Anita Pollard, moderator: Okay, it affords me great pleasure to introduce today's speaker in the person of Dr. Donald Lewis. Dr. Lewis is a graduate of the Philadelphia College of osteopathic medicine and is board certified in addiction psychiatry. In 2005, Dr. Lewis began his career with the Federal Bureau of Prisons as a staff psychiatrist at the Federal Medical Center in Rochester, Minnesota.

Since January 2009 he has been the chief psychiatrist for the Bureau which serves approximately 220,000 offenders in 118 facilities across the country, to include Hawaii and Puerto Rico. Dr. Lewis is geographically located at the medical center in Rochester, Minnesota. So I will be turning things over to Dr. Lewis for the presentation.

(Slide 1)
Dr. Donald Lewis, presenter: Hello there. Hope everyone can hear me. Hope everyone is having a great day. A little bit about myself. I always like to introduce myself although Anita already did that. I am from Philadelphia, born and raised. I did my medical school there before moving to Rochester, Minnesota just about twelve years ago for a residency at the Mayo Clinic and then fellowship in addiction medicine at the Mayo Clinic as well. And as Anita said, I have been working for the Federal Bureau of Prisons since 2005, first as a staff psychiatrist and then now as chief psychiatrist for the Federal Bureau and I have been in this role for just over three years now.

It is my great pleasure to talk to today on a topic that comes up with greater frequency in a prison setting and that is gender identity disorder. Now, we don't have a huge population by any means, and just within the Federal Bureau of Prisons, we have a little bit over 220,000 inmates. And only seventy-eight of them are identified as having gender identity disorder, but this is a growing issue. And it is also a litigious issue and diagnosis; so it causes a lot of consternation among staff out there. So it is a very important topic to be discussing.

As you probably know, gender identity disorder is difficult to treat. But you put a gender identity disordered patient in the correctional setting, now it's ten times harder. So this talk I'm giving is a pretty general talk about gender identity disorder. It was originally presented as a joint talk between psychology and psychiatry within the Federal Bureau of Prisons about six months ago or so, and it has been modified a number of times since then, and basically every couple of weeks I modify it again to update it with the newest information that's out there. So it is always a work in progress. I imagine it is going to continue that way over the next couple of years as well.

I hope you enjoy this talk, please let me know if you have any questions at the end. You can always use e-mail later, I'll give my e-mail address and that is a great way to reach me as well.

(Slide 2 – Objectives)
So there are many objectives for this talk. Overall we are going to define some of the key terms that are related to GID. We're going to review the diagnostic criteria for gender identity disorder, based on the DSM. We're going to show what the Bureau's new gender identity disorder policy is; that is the Federal Bureau of Prisons policy. We're going to review some of the history of transgender issues and also some of the relevant legal issues that have come up with GID as well.

Then go over the WPATH standards of care, that's the World Professional Association of Transgendered Health and they're the ones that put out the community standards for gender identity disorder. So we will discuss them and how they're applicable within the prison setting as well.

And then review some of the co-occurring disorders that are commonly associated with gender identity disorder. So a lot of stuff to discuss. Overall though it's going to be a pretty general discussion on gender identity disorder—what it is, how we've best identified it and how we can best treat it within the prison setting.

(Slide 3 – Continuing Education)
This is a joint from health and psychology services as it was given to the Bureau.

(Slide 4 – Definitions)
I am going to be giving this talk without psychology services present and you are going to see near the end of the presentation that the slides, the format changes a little bit. You can see which ones are performed by psychology in which ones are done by psychiatry and health services. But, I will be presenting the whole thing today.

We are going to start off with the basics. Definitions: So what is gender? Gender is really a psycho social construct. It's used to classify a human being is a man, woman, both or neither. And it encompasses all the relational aspects of the social identity, the psychological identity and the human behavior. So it is a pretty general topic. Man, woman, both or neither. A lot of people think of man or woman, but gender can encompass much more than that as well.

When we say gender identity, that's a person's sense of their own gender; so it's communicated to others by their gender expression. So gender identity is what one person feels that their gender is. And then they express that into the next term which is called gender expression. That can include how a person…includes their mannerisms, how they wear their clothing, hairstyle, choice of activities, games that they play, etc., makeup or not. How they express their gender is a way to usually identify their gender identity as well. It can be quite complicated for people who are not used to using these terms.

(Slide 5 – Transgendered in History)
For the people that can see the presentation, and for people that can't you can see the slides later, but throughout the slides, I have some famous transgender people throughout history. I would like to talk about this to show that it is not a recent phenomenon. Transgender has been around for a long time, and many people have been suffering with this disorder over the years. So just one person example is Albert Cashier.

He served in the American Civil War and did quite well during the American Civil War, was honored many times. He had a postwar accident. This was a female-to-male transgender born Jennie Hodgers. She wanted to fight in the Civil War, so she did. She dressed up as a man, she acted as a man, she felt she was a man her entire life. After the accident which was postwar, she was placed in a male soldiers' hospital. She fought during the war, and that was the appropriate place for her treatment. She stayed there for many years and the administration and the staff knew

that biologically she was female. But mentally, everything else she was male. So they kept her in the hospital and treated her like all the other soldiers.

Unfortunately, near the end of her life, she started developing Alzheimer's disease and the administration changed and transferred her to a different, a female hospital where she quickly passed away. It was an unfortunate situation, but at that time, it was very confusing for the administration. They didn't really deal with many gender identity disorder patients. She was one of the first ones and one of the most famous ones during the American Civil War.

(Slide 6 – Diagnosis)
So back to some definitions: What is gender identity disorder? First, I should really start off by saying that GID or gender identity disorder is somewhat a controversial name. Many people in the transgender community do not accept this title. The word "disorder" in the diagnosis is the key problem. It is called gender identity disorder. Many people with gender identity disorder really do not feel that they have any disorder whatsoever. So there has been a lot of back-and-forth as to how we are going to change the title of this. Are we going to change it to gender dysphoria? Gender incongruence? It hasn't been officially decided yet, but right now gender dysphoria seems to be the prevailing label for this disorder. However, it is very political; it is also an emotional phrase. So just for the sake of simplicity for the rest of this presentation, we will keep using gender identity disorder, although I know that is somewhat offensive to some people in the transgender community. But GID is the official diagnosis in the DSM, the Diagnostic and Statistical Manual. So it's just easier to continue using that, and that's the way it is in our policy at this current time.

So what is GID? It is strong and persistent cross-gender identification. Not merely a desire for or perceived cultural advantages of being the other sex. So a female who perceives and really identifies with the male gender believes that they are male and the opposite male for female. It is not just that he wants the benefits of maybe being female. It is the actual feeling that they are female inside for a male patient. So that is the simplest definition of gender identity disorder.

(Slide 7 – Definition)
For more definitions, and we have just one more slide after this one, but there are a lot of different definitions out there. The word transgender can often be used instead of GID. Many times it is preferred, sometimes it is not. It goes back and forth. Right now transgender is the preferred terminology for patients with gender identity disorder. It is the state of one's gender, not matching one's assigned sex. So it does not imply any form of sexual orientation, and that confuses a lot of people; especially when they don't know much about the LGBT community. But sexual orientation is just the direction of one's sexual interest towards members of the same, opposite or both genders. That's what sexual orientation is. That's their sexual interest. Transgender is their sexual state, their assigned sex and what they feel their sexual identity should be.

(Slide 8 – Definitions)
So to round out the definitions here, these are little bit more common. People have heard of these terms more: heterosexual - person attracted to the opposite sex, homosexual – a person attracted to the same sex, bisexual – both, and asexual – a person not attracted to either sex; so a lot of terminology to get through. We are going to be using GID during the majority of this topic, but some of these other definitions will come into play as well.

(Slide 9 – Transgendered in History)
Probably one of the most famous transgenders in current history is Nong Toom. A famous Thailand boxer, a champion boxer in Thailand born male; felt he was female his entire life and transitioned into female. And if you can see the slides, you can see the picture of his transformation into now he is an actress and a model. And there is a movie called "Beautiful Boxer" out there. It is a fantastic movie based on Nong Toom's transition from male to female.

(Slide 10 – GID)
So the next couple slides are going to be talking about, some of them are little bit more busy, is the DSM, the Diagnostic Statistical Manual definition – the diagnosis, how we classify gender identity disorder. So starting off with children, in children the disturbance as they call it, is manifested by four or more of the following: And they have such instances as repeated stated desire to be the opposite sex or an insistence that he or she is the opposite sex. So in some ways boys will have preference for cross-dressing or simulating female attire; girls will wear stereotypical masculine clothing.

There is persistent preference for cross-sex roles in make-believe fantasies; and then especially in stereotypical games and pastimes as well. Strong preference for playmates of the opposite sex as well. This is a cultural definition and it is something that is changing too. Because what are the stereotypical games and pastimes of the other sex? Well that changes each decade and it is hard to say.

(Slide 11 – GID)
When we get to adolescents and adults, GID according to DSM, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, a desire to live or be treated as the other sex or the conviction that he or she has typical feelings and reactions of the other sex. That is the current adolescent and adult definition for gender identity disorder.

(Slide 12 – GID)
There also has to be, according to the DSM, "a persistent discomfort with his or her sex and a sense of inappropriateness in the gender role of that sex." A little controversial, and I will talk about that a little bit more in a couple of slides.

(Slide 13 – GID)
Back to DSM in children, in boys, a lot of times there will be assertion that the penis or testes are disgusting or hope that they will disappear. There is an aversion towards rough-and-tumble play, etc. Girls, sort of the opposite, sensations and feelings that they have; the assertion that they will or hopefully will grow a penis and the do not want to grow breasts or menstruate.

(Slide 14 – GID)
In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics, so therefore requesting hormones, surgery or other procedures, vocal therapy, etc., to alter sexual characteristics and simulate the other sex. Or a belief that he or she was just born the wrong sex and that seems to be much more common within the transgender community is that belief.

(Slide 15 – GID)
It is not concurrent with a physical intersex condition that has to be ruled out such as medical hermaphrodites or people born with both sets of genitalia.

(Slide 16 – GID)
And then one of the most probably controversial parts of the gender identity disorder diagnosis and DSM is that the disturbance causes clinically significant distress or impairment in social occupational and other important areas of functioning. And when I get to the WPATH standards and talking about their recent changes to the standards of care and definitions for gender identity disorder, we will talk about the DSM a little bit more and some of the problems associated with it in the GID community.

(Slide 17 – Transgendered in History)
Another famous transgender is Lili Elbe. She actually was the first person to have gender reassignment surgery. It was in 1930. She was from Denmark. The surgery was actually performed in Germany. There are a number of fantastic pictures on the Internet that you can see of the transformation of Ms. Elbe. There is a novel out there called "The Danish Girl." I think it was in 2001, so about 10 years ago and it talks about her transformation from male to female, especially during that pivotal time in European history.

(Slide 18 – Duty to Treat)
So why do we talk about and why do we think it is important in the prison setting? Well, I'm going to talk about a couple legal slides here and why we need to be discussing gender identity disorder.

First of all as a federal institution and a prison, we have the duty to treat. We need to provide adequate medical care, just like adequate food and shelter. Withholding medical treatment is not unlike an infliction of physical abuse. And this is the National Advisory Commission of Criminal Justice Standards and Goals in 1976, and we have a duty to treat medical illnesses.

(Slide 19 – Supreme Court)
In 1976, this was again established by the Supreme Court. That the inmates have a right to be free of deliberate indifference to their serious healthcare needs. So we have to be treating their medical illnesses while they are in a prison setting. It doesn't matter that they're inmates or wards of the state.

(Slide 20 – Supreme Court)
Also in 1976, Bowering v. Godwin stated there were no underlying differences between the right to medical care for physical ills and its psychological or psychiatric counterpart. So now we have to treat not just medical illnesses, but also psychiatric illnesses that occur for any inmates. I bring this up only because of the question of why do we treat gender identity disorder, comes up all too often in the prison setting. It comes up from other correctional officers, it comes up from wardens at many institutions. Why are we treating this?

The simple answer is we have to. There's a legal mandate from 1976 that we have a duty to treat. Gender identity disorder is listed as a diagnosis in the Diagnostic and Statistical Manual so therefore we need to treat it.

(Slide 21 – GID)
As I stated in the next slide, it is listed as a diagnosis and there have been many court cases reaffirming this, such as Massachusetts and Wisconsin as two states in particular, but California, Washington DC as well, saying that we have to treat gender identity disorder. We do have a duty to treat it.

(Slide 22 – GID)
Plus there are lots of reasons why we should be treating it as well just from a mental health standpoint. If we withhold treatment for gender identity disorder, there are many other symptoms that can occur; and this will come up more in the psychology slides at the end of the presentation. But we're going to have increased anxiety, increased depression can occur. A lot of times, suicidal ideations can occur because we are not addressing GID. And then what we probably fear the most is the self-induced genital mutilations. Which happen,and we have had a number of cases in the Federal Bureau Prisons and they have happened in state prisons as well. And we fear that a lot. People will go to any risk that they can and they'll take a chance because they want to get treatment for their GID. And we don't want to get to that point where they have to do self-induced genital mutilation to get to that.

(Slide 23 – GID)
Why are we reviewing? There is a growing awareness of gender identity disorder in the United States. People are starting to understand transgender and see transgender people a little bit more in media and in the news. So it comes up and there is more awareness of it. Because of that there is probably a growing inmate population. We probably have the same number, but because of the awareness of it, more inmates are able to come forward with gender identity disorder. We have gone up from just about thirty or thirty-five patients two years ago to the seventy-eight that we have now. And that is mostly due to awareness of what GID is and that we can treat it and work with it.

There are also a number of high-profile court cases that seem to get the attention of the media and also get the attention of the prison system as well. Legislative mandates: that is the way that progress is usually made in regards to gender identity disorder. Fortunately or unfortunately, a lot of these cases go to court and it is the court that says you must do this particular treatment and therefore that changes the prison policy. I say that's fortunate and unfortunate, fortunate that it finalizes things and things will start to get done. Unfortunately that things get delayed and have to wait until the point where there is a court mandate to do treatment. But that is the way it has been for a lot of different things just in the systems in general. So we wait for legislative mandate to tell us that we need to provide treatment and then it becomes policy for the prison system.

And then there's an increased risk of sexual assaults and rapes and other problems that we have to worry about with these inmates. So they are under a little bit more caution. We have to watch them a little bit more carefully and make sure that they are safe while they are under our care.

(Slide 24 – GID)
There have been a couple different studies out there, but not a ton of great literature on gender identity disorder treatment in the prison system. California actually has done the best job in studying this. They also have the highest number of GID inmates out of any state. They have

shown that there is a prevalence of sexual assault for these inmates, increased prevalence of undesirable sexual acts, increased use of weapons with these sexual acts performed on these inmates. There is decreased officer awareness of the incidents that happen. Whether that is if they turn a blind eye or not, we don't know. And there is increased risk of self-harm with patients with gender identity disorder when they're in the prison system. So this is something we really need to be paying attention to.

(Slide 25 – Barriers to Treatment)
There are lots of barriers to treatment for these inmates. First of all, sometimes there are just policies forbidding treatment. That is the way the federal system was up until 2009, that there was just a policy saying that we are not going to really treat it or advance it. If there is new policy, providers are not often familiar with treatment protocols - how to treat GID. I get a lot of responses saying I have no expertise in this, therefore I cannot treat this; and that happens many, many times. It is quite frustrating because we're not experts in a whole bunch of different areas but we still treat them; and we have to look up stuff and realize we need to look at the inmate as a patient and treat them appropriately.

There are personal and political objections to care. There is trans-phobia out there and there's a lot of hatred towards the GID inmates. And there's a lot of, "we should not be taking care of these people at all," and again, you have to go back to the duty to treat. We just have to treat all the inmates as individuals and respect them.

And then there are lots of other questions: How do we address the inmate? You know, she, he? What pronouns do you use? Mr. or Mrs.? Do you just say inmate? And then where do you place the inmate if they're along the transition in the continuum of care between male to female let's say. Are they in a male facility? When do you place them in a female facility? Do you wait for surgery, etc.? So, just a lot of angst comes up with gender identity disorder inmates.

(Slide 26 – Standard of Care)
So on to what are the standards of care. There aren't any other standards of care out there except for this one: The World Professional Association for Transgendered Health, WPATH. They used to be a known by the old Benjamin Standards, and now they're called WPATH. They are the only ones preparing standards of care so by default they are the ones that we go to. That's again good and bad.

The good is they really are putting a lot of work into transgendered health and putting together the standards of care for clinicians and for patients. The bad is that they are also an advocacy group. So a lot of times they are biased and they will look towards advancing their cause, sometimes more than helping what is in the best interest of the patient or the facility. We have to think this is a prison setting; we have to do what is in the best interest of the taxpayers and the people at large as well. So good and bad, they are the only ones out there so we should be reviewing the standards and applying them as best we can within the prison setting. They are the gold standard for gender identity disorder treatment at this time.

(Slide 27 – WPATH (old))
Their old standards, which are prior to September of 2011, were based into three stages. The first stage was an evaluation stage. They would come with a correct or formal diagnosis; they would perform individual or group psychotherapy if it was indicated and then education about gender identity disorder. So the first stage is basically evaluation and education.

(Slide 28 – WPATH (old))
In stage two then, they would be referred to a physician for hormone replacement therapy if applicable, that would also be used for confirmation or rejection of the gender identity disorder diagnosis and if needed, they would continue individual or group therapy. So they would be getting hormones most likely in this stage two, and continuing therapy.

(Slide 29 – WPATH (old))
And then this should be stage three or truly stage 2A according to their old policy. It is to monitor the gender role transition, serve as an intermediary in matters that pertain to work and family to try to integrate them as their new gender into their work and their family. And if applicable, then make the referral for gender reassignment surgery, after a minimum of one year living full-time in the preferred gender role.

So, one year of living, if you're female to male, living as a male before the surgery is indicated. Then having the surgery and then doing post-op follow-up as needed and integrating within your work and your family while you are acting in that opposite or preferred gender role. That is the old policy.

(Slide 30 – WPATH (new))
Now in September of 2011, they held their biannual conference in Atlanta and issued new standards of care. So there's a lot of changes with these and I'll go over some of these. They're more clinician focused instead of patient focused. The old standards of care really focused on the patient doing the majority of work. The new standards of care kind of put that onus on the providers, the psychologist, the physicians, the endocrinologist, the psychiatrist etc., to do more of the care and the follow-up instead of the patient.

For the first time they have had references added to the standards of care. That was a complaint that many people had in the past that they had no references, and you could not review the work. So now they have references for the standards of care.

They went over a lot of the name change issues. They put gender dysphoria instead of gender identity disorder, and they talked about how it is controversial. Should we use gender incongruent? Should we use gender dysphoria? Should we use gender identity disorder because that is what is recognized in the DSM? They stuck with just gender dysphoria at this time being for what they want to call the transgender lifestyle.

They removed "real life experience necessary before surgery." I talked about that in the previous slide that there is supposed to be a one year time of living in the preferred gender, especially while integrating with work and family before surgery is indicated. Well that was a big problem for them when it came to a lot of lawsuits, especially in the prison setting. So they removed the "real-life

experience necessary before surgery." They were losing a lot of the lawsuits because the argument in the prisons was that prison is not a real-life experience. So therefore, they could not proceed to surgery. So they did remove that "real-life experience" in their standards of care so that is no longer necessary.

They still would like them to integrate within their work and family as best as possible and to spend some time. But there's no definitive time on how long they need to do that before surgery is indicated and there's no mention of the words "real-life." They added medical therapy as being part of the standards of care. And then they removed any use of binary language, and by that I mean in the DSM diagnosis, a lot of times it said, the opposite sex, prefer to the opposite sex gender. Well, they wanted to get rid of that because gender does not have to be two sexes. As I mentioned before in the definition, it is not just male or female, there is a whole continuum of gender between male and female. So they wanted to get rid of any language that said a male wanting to be the opposite sex because they found that quite offensive to say "the opposite sex" as if there are only two.

(Slide 31 – Changes to DSM)
So those were the highlights of the standards of care changes from the WPATH conference in September. They had a part of the conference talked about the changes come into the Diagnostic and Statistical Manual. This is coming down in 2013 and they have been working on these changes for at least five years now, and they still have 2013 as the year that the new DSM V is going to come out. I'm going to the American Psychiatric Association meeting in May this year and we'll see how things are progressing with that. But just with gender identity disorder which is a very tiny little part of the DSM, causes a whole lot of controversy. Should they change the name to gender dysphoria? With or without distress? So, that way people don't need to have that word disorder on there or that social occupational dysfunction. They can have gender dysphoria with no distress, and that can be listed as a diagnosis in the DSM.

Should it be even there at all, was a whole other question. Should we have gender identity disorder or gender dysphoria as a diagnosis in the Diagnostic and Statistical Manual? That was split pretty much fifty-fifty down the line at the WPATH conference.

I think if you asked most people with gender identity disorder or who are transgender, they do not feel the need for it to be in DSM because they really don't feel it is a disorder whatsoever. So they especially don't feel it is a psychiatric disorder. So they would like it removed.

However, the other fifty percent are very vocal in keeping it in DSM. Mostly because then it remains an insurable medical illness. And that is a big deal. Transitioning from one gender to another is extremely expensive and a lot of these patients cannot afford it. However, since it is listed as a medical or mental health disorder, insurances will cover it many times. So they want to keep it in DSM because then it is covered by insurance. That is very important issue for them and it is quite understandable why they would want to keep it in there. Even if they disagree with the fact that they don't feel it is a disorder at all.

And then the other part is should they move it from a psychiatric disorder, take it out of there and then move it just over to a medical diagnosis? So that it is no longer psychiatric condition, is no longer listed in DSM, it would just be listed in the ICD codes. The only problem with that is, the

problem with ICD is following what is in the DSM right now, and until the new ICD codes come out, which are going to come out I think in 2014, it will come out after the DSM. So there would be a transition problem between the time when the DSM comes out and the new ICD codes come out, that gender identity disorder might not be listed as a medical illness or might be lost in the transition. So the majority of people are wanting to keep it in the DSM, even if they don't feel it is an actual disorder, but they want to change the name to gender dysphoria. They may want to remove it from the other sexual disorders and put it in its own category within DSM as well. There's a lot of questions. And this is just one paragraph of the DSM.

The DSM of course has a lot of controversy with a lot of different diagnoses. The media has not really talked about too much with gender identity disorder. They've been talking a lot with autism and the autism spectrum of how that disorder is going to be changed in the new DSM. But I'm sure this will get some media attention as well. So 2013 is still the goal for the DSM changes and they still don't know what they're doing.

(Slide 32 – Trangendered in History)
Another famous transgender in history: this is Christine Jorgensen, born George Jorgensen, Jr. and was a big transgender activist, served in the war and was outed by the *New York Daily News* as an "Ex-G.I. Becomes Blond Beauty" and there's a picture of Christine Jorgensen on there as well. And this was the inspiration for the movie "Ed Wood" starring Johnny Depp. I don't know if people saw that, but it was a pretty good movie. Kind of takes some liberties with history like most movies do, but still a good representation of Christine Jorgensen's life.

(Slide 33 – FBOP Policy)
So on to the Federal Bureau of Prisons, what do we do? That's was a lot of introduction and stuff, and this will probably be a little bit quicker just going over what the Federal Bureau of Prisons does, what our policies is. We had an old program statement; this is the old one; that inmates who have undergone treatment for gender identity disorder will be maintained only at the level of change when they were incarcerated in the Bureau.

So, basically it is kind of like a freeze-frame approach. That was our old policy and that changed in 2009. We no longer have this freeze-frame approach that if they came in on hormones, they could stay on hormones, but if they did not come in on hormones, we were not going to prescribe hormones for them.

(Slide 34 – Current policy for GID)
Instead a new policy that basically every patient is treated as an individual with gender identity disorder and a separate treatment plan is created for all of them. They receive a thorough medical/ mental health evaluation, so they have health services review them and have psychology services review them. Plus all the outstanding community record that they can get. That is difficult for a lot of our inmates, especially ones that are immigrants or detainees from other countries. A lot of people were taken hormones surreptitiously, getting them off the street. We don't have a lot of good community records unfortunately. This evaluation includes an assessment of the inmate's treatment as best we can find out prior to incarceration, and that can include a whole bunch of different things for gender identity disorder.

(Slide 35 – Current policy for GID)
Then a proposed treatment plan is developed which promotes the physical and mental stability of the patient. We can use standards of care which are the WPATH standards as a reference when developing this treatment plan, and if a plan includes advancing the treatment for a patient with gender identity disorder, such as starting hormones for a patient who has not been on hormones prior, then the chief psychiatry (myself) is notified.

(Slide 36 – Current policy for GID)
What I do then is review the records and review the case with a multidisciplinary team. So, I consult with the medical director of the institution and the chief of psychology at the institution; also the regional medical director and regional psychology administrator as well, to determine the best cause of action for this patient. And that may include hormone therapy; it may include psychiatric medication to stabilize mental illnesses first, or other medical illnesses, may include endocrinology consultations as well. So there's a lot of different things that can happen with that, but it is a multidisciplinary team review.

(Slide 37 – Current policy for GID)
So that program statement, the old one, is still the one that is still officially on record, but it's in union negotiations right now. So the policy has been changed even though that policy is still there listed, that has not been our policy since December 2009. And we've sent out a memo explaining the new policy and have given many presentations on gender identity disorder in 2009, 2010, 2011. Having not given one to the field yet in 2012, but I probably will do it as well. Because again, many reasons why there's barriers to treatment. People just don't want to pay attention to it or they don't want to treat it whatsoever.

(Slide 38 – GID Guidance)
So in 2011, we put together a multidisciplinary team to write gender identity disorder guidance. The team members included custody, psychology, health services, psychiatry staff, nursing staff, and social workers to put together this sixteen-page gender identity disorder guidance that we gave to the Bureau and it is being reviewed by our legal staff right now before it is officially distributed a little bit more. But, to help staff deal with gender identity disorder patients. How should we best treat them?

(Slide 39 – GID Guidance)
There are lots of different categories in this. We go over all those definitions that I went over with you guys, are explained in a little bit more detail in the guidance. We go over initial designations, where should they be housed? Right now it's their gender at the time of sentencing, the housing assignments, how that works for them. Staff interactions, how should staff interact with these inmates? He, she the pronoun use, stuff like that. Clothing and commissary items, what should be available to a male-to-female transgendered inmate who's at a male facility right now? Should he have stuff like bras, hair relaxers, hair dye, makeup, stuff like that?

PREA and safety issues, the Prison Rape Elimination Act is being released I think next month. The formal guidelines for that, so we will have to update that in our GID guidance, but how that affects transgendered patients. Just the safety in general of these patients, the standards of care going over what the WPATH talks about. Then the role of health services, and that includes psychiatry if

necessary for these inmates. Which a subset of that would be hormone therapy. What are the risks, benefits of hormones, contraindications of taking hormones for certain inmates? Surgery, how that is the final stage of transformation process for gender identity disorder, and how that is going to be handled? Right now we have not done any surgeries in the Federal Bureau of Prisons. I would imagine, just by experience and how this is going, that it probably would take a legislative mandate at this point to pursue a surgery for a gender identity disorder case. That's what I would imagine. Lawyers are reviewing this now.

And then psychology services, how the psychologists, which we have at all of our institutions, can do a psycho-sexual history on these inmates and a GID evaluation for these inmates. And then what our standards of care are for treating these inmates within our institutions. A lot of these patients will not want psychology services, but they are mandated to have an evaluation at least performed once.

(Slide 40 – Transgendered in History)
Another famous transgender is Renee Richards. Renee Richards was born a male and was an ophthalmologist before transitioning to female and becoming a professional tennis player. In 1975, had his male-to-female surgery performed. At that time was denied entry by the US Tennis Association and she wanted to play as a female in the US Tennis Association, they denied her. This was actually overturned by the New York Supreme Court who ruled in her favor in 1977. Then she was able to play on the female team for the US Tennis Association.

(Slide 41 – MTF Hormonal Therapy)
So talking about hormone therapy just a little bit: the medications work by de-masculinizing if we are going from male to female. They de-masculinize by blocking production and the action of androgens and effect feminization by responsive but latent tissue. So the anti-androgen therapy decreases testosterone to normal or lower than normal female levels and use estrogen, progesterone, and spironolactone are all used for male-to-female transition.

(Slide 42 – Effect of Hormonal Treatment)
The effect of this most times causes reduced aggression for the inmates which is good. It alleviates mental discomfort which can be quite good and the risks are fairly manageable, are minimal, but are manageable. As you can imagine, there are risks to taking hormones so we do need to watch out for them and watch out for side effects.

(Slide 43 – Resource materials for Mental Health Professionals)
The rest of these slides are done by psychology services and some of them are an overview and some of them are little bit busy, but hopefully you can download them or read them at your leisure. But there are a number of different resources out there. The American Psychological Association, the WPATH as we talked about, gaycenter.org, and some other documentaries out there that are resources for staff the want to know a little bit more about transgendered mental health, how to treat these inmates. A lot of times they say they have had no training so we can refer them to this. There isn't any specialized training; there is no fellowship in gender identity disorder. There is no fellowship in transgendered medicine. So we have to learn it on our own. And these are some of the websites that we can give for resources.

(Slide 44 – GID Specific Treatment Targets)
What they want to target is progress in the gender exploration and transition; so to clarify gender issues, what gender issues they may have, possible transition options. And then assist with their transition decisions and basically your there to provide support during the transition. They have to come to the decision themselves and you are there as kind of a supportive therapist.

You also help them with the progress in general, personal growth and life enhancement to help with emotional stability, comfort with the self, improved relationships. Can you imagine there is a lot of stress going from one gender to another? And it affects a lot of people in your life, so how to improve those relationships in your life while you're transitioning is a tough issue for them to deal with and psychology can be very helpful for these inmates.

(Slide 45 – Treatment of Co-Occurring Mental Health Problems)
Depressive symptoms are positively impacted by the extent to which new gender identity is successfully incorporated into social roles and relationships. This is very key; I mean it is fine to treat in a vacuum, especially in a prison sometimes, treating a male-to-female transgender. But it is how they're going to act when they get out of prison that is more important, and that is something that needs to be prepared for and that they're not necessarily going to be prepared for. How they're going to react when they go back to the family or work situation, being in a new gender or transitioning? So although the vast majority of patients report satisfaction with hormone treatment, there are mental health problems that we still need to look at during this time. A lot of adjustment disorders, a lot of anxiety, a lot of depression that all can be treated and need to be watched. That's why it really is recommended that a psychologist follows with them. Even though a lot of times the patients don't want that, and some definitely don't need it. But I think it is very useful to have psychology follow these patients.

A lot of challenges as you can imagine this is very challenging, this disorder. So there's a lot of interpersonal challenges that the GID patients have. How do you inform a long-term sexual partner, especially if the relationship is formed before you had the feelings of being transgender? Or if you feel like all of a sudden, that you're lying to your spouse. And this happens a lot of times, that now they want to be the opposite gender. Well, your spouse may not understand that. So how do you deal with telling a long-term partner about that? How do you inform your parents and siblings? Very, very difficult thing and a very difficult phone call to make; telling your parents that you believe that you're the wrong gender.

If you change genders in the context of relationships with children. I don't think I have a slide on this, but there's a fantastic movie called "Transamerica" that I put on the recent update on this. I think it was in 2005, starred Felicity Huffman and it shows a male-to-female transgender and she's living her life now as a female before the surgery. And it is a movie that documents her life and her transition. But really it is a relationship with this new son that she found out that she had. I think a sixteen-year-old son. And its them dealing with that whole transition together, and it's a fantastic movie. Felicity Huffman got nominated for an Academy Award for that role, it's called "Transamerica." So how do you deal with children when you already have children or existing relationships? And then the work setting and the social setting that I talked about before; dealing with your friends, dealing with your coworkers; very, very difficult.

(Slide 46 – Four Stages of GID Disclosure/Acceptance)
The four stages of GID disclosure and acceptance: the first is identity awareness, so just disclosure of who you are; disclosure of your transgender identity to friends, coworkers, family etc. Identity performance, so behavioral expressions of transgender identity. Followed by identity congruence; that is acknowledgment of the transgender identity by others in your life, significant others, family, work people, etc.

And then hopefully, following that is identity support: acceptance and positive reinforcement of transgender identity by those significant others in your life. That is the goal and that is the hope for most of these patients is that they have all four of these stages done. They don't always happen unfortunately.

(Slide 47 – GID and Co-occurring Mental Health Issues)
Many mental health issues as you can imagine occur, and I've talked about this a couple of times. But there's stigma, discrimination associated with the condition just in general. That is not really a diagnosis and we should not be paying for it. History of victimization for these inmates. There's negative body and self-image, there's chronic dissatisfaction and discomfort with how they look. That happens before the transition and after the transition a lot. So there's a lot of body image issues which can lead to eating disorder issues and other mental health issues.

Oh and then a difficult childhood, adolescence, etc. We talked about how family relationships and peer relationships can be impaired.

(Slide 48 – GID and Co-occurring Mental Health Issues)
And many studies have been out there. There is not a lot of great ones though with a ton of strength behind them. But some of them are showing that sixty percent of them are clinically depressed and a male-to-female sample. Twenty percent have required hospitalization for mental illnesses and about one third have some history of a suicide attempt. I would think it'd actually be higher, but that study showed around a third.

And then continuing disagreement in the field as to whether GID individuals are more significantly mentally impaired or in general it is hard to say because we just don't have the numbers to really evaluate these patients.

(Slide 49 – Transgender in Media)
Now there is… I do have the Transamerica" slide on there. And that's Felicity Hoffman in the movie, a fantastic movie in 2005. I definitely recommend you watch that to show how she relates to her newfound son.

(Slide 50 – GID Treatment Guidelines)
Some guidelines: Supportive psychotherapy as I mentioned is encouraged. It is one of the best resources and things for these patients; counseling for clients who are questioning or confused, affirming individual choices around gender identification. Group therapy is wonderful and is a suggested modality, especially in the later stages of GID treatment; however, it is hard to do in a prison setting to have the time and the resources to do group therapy.

Our inmates are scattered throughout the Bureau. We don't have any particular one institution that takes GID patients, they are scattered throughout our 118 different facilities so group therapy is a little bit difficult for us. The collaborative professional working relationship is of course is important. And then a goal alignment between the GID client's needs and the therapist's outcome objectives. As in any of our mental health disorders, we need goal alignment between what the client wants and what the therapist expects. And a lot of times there is big differences between the two.

(Slide 51 – Effectiveness of Psychotherapy)
Eighty-seven percent in a study showed positive change occurred in their lives as a result of the psychotherapy. This was often true even when they felt the therapist did not have adequate experience in gender issues. And that comes up a lot because we don't have the experience, and a lot of therapists don't have experience in GID. But, therapy is still helpful, supportive therapy is still very useful for these patients even if they're not experts in GID treatment.

(Slide 52 – GID and the Effectiveness of Sexual Reassignment Surgery)
And then there is a laundry list, I mean these are postsurgical satisfaction, what are linked to a number of factors. What are negative prognostic factors? Well, they can occur in any surgery so this is not really specific for sexual reassignment surgery. But it is for almost everything.

(Slide 53 – GID and Positive Prognostic Indicators)
Some other positive prognostic indicators: Satisfaction with life after gender transition is more likely when individuals have solid professional lives, healthy family relationships, good social networks, and are emotionally stable. That's wonderful. Those four things, we don't typically have in the prison setting. How often do inmates have solid professional lives, healthy family relationships, and good social support networks? Very, very few. So that is very tough in a prison setting to have. But those are good, positive prognostic indicators for GID.

(Slide 54 – GID Diagnostic Controversy)
And then I already mentioned the DSM and the diagnostic controversy. It is fifty-fifty. It really is. Do we want to keep it in DSM or not? And we just don't know where that's going to go until the DSM comes out in 2013. They talk about it a little bit, but they're really keeping silent on what their overall plan is, and that's because I don't think they know exactly where they're going to place in DSM. My hunch is that they're going to keep in the Diagnostic and Statistical Manual. But I have a feeling they're going to rename it to gender dysphoria. But what it is actually going to say or where it's going to be the DSM, that I do not know.

(Slide 55 – Transgendered in History)
And then the last person I talk about here is probably the most famous transgender, in the United States at least, is Chaz Bono. Who was born Chastity from Sonny and Cher. A picture of him dancing on "Dancing with the Stars." I didn't watch that season so I don't know how well he did, but I think he actually got in a couple of weeks so that's good. But probably the most famous person that most Americans would know as transgender.

So that is a quick summary of gender identity disorder, going over a little bit of definitions and then what we do in the Federal Bureau of Prisons. I'm happy to take questions at any time or you can

download the slides and you can ask me questions later too. Anita, do you want to work on the questions and see how that goes?

Anita Pollard, moderator: Thank you again Dr. Lewis for your time today in sharing this important information with all of us. For those of you who are on the call again, a closed captioning recording of this session will be available on our NIC website, that's www.nicic.gov. That should be available mid-April so give us two to three weeks and that information should be available. Again, thank you for those of you who participated on this session, and we hope to be able to bring more health and public health related sessions to you in the near future so we ask that you just put our website as a favorite and frequent it for updated information. Thank you all again. Have a great day.

Dr. Donald Lewis, presenter: Thank you guys. Have a great day.