

Follow-up studies of our clinic showed that the SRT is effective in reducing of phasing out of the feelings of gender dysphoria.

A large amount of our patients feel happy with the SRT and have no regrets of the treatment.

In our group of 2200 cases six have expressed regrets. The diagnosis was not wrong, they are transsexuals. But because of social circumstances they expressed their regrets.

MF's have more social problems than FM's. They are lonelier, less often a job, less often a relation and less satisfied with their sexual life.

The etiology of transsexualism is still unclear. During the last decades there have been two theories proposed: one somatic and the other psychopathological.

All authors on gender identity development agree that in every child a sense of gender identity termed "core gender identity" can be found before the age of 3-4 years. "Core gender identity" can be described as the child's recognition that he is a boy or she is a girl, it proves to be resistant to change. On the basis of clinical evidence it seems that we can assume that the foundation of transsexuality is laid before the age of 4.

Transsexualism is in our point of view a sexual differentiation disorder.

Sexual differentiation is a multistep biological process.

Similar to other situations of errors in sexual differentiation (androgen insensitivity syndrome or the congenital virilizing hyperplasia) transsexualism must have the attention of the medical profession.

The finding of a biological index of a female brain differentiation in MF transsexuals could be a turning point in the approach to transsexualism from a number of standpoints.

First the medical profession: transsexuals are not mentally disturbed but suffer from a sexual differentiation disorder. Second medical insurances could be (legally) obliged to pay for the costs of SRT similar to other cases of an intersexed state. The legal system could be held to treat transsexuals like other forms of intersexes. The public might change its attitude towards this startling phenomenon. Religious institutions could be expected to label transsexualism no longer as a sin but as a sickness.

**I am very happy to be here in Valencia. It is an honour to be one of the directors of the conference: Identidad sexual y transexualidad. In daily life I am the coordinator of the Dutch gender team.**

**In the program of the conference we find many interesting lectures about sexuality, intersexuality and transsexualism.**

**All aspects of the phenomenon of transsexuality (somatic, psychological, cultural, social) will come up for consideration during the next days.**

**In modern Western societies, individuals pursuing sex reassignment have not always been taken seriously. The wish for sex reassignment surgery (SRS) has often been considered a whim of a disturbed mind.**

**Over the past two decades, the negative attitude among professionals towards SRS seems to be changing. In several countries transsexual patients are now diagnosed and treated by specialists, sometimes even in multidisciplinary gender teams. Treatment is often paid by national health insurance. In the Netherlands, legal provisions have made the adaptation of the birth certificate possible. In general one could say that scientific interest in transsexuality is increasing.**

**Still lots of questions and discussions remain. I am sure that this conference will be another step in expanding our knowledge and understanding by participating in the lectures and discussions.**

**I wish you all an interesting and studious conference.**

**Jos Megens**

**Coordinator the Amsterdam Gender Team**