

Guide to comprehensive care for persons in **transsexuality situations**



RECOMMENDED ACTIONS FROM THE
EDUCATION, SOCIAL AND HEALTH FIELDS

EUSKO JAURLARITZA



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Management, coordination and elaboration:

Department of Education, Linguistic Policy and Culture
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WORKING GROUP

Educational field: Department of Education, Linguistic Policy and Culture

- Begoña Garamendi Ibarra (Director of Educational Innovation).
- Luisa M^a Puertas (Berritzagune Nagusia).

Social field: Department of Employment and Social Policies

- José Luis Madrazo Juanes (Ex-Director of Family Policy and Community Development).
- José Javier Miguel de la Huerta (Director of Family Policy and Community Development).
- Lourdes Fernández Arce (Ex-Technical Head).
- Mikel Albaina Troya (Technical Head).

Health field: (Department of Health and Osakidetza)

- Jose Luis Quintas Díez (Assistant Director of Insurance and Health Contracting of the Department of Health).
- Iñaki Gutierrez Ibarluzea (OSTEBA. Director of Health Research and Innovation of the Department of Health).
- Carlos Sola Sarabia (Assistant Director of Osakidetza Healthcare).
- Adelina Pérez Alonso (Technical Head of Healthcare Sub-Directorate).
- Agustín Martínez Berriotxo (Assistant Medical Director Cruces University Hospital).
- Jaime Caramés Estefania (Plastic Surgeon of the Gender Identity Unit (GIU) of Cruces University Hospital).
- Susana Ponce de León Saenz de Navarrete (Psychiatrist of the GIU of Cruces University Hospital).
- Irune Rodrigo Larrazabal (Clinical Psychologist of the GIU of Cruces University Hospital).
- Itxaso Rica Echevarria (Child Endocrinologist of the GIU of Cruces University Hospital).
- Virginia Bellido Castañeda (Adult Endocrinologist of the GIU of Cruces University Hospital).
- María Luisa Guadilla Fernández (Child Psychologist of the GIU of Cruces University Hospital).
- Nieves Gómez Rodríguez (Basque Society of Family and Community Medicine-OSATZEN).
- Itziar Fernández Respaldiza (Basque Society of Paediatrics).

Affected persons field:

- Ares Piñeiro (Head of BERDINDU IBILTARI and Coordinator of the Area of Transsexuality of the State LGBT Federation).
- Aingeru Mayor (President of CRHYSALLIS Euskal Herria).
- Nerea García (Member of CRHYSALLIS Euskal Herria).



PRESENTATION

The publication of this guide responds to an ethical duty and the mandate of Law 14/2012, dated 28 June, on non-discrimination based on gender identity and recognition of the rights of transsexual persons, and also to the Basque Government's commitment to people. We believe respect for personal dignity to be a fundamental human right which involves free personal self-determination, which in turn includes each person's sexual identity, although this may not coincide with the sex they were assigned at birth.

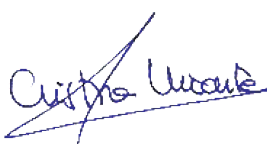
Persons in situation of transsexuality are, even today, a vulnerable collective, as recognised by Law 14/2012, dated 28 June, on non-discrimination based on gender identity and recognition of the rights of transsexual persons, and also Decree 147/2015, dated 21 July, together with the Declaration of Rights and Duties of persons in the health system of the Basque Country. That condition of vulnerability demands specific public policies to eliminate any discrimination to which they can be exposed during the exercising out of their civic rights and responsibilities.

Transsexuality is not a disorder, nor a mental illness, nor a sociopathy, it is a fact of diversity, one more variant in human diversity, which can be manifested from earliest childhood and which, in many cases, requires coordinated action in the fields of education, social work and healthcare. Although the cited Law 14/2012 urges the publication of a clinical guide for the health care of transsexual persons, we in the Government are of the opinion that the guide should include the three fields, so that the same document covers the actions and recommendations in an integrated manner.

The writing of this guide has been carried out by means of a highly participative working group from the fields of the affected persons (through their associations), from Osakidetza (Basque Health Service) and the Basque Government (through the three departments we represent). The intention was to have all possible points of view and sensibilities present in the writing of the guide, so therefore the profiles of those persons making up the group were varied with regard to the areas of knowledge, experience and competences (affected persons, technical staff, both clinical and from the fields of education and social policies, managers and directors) and with regard those they represent (institutions, scientific and professional societies and associations for affected and interested persons).

Precisely this heterogeneity of profiles and sensibilities has made possible a multidisciplinary result of great intellectual and ethical richness, but it has also led to great difficulties when the time came to reach a consensus on an acceptable text for everyone. Our thanks go to all those persons who participated in the writing of this guide for their technical efforts and the consensus they reached.

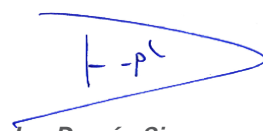
The Basque Government presents this guide as a living thing, not the end of the road. We are sure that it will serve to move forward in the non-discrimination of the collective of transsexual persons and with diversity in the expression of gender and as a support to professionals in the fields of social policy, educational and health for ensuring best practices are used in the care of these persons.



Cristina Uriarte Toledo
Minister for Education, Linguistic
Policy and Culture



Ángel Toña Guenaga
Minister of Employment and
Social Policies



Jon Darpón Sierra
Minister of Health



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1

INTRODUCTION

1.1. CONTEXT

Transsexuality is not a current phenomenon. It has existed since ancient times and in different cultures. The term transsexual began to be used in 1940 to refer to persons who suffer a disassociation between the sex assigned at birth and the sex to which they feel they belong¹. However, despite their universal existence (in almost all cultures and throughout the whole of history), transsexual persons like this, and those who live diverse realities with regard to the expression of gender (trans persons), still suffer manifest negative social discrimination involving a de facto violation of their rights as persons. Certainly, this discrimination and violation of rights is increasingly less severe. Over the last quarter of the last century and what we have lived of this one, in western countries we have made great progress towards non-discrimination and towards the normative positivisation of their specific rights, but there is still a long way to go.

Today we must still consider the collective of transsexual persons as a vulnerable collective, both in the social-cultural field and that of health. So much so that the declaration of the rights and duties of persons in the health system of the Basque Country identifies transsexual persons as a vulnerable collective (alongside six others). For this purpose, those persons who fulfil the following criteria are considered vulnerable, or belong to vulnerable collectives²:

1. Have limited autonomy or self-management due to internal agents (status or psycho-physical health) or external agents (resources, social-cultural situation, etc.).
2. Need specific measures to guarantee their access to health or social-health resources under equal and non-discriminatory conditions.

Due to this discrimination and the social concealment it has caused, it is not known with exactitude, even now, the number of persons who belong to this collective, especially that of persons who are not yet of legal age, more specifically pre-puberal children. As non-discrimination progresses, more transsexual persons are becoming known, above all children. This phenomenon means the social, education and health sectors are trying to guide and care for all these persons, adults and minors, designing programmes and protocols which systematise and guide actions in a comprehensive and coordinated way. A good example of this is the publishing of this “Guide to comprehensive care for persons in transsexuality situations”.

As we will see later, transsexuality is not a mental illness, nor a sociopathy, it is a fact of diversity, one more variant in human diversity, which can be manifested from earliest childhood and which, in many cases, requires some action in the field of healthcare. For that reason, for the care of these persons, specific actions are necessary in the education, social and healthcare fields. This guide is intended to gather recommended actions in the three fields in one single document. In this way we express, right from the start, the intention of acting in a comprehensive and integrated fashion in the care of this collective.

¹ LAW 14/2012, dated 28 June, on non-discrimination based on gender identity and recognition of rights of transsexual persons.

² DECREE 147/2015, dated 21 July, by which is approved the declaration on rights and duties of persons in the Basque health system.

1.2. JUSTIFICATION: MORAL DUTY, LEGAL OBLIGATION

Specific care for the educational, social and healthcare needs of transsexual persons is a moral duty, as well as a legal obligation. And this duty and obligation, which concerns all of us, is especially important for public services.

Specifically, not caring for the collective of transsexual persons implies damaging each one of the four basic principles of bioethics: non-maleficence, justice, beneficence and autonomy. As professionals in education, social services and healthcare, our moral duties with all persons are those of not doing them any harm, treating them with equal consideration and respect, procuring their greatest beneficence possible and all of this while respecting and taking into account their autonomy, the free development of their personality and their life project. Do we really apply and comply with these duties, which are universal and valid for any person, in our relationships with transsexual persons? This is the moral question we should ask ourselves to test our professional work in the care of transsexual persons.

Respect for the dignity of people is a fundamental human right which involves respecting free personal self-determination whenever this does not undermine the free self-determination of others. A transcendental dimension in personal self-determination is that of sexual identity. The fact that people have a sexual identity (their felt sex) different from the sex assigned at birth have their sexual identity denied conditions negatively the free development of their life project. This condition of transsexuality, even today, makes them vulnerable.

Vulnerability is at the origins of ethics. It is not a moral principle but the determination of a dimension of the human being. As David Hume pointed out, when putting forward his naturalistic fallacy, we cannot go from what “is” to the demand for what “should be”: because we are vulnerable does not mean that we should be vulnerable. That’s why it is our responsibility to suppress it or at least limit it. Vulnerability demands responsibility, and to speak about responsibility is to speak about moral duty³.

The exercising of this responsibility demands the development of specific public, education, social and healthcare policies. In public policies, the principle of equality does not mean treating all people equally, but giving the same to those who have the same need, that is: to give to each person according to their necessity.

But, as we have already said, care for transsexual persons, as well as a moral duty, is a legal obligation. More specifically, the writing of this Guide is a mandate collected in article 9 of chapter III (“*healthcare of transsexual persons*”) of *LAW 14/2012, dated 28 June, of non-discrimination based on gender identity and recognition of the rights of transsexual persons*.

³ “Declaration of the rights and duties of persons in the health system of the Basque Country” page: 50
http://www.osasun.ejgv.euskadi.eus/contenidos/informacion/derechos_deberes/es_1257/adjuntos/Declaración%20Derechos%20y%20Deberes.%20Fundamentación%20ética%20y%20jurídica.pdf

The complexity of the situation of transsexual persons requires comprehensive care that goes beyond the field of mere registration (regulated by the Spanish state by Law 3/2007, dated 15 March; although it excludes minors). For this reason, the Basque Parliament approved Law 14/2012, dated 28 June, in order to proceed towards the provision of comprehensive care for transsexual persons, and to move towards overcoming all discrimination that, because of the condition or personal or social circumstances of these persons, remains in legislation, and improvement of the regulatory development of the constitutional principles of non-discrimination, free development of personality and social, economic and legal protection of the individual, family and group, adapting the applicable regulations to the social reality of the historical moment in which we live.

At international level, we can highlight the European Parliament resolution of 12 September 1989, on discrimination against transsexual persons, which not only recognises the right of each person to establish the details of their identity as a human being, but urges members to establish a series of measures to favour their development. These include the following: the inclusion of treatment of genital surgery on the national health service, granting social benefits to transsexual persons who have lost their jobs or their homes because of their sexual adaptation, creation of consultancies for transsexuals, financial protection for self-help organisations, the adoption of special measures to promote the work of transsexual persons, and the right to change name and assignment of sex on birth certificates and identity cards.

Likewise of special importance is the resolution adopted by the Assembly of the Council of Europe on April 22, 2015, on discrimination against transsexual persons in Europe, which calls on Member States to establish procedures which are rapid, transparent and accessible, based self-determination, to allow transsexuals to change their name and sex on official documents, making these procedures available to all who wish to use them, regardless of age, health status and economic situation, and to abolish sterilisation and other compulsory medical treatments, as well as mental health diagnosis, as a prior legal obligation for the recognition of the sexual identity of a person. It also calls on states, with regard to sexual reassignment treatments and healthcare, to make the procedures of sex reassignment, like hormone treatment, surgery and psychological care, accessible to transsexual persons, and to ensure reimbursement by the public health system; to explicitly include transsexual persons in research programmes and suicide prevention measures; to explore alternative models of healthcare for transsexual persons based on informed consent; and to modify disease classifications used at national level and propose amendments to international classifications in order to ensure that transsexual persons, including children, are not considered mentally ill, while ensuring access to necessary medical treatment without stigmatisation.

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2

CONCEPTUAL FRAMEWORK

2.1. HISTORICAL BACKGROUND

The phenomenon of transsexuality is known and recognised in different cultures and religions throughout the history of humanity, usually related to the fields of spirituality and/or religion. The oldest references are found in the code of Hammurabi of the Babylonians; classical mythology is full of references to the possible combinations of anatomical and social sexual identity as well as sex changes. In ancient Rome they were identified as the Galli in their role as worshippers of Cybele. Sanskrit has the word “kliba” which designates people who could not consider themselves clearly either women or men. In Hindu culture there were “hijras”, males who ritually castrated themselves and became priestesses. In present day India the tradition persists.

Anthropological studies provide evidence of the presence and normalisation of transsexuality in different indigenous ethnicities of North America. For the Sioux, “winkte”; for the Yuma, “elsa”; among the Navajo, “nadle”. Also in Africa the phenomenon is contextualised in different ethnicities, such as the “sererr” of the Pokot people in Kenya or the “sarombavy” of Madagascar.

It is from the preponderance of monotheistic religions, which impose a dichotomous view of life, when any manifestation that transgresses the biological sexes is denied and pursued.

In the 19th and 20th centuries, with the secularisation of the western world, the door was opened to the scientific study of the “transsexual fact”. First as a deviation, later as a mental disorder, up to the present in which the tendency, and demand, is to remove it from the classification of mental illnesses.



2.2. CONCEPTS

Although for some people the clarification of concepts aimed for next can seem obvious, for others, including those in the field of health, education and social professionals, they can be opportune and advisable, given the proven conceptual confusion that can be observed.

The first major differentiation it is advisable to make is between the concepts of “**sexual identity**” and “**sexual orientation**”. Sexual identity is the consciousness of each person of identifying themselves or feeling that they belong to a sex. According to this concept, a person can be a cissexual man or a woman (when their felt sex, with which they identify, coincides with that assigned at birth) or a transsexual man or woman (when their felt sex, with which they identify, does not coincide with that assigned at birth). Sexual orientation, on the other hand, is sexual attraction felt by the person, which can be heterosexual (to feel attraction for people of the opposite sex), homosexual (to feel attraction for people of the same sex) or bisexual (to feel attraction for people of both sexes). Thus, transsexual persons, as the men or women they are, can be heterosexual, homosexual or bisexual.



Another important conceptual distinction, which is often confused semantically, is that of the concepts of “**sex**” and “**gender**”. Sex is what refers to the fact of being men or women. Gender is the set of manifestations and values which are culturally associated with each of the sexes. The term sex takes precedence over those of man or woman (male or female if we are referring to non-human animals) and the term gender takes precedence over those of masculine or feminine. Thus, gender could assimilate the characteristic role of each sex. We would define “masculine” as the characteristic of men, that is, that significantly more men than women share this characteristic. We would say the same of “feminine” but applying it to women.

The latter leads us to define “**non-normative gender behaviours**” as those behaviours which differ from social and cultural expectations and conventions. For example, a boy who likes playing with dolls or dressing as a princess, or a girl who likes playing rugby or doesn’t like wearing skirts. In adults there are also non-normative gender behaviours, for example men disparagingly called “effeminate” (although it should not be a humiliating adjective) or women also disparagingly called “butch”. These diverse experiences and expressions of gender do not have to be accompanied by transsexuality. A transvestite person or someone who behaves like the people in the previous examples does not have to have a divergence between their felt sex and that assigned at birth.

Within the existing diversity as far as possible ways of feeling and expressing gender go, we must also refer to another, known as “**transgender**”. A transgender person is someone who does not identify with either of the two genders or identifies with both at the same time. Ararteko refers to them, together with transsexual persons but differentiating from them, in a 2009 report⁴.

At last, to end this conceptual section, we refer to what is known in many forums by the name of “**trans**”. More than a concept, trans is an umbrella term used to encompass those whose sexual identity does not match the sex assigned to them at birth (men and transsexual women), as well as people whose gender behaviour does not match what is socially expected on the basis of sex (transgender, transvestites, queers, drag queens ...). According to the European Agency for Fundamental Rights, the term trans can cover many different sexual identities and gender expressions⁵. The investigation lists various subcategories, such as transsexual, transgender, transvestite, gender variants, queer, and it also describes the category “other” and those who describe their identity in their own words.

As you can see, the spectrum of diversity of sexual identities and gender expressions is very varied. They all deserve to be respected and cared for by public administrations, but not all of them will need health care. Even the degree of medical-surgical intervention to which transsexuals often subject themselves also varies greatly. This is about approximating

⁴ The situation of transgender and transsexual persons in the Basque Country (2009) Ararteko.

⁵ Being trans in the European Union (2014). European Union Agency for Fundamental Rights.

physical traits (adapting primary and secondary sexual characteristics) to the felt sex, but to what extent? To the fullest extent possible? No, to whatever extent, according to the felt need, each person wants. Because the degree of conformity or rejection of each person with their own genitals and their secondary sexual characteristics is variable.

It should be stated now that on the part of the Department of Employment and Social Policy, the option was proposed that this guide should recommend actions aimed at all persons grouped under the umbrella of the term trans and also should replace the word transsexual with trans in the title of the Guide. This recommendation is based on the fact that Berdindu references its activities in favour of lesbian, gay, “trans” and bisexuals, and also in consideration of the extraordinary report by Ararteko entitled “*The situation of transsexual and transgender persons in Euskadi*”. The decision finally adopted was that the actions in the educational and social fields reflected in this guide are targeting people throughout the diverse trans spectrum, but health measures refer exclusively to the care of transsexual persons.

It has also been decided to keep the word transsexual in the title of the guide because, as has already been mentioned, its genesis arises from a legal mandate requiring the health sector to produce a clinical guide, and Law 14 / 2012 is clear: “*The purpose of this Act is to guarantee the right of transsexual persons to receive from the Basque public administrations attention which is integrated and adapted to their medical, psychological, legal and other needs, in equal conditions to the rest of the population. Also, to protect, in general, their freedom in different spheres of social life and, in particular, in the various public services*”. The same Law, in Article 2, states that the Act applies to transsexual persons residing in the Basque Country.

2.3. GLOSSARY OF TERMS

Transsexuality is a condition attributable to some persons, therefore the term transsexual should never be used as a noun, always as an adjective followed by nouns: person, man, woman, child, thus avoiding the characteristic becoming a label. This rule also applies to the terms, trans, transgender, transvestite, heterosexual, etc.

SEXUAL IDENTITY: One's own awareness of belonging to a sex.

SEXUAL ORIENTATION: Sexual attraction felt by the person who in turn can be HOMOSEXUAL (if attracted to people of the same sex); HETEROSEXUAL (if attracted to the opposite sex or BISEXUAL (if attracted to people of both sexes).

GENDER: Set of behaviours, attitudes, expressions and/or social and cultural values that are associated with one or the other sex.

MASCULINE: Characteristic of men. That is, significantly more men than women share that characteristic.

FEMININE: Characteristic of women. That is, significantly more women than men share that characteristic.

NON-NORMATIVE GENDER BEHAVIOUR: Behaviours which differ from social and cultural expectations and conventions because they are associated with the other sex.

SEX: Each of the two sexual differentiations of the human being, man or woman.

TO SEX: To sort by sex; man or woman in humans; male or female non-human animals. Usually sexing is done at birth according to the genitals. In human beings, sexing should be rectified, if necessary, according to the sexual identity of each person, to their felt sex.

SEXUATION: Process of SEXUAL DIFFERENTIATION. Can be chromosomal, gonadal, genital and cerebral.

FELT SEX/PSYCHOLOGICAL SEX: Sex with which a person feels identified. The sex with which other people should identify him/her and treat them as such.

LEGAL OR CIVIL SEX: Sex which appears in the civil registry (as it appears on the birth certificate) and on identity documentation. And by extension on the documents of public administrations.

TRANSSEXUALITY: Condition or circumstance of life in which the self-sexual identity of a person (their felt or psychological sex) does not correspond to that assigned at birth based on their genitals.

TRANSSEXUAL: Adjective which expresses the condition of transsexuality.

TRANSSEXUAL MAN: Man sexed as a girl at birth. Man in the situation of transsexuality.

TRANSSEXUAL WOMAN: Woman sexed as a boy at birth. Woman in the situation of transsexuality.

CISSEXUAL MAN/WOMAN: Man or woman whose felt or psychological sex coincides with that assigned at birth.

INTERSEXUAL: Adjective which applies to the person who is born with ambiguous genitals (of both sexes) and/or biological characteristics associated to both sexes, or ambiguous.

TRANSGENDER: Adjective which indicates the condition of the same name, which is applied to persons who identify with both sexes at the same time or with neither of them.

TRANS: Umbrella adjective used to encompass those whose sexual identity does not match the sex assigned to them at birth (transsexual men and women), as well as people whose gender behaviour does not match that which is socially expected based on sex (transgender, transvestites, queers, drag queens ...).

TRANSVESTITE: Adjective designating a person who wears garments socially assigned to the opposite sex, either for excitement, as part of a show, or as a simple disguise.

TRANSPHOBIA: Fear and rejection towards persons who are transsexual, who look like it or who are associated with them in the imagination.

HOMOPHOBIA: Fear and rejection towards persons who are homosexual, who look like it or who are associated with them in the imagination.

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3

DESPATHOLOGISATION

DESPATHOLOGISATION

La The statement of motives to *Law 14/2012, of June 28, about non-discrimination based on gender identity and recognition of the rights of transsexual persons* presents an extensive argument on the need for depathologisation of transsexuality. Below part of that statement of motives is transcribed:

Since 1980, transsexuality has been classified as a mental disorder. Even today the international manual of mental disorders DSM-IV-R and ICD-10, developed by the American Psychiatric Association (APA) and the World Health Organisation (WHO), respectively, covers it and classifies it as “sexual identity disorder” or “disorder of gender identity”. As a result of such labelling, there is a medical diagnosis attached to the dissociation between biological sex and socially ascribed gender: gender dysphoria.

Although major international diagnostic classifications of disease include gender dysphoria as a disorder or mental illness, the number of experts and prestigious researchers who are seriously considering the withdrawal of this pathological label is increasing, in line with the agreement of the Basque Parliament, dated 30 September 2010, in which actions were presented before the World Health Organisation urging the withdrawal of the classification of transsexuality as a mental illness. Although unintentional, it is found to give rise to numerous violations of the basic rights of transsexuals (physical and psychological abuse, exclusion, loneliness, isolation ...).

In fact, transsexuals do not demand that they are cared for because they suffer from a disease or disorder, but because of social obstacles in the free development of their most fundamental rights and the pain and anguish that fills their lives because of these difficulties. Hence the premise should be assumed that the configuration of the sex of a person goes beyond the simple visual appreciation of their external genitalia, present at the moment of birth. We shall therefore adopt as a guide, not a purely biological concept of sex - as established by the European Court of Human Rights, following a unanimous decision on two important judgements of 2002 - , but above all, a psychosocial concept; recognising that the individual psychological characteristics that shape their way of being shall prevail, and granting sovereignty to human will over any other physical consideration.

In this sense, that expressed by the Yogyakarta Principles on the application of international human rights law in relation to sexual orientation and gender identity, presented on 26 March 2007 at the proposal of the International Commission jurists and the International Service for Human Rights, within the framework of the Fourth Session of Human Rights Council of the UN in Geneva (Switzerland) is unavoidable: “Notwithstanding any classifications to the contrary, sexual orientation and gender identity of a person are not, in themselves, medical conditions and should not be treated, cured or suppressed” ...

Certainly, over the last few years there have been advances in the demand for the depathologisation of transsexuality. In a double dimension. On the one hand, the

declassification of the disorder from the manuals of diseases has been sought. On the other hand, it has been requested that transsexual persons be recognised as protagonists and active participants in the medical treatment they may require, having the capacity and legitimacy to decide for themselves with autonomy and responsibility for their own bodies.

Together with these claims, and in relation to gender identity, in recent years there has also emerged a new socio-legal perspective that recognises the free expression of gender of persons as a fundamental human right. This prism has resulted in various documents and reports internationally, among which are included the aforementioned Yogyakarta Principles and the report “Human Rights and Gender Identity” by Thomas Hammarberg, Commissioner for Human Rights of the Council of Europe, published in July 2009. In those writings it was stated that further consideration of transsexual identities as mental or physical illness is a violation of human rights of persons.

The working group in charge of writing this guide shares the arguments of Law 14/2012. We share the conviction that transsexuality and other diverse expressions of gender are not diseases, but we also know that the vast majority of transsexual persons need health, social and education services to overcome the obstacles to the free development of their most fundamental rights. Regarding the health sector, the working group wants to show the effort that has been made, especially by doctors and medical group members, to draft a clinical guideline (as ordered by law 14/2012) about something that is not a pathology, a disorder or disease. Even when health interventions that are necessary to carry out (psycho-emotional support, hormonal treatment or surgical treatment) are complex, an attempt has been made to use non-pathologising and stigmatising language, but at the same time to be rigorous with health technology and scientific evidence. In this regard it should be noted that, at the strictly clinical level, it is inevitable to continue using the ICD-10 or DSM-IV-R codes so that the computer system that supports information from medical records of all attended persons fulfils its functions properly.



4

Objective and
fields of action

EDUCATIONAL FIELD

4.1. INTRODUCTION

One of the main educational functions of the inclusive school is to collaborate in a socialisation process that allows maturing, growth and comprehensive development for all students, valuing diversity as an opportunity to learn and as a rich resource to support learning. This requires creating educational contexts which take into account the different expressions of human diversity, cultural diversity, diversity of capacity, of socio-economic means, of functional diversity, of affective-sexual and gender diversity... Educational contexts where skills are developed through methodologies that facilitate dialogue, interaction, solidarity, equality and respect for all students, and which offer an experience where each person is recognised and valued, where each person feels protected, regardless of their reality or their circumstances.

However, it is necessary to take into account that we live in a society that does not always value all diversities, a sexist society that still educates in normative gender with frequent episodes of discrimination, assault and harassment. This reality is also reflected in school where some children and young people are having a difficult time when it comes to having a healthy development due to the nonconformity of their felt sex with that assigned at birth or due to behaviours that do not follow the rules of hegemonic masculinity or femininity. To be or to seem gay, lesbian, bisexual or trans and not comply with the gender rules culturally assigned to men and women are some of the most frequent causes of school bullying.

The inclusive school must respond to this reality with global approaches to coeducation and equality matters, based on knowledge and respect for the affective-sexual and gender diversity that pervade the policies, cultures and practices of schools. It is necessary to include measures to raise awareness of sexual affective diversity in the curriculum and within school life; to denature all forms of violence; to develop educational practices that promote good treatment, the prevention of gender violence and LGTBphobia, and those practices oriented to respond proactively and socially in situations of any type of bullying. These approaches, actions and measures will be reflected in all documents in the school (Educational Project, Curricular Project Coexistence Plan, Co-education and Prevention of Gender Violence Plan, Rules of Organisation and Operation, Internal Regulations, Protocols...) and their development will involve the entire educational community.

4.1.1. LEGAL FRAMEWORK

En In 2006, 29 recognised specialists from 25 countries, different disciplines and with relevant experience in the field of international human rights law unanimously adopted the **Yogyakarta Principles** on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity. In addition to agreeing a set of principles, they made some recommendations to states and the UN to advance equality, non-discrimination and the protection of all persons. They start out from the principle that *All human beings are born free and equal in dignity and rights* and specify that this

circumstance also refers to the fact that *Human beings of all sexual orientations and gender identities are entitled to the full enjoyment of all human rights*. Regarding the right to education, Principle 16 states that *Everyone has the right to education without discrimination based on sexual orientation and gender identity, and with due respect shown towards it*.

The **Organic Law of Education 2/2006, dated May 3**, amended by **Law 8/2013, dated December 9**, continuing the transversal work with regard to sexual diversity established in the Organic Law on the General Educational System 1 / 1990, dated October 3, included the recognition of affective-sexual diversity and critical evaluation of inequalities in order to overcome any sexist behaviour. This order makes cooperation compulsory in the eradication of homophobia and transphobia and acceptance and/or making visible of sexual diversity (Gallardo and Escolano, 2009).

With regard to the legislation of the Autonomous Community of the Basque Country, **Law 3/2005 on the Care and Protection of Childhood and Adolescence**, amended by **Law 3/2009, dated 23 December**, commits the institutions of the Autonomous Community of the Basque Country to the defence of the priority interest of childhood, which means the Educational Administration teaching about values that reject discrimination and promote diversity as a positive thing to be encouraged, for a non-sexist education, and with specific programs on matters of affective-sexual education (Article 24, paragraphs 2 and 8b).

In addition, **Law 1/1993, dated 19 February, about the Basque Public Schools**, in Article 3, paragraph 2 states that public school values include the promotion of development in freedom of personality and the comprehensive training of students, based on the values that make democratic coexistence possible, promoting, among other things, capacity and critical ability, equality, justice, participation, respect for pluralism and freedom of conscience, solidarity, social concerns, tolerance and mutual respect, as well as the defence of human rights.

Also **DECREE 236/2015, dated 22 December**, by means of which the Basic Education curriculum is established and implanted in the Autonomous Community of the Basque Country, includes the obligation to recognise affective-sexual and cultural diversity, that gender and cultural identities are flexible and diverse, and to challenge the models that promote inequality linked to cultural identities of gender and sexual orientation.

In the general provisions of chapter 1, article 2, paragraph 2 states that the competent department in education shall promote the development of school education plans aimed at creating a culture of peace and preventive socialisation of gender violence and practices based on respect for diversity of cultural identities, gender and sexual orientation and equal opportunities between women and men, dialogue, emotional development, development of strategies for peaceful resolution of conflicts and the rights and duties of all people in the educational community.

One of the most significant changes in recent years has been **Law 14/2012, of June 28, non-discrimination based on gender identity and recognition of the rights of transsexual persons**, which commits the Basque public administration in the objective of their

methods, curricula and resources so that they serve to enhance understanding and respect for diversity of gender identities. In particular, it states that the Basque education authority should make available training and awareness programs on gender identity, aimed at teachers and students at all levels of public education, and committed to ensuring adequate protection for transsexual students, staff and teachers from all forms of discrimination, social exclusion and violence based on gender identity, including bullying and harassment within the school environment (Chapter V, articles 16, 17 and 18).

Another important contribution **DECREE 234/2015, dated 22 December, on administrative documentation of transsexual persons**. It is advisable to clarify that, as explained in 2.2 of this Protocol, Possible basic organisational measures to adopt in the school, it is sufficient for the family, or the child and the teaching staff to meet and assess the situation, so that the school can adopt the measures decided, without having to take the formal route shown in the Decree.

Before closing the section on rules it is important to remember the existence of **Decree 201/2008** which lays out the Rights and Duties of pupils and students in non-university education centres in the Autonomous Basque Community, as well as the framework for action of schools in this regard.

According to all the above and in order to preserve the rights of students who are minors in the field of education system and to assist in the creation of educational centres that promote the inclusion of all diversities, positive coexistence and the achievement of safe frameworks for all its members, the following general principles and considerations will also be taken into account:

- The Basque Educational Administration shall ensure -within the framework of the “Master Plan for co-education and prevention of gender violence in the educational system” - that schools are spaces of respect, free from any pressure, aggression or discrimination for motives of gender identity or sexual orientation.
- Educational actions and measures will be developed to help overcome discriminatory attitudes, based on the idea of the inferiority or superiority of any sexual orientation and gender identity within the education system.
- In particular, the projects that the educational community develops have to take into account that acceptance of sexuality and gender identity occurs differently in people and they have to consider the importance of helping/supporting each person on this path. In this regard, in some circumstances, in addition to all the above, it may be necessary to take certain measures to facilitate and support minors and their families, their environment and their teachers.

There are specific circumstances in which there are legal obligations for the Educational Administration itself (**Law 14/2012, dated June 28, on non-discrimination based on gender identity and recognition of the rights of transsexual persons**) to provide the means for schools to take appropriate decisions to prevent these people and their families suffering, and to have close support that allows them to take their own decisions. Schools

are also obliged to take action in various areas of school life (name changes or not in different school pupil documents, use of spaces like lavatories, changing rooms ...). Likewise, families are entitled to know what to expect from the education system and their school in these circumstances.

To guide schools in these processes of support for minors whose sexual identity does not match the sex assigned to them at birth (students in a situation of transsexuality) and those students whose gender behaviours do not match what is socially expected on the basis of sex (transgender, transvestites, queers, drag queens ...) and their families, the Department of Education, Language and Culture Policy, is publishing this document. It contains some guidelines for the support of trans minors, their families, and their teachers in order to assist in the identification of needs and the adoption, where appropriate, of measures to facilitate the appropriate educational response. The task of the school is not to “label” these students but, as with the other students, to identify the barriers that they have for their development and for their academic success and to provide the means to remove them or minimise them, and always taking into account their families.

Scope of application of these recommendations: this protocol and the action measures proposed are aimed at all public schools and those supported by public funds that make up the Basque education system.

4.2. RECOMMENDATIONS OF ACTIONS FOR THE SUPPORT OF TRANS MINORS IN THE EDUCATIONAL FIELD

4.2.1. COMMUNICATION. ASSESSMENT

Situation detected by the family and/or the minor themselves

When it is either the family or the person/s who exercise/s legal guardianship of the student, or the minor themselves who inform the school that their sex does not match that which was assigned at birth based on their genitals, or that some of their gender behaviours differ from those expected socially according to their sex the school management passes on this information to the teaching team and guidance department or the counsellor or guide to analyse the situation and complete the information with persons deemed appropriate: tutor, teaching staff, classmates, family...

Situation detected by the teaching team

When the tutor of a group or any member of the team notice in a student the repeated presence of behaviours that might indicate a sexual identity mismatched with the sex assigned at birth based on their genitals or gender behaviours that do not meet with those socially expected on the basis of sex, they will proceed as follows:

- The teacher or tutor will inform the Management Team of the school.
- The Management Team will discreetly collect additional information about the situation and compare it with that of the tutor, teachers and non-teaching staff.
- The tutor - together with the Management Team - will assess the advisability of speaking to the minor about their situation.
- The tutor - together with the Management Team - will meet with the legal representatives of the minor to report on the observed situation, compare information and assess the situation.

Communication and support: TAKING DECISIONS

School Management may request the assistance of Berritzegune, at any point in the process, to analyse the situation and to receive help, advice and training at the school.

When necessary, Education Inspectors will receive information from the School Management about the situation in question, the steps taken to address it in the school and the resolutions adopted and will ensure that the action protocol is complied with.

After the initial family-school/school-family assessment, the decision-taking phase begins. At this point, we could find ourselves, broadly speaking, with two possible situations:

THE FAMILY AND THE SCHOOL SHARE THE ASSESSMENT OF THE SITUATION SET OUT:

- The Management Team will meet with families and the teaching team.
 1. The tutor - together with the Management Team - will assess the advisability of speaking to the minor about their situation.
 2. Management Team + family + guidance/adviser + tutor:
 - Identify educational and organisational needs arising from this situation and propose/discuss possible actions to be developed in the school, also report on the resources available to the education system and the school have in order to respond to the situation.
 - The school will offer the minor or their legal representatives the possibility of an individual tutor to support them in their process within the field of school. This person will be selected by the minor themselves from the teaching staff offered for the purpose.
 - The school will provide information to the family and/or legal representatives on existing resources if in the identification of the educational needs of the student there are any problems or difficulties in their personal and social development that will require the intervention of other specialised external resources.
 - The legal representatives will be informed about the resources, both public and pertaining to associations, which make possible the contact of that family with associations for families with minors in similar situations.
 3. Management Team + Teaching Team:
 - Situation information
 - Analysis of intervention proposals.
 - Agreements for the start-up of the measures under consideration.
 4. Management Team + Co-education Commission:
 - Organisation of awareness-raising and training sessions for the education community (teachers, students, families...).
- The agreements will be included in a support plan which will include, at least: measures agreed by the Teaching Team and the family, basic organisational measures, responsible persons...

-
- The functioning guidelines and measures to be adopted agreed to create a safe environment in the school for the minor who is experiencing the situation shall involve all members of the teaching team who interact with the minor, the Guidance Service of the school or advisor and the School Management.
 - The School Management shall ensure at all times the ordered and prudent exchange of information between the family and the school... or other administrative authorities involved in handling the process through which the minor is living.
 - The whole process will be managed with maximum discretion, always careful to preserve the privacy and wellbeing of the minor, giving priority to their superior right to freely develop their personality in accordance with their sexual identity and orientation over any other legitimate interest which could also be present.

THE FAMILY AND THE SCHOOL DO NOT SHARE THE ASSESSMENT OF THE SITUATION SET OUT

- The persons legally responsible for the minor, or one of them, do not accept the sexual identity or certain behaviours of the minor.

In this case:

- The Management Team and the Teaching Team shall adopt measures to ensure the well-being and inclusion of the minor in school.
 - The school will try to support the family in the process of understanding and taking on board and managing the situation, respecting the right of the minor to develop their own personality and identities. The Management Team and/or the guidance service or advisor shall keep communication open (monitoring, information about services...).
 - In the case of detecting indications of abuse or lack of legal protection, invoking law 3/2005, dated 18 February, on Care and Protection of Childhood and Adolescence, the Management Team shall proceed to inform Social Services of the situation.
 - The Management Team and the Co-education Commission shall organise awareness-raising and training sessions for the education community (teachers, students, families...).
- The school does not accept taking organisational measures requested by the family, as referred to in point 2.2.

In this case:

- The family will make the facts known to the Education Inspectors.

4.2.2. POSSIBLE ORGANISATIONAL MEASURES TO ADOPT IN THE SCHOOL

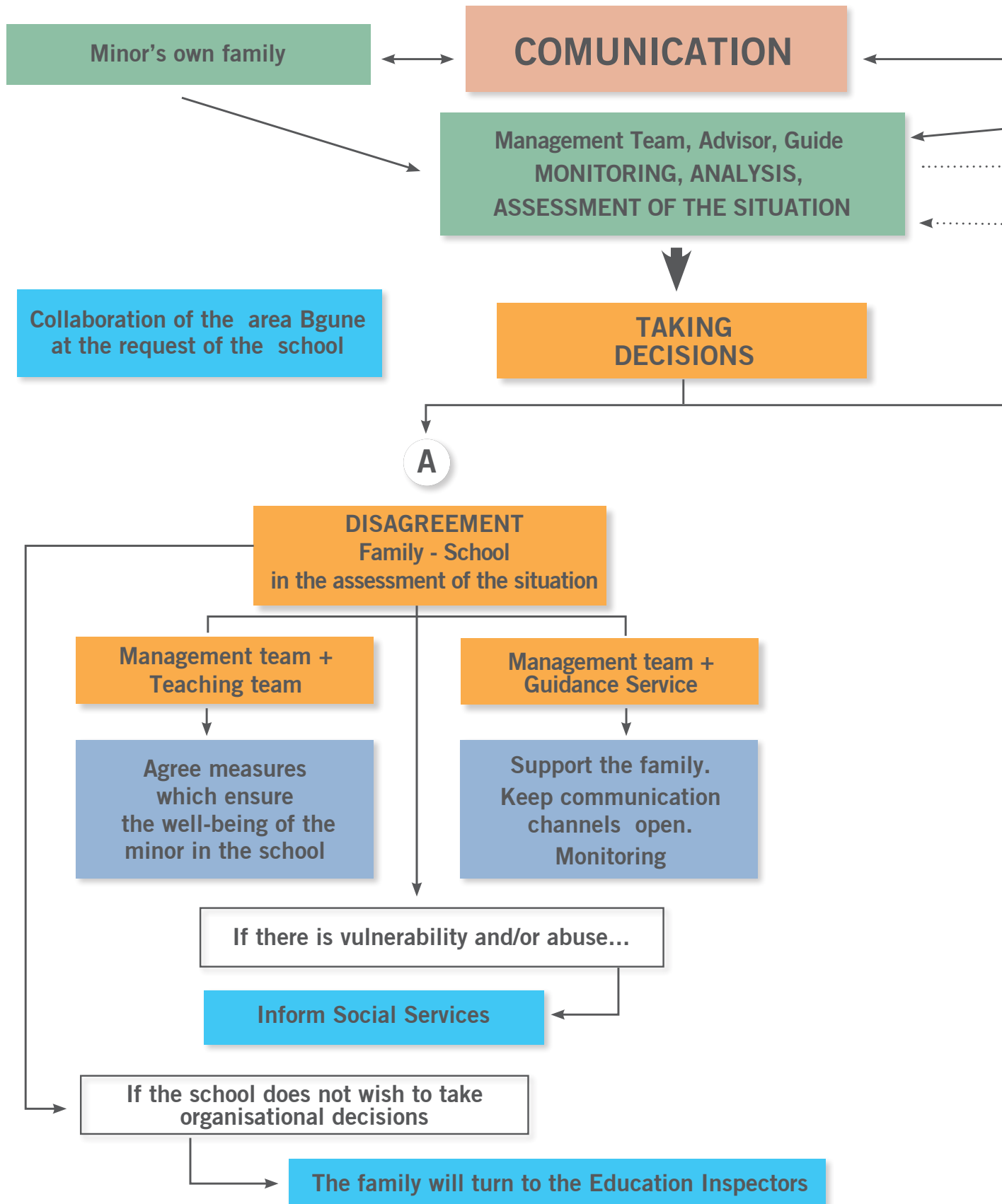
Because every person is unique, it is fundamental to listen to the needs raised in each case. According to them, the teaching team, the minor and their family will be able to evaluate the adoption of any of the following measures:

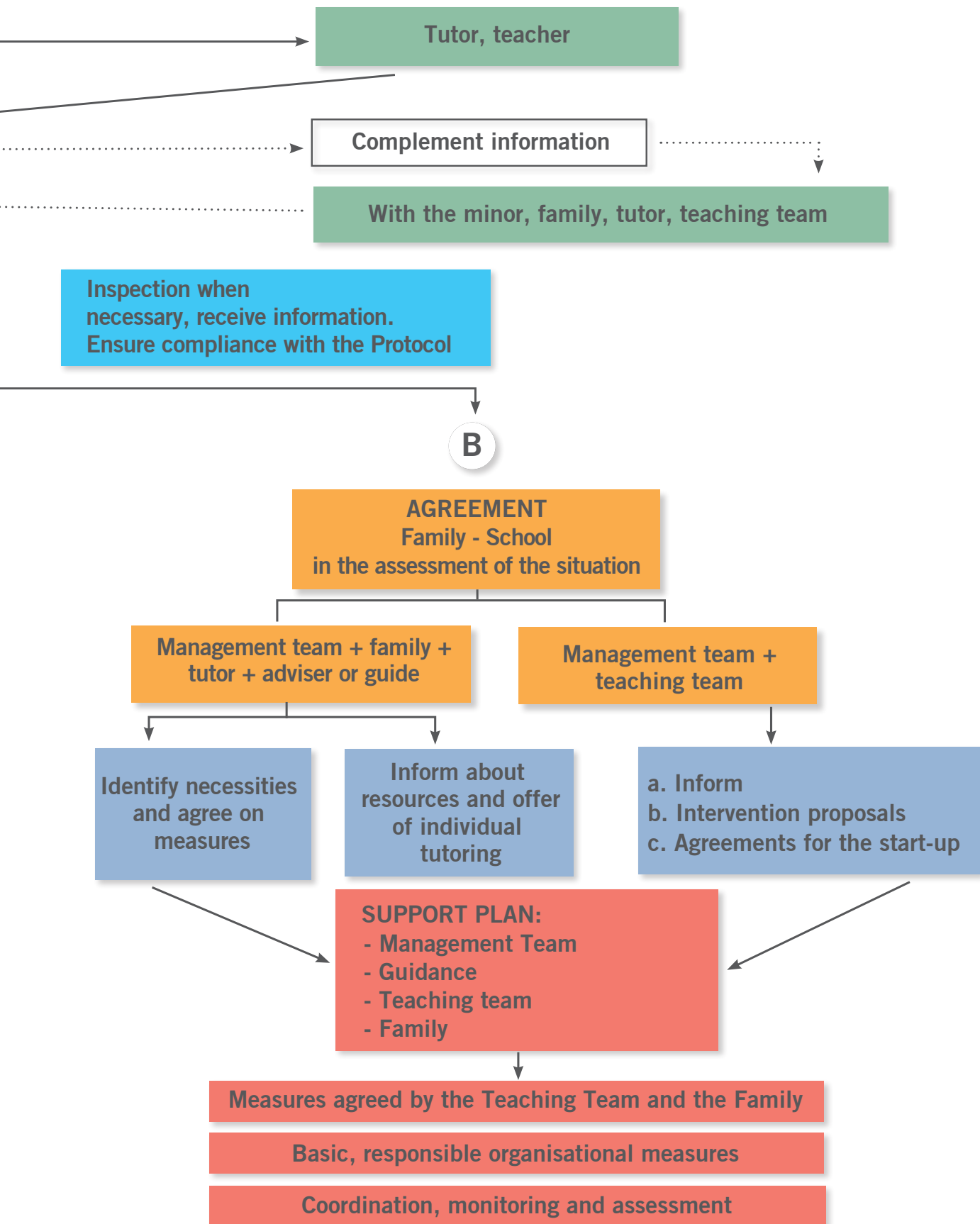
- The teaching staff and the non-teaching staff will address the pupil by the name given to them by him/her and/or by the family, in both curricular and extracurricular activities, including examinations.
- The administrative documentation for internal use in the school (class lists, newsletters, qualification reports, library cards, student cards...) will be altered to the sex with which the student feels identified.
- In addition to the awareness raising training activities organised in the school, the group-class tutor will devote periods of reflection in the group itself oriented towards making visible and integrating the existing sexual diversities in the classroom.
- In the context of the school, there will be guarantees with regard to the use of the clothing with which each person identifies, including in the cases of schools that have uniforms.
- The necessary steps will be taken so that the trans pupil can access and use all spaces in the school which are for segregated use (bathrooms, changing rooms...) according to their preference. The opinion of the minor will always be taken into account and, as is obligatory, actions will be taken to guarantee their safety and privacy.
- If, for reasons in accordance with specific aims, the separation/organisation by sex of certain activities is needed at any point, the teaching staff will take into consideration the sex with which the student feels identified or other circumstances.
- In cases where the school has sports teams or sporting competitions in which there is separation by sex, the minor will participate, if they so desire, in the teams or competitions corresponding to the sex with which they feel identified.
- All these measures will be included in the Coexistence Plan and the Co-education and Prevention of Gender Violence Plan of the school, as well as in the Report of Findings or Risk Reduction Index.

4.2.3. PROCEDURE IN POSSIBLE CASES OF DISCRIMINATION, SCHOOL BULLYING, GENDER VIOLENCE OR CHILD ABUSE DUE TO TRANSPHOBIA

1. The necessary measures will be established, stated in the Coexistence Plan and the Co-education and Prevention of Gender Violence Plan, to prevent or intervene before conducts of discrimination or possible school bullying, gender violence or child abuse which might arise, in which case the corresponding protocols will be activated. Faced with any physical or psychological aggression for reasons of sex or sexual orientation, the reaction of School Management, the teaching staff and the educational community as a whole, especially including the students, should be forceful and clear, as foreseen in DECREE 201/2008, dated 2 December, on rights and duties of students of non-university teaching centres of the Autonomous Community of the Basque Country.
2. Any member of the educational community who knows of or suspects a situation of school bullying, gender violence or child abuse against any student, due to sexual identity or orientation has the obligation of informing the tutor, adviser, guide of the school or the Management Team. In any case, the recipient of the information will always inform School Management.
3. In case in which it is considered that there could be a situation of school bullying, gender violence or child abuse due to **sexual identity and orientation the corresponding Protocol** for harassment between equals will be activated and the Education Inspectors will be informed.
4. In those cases where, because of the attitude of the family towards the sexual identity of the pupil or non-normative behaviour, signs of abuse, the existence of vulnerability or child risk are detected, the facts must be made known to the competent authorities in the protection of minors, public prosecution service or judicial authority, communicating the data and information resulting therefrom, and must cooperate with those authorities taking into account the priority interests of the minors. (Law 3/2005, dated 18 February, Care and Protection of Childhood and Adolescence. Article 25, paragraph 2).

4.3. FLOW DIAGRAM OF ACTIONS





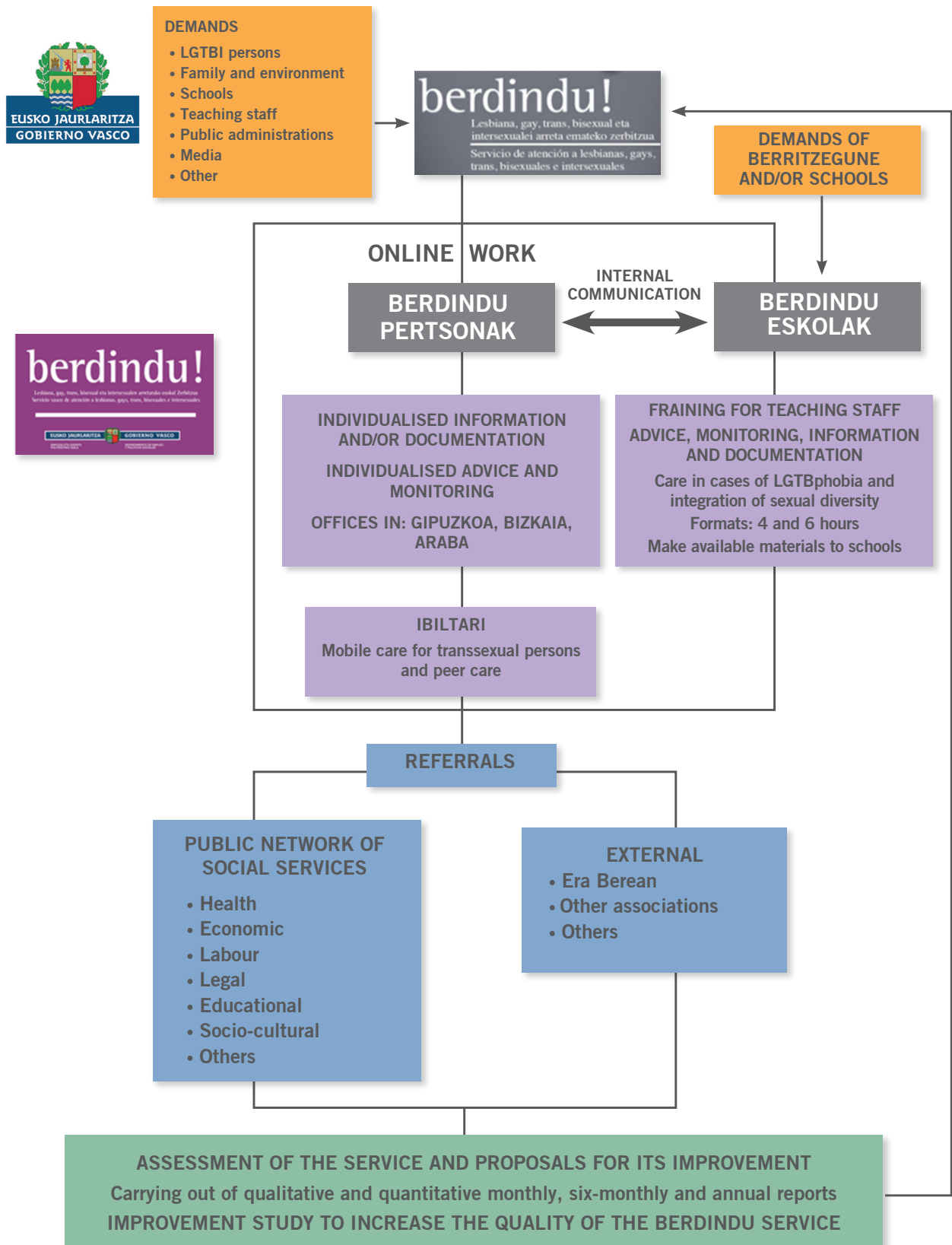


5

Objective and
fields of action

SOCIAL FIELD

5.1. FLOW DIAGRAM OF BERDINDU ACTION



5.2. INTRODUCTION

On 4 February 2000 the Plenary Session of the Basque Parliament approved a proposal of non-binding resolution in which it urged the Basque Government to promote the starting up of an information, care and advice service for gays, lesbians, transsexuals, bisexuals, intersexuals (LGBTI) and environment, in collaboration with the Basque Regional Governments (Diputaciones Forales) and main City Halls. Said Proposal made manifest a firm political will to articulate public policies in the battle against discrimination due to reasons of sexual orientation or identity and in favour of the rights of said collective.

This was the origin of what became a reality two years later, promoted by Parliament and started up by a Government Agreement, dated 4 November 2002: the Berdindu Service, Basque Service of Care for Lesbians, Gays, Transsexuals, Bisexuals, Intersexuals and environment, attached to the Department of Employment and Social Policy through their direction of Family Policy and Community Development.

It is, without doubt, an important achievement that it has been developed until its current configuration has been reached. Because the Berdindu Service encompasses at the present two perspectives in accordance with the fundamental concerns of the Government in the field in which we are interested:

BERDINDU PERTSONAK/IBILTARI

Information, care and advice for lesbians, gays, transsexuals, bisexuals, intersexuals (LGBTI) and environment, families with minors with sex/gender diversity, as well as transvestites, transgender persons, queers, etc.

Berdindu Ibilitari, mobile care throughout the territory of the Autonomous Community of the Basque Country and “peer care” which consists of all users of the service being cared for by a transsexual person with the same sexual identity as their own.

BERDINDU ESKOLAK

Advisor to schools on matters of sexual, family and gender diversity.

Inform the offices of the Berdindu Ibilitari service.

Online work.

Involves Berritzegune Nagusia and the Department of Education, Linguistic and Cultural Policy of the Basque Government in the actions to be carried out from month to month.

Information, care and advice for families with minors with sex/gender diversity, whenever it is required by the school.

5.3. BERDINDU SERVICE

5.3.1. WHAT IT IS

Berdindu is a public service for information and care for matters related to sexual, family and gender diversity, promoted by the Department of Employment and Social Policy of the Basque Government.

5.3.2. FUNCTIONS

The functions of the service are:

- Care and advice for lesbians, gays, transsexuals, bisexuals and intersexuals, as well as their environment, in relation to any matter derived from sexual orientation or sexual identity and/or gender.
- Information and care for the education community, the different social and professional agents, the media and society in general with the objective of eliminating LGTBphobia.
- Design and proposal of equality and on-discrimination policies in relation to the LGBTI collective.

Berdindu also **carries out**, in collaboration with the LGBTI collective:

- Social awareness-raising campaigns.
- Coordination with associations and cooperative bodies.

5.3.3. COMMITMENTS

The public service BERDINDU undertakes to take emotional and social care of LGBTI persons, as well as families with minors with sex/gender diversity, with the intention of them achieving the emotional integrity to achieve their social insertion with equality of rights with others, so that their social and family environment protects them from possible situations of social rejection or discrimination.

The services works uniquely and exclusively in the provision of services of emotional and social care, without interfering in medical questions within the framework of the public health services covered by Osakidetza Basque Health Service, and which in part are described in Chapter III “Health Care” of Law 14/2012, dated 28 June, on non-discrimination based on gender identity and recognition of the rights of transsexual persons.

In particular, all matters related to diagnostics and hormonal treatments, plastic surgery interventions, and any other type of medical intervention which affects the work carried

out by the medical care and nursing professional staff, psychological, psychotherapeutic and sexology care, are expressly excluded from the BERDINDU Public Service. These are attended to by the Reference Unit for assessment and multidisciplinary support treatment for trans persons, created in 2009 at the Cruces Hospital, within Osakidetza Basque Health Service.

Direct work with minors is excluded, Berdindu concentrates on the care of their family environment, school, etc. In these matters they act in accordance with that laid out in Law 3/2005, dated 28 February, on care and protection of childhood and adolescence.

5.3.4. HOW IT IS STRUCTURED

The Berdindu Public Service is structured in different levels according to different target persons or bodies of the care, giving priority to online work and the efficient and responsible use of public funds.

- **Berdindu Pertsonak/Ibiltari:** Its aim is to offer information and support to all lesbians, gays, transsexuals, bisexuals, intersexuals and environment who request it, as well as to families with minors with sex/gender diversity. The service is offered in all three Basque territories, and managed by the following associations: Aldarte (Bizkaia, Araba), Errespetuz (Mobile Service) and Gehitu (Gipuzkoa).
- **Berdindu Eskolak:** Its aim is to train and advise the teaching staff of schools in the Autonomous Community of the Basque Country in matters of sexual, family and gender diversity Service managed by Guztiok.

5.3.5. MATERIAL RESOURCES

The features of the Berdindu Service are supported on the infrastructure available to the bodies who manage it in their respective headquarters at:

C/ Kolon 50 (San Sebastián)

C/ Berastegi 5 (Bilbao)

C/ Zapatería 39 (Vitoria - Gasteiz)

C/ Benidorm 1 (Bilbao)

This infrastructures is complemented by a mobile care service for trans persons (transsexual or transgender persons) (Berdindu Ibiltari) enabling the user who so desires to be attended to in their place of residence. It is a service based on “paired care”, which consists of all users of the service being cared for by a transsexual person with the same sexual identity as their own.

5.3.6. BASIC PRINCIPLES OF ACTION

Care for the persons who use the public service is guided by the following principles:

- Confidentiality.
- Cordiality.
- Respect.
- Professionalism.
- Efficacy.
- Quality.
- Unconditional support and acceptance (no judgment or valuing).
- Adaptation to the characteristics of the user or school in question.
- Active listening: investigate, confirm listening, ask open questions, recapitulate...
- Empathy.
- Stimulation of the user's own resources.

In addition, the mobile service is guided by the principle of "peer care", which consists of all transsexual users of the service being cared for by a transsexual person with the same sexual identity as their own.

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5.3.7. ROUTES TO CARE

Berdindu Pertsonak: There are three main routes to care from the Service: telephone, in person and e-mail. In each and every case, this is guided by the principles of action mentioned above.

Berdindu Pertsonak: For the specific case of care for transsexual persons a mobile service is made available which avoids users having to travel.

Berdindu Eskolak: The main care route is in person, visiting the school with the objective of attending to the demands of the teaching staff. Once in the school they may require Advice or Training. There is also an e-mail address and telephone care available although these routes are used above all for the first contact between the person responsible for the school (or whoever requires our services) and Berdindu Eskolak.

5.3.8. REFERRAL

The advice offered by the public Service, in those specific cases of in-person demand, has a basic level of care. From there, and should the demand require it, the corresponding

routes of referral are established, either to other services of the body, of Berdindu Service itself, or to external services.

In addition to the above-cited, the Berdindu service and especially Berdindu Ibiltari, informs users of the service of the existence of the Gender Identity Unit of Cruces Hospital, a unit of reference for the whole of the Autonomous Community of the Basque Country.

Berdindu Eskolak, should demand require it or it is considered important, coordinates with the rest of Berdindu services providing information of that data which could be significant in being able to provide a more complete service to the users. The school will also be informed about Berdindu Pertsonak and Berdindu Ibiltari.

5.3.9. COORDINATION: REPORTS AND ASSESSMENTS

The Berdindu Pertsonak Services (with offices in Alava, Vizcaya and Gipuzkoa and the Ibiltari mobile service) and Berdindu Eskolak are in permanent coordination with the other bodies who makes up the Service, as well as with the Management of Family Policy and Community Development of the Basque Government. To this end the reports listed below are periodically prepared:

- **Monthly, six-monthly, annual and closure reports:** All demands attended throughout the service.
- The Berdindu service makes available to all users a questionnaire to evaluate the service which, in addition, makes it possible to suggest improvements. With this data an **Assessment Report** is produced every six months.

Berdindu Eskolak is also in permanent coordination with Berritzegune Nagusi, and makes available to teachers a questionnaire to evaluate the service itself, which in addition, makes it possible to suggest improvements.

5.3.10. COLLABORATION

The Berdindu Pertsonak and Eskolak public services work online and collaborate with the Department of Education, Linguistic Policy and Culture of the Basque Government, the Gender Identity Unit of Cruces Hospital, Era Berean, the Social Services Public Network, the rest of the LGBTI collective, and any other body in the field of social intervention.

5.4. BERDINDU SERVICE: THEORETICAL BACKGROUND

The realities we live around the collective of lesbians, gays, transsexuals, bisexuals, intersexuals (LGBTI) and their environment in the Basque Country are not univocal but present a dual character: on the one hand, a social and political acceptance which keeps on growing, and on the other hand, limiting and occasionally negative contexts for the development of diversities and sexualities in terms of freedom and dignity.

The existence of a negative social prejudice is confirmed through LGBTIphobic situations and attitudes in numerous areas of society. Thus, there are still physical aggressions, insults, threats and situations of discrimination in different spaces, which require a response to bring about their eradication and to avoid the sensation of vulnerability and isolation which the victims have in many cases. During 2014 in Berdindu 20 reports from lesbians, gays, transsexuals and bisexuals who suffered a situation of aggression, discrimination and/or rejection due to their sexual orientation or sexual and/or gender identity.

The trans collective, and especially transsexual persons, represents one of the sectors of the population who suffer most and who, subjectively and objectively, has had a greater number of rights violated. Society's incomprehension, constructed by a still sexist language which is far-removed from reality, as well as the lack of legitimate and respected references which are adjusted to social reality, has its maximum expression in the survival of its perception as a mental illness, due to its consideration as such in the WHO catalogue.

That is why Berdindu demands the removal of transsexuality from the list of mental illnesses, and, therefore, actively supports the depathologisation of transsexuality, and freedom of sexual and/or gender identity.

Impressive advances have been made in society and in the legal framework: Common law couples, Law 14/2012; Government Programme, Work Plan, Decree 234/2015, dated 22 December, on the administrative documentation of transsexual persons. There have also been advances with regard to the depathologisation of transsexuality, in which we can highlight the agreement of the Basque Government, dated 30 September 2010, in which actions are urged before the WHO for the removal of the classification of transsexuality as a mental illness. This is the working framework of the Berdindu public service. Deserving of a special mention are:

”Basque Government Programme”, 2012-2016.

“... Area 1.26. Equality Policies...”

“... Objective 1.26.5. Respect for affective and/or sexual diversity...”

“...Initiative 1. Strengthen the associations and collectives of lesbians, gays, transsexuals and bisexuals checking the instruments of subsidies, specialising in the agents and propitiating the complementary nature of the proposals...”

“...Initiative 2. Train staff in the management of affective-sexual and gender identity diversity throughout all Basque Government policies.

“...Initiative 3. Create an advisory board on affective-sexual and gender identity diversity with the aim of improving interinstitutional coordination and the harmonising of policies...”

“...Initiative 4. Assess the 2012-2013 work plan for non-discrimination due to motives of sexual orientation and gender identity and boost the development of knowledge in the field of affective-sexual diversity...”

“LAW 14/2012, on non-discrimination based on gender identity and recognition of the rights of transsexual persons”.

“...This law aims to contribute and move towards overcoming all discrimination that because of the condition or personal or social circumstances of people remains in legislation, and improvement of the regulatory development of the constitutional principles of non-discrimination, free development of personality and social, economic and legal protection of the individual, family and group, adapting the applicable regulations to the social reality of the historical moment in which we live...”

This law encompasses the whole collective of transsexual persons, including minors and immigrants, and in addition covers all those areas of life of transsexual persons: the areas of health, school, work, jurisprudence, social..., as well as granting administrative documentation in accordance with the identity of the person from the first moment, and it was a historical landmark, with the Autonomous Community of the Basque Country a pioneer and reference point in said material at a global level.

“2011-2012 work plan for the equality and non-discrimination for motives of sexual orientation and gender identity of the Basque Government”

“...To tackle policies of equality and non-discrimination due to sexual orientation and gender identity in the period 2011-2013, this work plan has five areas of priority action...”

“...Health and healthcare, education, employment and labour market, vulnerable collectives and awareness-raising...”

“...these five areas encompass the most urgent needs of lesbians, gays, transsexuals and bisexuals in our society. Needs which have been detected by the Basque Government and the LGBT collectives...”

“DECREE 234/2015, dated 2 December, on administrative documentation of transsexual persons”.

“... This Decree is to regulate the administrative documentation that transsexuals may have once they have registered the correction of the content referring to sex in the civil registry or, in the case of immigrant transsexual persons resident in the Autonomous

Community of the Basque Country, until such time that they can proceed with the registration change in their country of origin ... “

“Creation and start-up of the Gender Identity Unit of Cruces Hospital”, 2009. Osakidetza.

“...It is the Gender Identity Unit of reference for the entire Autonomous Community of the Basque Country. To care for, inform and advise users derived from primary care centres in the three Basque capitals...”

Although the advances produced in the last few years are undeniable, as has been cited, so too is the fact that social equality and equal opportunities are still a long way from being a reality. It is a fact which is made obvious by the demands received in the Berdindu Service, demands that make plain the serious difficulties which even today many persons must face to live their sexuality naturally. Lack of knowledge, lack of references, prejudices, and outdated moral criteria are just some of the ingredients which perpetuate the situation.

There are many areas which make up this complex web of deficits: LGBTI minors, transsexuality, homoparental families, elderly LGBTI persons, persons affected by HIV, lesbian women... and many studies which bear witness to it. We mention some of them below:

“Attitudes of students to affective-sexual diversity” 2014. GUZTIOK/GEHITU

“... Persistence of homophobic behaviours (“Insults”, “Bad-mouthing”, “Rumours”, “Physical aggression”...) of which 27% of young people declare themselves responsible / Extensive outreach and face-to-face index of the same (87%) / Imbalance as far as the degree of acceptance of affective manifestations between same and different sex is concerned / Discomfort or visceral rejection of almost half of the boys against displays of affection between boys / Discomfort or overt rejection of a third of the same before a transsexual or gay classmate / Perception of school as an unsafe framework for at least half of all young people... “

“Discrimination due to sexual orientation and/or gender identity in Spain”, 2013. FELGT / COGAM

“...Some sectors of the LGBT population show a special degree of vulnerability. In general, women get the worst of it, although groups formed by transsexual persons and those affected by HIV are in a situation of serious risk of discrimination. For that, the public administrations should take specific measures for the reduction of the stigma they suffer. Also, LGBT adolescents, young and elderly people should be the object of special consideration in the implementation of public policies designed to protect them against the different forms of discrimination they can suffer because of their sexual orientation or gender identity...”

“Youth in Spain Report”, 2012. INJUVE

It is a reflection of how society perceives the fact of LGBT and states that in the youth environment there are still very evident features of LGTBphobia and discrimination, in

different forms, from structural hostility to physical violence, from insults to laughter. Thus, 77.4% of young people have heard insults and 18.1% have been present at beatings and pushing and shoving. Gossip, humorous mockery or insults are not often understood as LGBTIphobic behaviour, meaning that their negative effects are played down.

“Vulnerable childhoods”, 2011 ARARTEKO

Includes among its main conclusions, the following:

“...The existence of a worrying degree of rejection of homosexual persons - and transsexuals - in the school population, which is translated into hostile attitudes, stigmatisation or rejection (when not into verbal or physical aggressions) against adolescents or teachers of homosexual orientation or transsexual identity...”

“...The need to put in place public policies which generate appropriate conditions so that young people with different sexual identities have their dignity and basic rights protected...”

“...The need to promote prevention protocols against homophobic and transphobic violence, affecting the training and education of teachers and students...”

“Adolescents in the Basque Country. An approach from empowerment”, 2009. EMAKUNDE

“... The existence of a ‘concealment’ or ‘invisibility’ of some homosexual practices in the collective of adolescents in our region is still being observed”, and they are slightly more visible in boys (4% say they maintain relationships with persons of the same sex), than in adolescent girls (with almost 1% in “stable couples of the same sex”) ... “

“Visibility and social participation of lesbian women in the Basque Country”, 2007. Inmaculada Mújica

“... The male-centred culture to which we belong denies many things to women, including their sexuality and the ability to live a full life, so their feelings, the sensations and experiences of women’s sexuality, are ignored. Despite the enormous social information that exists, through numerous publications and research, many women are still unaware of aspects of their sexuality and help maintain numerous taboos that not only damage themselves but reinforce the idea that sex is secondary for women and to live it pleasurably is not important. Lesbian women also suffer prejudice due to this situation which serves to make visibility even more difficult...”

“Old age and sexual orientation”, 2004. Beatriz Gimeno

“The most common situation is that even if it is a person who has lived openly as LGBT for most of their adult life, they now find themselves at the point of having to live in an old people’s home, having to hide their sexual orientation, gender identity, or their body, not to put themselves in situations of vulnerability before discrimination or abuse. “

And we could go on, but it is probably not necessary. They are indicators that reflect the persistence of a breeding ground for uncertainty, discomfort, fears, visceral rejection... with regard to non-normative orientations and identities. They are affective life experiences which sometimes turn into interiorised negative action. It is the legacy of a sexual prejudice which persists on an affective plane, which limits free expression of sexual, family and gender diversity which lays bare the need to carry on laying the foundations for the gradual implementation of social and opportunity equality. The Berdindu public service is, in fact, a firm commitment to said task.

5.5. BERDINDU PERTSONAK/IBILTARI: PROTOCOL OF ACTION

5.5.1. SPECIFIC OBJECTIVES

- To take in any person who turns to the service.
- To inform about any demand which could be made by them or, should it arise, to channel said demands to the person, body or service responsible for said matters.
- To offer emotional support in cases that require it.
- To establish routes of referral in those demands in which, for the complexity of the factors involved, are judged to need a more specific professional attention.
- To serve as a connecting link with other services offered by the body, the Berdindu Service on the whole or, should the case arise, external services, gender identity unit and/or public network of social services, or other services.
- To be a reference point for other Public Administrations.

5.5.2. INTERVENTION TARGET PERSONS

LGBTI population: All persons who require information, advice or emotional support in relation to their life related to sexual and/or gender orientation or identity.

We include for guidance a brief review of the typology of demands attended to up to the present day in the Service.

- Doubts about their own desire or sexual identity.
- Non-acceptance of their own sexual orientation and/or sexual and/or gender identity.
- Discovery of lesbian, homosexual or bisexual orientation after extensive heterosexual experience.
- LGBTI person with children.
- Expression in the public area of one's own sexual orientation and/or identity, closest environment: family, friends.... visibility.
- Need for references and socialisation.
- transsexual persons and/or their family members.

Social environment: Care for the closest family environment, as well as parents of minors with sex/gender diversity. This would be to provide information and assistance to the

closest social environment to the family/minor (friends, other parents of friends of the minor, etc.) minors with sex/gender in order to properly address a situation faced with which they feel ignorant and lacking in resources.

Other collectives: All those groups that so require: schools, leisure groups, workplace, HIV-positive population ... The specific demands relating to teacher training and advice for schools are channelled through the specific service created for this purpose (see Berdindu Eskolak).

5.5.3. SERVICES

Intervention is made up of the following services:

Shelter and Information: The Area of Shelter and Information is the entrance door and calling card of the public Service. The functions of this area are, primordially, to listen to and channel the expectations of the questioners of the person who turns to the Service. From this area an assessment is made of the need, demand or problems presented with the aim of providing the information requested, informing about external resources when necessary and/or referring, according to demand, towards other services of the centre. Attention is given to all those demands for information referring to the LGBTI collective that the person using the Service makes: legal, sexual health, leisure and free time...

Documentation: Available to interested persons, there is a documentary collection consisting of books, magazines, press, videos, newspapers ... which covers topics such as lesbianism, homosexuality, transsexuality, sexual, family and gender diversity, the history of homosexuality, transsexuality in childhood, etc... In addition, the design and development of training materials for the whole of society to facilitate dialogue, communication and awareness raising of the realities of LGBTI is included within this service.

Support and guidance: Support and guidance needs will be covered which confront the situation of those persons who feel doubts with regard to their sexual orientation/identity. Said support and guidance work is framed within a basic level of care, establishing referral routes for those case which could need more specific professional attention.

5.5.4. STAFF

Appropriate provision of the Service requires the following staff resources:

Head of Berdindu Pertsonak Service: A properly trained person with experience in the field of care which covers among its functions, as well as those belonging to the field of care , coordination and collaboration in the design and carrying out of different social intervention plans.

Head of Berdindu Ibiltari Service: A transsexual person with experience in the field of care which covers among its functions, as well as those belonging to the field of

care , coordination and collaboration in the design and carrying out of different social intervention plans.

- Given the peculiarity of the service, the persons responsible for it will carry it out in an itinerant manner and in the format of “peer care”, giving an overall coverage to the whole of the Autonomous Community of the Basque Country.

Service support staff: The Service will be reinforced by those resources, both staff and materials, belonging to the body.

5.5.5. CASE REGISTRY

In order to have accurate information of cases attended by the service, a detailed record of all demands attended and their main characteristics is kept. In this way, the data that may involve the identification of the user only and exclusively form part of the registration of the reference body.

5.5.6. COORDINATION: REPORTS AND ASSESSMENTS

The Berdindu Pertsonak/Ibiltari Services are in permanent coordination with the other bodies who makes up the Service, as well as with the Management of Family Policy and Community Development of the Basque Government. To this end the reports listed below are periodically prepared:

Monthly, six-monthly, annual and closure reports: Set of care actions made by the public Service, demand characteristics: age, origin, training

The Berdindu public service makes available to all users a questionnaire to evaluate the service which, in addition, makes it possible to suggest improvements. With this data an **Assessment Report** is produced every six months.

5.6. BERDINDU ESKOLAK: PROTOCOL OF ACTION

5.6.1. SPECIFIC OBJECTIVES (TRAINING, CONSULTANCY)

- **Advisory services and training for teachers in schools** to deal with cases of homophobia, lesbophobia, transphobia, and to integrate sexual, family and gender diversity into the tutorial plan and raise awareness in all primary and secondary schools.
- Carry out both a qualitative and quantitative monitoring of the interventions.
- Advise and facilitate material for classroom work.
- Offer a consultancy service to teachers and schools.
- Monitor the cases consulted.
- Action proposals.
- Involve Berritzegune and the Department of Education, Linguistic and Cultural Policy of the Basque Government in the planning, execution, and assessment of the activities.
- Information, care and advice for families with minors with sex/gender diversity, whenever it is required by the school.

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5.6.2. INTERVENTION TARGET PERSONS

The service is aimed at:

- Primary and Secondary Schools.
 - Schools with LGBTI discrimination and/or bullying problems.
 - Schools interested in integrating the perspective of sexual, family and gender diversity and Family Diversity.
- Guides, Advisors, school management and teachers in general.

5.6.3. SERVICES

In coordination with Berritzegune and the Department of Education, Linguistic and Cultural Policy of the Basque Government, Berdindu Eskolak offers:

Advice and Consultancy Service

- Itinerant, travelling to each school as demanded or according to specific cases.
- Aimed at advisers, guidance departments and/or school management. Also tutors involved or especially interested, with a certain level of involvement, and who are interested.

- Reception of the demand or specific problem (interest of management of a problem), as well as documentation and identification of same.
- Information about Berdindu and all the available resources of the Government.
- Guidance for the identification of, and action against, cases of homophobic, lesbophobic and transphobic bullying.
- Information about a selection of the available and accessible materials most appropriate for their specific case and level. Selection and despatch of these materials.
- Information about basic training.

Basic training about sexual, family and gender diversity

- Intended for awareness-raising and training in sexual, family and gender diversity material for staff of one same school in the following situations:
 - That there is a case of discrimination and there is a desire to do something to tackle it in a coordinated manner by the teaching staff through didactic units or material.
 - That there is a wish to integrate sexual, family and gender diversity into the tutorial plan.
- Groups of a maximum of 30-35 teachers from the same school.
- Information about Berdindu and all the available resources of the Government.
- All the material used is provided.

5.6.4. STAFF

Head of Berdindu Eskolak Service: A properly trained person with wide experience with teaching staff in diverse schools in the Autonomous Community of the Basque Country.

- The service is carried out in an itinerant manner, giving complete coverage to the whole of the Autonomous Community of the Basque Country, offering daily attention, adapted to the needs of the school, from Monday to Friday, during school hours.

Service support staff: The Service is reinforced by those resources, both staff and materials, belonging to the body.

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6

Objective and
fields of action

HEALTH FIELD

6.1. AETIOLOGY. INCIDENCE AND PREVALENCE

6.1.1. AETIOLOGY

The aetiology of transsexuality has been a subject of continuous debate and there are stern defenders of different approaches, from those who seek biological or cerebral causes, to those who only attribute these phenomena to cultural or social causes. Although there is currently a general consensus that nothing concrete can be said with total conviction, the most recent research seems to have found a biological origin of the manifestations of non-conventional gender identity⁶. However, it is not the reason for this document to distinguish the nature and origin of the condition of transsexuality, but to tackle in a pragmatic way the different actions which should be guided from the health system to the resolution of the problems inherent from the perspective of the system itself in the management of persons when they demand specific health services.

6.1.2. INCIDENCE AND PREVALENCE

There are no specific and formal studies on the incidence and prevalence of transsexuality and evidently even fewer on non-conventional gender behaviours, in general, either because they have not been carried out, or because the efforts to reach realistic estimates are loaded with enormous difficulties⁷. Although the existing studies of prevalence established that there existed a similar proportion of transsexual persons, it is plausible that the cultural differences from one country to another would alter both the expressions and behavioural manifestations of different gender identities and the extent in which felt or perceived sex - as distinct from that biologically assigned - is really present in a population. Even if in the majority of countries, crossing the normative gender limit generates moral censure instead of understanding, there are examples in certain cultures of non-conformist gender behaviour (for example, in spiritual leaders) which are less stigmatised or even venerated in some cases⁸.

A recent systematic revision and meta-analysis of studies on prevalence of transsexuality concluded that throughout the last 50 years there have been different estimates of the prevalence of transsexuality with a wide variety in the estimates due to or partly explained by the methodology employed, the diagnostic classification employed and the year in the country in which the studies were carried out. The prevalence determined in the meta-analysis of 12 studies was 4.6 in every 100,000 individuals, with 6.8 in the case of transsexual women and 2.6 in transsexual men. The temporal analysis of the data

⁶ Saraswat et al, 2015

⁷ Institute of Medicine, 2011; Zucker y Lawrence, 2009

⁸ Besnier, 1994; Bolin, 1988; Chinas, 1995; Coleman, Colgan, y Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, y Dumronggittigule, 1997

determined an increase in informed prevalence over time⁹. The authors themselves state that although the last few years have been more realistic estimates of transsexuality, the majority of them still suffer from methodological faults and are circumscribed to the approximation studies from the perspective of the health system and not from that of the general population. In fact, with reference to the population between 2 and 16 years old, the Chrysallis Euskal Herria association reports that, caring for minors whose families are in said association, the rate of prevalence of minors in the situation of transsexuality is quite a lot higher in the Basque Country than Navarre. In the case of Navarre with the Association's minors who have already carried out transition, the rate is over 1/10,000.

⁹ Arcelus et al, 2015

6.2. OBJECTIVES

The objectives of this work are:

GENERAL OBJECTIVE

To establish a comprehensive framework of action from the Health System of the Basque Country at the service of transsexual persons who require the participation of the health system.

SPECIFIC OBJECTIVES

To establish the practice guidelines and recommendations which are going to be implemented at different levels of care.

Paediatric age:

- To draw up recommendations and circuits for the identification of cases and their differential handling.
- To draw up recommendations for the psychiatric and psychological assessment and, if necessary, psycho-emotional support and/or psychiatric care.
- To draw up recommendations for the endocrinological assessment and, if necessary, hormonal treatment.

Adult age:

- To draw up recommendations and circuits for the identification of cases and their differential handling.
- To draw up recommendations for the psychiatric and psychological assessment and, if necessary, psycho-emotional support and/or psychiatric care.
- To draw up recommendations for the endocrinological assessment and, if necessary, hormonal treatment.
- To draw up recommendations for the surgical assessment and, if necessary, surgical intervention.

6.3. METHODOLOGY

6.3.1. DEFINITION OF QUESTIONS. PICO FORMAT (PATIENTS, INTERVENTION, COMPARISON AND RESULTS)

The formulation of the questions was carried out by the clinical group with the help of the methodology coordinator. Initially the questions were formulated in generic language to be transformed into the PICO question format, the sections in which the questions were divided corresponded to those of the structure in this document.

To advance from a generic clinical question to one formulated specifically with the PICO method, the following components should be taken into account:

- **Patient/person:** age groups, state of the disease (in this case not a disease but a condition), concurrent disorders, etc.
- **Intervention:** technique, device, pharmaceutical, procedure or form of action, prognostic factor, aetiological agent, diagnostic tests, etc.
- **Comparison:** refers to the alternative to the studied intervention, such as: habitual or placebo treatment, absence of a risk factor, absence of aetiological agent, gold standard or reference standard of a diagnostic test, etc.
- **Results (outcomes):** clinically important variables of the result in the case of studies on efficacy, prognosis or aetiology, and estimators of performance or validity.

They were initially divided according to the field of action: Primary care or Gender Identity Unit (GIU).

Next according to the age of the transsexual person: 1) adult age and 2) paediatric age.

Then the blocks were divided into sub-sections: Paediatric age: a) identification of cases. Psychological assessment and psycho-emotional support; b) endocrinological assessment. Hormonal intervention. Adult age: a) identification of cases. Psychological assessment and psycho-emotional support; b) endocrinological assessment. Hormonal intervention; c) surgical assessment. Surgical intervention.

The **questions** arrived at by the work group were as follows:

HEALTH CARE IN THE FIELD OF PRIMARY CARE

What is the role of paediatrics in primary care?

What is the role of family and community medicine?

GENDER IDENTITY UNITS

What are GIU and what use are they?

How are users received when they go to the GIU?

HEALTH CARE IN THE GIU FOR PERSONS OF PAEDIATRIC AGE

CASE IDENTIFICATION. PSYCHOLOGICAL AND ENDOCRINOLOGICAL ASSESSMENT

How do we identify the transsexual condition in persons of paediatric age?

Is it necessary to have an interview with the child at the initial assessment? And during the monitoring?

How do we identify, from the psychological point of view, persons of paediatric age who can benefit from hormonal intervention?

Form the psychological point of view, how is the beginning of hormonal treatment handled in persons of paediatric age?

Is it advisable to carry out social transition at paediatric age?

ENDOCRINOLOGICAL ASSESSMENT. HORMONAL INTERVENTION

What is the medical study that is recommended to carry out before beginning hormonal intervention in persons of paediatric age?

In what situations is hormonal intervention not advised?

What are the objectives of hormonal intervention?

wWhat pharmaceutical products are used in hormonal intervention in transsexual persons of paediatric age? Are they safe? Is there effect reversible or irreversible? What risks/side effects are there?

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HEALTH CARE IN THE GIU FOR ADULT PERSONS

CASE IDENTIFICATION. PSYCHOLOGICAL AND ENDOCRINOLOGICAL ASSESSMENT

How do we identify the transsexual condition in adult persons?

What type of psychological assessment is recommended?

How do we identify, from the psychological point of view, persons who should be referred towards endocrinological assessment?

How do we identify, from the psychological point of view, persons who should be referred towards endocrinological assessment?

ENDOCRINOLOGICAL ASSESSMENT. HORMONAL INTERVENTION

What is the medical study that is recommended to be carried out before beginning hormonal intervention?

In what situations is hormonal intervention not advised?

What are the objectives of hormonal intervention?

What is the most appropriate hormonal intervention in the case of transsexual women? What benefits, risks/side effects are there?

What is the most appropriate hormonal intervention in the case of transsexual men? What benefits, risks/side effects are there?

What is the recommended monitoring plan after beginning hormonal intervention?

SURGICAL ASSESSMENT. SURGICAL INTERVENTION

What is the medical study that is recommended to carry out before beginning surgical intervention?

In what situations is surgical intervention not advised?

What are the objectives of surgical intervention?

What is the most appropriate surgical intervention in the case of transsexual women? What benefits, risks/side effects are there?

What is the most appropriate surgical intervention in the case of transsexual men? What benefits, risks/side effects are there?

6.3.2. INCLUSION AND EXCLUSION CRITERIA

A pragmatic information search centred on systematic revisions, clinical practice guides and consensus documents with explicit methodology was carried out.

Non-explicit consensus documents, low-quality systematic revisions and individual studies were ruled out.

6.3.3. INFORMATION SEARCH

The information search was carried out in the following databases: Medline, Embase, National Guidelines ClearingHouse, Cochrane database of Systematic Reviews, CRD (INA-HTA, NHS EED and DARE).

6.3.4. CRITICAL READING

To conduct the critical reading, the FLC Critical Reading platform of Osteba, Department of Health of the Basque Government was used. <http://www.lecturacritica.com/es/>.

6.3.5. DRAWING-UP OF RECOMMENDATIONS

Recommendations are drawn up by the group with the help of the methodological coordinator following the SIGN method. Scottish Intercollegiate Guidelines Network. <http://www.sign.ac.uk>

6.4. HEALTH CARE IN THE FIELD OF PRIMARY CARE

Primary health care is the entrance door to the public health system and as such is involved in all processes related to health and quality of life of persons. The **Primary Care and Family Doctor paediatrician is key** in comprehensive care for the persons in their field of influence. Their privileged position, accessibility and global proximity in the direct treatment from birth until death facilitates the perception and communication of worries of those affected and family members in all areas of development.

The primary care team has the objective of individualised comprehensive care of the person in a situation of transsexuality or with expressions of diverse gender before all the care demands that occur related to the process, which do not require assessment at other levels of care, in addition to being in charge of all preventive measures that may be required over time for improving their health in general.

It is through the arranged visits and spontaneous appointments that arise over time that a **relationship of bilateral trust** between primary care providers and their patients is forged, placing the figures of the doctor and primary care nurse in a strategic position for the early detection of health needs.

Because transsexuality is increasingly emerging phenomenon, primary care staff should have a fundamental role in the coordination and continuity of care to the person with this condition, so they will need to have the knowledge and skills suitable to be able to provide any person who requests it with the necessary information regarding issues of sexual identity and diversity of gender expression.

Health needs linked to transsexuality are dynamic and changing and all professionals involved in their care, especially primary care professionals, must **be sensitive to the needs covered and those which remain to be covered**, with assessment of the social, cultural and family environment in each case being especially important. **Training and updating** of all professionals is fundamental in the field of sexual diversity in order to achieve the comprehensive and high quality care which allows full personal development regardless of the conditions possessed by the persons we attend.

Recommendation

Training and updating of professionals Primary Care in the field of sexual diversity is recommended so that they can carry out with competence the role of coordination of specialised social, educational and health agents involved in providing care for transsexual persons, as well as providing guidance and support for them over time.

6.4.1. PAEDIATRIC PRIMARY CARE

What is the role of paediatrics in primary care?

Healthy Child Programmes (HCP) are aimed at monitoring and promoting of the health of minors under 14 years of age through activities including health education, conducting preventive work, screening and early detection of certain diseases and promoting self-care and autonomy.

The Primary Care Paediatrician (PCP) is in a crucial situation for detecting a minor in a situation of transsexuality, often being the first point of contact with the health services. It is therefore essential that the PCP is equipped with basic knowledge of how the sexual identity of human beings develops.

The identity can only be recognised and expressed by the person themselves when a certain psycho-cognitive development is achieved, and this moment varies from individual to individual. Usually, from 2-3 years of age onwards, with the acquisition of a language, minors begin to refer to themselves as a boy ("I am a boy") or a girl ("I am a girl"). These expressions will become increasingly evident and will settle over time on one way or the other if we let them express themselves without external constraints.

In transsexual minors, the core symptom is the feeling of belonging to a sex that does not correspond to the one that was assigned to them at birth based on their external genitals. This phenomenon, per se, is not a condition, but a fact of sexual diversity that will require comprehensive social, educational care, and in the majority of cases, although it is not a disease, it also require health care.

In these cases the role of the PCP is to transmit to families that what really matters is not to decide imminently "what sex they are," but to listen to the child's felt identity, respect it and make them feel accepted and loved and thus allow the free development of a full personality, avoiding feelings of rejection, anxiety or isolation.

The initial work of the PCP is to differentiate for the minor in probable situation of transsexuality between the so-called non-normative gender behaviour or non-normative roles, that is, behaviour that is culturally associated with being a boy or a girl, a man or a woman. For example: boys who prefer playing with dolls, dressing up as princesses, girls who play at fighting or football...

The recommended approach is to observe, given that the appearance of a behaviour of non-normative gender, not associated in time with a feeling of discrepancy between felt sex and the sex assigned at birth should not be interpreted as a sign of suspicion of a minor in a situation of transsexuality and it should be explained as such to their parents by providing information and support if necessary.

It is advisable to discriminate correctly from the beginning between minors in situation of transsexuality and minors with other types of symptomatology, above all those, much

more frequent, non-normative gender behaviours; but also other processes which will require Specialised Attention in the Gender Identity Unit. The best guarantee for good practice is to listen to the girl or boy tell the story in their own free expression of what they are experiencing and feeling with regard to their own sexual identity.

The PCP can witness events that help them intuit that they find themselves before the possibility of a boy or girl in a situation of transsexuality. All of these are all data that could appear and that should place the PCP on alert and assess in each case referral to the Gender Identity Unit of reference (GIU Cruces Hospital). Some frequent characteristics are:

- That the minor refers to him or herself in a clear and sustained manner as a boy or girl: “I’m a boy”, “I’m a girl” in discrepancy with the sex assigned to them at birth.
- That they ask others to address them as feminine or masculine in discrepancy with the sex assigned to them at birth.
- That they have thought of a name corresponding to the felt sex.
- That they show discomfort with regard to their genitals.
- That later on, above all at the beginning of puberty, symptoms of discomfort appear or increase, anxiety and sadness regarding the changes taking place in their body with the first signs of secondary sexual development.
- That during adolescence, a period that can be shared with the primary care family doctors (PCD), there are data advising of a greater risk of depression, including suicidal ideation. The family and social atmosphere in which they are immersed has a fundamental influence as well as the difficulties to find themselves and accept themselves. All of this makes reference to the seriousness of the component of discomfort that accompanies in this case the pure condition of transsexuality.

It is advisable to refer to the GIU in the following cases:

- Prepubescent or pubescent boys whose sexual identity does not coincide with that assigned to them at birth and who show, either on the part of the minor or their family, the desire for a specialised assessment. Fundamentally if there are added symptoms of anxiety, depression, suicidal ideation, conflicts with peers (bullying) or with parents.
- Peripubescent children who have not previously needed an assessment in the GIU due to the absence of discomfort and evidence of appropriate family and social acceptance, who request a consultation with the GIU, with the aim of assessing the opportune prescription of medical treatments.
- Parents of children or adolescents who display incomprehension, rejection and/or discomfort with the non-normative gender behaviours of their son or daughter despite a correct intervention from the PCP.

Recomendation

Primary care paediatricians are advised to refer to the Gender Identity Unit minors whose sexual identity does not coincide with the sex assigned at birth, fundamentally if there is a coexistence of added symptoms of anxiety, depression, suicidal ideation, conflicts in relations with peers (bullying) or with parents.

In any case, before puberty, the work to carry out with girls and boys in situation of transsexuality should have its centre of gravity in primary care, because in principle at these ages there is no need for specialised health intervention, but rather guidance, especially for their parents, helping them to understand the reality of their sons or daughters. However, it is advisable to report and maintain a link, although not one-to-one, with the child endocrinologist of the GIU, to plan ahead the possible necessary medical interventions.

Once faced with a case of a transsexual boy or girl, the PCP can adopt a series of measures and specific care which will be mutually agreed in advance. Thus it is important to address him or her by their felt identity, to agree a name to do so if he or she so desires, pay attention to language and the necessary physical explorations, ensuring a safe and private environment both in spontaneous consultations and health checks.

The desired information will be given to the father and mother at the same time, whenever possible, in a place that guarantees privacy and ensuring that the necessary time is available for attention in each case. The maximum care will be taken with the language used, trying to keep it clear, respectful, comprehensible and appropriate to the emotional and cultural situation of the family, guaranteeing the maximum receptivity and comprehension of the parents.

At the same time it is important for the PCP to be familiar with and offer information regarding the available specialised care resources, as well as those at social level, family support associations, which allow families who so wish to share reflections and strategies, and the possibilities within the educational environment which facilitate the normalisation of the process (Berdindu).

The PCP, whenever possible and with the prior consent of the boy or girl and their family, should establish regular two-way communication with the school, possibly with the need for meetings in person with tutors and guides, in which knowledge of the perceived possible difficulties is widened, and also with local social services with the sole objective of providing the necessary care for the full development of the transsexual person, optimising their psychological transition and boosting their social acceptance.

On the other hand, when aged 14 and about to transfer to family medicine, also with prior consent, the PCP will inform the corresponding PCD of the personal and family situation of the minor, passing on as far as possible their individual preferences, needs and circumstances, thus promoting comprehensive care and the necessary training to promote knowledge, understanding and care of the person in situation of transsexuality.

Guidance will be the corner stone during the early phases of care of minors in situation of transsexuality and their families. Those responsible for the upbringing are not the cause of the sexual identity of the person, however, feelings of guilt, obstinacy, prejudice and fear can prevent it being expressed in a natural way. For this reason, among others, paediatricians are very important in the role of empathic support and guide during the whole process of acceptance of the condition of transsexuality.

Recomendation

Primary care paediatricians play a crucial role in the detection of boys and girls in situation of transsexuality, as well as in the guidance and help for parents in understanding the reality of their sons and daughters, especially before they reach puberty.

6.4.2. FAMILY AND COMMUNITY MEDICINE

What is the role of family and community medicine?

The collective of **adolescents**, users of our consultancies, is that aged between 14 and 21, although we refer to the preadolescent or puberal stage as that between 10 and 15, the time at which the hormonal awakening takes place and where many changes in physical appearance take place (secondary sexual characteristics) and affective-behavioural changes which mark their future evolution.

Said changes cause self-alienation in the adolescent, who does not recognise their body, which does not feel like part of themselves, with the possibility of rejecting it if they do not identify with it. Their ideas and values change as a product of the emotional immaturity and instability which characterises this stage. That is why adolescence is a decisive moment where there are frequent crises of identity. The adolescent is a subject in development immersed in a changing and unstable universe, so it is necessary to discern with the most objective criteria possible what exactly they demand and if that demand has to do with their sexual identity or rather with the process of reaffirmation of their own personality that is typical for the age at which they find themselves.

Usually they come accompanied by a family member, father, mother or the legal guardian responsible for their care. The parents may adopt disparate attitudes to the transsexuality of their children, trying to take back control of the situation, sometimes with excessive protectionism, because they identify discriminatory positions in their most immediate social environment (school, friends...) For this reason they display urgency in solving “the problem” they see and feel that it is getting out of their hands. On other occasions, the attitude is one of denial, rejection or indifference. In either case they will need information and perhaps psychological help.

It has already been said that the only way of identifying transsexuality is through the story told by the subject about their own identity. Therefore, in the consultancy, we

should listen to the adolescent empathically, without judgement, without pathologising, respecting their privacy when it comes to carrying out clinical explorations and always with their consent.

It would be advisable to address them using their surname or the name with which they identify and to make the parents see that family support and understanding are fundamental, because there could be cases of school bullying where the experiences can become unbearable and there is a significant reduction in the quality of the parent-child relationship. Above all, it is necessary to free the parents from any breakout of guilt with regard to the feelings of identity of their children.

Therefore, the mission of family doctors will be to attend to all these demands with respect and consideration, supporting, advising and guiding at all times and alleviating the discomfort of the patient, should there be any, aside from the intervention of other specialists.

As health intervention is multidisciplinary and multidimensional, when we detect a case of these characteristics the patient is referred to the GIU of the Cruces University Hospital for more specific individual health care, maintaining the interrelationship constantly throughout the process. There is also the possibility of communicating with the reference Mental Health Centre if we have any doubts about the case we are dealing with or if we observe any concurrent pathology that needs to be stabilised.

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The mission of family doctors will be to attend to adolescents and adults in with respect and consideration , supporting, advising and guiding them at all times and alleviating their discomfort, should there be any, in addition to the intervention of other GIU specialists with whom it is recommended to maintain fluid communications.

6.5. GENDER IDENTITY UNITS

What are GIU and what use are they?

This is the name that has been adopted throughout the National Health Service by the health units that care for persons in situation of transsexuality, although it would be more appropriate to call them units of health care for transsexuality (for conceptual coherence, because transsexuality is not a question of gender but sex identity).

The care units aim to cover the health management of persons who because of the characteristics of the condition to be handled, the needs of said persons, low prevalence-incidence in a specific geographical environment, the complexity of the coordination of services or the high degree of specialisation of the professionals and the care to be carried out, require a differential development of care elements on top of the base of the aforementioned justification.

The function of the centres or units of reference for the health care of transsexuality consist in identifying or verifying the condition of transsexuality and the comprehensive guidance and treatment of the person by a specialised team. The justification of the implementation of the functional unit is based on two specific parameters, the prevalence and incidence of the condition and the specialisation and coordination inter and intra levels required.

The process followed in the handling of transsexual persons from the point of view of health consists of managing comprehensively the different actions that are derived from the need of each person and that cover psychological guidance, evaluation and the endocrinological support treatment and finally, in the cases where it is considered plausible and the person so request it, surgical intervention. We can summarise it in four sentences:

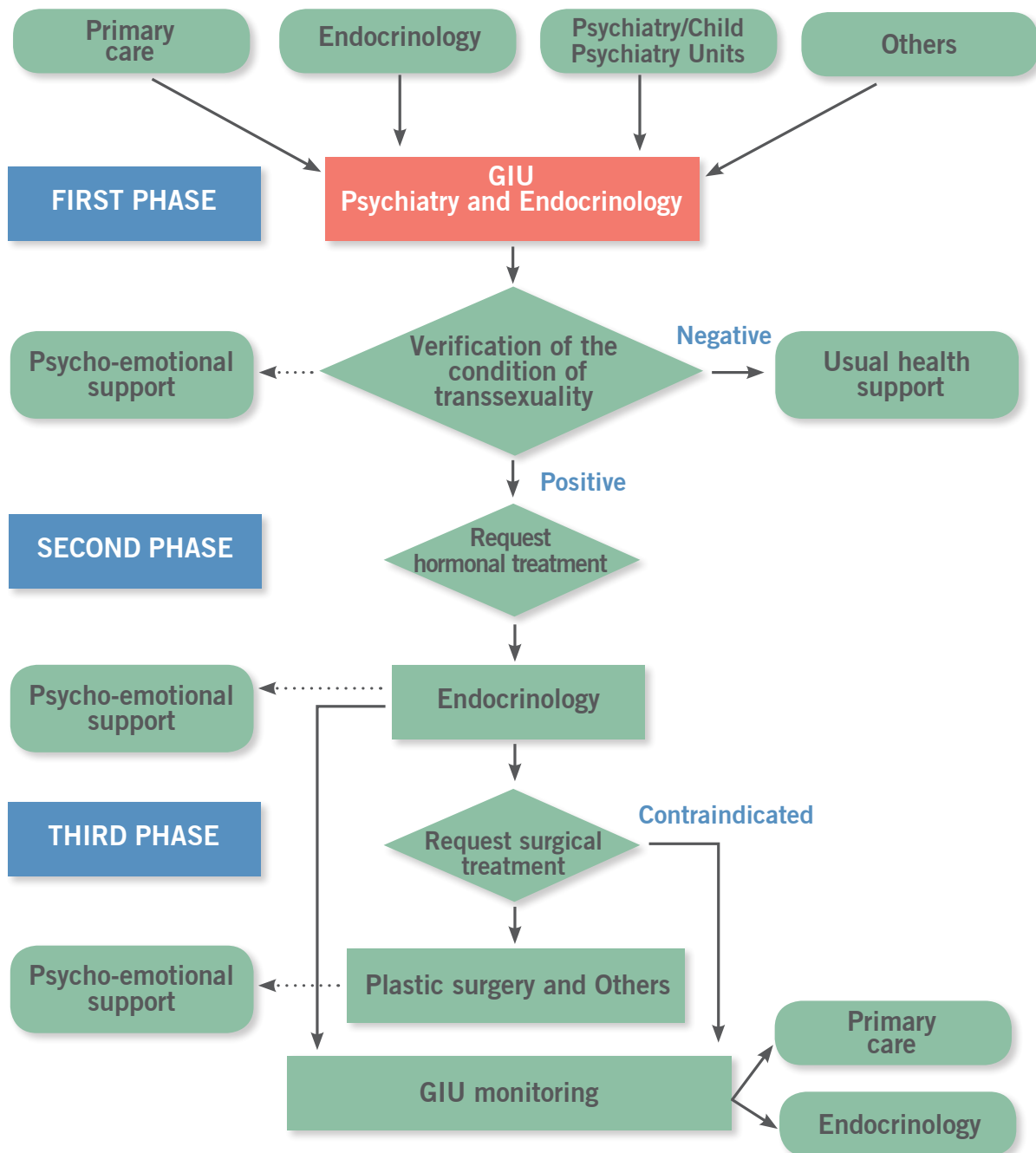
1. Case identification.
2. Psychopathological assessment and, if necessary, psychiatric-psychological support and psycho-emotional support treatment.
3. Endocrinological assessment and treatment.
4. Surgical assessment and treatment.

The GIU of Cruces University Hospital

In 2009, Osakidetza created a unit of reference of Gender Identity (GIU) for the whole of the Autonomous Community of the Basque Country located at Cruces Hospital, to cover the health needs of transsexual persons, with a multidisciplinary composition: Psychiatry, Psychology, Endocrinology, Plastic and Reconstructive Surgery, without prejudice that together and depending on the cases to be handles (personalised management), other types of specialisations will be incorporated into the team, such as: Dermatology,

Gynaecology, Urology, Internal Medicine, ENT (Otolaryngology) rehabilitation. In 2013 representatives of Paediatric Endocrinology and Psychiatry were incorporated.

From its creation up until the end of 2015 it has treated more than 150 persons in situation of transsexuality, whether for hormonal or surgical treatments. The general functioning can be represented with the following flow diagram:



- According to the age and puberal development circumstances of persons, the assessment and monitoring will be carried out by paediatric or adult specialists.
- Not everyone has to go through all the phases.
- The third phase is only applicable to adults.

How are users received when they go to the GIU?

Depending on the origin of the referral of the person (family doctor, paediatrician, endocrinologist of health centre or other hospital, mental health module or others) and the degree of social and health evolution of the process of change in their sexual identity, they will be given an appointment in the first instance with one specialist or another of the GIU itself.

The psychology and psychiatrist professionals and endocrinologist of the GIU are those responsible for the reception of the person demanding attention and their families (should the case require it), explaining the functioning of the unit.

Recomendation

It is recommended that the reception of these persons is carried out by the first GIU specialist with whom they have an appointment, making it clear from the beginning that they are being cared for from the GIU and not from the Psychiatry or Endocrinology Service of the hospital.

The persons who arrive at the GIU could have previously had different social and/or health trajectories in their biographical process in relation to their sexual identity, in duration as well as intensity. This will condition and determine the number and type of actions to be carried out in the GIU.

Meanwhile, persons can come to the GIU to have their condition of transsexuality certified (as provided for in Law 14/2012) and/or directly demanding some medical or surgical treatment. In the latter case, they will be informed that it is necessary for this to carry out a verification of the condition (even having a medical certificate from another service, unit or doctor) and a screening of possible associated or concurrent pathologies, which includes a endocrinological assessment as well as psychopathological. All that to guarantee, as far as possible, the clinical safety of persons subjected to medical and/or surgical treatments.

Likewise, in the reception session, they will be informed that during the time of caring for the persons in the GIU, in any phase of the process, they and/or their families will be able to demand psycho-emotional support on the part of the GIU psychologists, or, should it be required, on the part of psychiatrists. Also the rest of the GIU professionals will be able to apply for these supports for transsexual persons when they consider it opportune.

Recomendation

The identification of the condition of transsexuality (according to that provided for in Law 14/2012) shall be carried out either inside or outside the GIU. Access to any required medical or surgical treatment will require in all cases the verification of the condition of transsexuality and the screening of possible associated or concurrent pathologies, which includes a endocrinological assessment as well as psychopathological.

6.5.1. HEALTH CARE IN THE GIU FOR PERSONS OF PAEDIATRIC AGE

- **CASE IDENTIFICATION. ENDOCRINOLOGICAL AND PSYCHOLOGICAL ASSESSMENT AND THERAPEUTIC SUPPORT**

We should take into account that the sexual identity and expressions of gender form part of the personality and this is a dynamic system which develops in reciprocal relationship with the medium and includes at the same time dispositional, cultural and socio-historical factors.

Some studies have described differences in the proportion of children and adolescents who persist in adult age as transsexual or transgender persons. They state that persistence of transsexuality in adult age is the majority in the case of adolescents, with lower proportion of those in childhood. Meanwhile, the presentation of non-normative behaviours in paediatric age varies between 6 and 23% of cases¹⁰. This means that many of these studies on persistence are really presenting data on the correct or incorrect identification of prepuberal cases, rather than about the persistence or not of the sexual identity in adult age. In any case, in health care prepuberal boys and girls in situation of transsexuality do not take any irreversible therapeutic decisions, something which can occur in adolescence, where the persistence of the condition in adult is, according to these studies, generalised.

How do we identify the transsexual condition in persons of paediatric age?

The discrepancy between the felt sex and that assigned at birth is the central component of the process of identification of the condition of transsexuality. **The condition of transsexuality is identified via active listening to the story of the person expressing their own sexual identity. There is no objective medical proof that determines this condition. Therefore, it is fundamental to ensure that the story is authentic and not conditioned by external agents (socio-family) or internal agents (psychopathology).** For this reason, it is also necessary to analyse and screen possible (although rare) psychopathological processes which can alter or distort that story (for example personality disorders named by Law 14/2012).

The screening of mental illness or disorder is necessary to carry out for two reasons: to authenticate that the person's story is not conditioned by possible pathologies and, should they be detected, to treat them. Making a psychopathological assessment does not, therefore, mean considering transsexuality as a psychopathological fact in itself.

But in the majority of cases, the main differentiation corresponds to the so-called "non-normative gender behaviours". Expressions of the type "I'm a boy" or "I'm a girl" tell us that we are before a boy or girl who clearly expresses their condition of transsexuality.

¹⁰ Cohen-Kettenis, 2001; Zucker y Bradlet, 1995

However, the expression “I want to be a boy” or “I want to be a girl” makes us tend to think about discriminating a non-normative gender behaviour. Although at times things are not so simple, sometimes the persistent denial on the part of others of their own identity and the denial of the possibility of transsexuality can lead the subject to have difficulties in expressing their own identity clearly. That is why, in addition to active listening and without prejudice, it will be fundamental to make possible the expression of their own identity authentically and without conditions.

The symptomatology compatible with transsexuality frequently begins at an early age, generally in the child-youth population¹¹. In these cases the minor or adolescent shows:

- Perception or conscious, maintained or insistent, of not being the sex they were assigned at birth.
- They may display a more or less severe discomfort before the denial of their identity and the imposition of roles and social manners associated with the sex they were assigned at birth.
- They may display a more or less severe discomfort due to the bodily characteristics associated with the sex they were assigned at birth.
- In addition it is frequent that all that leads to a greater or lesser affective and social repercussion.

The codification of these symptoms, in the present day, until the international classification systems change, is carried out based on the classification systems DSM 5 and ICD 10. This codification is necessary and unavoidable for the correct and safe functioning and use of computer-based medical records. The recently published DSM V appears as Gender dysphoria in children 302.6 (ICD 10: F64.2 WHO). It is necessary to stress that all these systems try to classify groups of symptoms and conditions, not the individuals themselves, although, as we have already said in this guide, we align ourselves with the demand to stop identifying transsexuality as a disorder or disease. Another different thing is the need to codify symptoms and signs, like the “dysphoria”, which means discomfort, so therefore is not a disease, but a symptom and, when it occurs, it is necessary to note it and codify it in the medical records of each person.

In cases in which there is an associated discomfort (what is called in clinical fields gender dysphoria), the intensity and expression of the same depends on the personal biographical process. The expression of discomfort in relation to bodily characteristics is, for example, more frequent and evident in adolescents than in children.

In parallel to these psychological actions, it is worth carrying out complementary tests necessary to rule out possible disorders of sexual differentiation (intersexuality or hermaphroditism).

¹¹ American Psychiatric, 2013, WPATH, 2012

Recomendation

The identification of the condition of transsexuality in childhood is done via active listening or the boy or girl's own story, making possible the expression of their own identity and ensuring that the story is authentic and not conditioned by external agents (social/family) or internal agents (psychopathology). It is an extensive, complex and highly individualised process that is advisable to be carried out in a Gender Identity Unit which includes child psychiatry and psychology professionals, as well as paediatric endocrinology professionals.

Is it necessary to have an interview with the child at the initial assessment? And during the monitoring?

- If it is a pre puberal boy or girl, the initial interview is carried out with the parents/guardians and should they identify a need for psychiatric/psychological care for the child, they will intervene with the minor. If the family so desires, due to geographical proximity, they will be referred to the Child Psychiatry Units of reference and it will always be possible to consult Child Psychiatry through said units or the GIU of Cruces Hospital.
- If the boy or girl is older (in puberty or near puberty), they will be present right from the first interview.

EI The process of identification of the condition of transsexuality depends to a large extent on the information supplied by the transsexual girls and boys themselves and/or by the family and social environment. It is carried out by means of clinical interviews of both parents and children and adolescents by: GIU Psychology and Child Psychiatry. The breadth and intensity of these tests will depend on the consultations and psychological studies which have been able to be carried out on these boys and girls outside the GIU (whether Osakidetza or private) and also the degree of evolution of maturity of the felt identity.

It is relatively common for transsexual boys, girls and adolescents, whose identity is not respected and guided, to have coexisting internalised disorders, such as anxiety and depression¹². And also the prevalence of disorders on the autistic spectrum seems higher in these minors than in the general population (17). However, the great majority of boys, girls and adolescents with transsexuality or with non-normative gender behaviours do not present any serious underlying psychiatric illness, such as psychotic disorders (18).

In the case of not identifying the need for psychiatric/psychological care for the minor, an annual follow-up of the parents will be carried out. Upon arriving at peripuberal age, an assessment of the minor is required if it has not been carried out before.

When on some occasions concomitant psychopathology is diagnosed, the prescribed therapeutic approach should be facilitated in each case and a complementary monitoring, rigorous and continuous, of the minor, and their family, if it is approachable, within a framework of multidisciplinary teams and with a specific protocol.

¹² Eran y Perry, 2001; Yunger et al, 2004; Cohen-Kettenis et al, 2003; Wallien et al, 2007; Zucker et al 2002; de Vries et al, 2011

Recomendation

If it is a pre puberal boy or girl, the initial interview is carried out with the parents/guardians and should they identify a need for psychiatric/psychological care for the child, they will intervene with the minor. If the family so desires, due to geographical proximity, they will be referred to the Child Psychiatry Units of reference and it will always be possible to consult Child Psychiatry through said units or the GIU of Cruces Hospital.

How do we identify, from the psychological point of view, persons of paediatric age who can benefit from hormonal intervention?

Having identified the condition of transsexuality, and if the minor together with their family demands hormonal intervention, the eligibility criteria for starting any hormonal intervention are similar to those of adults, but with additional assessments in adolescents¹³: psychopathological stability (absence of active psychosis, drug consumption, suicide attempts, sociopathies ...) and good social support from their closest environment and all of this by means of a monitoring over time up until the moment considered ideal for endocrinological intervention with drugs.

Guaranteeing psychological and social support can condition the development of family psychotherapy and guidance for the parents to face decision making, so the time need to work on it can vary. With the aim of creating realistic expectations with regard to the future life of the adolescent, the GIU specialists should make detailed reports on the effects of treatment for fertility and psycho-emotional maturation, the possibilities and limitations of the hormonal therapy and other types of treatments such as psychological interventions¹⁴.

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Recomendation

It is advised that as well as good social support and psycho-emotional support on the part of the Mental Health team, the endocrinology specialists of the GIU should make detailed reports to the minor and their guardians about the effects of the endocrinological treatments, their benefits (real expectations) and risks, as well as about the commitment to carry out established psychological-endocrinological monitoring.

Form the psychological point of view, how is the beginning of hormonal treatment handled in persons of paediatric age?

Psychopathological assessment of the minor is an essential requirement for hormonal intervention, whereas psychotherapy is not, although it is advisable¹⁵. Psychological intervention or psychotherapy is designed to resolve and existing comorbidity and to

¹³ WPATH, 2012

¹⁴ GIDSEEN, 2015; De Vries et al, 2014

¹⁵ WPATH, 2012

reduce the discomfort that the child could, in some cases, experience in relation to their sexual identity.

During childhood, before the onset of puberty, it is not advisable to begin any endocrinological or surgical treatment. Before puberty, once the condition of transsexuality has been identified or verified, it makes sense that all work carried out with these boys and girls is attended to in the area of primary care because, in principle, they do not need any differential health care, what they need is for their parents to be cared for and guided so that they can understand the reality of their children and guide them in their process. (See the section on attention in primary care):

Recomendation

We recommend that the psychological approach should be individualised and comprehensive and take care of:

- *The boy or girl through psychoeducation of transsexuality; psycho-emotional guidance and support; to advise on the start of the social transition if it has not yet occurred; psychotherapy (if necessary) to improve self-esteem and the use of coping strategies for the difficulties concerned.*
- *The family, providing information, strategies of support and to resolve complex situations and guidance during the transition.*
- *Advice for the school.*

Is it advisable to carry out social transition at paediatric age?

Social transition is the name given to the fact that a person whose sex does not coincide with that assigned at birth passes over to living in all areas of life in accordance with their sex, which involves other's changing their viewpoint with regard to recognition and respect for their identity. Being able to have a childhood and adolescence in accordance with one's sexual identity is a fundamental right, expressly recognised in the Law of Legal Protection of the Children and Young People. In fact, the beginning of the social transition of some boys and girls takes place before their first contact with a GIU, because it is not something that can be prescribed by health professionals.

The degree in which families allow their little sons or daughters to carry out a social transition to another gender role is varied. This is a controversial subject, and the opinions expressed by health professionals are divergent¹⁶. The current base of evidence is insufficient to predict the results in the long term of specifying a transition of gender roles in early infancy. The observation of results in boys and girls who completed the social transition at pre puberal age will contribute enormously to future clinical recommendations¹⁷. In the same way, the base of evidence is also insufficient to predict the long term results of postponing the moment of beginning the social transition of gender roles.

¹⁶ Zucker, 2008; Steensma, 2011

¹⁷ WPATH, 2012

Some preliminary studies (“Context of development, psychological adjustment and sexual identity in transsexual minors” by Cruz Flores, 2014) or a recent study by Olson et al. 2016), show that the social transition at paediatric age is usually beneficial, in the short term, for the minor. The Olson study shows that those children in a situation of transsexuality supported by their families and who have made the social transition have very low rates of associated psychopathologies, very similar to the average general population levels and much lower than those who have not made the transition, so that while it is advisable to carry out scientific studies that monitor this phenomenon, both due to the evidence we have, and due to that recognised by the Law on Legal Protection of Children and Young People, it is advisable to accept and respect the sexual identity expressed and guide the minor in what is called the social transition if they so demand.

If when they are received in the GIU a boy or girl has not started the social change of gender role, the mental health professionals can help families make decisions about when to start that process of change. They should provide information and help them to consider the potential benefits and challenges of each option, identifying possible solutions or intermediate proposals. A change back to the gender role corresponding to the sex assigned at birth can be very painful, so much so that the postponement of this second social transition could be forced by the boy or girl¹⁸. For reasons such as these, parents may prefer to take this change of role as an exploration in living in another gender role, rather than as an irreversible situation.

Recomendation

In the case of the social transition not having been started, in the absence of sufficient scientific evidence, it is recommended that the mental health team of the GIU should provide information to help families make decisions about the timing and process of change in the gender role of their sons or daughters. Once the decision is made by the child and his family, the role of health professionals (of the UIG and / or primary care) will accompany them during it.

• ENDOCRINOLOGICAL ASSESSMENT

Transsexual persons or those in the process of identification or verification of the condition at an age lower or equal to 14 years who request it will be cared for in the Paediatric Endocrinology section. Persons older than 16 years will be cared for in the Endocrinology service. In minors of ages between 15 and 16 years old, according to the clinical situation (puberal development, transition to felt sex carried out or not, assessment by the paediatric or adult mental health team, etc.) proposals will be made individually to attend either the paediatric or adult endocrinological service.

¹⁸ Asenjo-Araque et al, 2013

What is the medical study that is recommended to carry out before beginning hormonal intervention in persons of paediatric age?

Current consensus guides recommend making a series of complementary explorations before starting endocrinological treatment which include¹⁹:

- Karyotype.
- Complete blood analysis: complete blood count, blood chemistry, sexual steroids (testosterone or estradiol), gonadotropins (LH and FSH), prolactin, DHEA-S, insulin, phospho-calcium metabolism analysis (calcium, phosphorus, magnesium, FA, Vitamin D and PTH).
- Bone age.
- Densitometry.

During hormonal therapy it is advisable to periodically carry out some complementary studies to objectify the efficacy of the treatment and rule out undesired effects²⁰:

- Six-monthly/annual analysis (HRF, biochemistry, sex steroids, LH, FSH, Insulin, analytical phospho-calcium metabolism). Include study of coagulation in treatment with oestrogens.
- Annual bone age (until reaching the maximum according to the sex).
- Annual densitometry.

Recomendation

Before starting the hormonal therapy of a transsexual minor we recommend carrying out a series of complementary explorations laid out in the current consensuses. Part of these explorations must be repeated periodically during the time the hormone treatment is maintained.

In what situations is hormonal intervention not advised?

If the minor wants hormonal intervention there are no absolute contraindications to carrying it out. The additional situations that involve a possible increase in coagulability (drugs, diseases, previous thromboembolic events) and some other serious pathologies, are a relative contraindication for oestrogenic treatment which must be assessed individually.

Recomendation

Hormonal intervention is contraindicated when the condition of transsexuality has not been identified or, if despite being identified, the minor does not wish to be treated.

¹⁹ Wylie C. Hembree 2009

²⁰ Wylie C. Hembree 2009, Johanna Olson MD 2011, Stanley R. Vance 2014

What are the objectives of hormonal intervention?

There are two objectives of hormonal intervention and they are applied sequentially:

- To slow down puberal development in the assigned sex using GnRH analogues.
- To induce the development of secondary sexual characteristics in the felt sex associating sexual hormones (testosterone or oestrogen).

Recomendation

We recommend starting the hormonal intervention when it is required to slow down puberal development in the assigned sex and, later, to induce the development of secondary sexual characteristics in the felt sex.

What pharmaceutical products are used in hormonal intervention in transsexual persons of paediatric age? Are they safe? Is there effect reversible or irreversible? What risks/side effects are there?

Hormonal treatment in transsexual minors consists of two clearly differentiated phases: an initial phase to slow down puberal development using **GnRH analogues** and a later one to induce the development of secondary sexual characteristics with **sexual hormones (testosterone or oestrogens)**²¹.

1. GNRH ANALOGUES

The first phase of hormonal treatment starts with GnRH analogues when the minor reaches puberal development in Tanner phase 2²². This moment is identified by the clinical confirmation of puberal beginning (presence of mammary nodule or testicular volume of 4 ml) accompanied by hormonal levels and bone age in accordance with the same. The family and the minor must be informed of the expectations of this treatment (to slow down the development of secondary sexual characteristics of the assigned sex and the puberal growth spurt), of their reversible effect and of the possible adverse effects that could appear. After understanding and accepting it, they will give their approval by signing the informed consent (parents/guardians and minor if older than 12 years of age)²³.

The drug proposed is Triptorelin (monthly acetate administered intramuscularly at a dose of 60-90 mcg/k, every 28 days). This drug has no remarkable adverse effects²⁴, its efficacy in slowing down puberal development has been widely demonstrated and its effect is reversible²⁵. There are preparations of much longer action but there is much less experience using them.

²¹ Wylie C. Hembree 2009, Johanna Olson MD 2011, Stanley R. Vance 2014

²² Wylie C 2009, Johanna Olson MD 2011, Walter J. 2012, Stanley R 2014

²³ Stanley R. Vance 2014

²⁴ Delemarre-van de Waal HA 2006

²⁵ Wylie C 2009, de Vries AL 2011, Stanley R 2014, Annelou L.C. de Vries. 2014, Stephen M. Rosenthal 2014

The minors will be checked periodically every 4-6 months by the paediatric endocrinology section. The treatment with analogues should be maintained while no other type of intervention is carried out which eliminates endogenous sexual hormones²⁶, which cannot be done before reaching legal age.

The possible adverse effects of this therapy are scarce and slight, and include abdominal pain, nausea, asthenia, erythema or swelling at the injection site, bone and joint pains, headaches, mood swings and hot flashes.

Recomendation

We recommend starting treatment with GnRH analogues in transsexual minors who request it in stage II Tanner, to slow down the development of sexual characteristics in the assigned sex, after having done a thorough analysis from the endocrinological point of view, having reported in detail to the minor and their parents regarding the expected clinical effects and possible adverse effects, and after the completion of an informed consent from.

2. SEXUAL HORMONES

According to the specific situation of each transsexual minor (gender, size, bone age, age at which they have made the transition and emotional situation) the moment to start hormone therapy (oestrogens or testosterone) will be chosen individually, with the consent of the minor/family, the knowledge of the GIU²⁷, and the current recommendations of experts. The current consensus of the American Society of Endocrinology proposes starting this treatment at 16 years of age (Wylie C 2009), but this age is after the normal onset of puberal development for most people, so it should not necessarily be set as the general standard.

The family and the minor must be informed of the expectations of this treatment which include the development of secondary sexual characteristics in the felt sex and its undesired effects, including infertility. They must also be informed of the real options of impeding fertility, should there be any²⁸. The attainable effects of the therapy include)²⁹.

- **Oestrogens:** breast development, increased growth (variable pubertal growth spurt according to bone age) and female disposition of body fat.
- **Testosterone:** increased body hair and male pattern thereof, appearance of facial hair, enlarged clitoris, acne, increased muscularity and male distribution thereof, increased growth (growth spurt according to bone age) and voice change to a deeper tone.

²⁶ Wylie C. Hembree 2009, Stanley R. Vance 2014

²⁷ Johanna Olson MD 2011, Norman P. Spack 2012, Stephen M. Rosenthal 2014, Stanley R 2014

²⁸ Stanley R. Vance 2014

²⁹ Stanley R. Vance 2014

There are various hormonal treatment guidelines³⁰. The minors/families will be informed about them and the advantages and disadvantages of each one of them and an agreed decision will be made on the best option for each minor.

The guidelines proposed to induce puberal development are:

- **Transsexual women:**

- **17-beta-Estradiol orally:** 5 mcg/k/day, increasing the dosage progressively until reaching 20 mcg/k/day 2 years after starting (maximum dose 2 mg/day).
- **Transdermal oestrogen** for two years with progressive dosage.
- **Etinil-Estradiol orally:** 50 ng/k/day, increasing progressively until reaching 150-200 ng/k/day after 2 years' therapy. At the end of puberal development, move on to 17 beta-estradiol.

- **Transsexual men (testosterone esters):**

- **Testosterone cypionate or enanthate:** 50 mg/3-4 weeks until reaching the maximum dosage of 250 mg/3-4 weeks after 2-3 years' therapy.
- Daily **testosterone gel** with progressive dosage for 2 years.

During the therapy the minors attend the service paediatric or adult endocrinology service to assess the efficacy of the treatment, make the necessary dosage adjustments, undergo periodic complementary examinations and to monitor possible adverse effects³¹.

The possible adverse effects derived from the hormonal treatment, as well as infertility, are rare but can appear and some of them can be severe (Table 1).

- **Testosterone:** can cause headaches, fluid retention, arterial hypertension, polycythemia, dyslipidemia, liver disorders, behavioural disorders, increased libido, acne, baldness and hyperprolactinemia. In general they are associated with large doses of testosterone and their appearance can require a decrease in the dosage or even the suspension of treatment.
- **Oestrogens:** Phlebitis, thromboembolism, breast cancer, liver diseases, behavioural disorders, hypertension, dyslipidemias, hyperprolactinemia, nausea, fatigue, anorexia, weight gain, emotional lability, headaches, dizziness and fluid retention.

Recomendation

We recommend informing the transsexual minor and their guardians in detail about the possible adverse events derived from hormonal treatment before starting any action, and the completion of an informed consent.

³⁰ Wylie C. Hembree 2009, Johanna Olson MD 2011

³¹ Wylie C. Hembree 2009, Johanna Olson MD 2011

Recomendation

We recommend carrying out a periodical monitoring of the hormonal therapy from the endocrinological point of view to assess the efficacy of the treatment, make the necessary dosage adjustments, undergo the established periodic complementary examinations and to monitor possible adverse effects..

6.5.2. HEALTH CARE IN THE GIU FOR ADULT PERSONS

- **CASE IDENTIFICATION.
ENDOCRINOLOGICAL AND PSYCHOLOGICAL ASSESSMENT**

How do we identify the transsexual condition in adult persons?

When a doctor of any care level encounters a person who expresses discomfort with the sex they were assigned at birth, and/or expresses that their felt sex does not coincide with that assigned at birth, they can refer the case to the Gender Identity Unit at Cruces University Hospital. Likewise, they should also refer to said GIU persons who request medical (hormonal) and/or surgical treatments and who present a medical certificate accrediting their condition as person in situation of transsexuality (according to the criteria included in Law 14/2012) or, even if they do not have this certificate, they have undergone a journey, more or less long, of social and family transition towards their felt sex, and have also started some kind of medical or surgical treatment.

As stated in the chapter about care for minors, **the condition of transsexuality is identified via active listening to the story of the person expressing their own sexual identity. There is no objective medical proof that determines this condition. Therefore, it is fundamental to ensure that he story is authentic and not conditioned by external agents (socio-family) or internal agents (psychopathology).** For this reason, it is also necessary to analyse and screen possible psychopathological processes which can alter or distort that story (for example personality disorders named by Law 14/2012).

The screening of mental illness or disorder is necessary to carry out for two reasons: to authenticate that the person's story is not conditioned by these possible pathologies and, should they be detected, to treat them. Making a psychopathological assessment does not, therefore, mean considering transsexuality as a psychopathological fact in itself.

This process, which includes the checking and screening of concurrent illnesses, is carried out following the criteria established by the scientific community. "Health professionals should refer to the most up-to-date diagnosis criteria and the appropriate codes to apply them in their areas of professional practice³².

³² The Standards of Care - World Professional Association for Transgender Health 7ª edición, Guía de práctica clínica para la valoración y tratamiento de la transexualidad. Grupo de Identidad y Diferenciación Sexual de la SEEN, 2012

The codification of these processes, in the present day, until the international classification systems change, is carried out based on the classification systems DSM and ICD 10. This codification is necessary and unavoidable for the correct and safe functioning and use of computer-based medical records. This also makes it necessary to codify, in a differentiated manner, the possible associated disorders (discomfort, mood and affective states, or psychopathology where it exists). All these systems try to classify groups of symptoms and conditions, not the individuals themselves. They are support tools for standard identification and classification, internationally accepted, which should be used only for purposes of codification.

Likewise, before, after or in parallel, according to the cases, it is recommended to carry out a hormonal study, and a karyotype if necessary. The objective of these complementary tests is to rule out the presence of hormonal or chromosomal alterations which could condition the symptoms of secondary transsexualism or alterations of sexual differentiation. These tests are not required by Law 14/2012 for the accredited identification of the condition of transsexuality, however, from the clinical point of view and that of the patient's safety, they are necessary

Recomendation

It is advisable to carry out a correct identification or verification of the condition, with proper screening, both psychopathological and endocrinological, as the lack of certainty at this stage may be associated with contradictory and/or harmful actions in subsequent phases and is a negative predictive factor for further developments.

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What type of psychological assessment is recommended?

Psychological assessment is carried out by means of clinical interviews conducted by Mental Health, psychiatry and clinical psychology professionals, in parallel.

These interviews will be conducted individually with the person, as well as with the partner, family members and friends, if possible, to get to know as truthfully as possible the circumstances that surround the person and their environment.

In the clinical interview a complete anamnesis is carried out, collecting data such as, health history, biographical data, appearance and evolution of feeling of sexual identity/gender identity, socio-family history, etc.

In some cases it is advisable to carry out psychometric testing.

The psychological evaluation needs variable time according to the degree of socio-health evolution of the person in relation to the degree of expression of gender identity and understanding of the same on the part of their socio-family environment. If the process is incipient it will require a minimum of between three and six months.

The evaluation should include the following aspects: the expression of sexual identity and associated discomfort (if any), the history and development of feelings of discomfort (if any), impact on mental health of the stigma attached to gender nonconformity, and

the availability of support from family, friends and peers (for example, contact with transsexual individuals or groups). The assessment can give rise to no diagnosis, to a formal diagnosis related to gender dysphoria, and/or other diagnosis which describe aspects of the health of the user and how they fit in psycho-socially³³.

It is also advisable to carry out couple or family interventions when the objective is to optimise social support, fundamentally in those couples and families that do not find it easy to accept transsexuality and display suffering faced with the process.

Recomendation

It is advisable to carry out a psychological assessment complemented with psychopathological screening to broaden the knowledge of the person and to assess possible areas of intervention and health. This assessment will be adapted in its intensity and duration to the degree of evolution and maturation of the person in their condition of transsexuality.

What has come to be called in literature “experience of real life”, that is, social transition, means that the person lives, works and relates to others in activities of their life in accordance with their felt sex in a stable manner. Although the Identity and Sexual Differentiation Group of SEEN (Spanish Association of Endocrinology and Nutrition) (Clinical practice guidelines for the assessment and treatment of transsexuality, 2012) considers it particularly important for the person to have real experience of the role of their felt sex before starting invasive and irreversible treatments, it is not recommended in this guide, necessarily, to carry out what has been called a “test of real life” before starting, at least, one treatment of hormonal change because otherwise we jeopardise the physical and psychological integrity of the person. According to the testimony of transsexual persons themselves, collected and endorsed by Arateko in their report “The situation of transgender and transsexual persons in Euskadi” of 2009, that test is very difficult and painful for persons who go through it without the support of hormone treatment or surgery. Due to the rejection transgression of the established genders provokes in society, the person suffers severe discrimination with the consequent psycho-emotional suffering and, on occasion, it can lead to aggressions, even in their own family environment.

Therefore, the time to begin the social transition should be decided by the person involved and it should never be set as a prior condition for starting hormonal or surgical treatment.

Recomendation

n adults, it is recommended to support each person in their decision to begin the social transition. This social transition should not be demanded as a requirement for the beginning of hormonal or surgical therapies.

³³ Bockting et al., 2006; Lev, 2004, 2009

How do we identify, from the psychological point of view, persons who should be referred towards endocrinological treatment?

1. NECESSARY CRITERIA TO BEGIN HORMONAL THERAPY³⁴

- Identification of the condition of transsexuality carried out by the GIU.
- The person has made progress in the control of the possible problems they have to face with the aim of maintaining or improving (if necessary) a stable mental health.
- To know for sure the effects of the hormones, their benefits (real expectations) and risks, as well as the commitment of the user to carry out the established psychological-endocrinological monitoring.
- No contraindication of the treatment after the review of the requested complementary explorations.

2. ADDITIONAL CRITERIA TO BEGIN HORMONAL THERAPY

- Hormones will be used responsibly, in accordance with the guidelines laid out by the endocrinologist, avoiding self-medication.
- Absence of sociopathies, drug consumption, psychosis, suicide attempts.
- Hormones can be given to persons who request them, independently of whether or not they initially want surgery, if they fulfil the cited criteria.

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Recomendation

The transition to hormone treatment in adults needs to be carried out once the condition has been identified or verified, and they know the benefits and risks of hormone treatment and commit to undergoing monitoring by GIU professionals during the process.

How do we identify, from the psychological point of view, persons who should be referred towards endocrinological assessment?

Some transsexual persons perceive surgery as a necessary process to achieve a fully satisfactory life in the role of their felt sex. The health system, as the system of guarantee, must assert that all the necessary conditions are so that said process is carried out with the greatest guarantees of success, satisfaction and the full awareness of the user of the circumstances that surround the treatment and its possible consequences³⁵.

³⁴ The Standards of Care - World Professional Association for Transgender Health 7ª edición; Guía de práctica clínica para la valoración y tratamiento de la transexualidad. Grupo de Identidad y Diferenciación Sexual de la SEEN, 2012

³⁵ The Standards of Care - World Professional Association for Transgender Health 7ª edición; Guía de práctica clínica para la valoración y tratamiento de la transexualidad. Grupo de Identidad y Diferenciación Sexual de la SEEN, 2012

3. NECESSARY CRITERIA TO BEGIN SURGICAL THERAPY

- Identification of the condition of transsexuality carried out by the GIU.
- The person has made progress in the control of the possible problems they have to face with the aim of maintaining or improving (if necessary) a stable mental health.
- Be older than 18 years of age, in the case of genital surgery.
- To know for sure the effects of the surgery, its benefits (real expectations) and risks, as well as the commitment of the user to carry out the established psychological-surgical monitoring.

Recomendation

Referral for surgical assessment should be made once the person requesting the intervention has carried out the identification of the condition of transsexuality in the GIU and their fulfilment of the other requirements will be analysed individually.

• ENDOCRINOLOGICAL ASSESSMENT. HORMONAL INTERVENTION

What is the medical study that is recommended to carry out before beginning hormonal intervention?

It is necessary that the doctor or endocrinological doctor of the GIU completes a full medical history, with special emphasis on lifestyle habits, family history of malignancies, early cardiovascular disease and thrombotic phenomena, as well as about puberal development and gonadal function. They will also be asked about the use of previous hormonal treatments (name, drug dosage and duration of treatment), and additional studies (if any) conducted in the previous phase or outside the GIU.

A complete physical examination must be carried out, including secondary sexual characteristics (Tanner stages), breast and genital examination, cardiopulmonary auscultation, abdominal examination, blood pressure, anthropometry and bioelectrical impedance analysis, whenever possible.

Also an analytical study must be carried out that includes general biochemistry, liver profile, lipid profile, uric acid, blood count, coagulation, serology (HBV, HCV, HIV, syphilis) and basal hormonal study if not previously done, including FSH, LH, DHEA-s, 17-OH-Progesterone, PRL, TSH, estradiol / testosterone, SHBG. A karyotype will also be requested. In the case of unsupervised hormone treatment, a cleansing period of at least one month must be completed prior to the carrying out of the analyses³⁶.

³⁶ Moreno-Pérez et al 2012

The objective of this exploration and complementary tests, is to rule out hormonal or chromosomal alterations that might affect a secondary transsexualism diagnosis (congenital adrenal hyperplasia, virilising tumour, androgen resistance, chromosomal abnormalities, testicular agenesis or hypogonadism of any kind, etc.) as well as other associated processes that contraindicate hormonal therapy³⁷.

Recomendation

It is recommended that a correct clinical assessment (clinical history and detailed physical examination) and a series of additional tests (including complete blood test, karyotype, serological tests, body composition studies and densitometry) are carried out prior to the start of hormone treatment.

In what situations is hormonal intervention not advised?

In some cases hormone therapy may be contraindicated, temporarily or permanently, by the presence of other concomitant pathologies³⁸:

- Transsexual women: thromboembolic disease, stroke, active liver disease (transaminases more than 3 times the normal upper limit), kidney failure, severe hypertriglyceridemia, morbid obesity, badly controlled diabetes, severe migraines, family history of breast cancer, prolactinoma.
- Transsexual men: active liver disease, kidney failure, ischemic heart disease, severe hypertriglyceridemia, morbid obesity, badly controlled diabetes mellitus.

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Recomendation

It is recommended that the diseases that may be exacerbated by hormonal treatment or are contraindicated are previously assessed at the beginning of treatment.

What are the objectives of hormonal intervention?

Hormonal intervention has two basic objectives³⁹:

- To reduce the concentration of endogenous hormones and therefore the secondary sexual characteristics of the biological sex.
- To reduce endogenous hormones and increase those pertaining to the felt sex using in principle hormonal therapy similar to that of hypogonadal patients.

³⁷ Sanchez Planell et al 1994; Moreno-Pérez et al 2012

³⁸ Harry Benjamin 2011; Moreno-Pérez et al 2012; Moore E et al 2003; Toorians AW et al 2003

³⁹ Levy A et al 2003; Wylie C Hembree et al 2009; Bhasin et al 2006

Before starting treatment patients should be given clear individualised information about the possible benefits and harms of it so as not to create false expectations. The total disappearance of secondary sexual characteristics is not always possible. Genetic inheritance influences the response of target tissues to hormonal therapy, with large interindividual variability, and this effect cannot be overcome by administering supraphysiological dose. The maximum effect in certain aspects may not be revealed until after 2 or 3 years of treatment.

All transgender persons must be informed and advised about fertility options prior to treatment with sex hormones of the desired sex⁴⁰.

In this phase, the transsexual person and the endocrinologist responsible will sign the informed consent in which the indications, contraindications and possible side effects of the treatment are included, as well as the option to not treat, and its consequences.

Recommendation

It is recommended that transgender persons are informed of the objectives, favourable effects and possible side effects of hormone treatment and that they sign, prior to treatment, the informed consent established by the GIU.

It is recommended that transgender persons are informed and advised about fertility options prior to hormone treatment.

What is the most appropriate hormonal intervention in the case of transsexual women? What benefits, risks/side effects are there?

The most effective therapy is the combination of compounds that suppress endogenous androgen production and/or action, along with oestrogen administration for the induction of female secondary sex characteristics. The aim is to eliminate the growth of sexual hair and induce the formation of female breasts and female body fat distribution⁴¹.

Oestrogens

They are preferably administered via oral or transdermally. Intramuscular preparations are not advisable. The proposed treatment guidelines are:

- Valerate of 17 β -estradiol via oral: 2-6 mg/day.
- Transdermal oestrogens: 100 μ g/3-7 days.

Transdermal is the route with fewest thromboembolic effects, so it can be advantageous in older patients⁴².

⁴⁰ Wylie C Hembree et al 2009; Moreno-Pérez et al 2012; Gómez-Gil E et al 2006

⁴¹ Moore et al 2003; Moreno-Pérez et al 2012; Gómez-Gil E et al, 2006; Wylie C Hembree et al 2009

⁴² Asscheman H et al 2011; Toorians AW et al 2003

Before a surgical intervention it is advisable to suspend hormonal treatment during 2-3 weeks due to the thromboembolic risk of immobilisation⁴³. If it is decided to carry out a gonadectomy it will not be necessary to give anti-androgen therapy later on. Oestrogenic treatment has to be maintained at the appropriate dose to avoid clinical hypogonadism and loss of bone mass⁴⁴.

Anti-androgens

The proposed treatment guidelines are⁴⁵:

- Cyproterone acetate: has a double effect, blocks the androgen receptor and inhibits gonadotropic secretion. This is the preparation of choice, at dosage of 50-100 mg/day.
- Flutamide and finasteride: prevents the final action of testosterone⁴⁶, but does not decrease its concentrations, so it should be reserved for cases of cyproterone acetate intolerance.
- GnRH analogues produce a transitory blocking of the production of LH and FSH, diminishing testicular production of testosterone. Due to its high cost and the lack of approval with this indication, its use should be reserved for adolescents, as explained in the corresponding section, and for those persons resistant to anti-androgen preparations.

Estradiol concentrations should be maintained at the normal average values of a premenopausal woman or at the upper limit of the normal follicular phase for each reference laboratory, together with concentrations of testosterone within female limits⁴⁷.

The favourable and unfavourable effects of the treatment are collected in table 1.

Recomendation

We recommend that hormonal treatment is prescribed and monitored by an endocrinologist with experience in the handling of integrated sexual steroids in the GIU.

In the case of transsexual women, it is recommended to start hormonal treatment with oestrogens and anti-androgens. After the gonadectomy, if necessary, it is recommended to maintain only the oestrogen treatment.

It is recommended to consider different types and means of administration of the oestrogens, individualising the most appropriate in each case.

It is recommended to maintain the levels of oestrogens in the normal physiological range of a pre-menopausal woman.

43 Moreno-Pérez et al 2012

44 Ettner 2013

45 Levy et al 2003; Moreno-Pérez O et al 2010; Moreno Pérez et al 2012; Wylie C Hembree et al 2009

46 Dittrich et al 2005

47 Moreno-Pérez et al 2012; Wylie C Hembree et al 2009

What is the most appropriate hormonal intervention in the case of transsexual men? What benefits, risks/side effects are there?

The treatment is based on the use of masculine hormone or testosterone. The objective in this case is to stop menstruation and induce virilisation, including the pattern of sexual hair and a masculine morphotype and hypertrophy of the erectile organ. Hormonal treatment also involves an increase in the muscular mass, a drop in fat mass and an increase in libido⁴⁸. The most widely-used preparations are testosterone esters administered intramuscularly or in gel applied topically. The proposed hormonal treatment guidelines are⁴⁹:

- Testosterone enanthate: 100-250 mg c/2-4 weeks.
- Testosterone undecanoate: 1000 mg im, followed by 1000 mg after 6 weeks and 1000 mg every 12 weeks.
- Testosterone gel: 5-10 g containing 50-100 mg of testosterone applied daily.

The objective is to maintain the concentrations of testosterone within the reference values for the male population (320-1000 ng/dl).

Except in isolated cases, amenorrhea is achieved after 2-3 months of treatment. In a few cases it is necessary to resort to using GnRH analogues or progestagens if menstrual bleeding persists. Androgenic treatment must be stopped after gonadectomy, if it is carried out, to avoid hot flashes and loss of bone mass⁵⁰.

The favourable (desired) and unfavourable effects of the treatment are collected in table 1.

Recomendation

In the case of transgender men, hormonal treatment is recommended with testosterone, which must also be maintained after the gonadectomy, if applicable.

It is recommended to consider different types and means of administration of testosterone, individualising the most appropriate in each case.

It is recommended to maintain the levels of sexual hormones in the normal physiological range of the male sex.

What is the recommended monitoring plan after beginning hormonal intervention?

Transsexual persons should be evaluated in Endocrinology consultations every 3-4 months during the first year of hormone treatment and then every 6-12 months for life⁵¹. Weight,

48 Pérez et al 2012

49 Gooren et al 2008; Moreno-Pérez et al 2012

50 Moreno-Pérez et al 2012

51 Moreno-Pérez et al 2012; Wylie C Hembree et al 2009

blood pressure, blood count, renal and liver function, hydrocarbon metabolism, uric acid, lipid profile and hormones (FSH, LH, estradiol/testosterone) will be monitored. In transsexual women PSA and PRL will also be determined⁵². Also, in all transsexual persons under hormonal treatment the onset of cardiovascular risk factors should be assessed throughout monitoring and, in this case, be treated according to the established clinical practice guidelines⁵³. Following the gonadectomy, it is also necessary to carry out periodic monitoring (every 3-5 years) of bone mineral density⁵⁴.

There are few reported cases of hormone-dependent cancer in transsexual persons, however the probability of occurrence increases with the duration of exposure to hormone treatment and age⁵⁵. There are few reported cases of the appearance of breast cancer in transsexuals.

Some studies suggest that the incidence (in both women and transgender men under crossover hormonal treatment) is no higher than in the general population⁵⁶; however performing regular physical examinations on the part of the transsexual person and the clinician is necessary⁵⁷. There have also been reported isolated cases of prostate cancer in transsexual women with late onset of hormonal treatment, so it is recommended from 50 years old onwards to carry out screening for prostate pathology by among others PSA determination and to evaluate a digital rectal examination according to this⁵⁸.

Recommendation

It is recommended to carry out a close clinical analysis by the Endocrinological specialist if the GIU every 3-4 months during the first year of hormonal treatment and thereafter ever 6-12 months.

It is recommended that transgender persons under hormonal treatment carry out screening for cardiovascular risk factors during monitoring.

Periodic monitoring is recommended (every 3-5 years) of bone mineral density after a gonadectomy.

It is recommended that transsexual men follow the instructions for the general population regarding screening for breast cancer.

It is recommended that transsexual women follow the instructions for the general population regarding prostate cancer screening from the age of 50 onwards.

⁵² Wylie C Hembree et al 2009

⁵³ Hembree et al 2009; American Academy of Family Physicians, 2005; Eyler, 2007; World Health Organization, 2008

⁵⁴ Moreno-Pérez et al 2012

⁵⁵ Mueller et al 2008

⁵⁶ Gooren et al 2013; Brown et al 2015

⁵⁷ Moreno-Pérez et al 2012; Wylie C Hembree et al 2009

⁵⁸ Moreno-Pérez et al 2012; Wylie C Hembree et al 2009; Gooren et al 2014; Trum et al 2015

Table 1. Favourable and unfavourable effects of crossover hormonal treatment

	OESTROGENS AND ANDROGENS	TESTOSTERONE
Favourable	<ul style="list-style-type: none"> - Mammary hyperplasia - Descent of erection, spermatogenesis and testicular volume - Descent of terminal hair - Slight change in voice - Feminine distribution of fat 	<ul style="list-style-type: none"> - Partial mammary atrophy - Secondary amenorrhea - Hypertrophy of erectile organ - Increase in terminal sexual hair - Change in tone of voice - Increase in muscular mass
Unfavourable	<ul style="list-style-type: none"> - Depression - Anomalous descent in libido - Increase in prolactin - Venous thrombosis - Liver failure - Cholelithiasis - Infrequent: breast cancer, prostate cancer 	<ul style="list-style-type: none"> - Aggressive behaviour, psychosis - Anomalous increase in libido - Facial acne - Androgenic alopecia - Endometrial hyperplasia - OSAS - Polycythemia - Liver disease

• **SURGICAL ASSESSMENT. SURGICAL INTERVENTION**

What is the medical study that is recommended to carry out before beginning surgical intervention?

Surgical interventions on secondary sexual characteristics and genitals are usually the last step in the treatment of some of transsexual persons.

While some transsexual persons have a good acceptance of body image, there are cases where genital surgery is essential in the final treatment. In the latter group, the surgical modification of primary and secondary sexual characteristics can help reach greater congruence with sexual identity.

Therefore, an individualised assessment of each case by all members of the GIU in a clinical session is necessary.

As with any surgery, a preoperative study by the anaesthetist is required in which it is confirmed that the patient's health status is optimal to be able to carry out the intervention. This study, as has been stated, is performed by the anaesthetist through a proper anamnesis and physical examination, which are supported by different tests:

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1. Chest x-ray.
 2. Analysis including blood count and coagulation as well as a preoperative biochemical profile.
 3. Electrocardiography.

These tests can be completed with others if deemed appropriate by the anaesthetist performing the preoperative assessment.

This preoperative study determines the anaesthetic risk which is classified by ASA scale which has a validity ranging between 6 and 12 months, depending on said risk.

Recomendation

Complete surgical medical assessment prior to the consideration of a proposal of surgery is recommended.

In what situations is surgical intervention not advised?

As previously stated, only those who show desire to have sex genitals in accordance with their felt sex would benefit from a surgical intervention. To do this, a number of criteria are considered. Without compliance with them surgery would be rejected or postponed until compliance with them is achieved. Said intervention criteria would be:

- Be older than 18 years of age, in the case of genital surgery.
- Knowledge of different types of surgical surgery techniques and the irreversibility of surgery and its limitations, hospitalisation time, possible complications and rehabilitation, with the signing of informed consents.
- Approval from the multidisciplinary unit.

Likewise, the anaesthetic risk associated with the general health of the person may contraindicate surgery; at least until the general health of the patient improves in cases where this is possible.

All this information must be provided in writing and in clear language, and must be considered prior to the intervention, so that doubts can be assuaged and the person can sign the consent adequately informed.

Recomendation

It is recommended to undergo surgical assessment prior to intervention and to meet a set of criteria for intervention among which are included being of legal age and the knowledge and absorption of the consequences of the intervention.

What are the objectives of surgical intervention?

Surgical intervention allows a modification of the primary and secondary sexual characteristics that make it possible to achieve greater congruence with sexual identity in some persons

Also, surgery aims to achieve the best possible functional result from different points of view:

- Urological.
- Sensitivity.
- Sexual.

In all cases, long-term post-operative monitoring is vital, helping to identify possible post-operative difficulties that may arise and therefore be able to act accordingly. In short, monitoring the person helps improve the quality of the surgical outcome.

Recomendation

It is recommended to carry out long-term post-operative monitoring that identifies early complications and proposes measures to remedy them satisfactorily.

What is the most appropriate surgical intervention in the case of transsexual women? What benefits, risks/side effects are there

Surgical interventions in transsexual women are divided into two groups according to the anatomical region:

- 1. Breast surgery:** breast augmentation with implants or lipofilling.
- 2. Genital surgery:** penectomy, vaginoplasty, clitoroplasty and vulvoplasty.

Breast augmentation is usually performed by breast prosthesis and occasionally by means of lipofilling techniques. In the first case, infection and capsular contracture, although rare, are the most common complications. In the case of lipofilling, fat necrosis and the resulting loss of implanted volume along with infections and hematomas (common to any surgical intervention) are the most probable complications.

Genital surgery on transsexual women includes penectomy, vaginoplasty, clitoroplasty and labiaplasty, by means of the penile skin inversion technique (considered the technical gold standard (Gennaro Selvaggi et al, 2005; Horbach et al, 2015), with erogenous sensitivity as well as the creation of a functional vagina for sexual intercourse and the most acceptable cosmetic result being the main objectives of this surgery. The intestinal vaginoplasty technique may be an alternative.

The most common complications in this surgery are:

1. Partial or complete necrosis of the vagina and labia.
2. Appearance of recto-vaginal fistules.
3. Urethral stricture.
4. Creating vaginas of insufficient length for sexual relations.

It should be noted that a second intervention may be necessary to improve the aesthetic appearance and/or function of the breasts and genitals.

Recomendation

An individualised assessment of genital surgery on transsexual women is recommended.

The surgical procedure of choice in breast augmentation surgery should be performed in an individualised manner and may include lipofilling and breast implants.

The surgical procedure of choice in genital surgery is penile skin inversion. The intestinal vaginoplasty technique may be an alternative.

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What is the most appropriate surgical intervention in the case of transsexual men? What benefits, risks/side effects are there?

As in the previous case, we can split the surgery into two groups, depending on the anatomical region:

1. Mammary surgery: mastectomy.
1. Genital surgery: reconstruction of the pars fixa of the urethra, phalloplasty, vaginectomy, scrotoplasty, and placement of penile and testicular prostheses.

The technique of mastectomy in these persons is conditioned by mammary volume, so a subcutaneous mastectomy can sometimes be sufficient, while in other cases it may be necessary to perform a skin resection and even perform a nipple-areola complex free graft⁵⁹. Therefore, the possible complications include:

1. Necrosis of the nipple-areola complex and/or loss of sensitivity.
2. Irregularities in the surrounding area.
3. Anti-aesthetic scarring.

⁵⁹ Monstrey et al, 2008

Phalloplasty is the main genital procedure in these persons and is accompanied by vaginectomy, scrotoplasty, urethroplasty and placement of penile prosthesis to achieve erection, and testicular prosthesis⁶⁰.

Among phalloplasty techniques, the most common is the creation of a neopenis by means of a forearm free flap⁶¹ based on the radial artery and its concomitant neurovascular pedicle. Its objectives are:

- The creation of an aesthetically acceptable neopenis.
- The possibility of erection, for sexual relations, and tactile and erogenous sensitivity.
- Micturition through the neourethra.

However, these are complex techniques that are not exempt from possible complications and that may require additional interventions to improve the functional and aesthetic result. Among said complications we can emphasise:

1. Urinary stricture and fistules.
2. Partial or complete necrosis of the neopenis.
3. Aesthetic and/or functional results that do not match expectations.

108 **Recomendation**

An individual assessment of genital surgery in transsexual men is recommended. The genital surgical intervention of choice in mastectomy is dependent on breast volume and may include subcutaneous mastectomy, skin resection and nipple-areola complex free graft.

The surgical procedure of choice is the creation of a forearm free flap neopenis.

⁶⁰ Gennaro Selvaggi et al, 2009

⁶¹ Monstrey et al, 2009

6.5.3. SUMMARY OF RECOMMENDATIONS

• HEALTH CARE IN THE FIELD OF PRIMARY CARE

- Training and updating of Primary Care professionals in the field of sexual diversity is recommended so that they can carry out with competence the role of coordination of specialised social, educational and health agents involved in providing care for transsexual persons, as well as providing guidance and support for them over time.
- Primary care paediatricians are advised to refer minors whose sexual identity does not coincide with the sex assigned at birth to the Gender Identity Unit, fundamentally if there is a coexistence of added symptoms of anxiety, depression, suicidal ideation, conflicts in relations with peers (bullying) or with parents.
- Primary care paediatricians play a crucial role in the detection of boys and girls in situation of transsexuality, as well as in the guidance and help for parents in understanding the reality of their sons and daughters, especially before they reach puberty.
- The mission of family doctors will be to attend to adolescents and adults in with respect and consideration, supporting, advising and guiding them at all times and alleviating their discomfort, should there be any, in addition to the intervention of other GIU specialists, with whom it is recommended to maintain fluid communications.

• ENTRANCE DOOR TO THE GIU. RECEPTION OF PERSONS

- It is recommended that the reception of these persons is carried out by the first GIU specialist with whom they have an appointment, making it clear from the beginning that they are being cared for from the GIU and not from the Psychiatry or Endocrinology Service of the hospital.
- The identification of the condition of transsexuality (according to that provided for in Law 14/2012) shall be carried out either inside or outside the GIU. Access to any required medical or surgical treatment will require in all cases the verification of the condition of transsexuality and a differential diagnosis which includes a endocrinological assessment as well as psychopathological.

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Paediatric age

• CASE IDENTIFICATION.

PSYCHOLOGICAL EVALUATION AND THERAPEUTIC SUPPORT

- The identification of the condition of transsexuality in childhood is done via active listening or the boy's or girl's own story, making possible the expression of their own identity and ensuring that the story is authentic and not conditioned by external agents (social/family) or internal agents (psychopathology). It is an extensive, complex and highly individualised process that is advisable to be carried out in a Gender Identity Unit which includes child psychiatry and psychology professionals, as well as paediatric endocrinology professionals.

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- If dealing with a pre-pubescent boy or girl, we recommend the carrying out the initial interview with the parent/guardian and should the need for psychiatric/psychological care for the child be identified, an intervention with the child will take place. If the family so desires, due to geographical proximity, they will be referred to the Child Psychiatry Units of reference and it will always be possible to consult Child Psychiatry through said units or the GIU of Cruces University Hospital)
 - It is advised that as well as good social support and psycho-emotional support on the part of the Mental Health team, the minor and their guardians know for sure the effects of the endocrinological treatments, their benefits (real expectations) and risks, as well as about the commitment to carry out established psychological-endocrinological monitoring.
 - We recommend that the psychological approach should be individualised and comprehensive and take care of:
 - The boy or girl through psychoeducation of transsexuality; psycho-emotional guidance and support; to advise on the start of the social transition if it has not yet occurred; psychotherapy (if necessary) to improve self-esteem and the use of coping strategies for the difficulties concerned.
 - The family, providing information, strategies of support and to resolve complex situations and guidance during the transition.
 - Advice for the school.
 - In the case of the social transition not having been started, in the absence of sufficient scientific evidence, it is recommended that the mental health team of the GIU should provide information to help families make decisions about the timing and process of change in the gender role of their sons or daughters. Once the decision is made by the child and his family, the role of health professionals (of the UIG and / or primary care) will accompany them during it.

• ENDOCRINOLOGICAL ASSESSMENT

- Before starting the hormonal therapy of a transsexual minor we recommend carrying out a series of complementary explorations laid out in the current consensuses. Part of these explorations must be repeated periodically during the time the hormone treatment is maintained.
- Hormonal intervention is contraindicated when the condition of transsexuality has not been identified or, if despite being identified, the minor does not wish to be treated.
- We recommend starting the hormonal intervention when it is required to slow down puberal development in the assigned sex and, later, to induce the development of secondary sexual characteristics in the felt sex.

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- We recommend informing the transsexual minor and their guardians about the possible adverse events derived from hormonal treatment (oestrogens or testosterone) before starting any action, and the completion of an informed consent.
 - We recommend starting treatment with GnRH analogues in transsexual minors who request it in stage II Tanner, to slow down the development of sexual characteristics in the assigned sex, after having carried out a thorough analysis from the endocrinological point of view, having reported in detail to the minor and their parents regarding the expected clinical effects and possible adverse effects, and after the completion of an informed consent form.
 - We recommend carrying out a periodical monitoring of the hormonal therapy (oestrogens or testosterone) from the endocrinological point of view to assess the efficacy of the treatment, make the necessary dosage adjustments, undergo the established periodic complementary examinations and to monitor possible adverse effects.

Adult age

• CASE IDENTIFICATION. ENDOCRINOLOGICAL ASSESSMENT AND PSYCHOLOGICAL AND THERAPEUTIC SUPPORT

- It is advisable to carry out a correct verification of the condition, with proper screening, both psychopathological and endocrinological, as the lack of certainty at this stage may be associated with contradictory and/or harmful actions in subsequent phases and is a negative predictive factor for further developments.
- It is advisable to carry out a psychological assessment complemented with psychometric tests to broaden the knowledge of the person and to assess possible areas of intervention and health. This assessment will be adapted in its intensity and duration to the degree of evolution and maturation of the person in their condition of transsexual.
- In adults, it is recommended to support each person in their decision to begin the social transition. This social transition should not be demanded as a requirement for the beginning of hormonal or surgical therapies.
- The transition to hormone treatment in adults needs to be carried out once the condition has been identified or verified, and they know the benefits and risks of hormone treatment and commit to undergoing monitoring by GIU professionals during the process.
- Referral for surgical assessment should be made once the person requesting the intervention has carried out the identification of the condition of transsexuality in the GIU and their fulfilment of the other requirements will be analysed individually.

• ENDOCRINOLOGICAL ASSESSMENT. HORMONAL INTERVENTION

- It is recommended that a correct clinical assessment (clinical history and detailed physical examination) and the carrying out of additional tests (including complete blood test, karyotype, serological tests, body composition studies and densitometry) are carried out prior to the start of hormone treatment.
- It is recommended that the diseases that may be exacerbated by hormonal treatment or are contraindicated are previously assessed at the beginning of treatment.
- It is recommended that transgender persons are informed of the objectives, favourable effects and possible side effects of hormone treatment and that they sign, prior to treatment, the informed consent established by the GIU.
- It is recommended that transgender persons are informed and advised about fertility options prior to hormone treatment.
- We recommend that hormonal treatment is prescribed and monitored by an endocrinologist with experience in the handling of integrated sexual steroids in the GIU.
- In the case of transsexual women, it is recommended to start hormonal treatment with oestrogens and anti-androgens. After the gonadectomy, if necessary, it is recommended to maintain only the oestrogen treatment.
- It is recommended to consider different types and means of administration of the oestrogens, individualising the most appropriate in each case.
- It is recommended to maintain the levels of oestrogens in the normal physiological range of a pre-menopausal woman.
- In the case of transgender men, hormonal treatment is recommended, which must also be maintained after gonadectomy, if applicable.
- It is recommended to consider different types and means of administration of the testosterone, individualising the most appropriate in each case.
- It is recommended to maintain the levels of sexual hormones in the normal physiological range of the male sex.
- Close clinical-analytical monitoring by the specialist in Endocrinology of the GIU is recommended every 3-4 months during the first year of hormone treatment and then every 6-12 months thereafter.
- It is recommended that transgender persons under hormonal treatment carry out screening for cardiovascular risk factors during monitoring.
- Periodic monitoring is recommended (every 3-5 years) of bone mineral density after a gonadectomy.

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- It is recommended that transsexual persons follow the recommendations for the general population for breast cancer screening.
 - It is recommended that transsexual women follow the recommendations for the general population for prostate cancer screening from the age of 50.

- **SURGICAL ASSESSMENT. SURGICAL INTERVENTION**

- Complete surgical medical assessment prior to the consideration of a proposal of surgery is recommended
- Surgical assessment prior to intervention is recommended, as is meeting a set of criteria for intervention among which are included being of legal age, supervised hormonal therapy and knowledge and absorption of the consequences of the intervention.
- It is recommended to carry out long-term post-operative monitoring that identifies early complications and proposes measures to remedy them satisfactorily.
- An individualised assessment of genital surgery on transsexual women is recommended.
- The surgical procedure of choice in breast augmentation surgery should be performed in an individualised manner and may include lipofilling and breast implants.
- The surgical procedure of choice is the inversion of penile skin. The technique of intestinal vaginoplasty may be an alternative.
- An individual assessment of genital surgery in transsexual men is recommended.
- The surgical procedure of choice is dependent in the mastectomy is dependent on breast volume and may include subcutaneous mastectomy, skin resection and nipple-areola complex free graft.
- The surgical procedure of choice is the creation of a forearm free flap neopenis.

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