

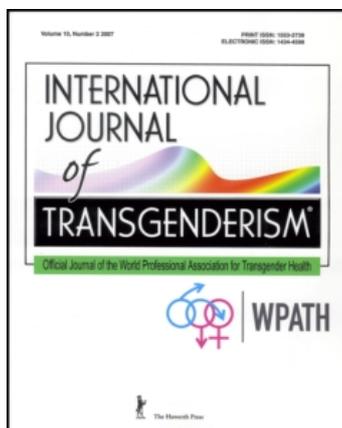
This article was downloaded by: [Wassersug, Richard]

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Publisher Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



International Journal of Transgenderism

Publication details, including instructions for authors and subscription information:

<http://www.informaworld.com/smpp/title~content=t792306875>

The Development of Standards of Care for Individuals with a Male-to-Eunuch Gender Identity Disorder

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Online publication date: 13 May 2010

To cite this Article Vale, Kayla , Johnson, Thomas W. , Jansen, Maren S. , Lawson, B. Keith , Lieberman, Tucker , Willette, K. H. and Wassersug, Richard J. (2010) 'The Development of Standards of Care for Individuals with a Male-to-Eunuch Gender Identity Disorder', *International Journal of Transgenderism*, 12: 1, 40 – 51

To link to this Article: DOI: 10.1080/15532731003749095

URL: <http://dx.doi.org/10.1080/15532731003749095>

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The Development of Standards of Care for Individuals with a Male-to-Eunuch Gender Identity Disorder

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ABSTRACT. Currently, the WPATH *Standards of Care (SOC)* provide guidelines for the treatment of male-to-female (MtF) transsexuals suffering from a gender identity disorder (GID). However, a large number of men with gender dysphoria who desire to be emasculated do *not* fit the classical pattern of MtF transsexualism. They loathe their manhood, but do not identify as, nor wish to be, female. Instead, they seek castration to become something outside the binary sexes. The formal term for such an individual is “eunuch,” which we here refer to as an MtE transgendered individual. The WPATH SOC, as currently written, are not applicable to these individuals. Indeed, neither the *Diagnostic and Statistical Manual IV (DSM-IV)* nor the International Classification of Diseases 10 (ICD-10) currently recognizes MtE transgenderism as a specific GID. The closest category into which MtE transgenderism fits in the *DSM-IV* is “GID Not Otherwise Specified” (GIDNOS). This vague diagnostic category has been a barrier for MtE individuals to receive treatment. An online survey posted at www.eunuch.org provided data on more than 300 individuals who have had voluntary genital ablations (as well as approximately 1,300 self-identified “eunuch wannabes”). More than half of the men who had surgery either did it themselves or resorted to medically unqualified underground “cutters.” This article offers a draft MtE SOC that outlines the criteria that we believe should be satisfied prior to surgical treatment. This draft MtE SOC is designed to initiate discussion of an unserved population of individuals with gender dysphoria, who are currently at risk of serious injury or death from the lack of medical care.

KEYWORDS. Eunuch, gender dysphoria, standards of care, castration

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INTRODUCTION

Surveys of voluntary eunuchs and men who desire to be voluntarily castrated have indicated that a large proportion of these individuals appear to be suffering from a gender identity disorder (GID) in which they do not wish to be male, but neither do they wish to be female (Wassersug, Zelenietz, & Squire, 2004; Brett, Roberts, Johnson, & Wassersug, 2007; Roberts, Brett, Johnson, & Wassersug, 2007; Johnson, Brett, Roberts, & Wassersug, 2007; Johnson & Wassersug, 2010). We have termed this a male-to-eunuch (MtE) GID, and are here proposing standards of care (SOC) for professionals to employ when treating such individuals. While not frequently reported as such in the literature, individuals with an MtE GID may be quite numerous. Cohen-Kettenis and Pfäfflin (2009) reported that 24% of 1,049 transsexuals who were diagnosed as MtF in the Netherlands did not go forward for full sexual reassignment surgery once they were able to obtain castration. Johnson and Wassersug (2010) have proposed that many of these individuals may be more properly diagnosed as MtE.

Eunuchs are biological men whose testicles have been removed or destroyed, such that testicular production of testosterone and sperm is not possible (McKenna, Lieberman & Wassersug, 2010). Although many MtE transgendered individuals publicly present as male, many others identify with a third sex that is neither male nor female. MtE individuals who present as male may desire castration because they are bothered by their libido, have a dysmorphic perception of their genitals (Johnson, Wassersug, Roberts, Sutherland, & First, 2010), or have a masochistic ideation or paraphilia concerning genital mutilation (Wassersug & Johnson, 2007). MtE individuals who do not feel strongly masculine or identify with the male gender desire castration for the purpose of emasculation. Both of these types of MtE transgendered individuals may desire to be chemically or surgically castrated, whether they identify as “male” or not.

Purpose of Standards of Care for MtE Transgendered Individuals

An MtE transgendered individual is a biological male who does not fully identify as male; however, unlike an MtF transsexual woman, he does not identify as, nor wish to be, female. Many of these individuals despise being male and desire chemical or physical treatment for the purpose of emasculation, yet are deemed ineligible to receive hormonal or surgical therapy by the medical community. A primary barrier preventing these men from receiving proper medical treatment is that MtE transgendered individuals do not fit the current definition of GID as defined in the *Diagnostic and Statistical Manual—Fourth Edition (DSM-IV-TR)*; (American Psychiatric Association, 2000), nor do they satisfy the International Classification of Diseases 10 (ICD-10; World Health Organization, 1993) definition of transsexualism. As a result, MtE transgendered individuals are unable to satisfy the *WPATH Standards of Care* (Meyer et al., 2001) eligibility and readiness criteria, which provide treatment guidelines for male-to-female (MtF) and female-to-male (FtM) transsexuals. This barrier to proper medical treatment for MtE transgendered individuals drives many of these men to perform self-castrations, to seek the services of underground “cutters,” or to enlist the assistance of a friend or lover to perform their castration. For example, data collected from a recent online survey posted at www.eunuch.org, answered by men who have been castrated, penectomized, or both castrated and penectomized, indicated that fewer than one third of the self-selected respondents—36.9% (66 of 179) of voluntarily castrated men, none of the voluntarily penectomized men (0 of 15), and 23.2% (13 of 56) of men who were voluntarily both castrated and penectomized—received surgical treatment that was performed by a medical doctor. A majority of these individuals’ genital surgeries were performed by non-surgeons, including friends, lovers, veterinarians, and the men themselves.

Data collected by Wassersug and Johnson (2007) indicated that fewer than 10% of MtE transgendered individuals, who said they were actively seeking castration but had not yet undergone the procedure, had already met with a medical doctor to discuss the procedure. Of this sample of individuals who were seeking castration, 21% had attempted to contact an underground cutter and 19% had attempted self-castration. Only 47% of the 92 MtE transgendered individuals in that study who had been surgically castrated were castrated by a medical doctor.

Roberts and colleagues (2007) indicated that only 13% of 731 MtE transgendered individuals who had not yet been castrated but were *considering castration* had contacted a medical doctor. Only 26% of the individuals who were *actively seeking castration* had contacted a medical doctor to discuss potential procedures. The data collected by Roberts and colleagues indicated that individuals actively seeking castration were two times more likely to have contacted an underground cutter or have attempted a self-castration, than to have contacted a medical doctor. Some of the identified factors that prevented MtE transgendered individuals from receiving medical castration included fear of rejection, fear of being labeled as mentally ill, and fear of the reactions of friends and family should they find out (Roberts et al., 2007; Johnson et al. 2007).

According to data collected by Brett and colleagues (2007) from an online survey answered by 92 castrated men, 12% ($N = 11$) of castrated individuals performed their own castrations. Respondents identified barriers to receiving medical castration, which included embarrassment to speak to doctors about their castration ideations, rejections by doctors when they had approached them, fear of being labeled as mentally ill or insane, and anxiety about the social stigma that may be attached to their desire for castration. The authors noted that a major barrier for doctors, who might otherwise provide treatment to MtE transgendered individuals, is the absence of a specific GID diagnostic category under which MtE transgendered individuals could be classified. Without a GID diagnosis, an MtE transgendered individual, who may seek medical treatment, will likely be denied surgery by the

medical community and may thus resort to a more dangerous method of castration.

The primary goal of creating SOC, specifically for biological males who desire emasculation, is to provide a set of guidelines that will ensure the proper psychological, psychiatric, and surgical treatment of these transgendered individuals.

Preliminary analysis of a recent online survey, posted at www.eunuch.org, indicates that there is a growing demand for surgery among MtE transgendered individuals who have not yet been castrated. More than 1,300 individuals who responded to the question, "What is your current state?" indicated that they are "wannabes" who desire to be castrated, penectomized, or castrated and penectomized. (The word "wannabe" [as in "want to be"] is popularly and nonpejoratively used by the online eunuch community.)

Professionally recognized SOC for MtE transgendered individuals should provide patients and mental health professionals with information regarding treatment options, as well as guidelines to ensure the proper administration and management of hormonal or surgical treatment when it is justified. This article proposes such standards of care. It is purposefully formatted in parallel with the existing SOC for MtF transsexuals (Meyer et al., 2001). The proposed standards for MtE individuals are the result of review of the available scientific literature and data, and consensus among the authors. These proposed standards have not (yet) been reviewed or formally adopted by the World Professional Association of Transgender Health. They are presented here for discussion of the needs of an unserved population of individuals with gender dysphoria, who are currently at risk of serious injury or death from the lack of corresponding medical care.

Goal of Treatment

The first step in treatment should be to sort those with castration paraphilias or who merely fantasize about castration and are at little or no risk of permanent physical injury from those with a genuine MtE GID. The intention of treatment for MtE transgendered individuals is then to provide relief and comfort

to allow for psychological well-being. Standards of care to guide treatment have the potential to prevent dangerous self-mutilations and/or unsupervised use of pharmaceuticals obtained through the Internet or other black market channels.

DSM-IV Gender Identity Disorder and Gender Identity Disorder Not Otherwise Specified

The *DSM-IV* outlines two criteria, A and B, which must be presented by an individual prior to receiving the diagnosis of a gender identity disorder (GID). The *DSM-IV* GID Criterion A, “evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is of, the *other* sex” (*DSM-IV-TR*, 2000, p. 576; emphasis added), does *not* apply to MtE transgendered individuals. Many MtE transgendered individuals have a strong and persistent desire to be something other than male; however, unlike MtF transsexuals, MtE transgendered individuals do not wish to be feminized. The *DSM-IV-TR* GID Criterion B, “persistent discomfort about one’s assigned sex and a sense of inappropriateness in the gender role of that sex” (*DSM-IV*, 2000, p. 576) is, however, applicable to MtE transgendered individuals. Though MtE transgendered individuals do not desire to be female, many of these individuals are nevertheless uncomfortable as males.

Gender Identity Disorder Not Otherwise Specified (GIDNOS) is applicable to individuals who have a “persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex” (*DSM-IV-TR*, 2000, p. 582). This definition includes individuals who desire to be castrated, yet still intend to publicly present as male. As Hage and Karim (2000) have noted, it is difficult for those diagnosed with GIDNOS to receive medical treatment and that “like the transsexuals before, the persons with GIDNOS may be compelled to obtain hormones on the black market and to undergo surgery in the hands of inadequately trained surgeons and outside of reputable gender clinics” (p. 1225).

ICD-10 Gender Identity Disorder

The ICD-10 defines transsexualism as a GID in which the individual “desires to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormonal treatment” (World Health Organization, 1993, pp. 133–134). Unlike MtF and FtM transsexuals, MtE transgendered individuals do not have a desire to be a member of the *opposite* sex. MtE transgendered individuals may instead desire to be neither male nor female, and will experience discomfort with their biological male sex characteristics. Rather than desiring hormones or surgery for the purpose of making one’s body *more* congruent with the opposite sex, an MtE transgendered individual desires hormonal treatment and/or surgical treatment principally as a means to eliminate male characteristics and to make his body and/or psychological state *less* congruent with their biological sex. They may, however, have ideas of what it would mean to live as eunuchs, and they may seek to make their bodies, minds, and presentations more congruent with what they understand as a eunuch gender.

The ICD-10 diagnostic criteria stipulate that this transsexual identity should have been persistent for at least 2 years and must not be the symptom of another disorder (World Health Organization, 1993). Wassersug and Johnson (2007) indicate that MtE transgendered individuals’ castration ideations frequently begin before or during puberty, and this desire grows with age. Roberts and colleagues (2007) noted that the mean age at which MtE transgendered individuals first attempted to castrate themselves was 21.7 years, with a quarter of them attempting castration by age 12. The mean age of actual castration was 46.2 years. On average, these MtE transgendered individuals who have already been castrated actively sought their castration for 15.7 years before finally receiving chemical or physical castration. This indicates that the average MtE transgendered individual will live with a GID for more than 15 years before finally receiving the treatment he requires. While such MtE transgendered individuals certainly satisfy the ICD-10 2-year minimum criterion, the

ICD-10 diagnosis of a transsexual identity is nevertheless inapplicable to MtE individuals. This is simply because MtE transgendered individuals do not desire to live and be accepted as members of the opposite sex, which is a central component of the ICD-10 transsexual identity diagnosis. For this reason, an MtE classification appears to more accurately describe individuals who seek emasculation, yet still wish to live and be accepted by the medical community as members of a nonmale, nonfemale sex category.

Related Disorders

As indicated by data in Brett and colleagues (2007), some males seeking surgical castration suffer from body integrity identity disorder (BIID). An individual suffering from BIID desires amputation of a specific body part in order to make his or her body “whole” or “complete.” BIID is most commonly discussed in the context of a desire for amputation of a lateral appendage (i.e. a leg or arm). However, a BIID diagnosis can equally well apply to some males who have obsessive desires for castration or penectomy (Johnson et al., 2010). Such males, who desire genital amputation and suffer from extreme stress and disruption to their social, occupational, and personal well-being as a result of this obsession fit a BIID diagnosis. BIID is not currently recognized as a psychological disorder in the *DSM-IV* or ICD-10 for either an obsession focused on the genitals or on lateral appendages, such as arms or legs. That there are no accepted diagnostic criteria prevents many individuals suffering with BIID from receiving proper treatment.

The *DSM-IV* classification of body dysmorphic disorder (BDD) is a related disorder in which the individual perceives and obsesses over a real or imagined defect in his appearance. This obsession causes severe stress that results in social and occupational impairment. A male suffering from BDD who perceives a defect in his testicles and/or penis may seek castration to reduce his stress. However, it is more likely that an individual who desires a castration or penectomy as the result of a psychological disorder is suffering from BIID than from BDD. BDD differs from BIID, in that individuals suffering

from BDD do not usually desire the amputation of the “defective” body part, but rather wish for their “defect” to be corrected. There is currently no ICD-10 equivalent for BDD.

Defining the Male-to-Eunuch Population

Like most MtF transsexuals, MtE transgendered individuals desire emasculation to become “not male.” However, unlike MtF transsexuals, MtE individuals do not identify as, or desire to become, females. In addition to the desire to become neither of the binary genders, other motivating factors for castration include the desire to reduce a perceived overactive libido, spiritual or religious ascetic desire, or to reduce sexual predatory impulses (Israel, 1996; Israel, 1998; Wassersug & Johnson, 2007). Data collected by Roberts and colleagues (2007) indicated that sexual motivation was the primary factor for 52% of MtE transgendered individuals seeking castration. Libido reduction was the primary motivating factor for 44% of MtE individuals who had been castrated. Other reported motivating factors among all eunuchs included aesthetic appearance of the genitals, health concerns, inhibition of sexually inappropriate behavior, religious motivation, or sexual fantasy. A few respondents to the surveys, both “wannabes” and those already castrated, indicated that their initial interest involved their desire to preserve their treble choir voices. None achieved castration at such a young age. Others desired voluntary castration because of fear that they might actuate pedophilic desires, though they denied having yet done so. Those who had been castrated expressed pleasure at their reduced libido (unpublished data).

MtE castration ideation typically begins before or during puberty, and the desire to be castrated tends to increase with age (Wassersug & Johnson, 2007). Johnson and colleagues (2007) collected data from MtE transgendered individuals who had been castrated. Among these individuals, the retrospectively self-reported youngest age of initial active interest in physical castration was 4 years old, and the oldest age was 72 years. The mean age of actual castration was 41.6 years; however, there was a wide range of ages of castration from 16 to

80 years (Johnson et al., 2007). A second, but larger, online survey that Wassersug and Johnson (2007) posted found a similar mean age of castration of 38.6 years among 245 voluntary eunuchs.

According to the online questionnaire analyzed by Roberts and colleagues (2007), 79% of individuals who had been castrated identified as male. Only 13% identified as “other” or as a member of a third, nonmale, nonfemale gender. Those who identify as male may consider themselves or be considered as MtE transgendered individuals because they sought emasculation even if not feminization. Of the individuals who desired castration but had not yet been castrated, 59% identified as males while 25% identified as “other” or as a member of a third gender. Johnson and colleagues (2007) indicated that a far greater number of anatomic eunuchs identify as male in comparison to chemically castrated eunuchs who were more likely to identify as female or as a member of an unidentified third gender.

PROPOSED STANDARDS OF CARE

Role of Mental Health Professionals

Prior to the administration of treatment, the mental health professional must accurately diagnose the patient as an MtE transgendered individual and identify any comorbid disorders that may also be present. He or she must provide the patient with sufficient psychotherapeutic counselling and ensure that the patient is fully aware of all available treatment options and their implications. The mental health professional must ensure that the patient meets all eligibility and readiness criteria before recommending hormonal or surgical treatment. It is the responsibility of the mental health professional to provide letters of recommendation to medical or surgical colleagues that include all of the patient’s relevant medical history as well as information concerning the patient’s progress in therapy. Finally, the mental health professional must be readily available to the patient during the treatment and post-treatment processes.

Training of Mental Health Professionals

To be able to rule out similar gender issues and thus ensure accurate diagnoses, mental health professionals must be professionally trained in GIDs and transsexualism and they should have a thorough understanding of the nature of the MtE transgendered population. In addition, mental health professionals must be able to diagnose and treat individuals suffering from BIID or BDD, as well as any related disorders. They must also be aware of the diagnoses and treatments of potential comorbid psychological disorders that the patient may be suffering from in addition to his gender dysphoria.

The WPATH *SOC* (Meyer et al., 2001) outlines the minimum requirements that a competent mental health professional must satisfy before treating an MtF or FtM transgendered individual. These criteria are applicable to mental health professionals who are treating MtE transgendered patients and should be the same as those for treating all other transgendered individuals. The requirements that the mental health professional must satisfy include

1. a master’s degree or equivalent in clinical behavioral science,
2. specialized training and assessments of *DSM-IV* or *ICD-10* sexual disorders,
3. documented supervised training and competence in psychotherapy, and
4. continuing education in treatment of gender identity disorders.

Documentation Letters for Hormonal or Surgical Treatment

Similar to the protocol intended for MtF and FtM transgendered individuals that is outlined in the WPATH *SOC* (Meyer et al., 2001), an MtE transgendered individual seeking hormonal therapy must receive one letter of recommendation from a mental health professional with the certifications mentioned earlier prior to the commencement of his hormonal treatment.

If he or she believes that the MtE transgendered patient is both eligible and ready for hormonal or surgical treatment, the mental health

professional should provide the patient with the necessary letter(s) of recommendation.

Diagnostic Assessment

An MtE transgendered individual must satisfy the following criteria for hormonal or surgical treatment:

1. The individual is a biological male who does not wish to be a reproductive male, regularly experience erections and ejaculations, and/or experience a typical male libido.
2. The individual does not identify as, nor wish to be, female or to receive treatment appropriate for MtF transsexuals.
3. The desire to be castrated is not the result of another psychological condition, for example, BDD, BIID, castration paraphilia, or schizophrenia.

Psychotherapy

The intention of psychotherapy is for the mental health professional to provide MtE transgendered individuals with effective long-term coping skills that address the psychological, behavioral, physical, emotional, and societal difficulties that they may face prior to, during, and following treatment. In addition, psychotherapy should assist patients to become more comfortable with their internal self-perceptions and identities. The total length of psychotherapy should be determined by the mental health professional and the patient together, as the appropriate duration of treatment will vary depending on the circumstances of each patient's individual needs and progress in therapy. Psychotherapy should provide the patient with an improved understanding of the various treatment options that are available, as well as information concerning all possible consequences and implications of each treatment option.

During therapy, the therapist must take into account the patient's medical and personal history, the patient's current social and occupational situation, as well as any maladaptive behaviors or beliefs that may hinder the patient's progress in therapy. Continuation of psychotherapy fol-

lowing hormonal or surgical treatment will assist the patient in adapting and becoming comfortable with the psychological, physical, emotional, and behavioral changes that hormones and/or surgery will have imposed on him.

Hormonal Therapy

There are two types of MtE transgendered patients who could benefit from hormonal therapy: those who seek hormonal treatment but have no desire for surgery, and those who desire surgery but have no previous real-life experience of being androgen deprived. Both types of MtE transgendered individuals may seek hormonal therapy as a means to control sexual urges and libido, to control masculine aggressive tendencies, or to eliminate some male physical characteristics, such as body hair.

Individuals who meet the eligibility and readiness criteria for hormonal treatment may receive androgen deprivation hormones such as LHRH agonists (which inhibit testosterone secretion), progestins, or antiandrogens to block or neutralize testosterone activity. The administration of these drugs will reduce the individual's physical, psychological, and emotional male characteristics and tendencies. This includes a lower libido as well as a lower level of reactive aggressiveness. Androgen-deprivation hormones in the absence of feminizing hormones (i.e., estrogen and its analogues) will decrease typical male characteristics without substantially promoting female characteristics, such as breast development.

Eligibility Criteria for Hormonal Therapy in Adults

There are three eligibility criteria for MtF or FtM transsexuals set out by the WPATH SOC (Meyer et al., 2001) that apply to MtE transgendered individuals seeking hormonal therapy. The MtE patient must

1. be at least the age of majority in his jurisdiction;
2. have sufficient knowledge of the possible side effects and implications of androgen deprivation; and
3. engage in psychotherapy for an appropriate duration as determined by the mental

health professional and patient (usually at least three months).

Readiness Criteria for Hormonal Therapy in Adults

Unlike the eligibility criteria, the fulfillment of the readiness criteria is a subjective assessment of the degree to which the patient is deemed “prepared to handle the effects and implications of androgen deprivation.” This evaluation is carried out by the mental health professional or by the physician prescribing the hormonal drugs. The mental health professional must assess the patient’s progress throughout therapy and indicate whether he or she believes the patient has demonstrated a sufficient level of responsibility to manage hormonal treatment. In addition to meeting certain eligibility and readiness criteria, the patient must provide informed consent in which he acknowledges his full understanding of the implications of hormonal treatment, including any negative side effects, and authorizes the prescribing physician to initiate the administration of treatment.

Exception to the Eligibility and Readiness Criteria

The WPATH SOC (Meyer et al., 2001) outline circumstances under which hormones should be provided to a patient who has not satisfied the preceding criteria. Like FtM and MtF transsexuals, MtE transgendered individuals could be provided hormones without meeting the eligibility criteria if the likely alternative to prescribing hormones is the use of black-market drugs, unmonitored self-medicating, or self-harm. Supervised hormonal treatment devoid of the eligibility criteria is undoubtedly a safer alternative than unmonitored self-medicating.

Possible Side Effects of Hormonal Therapy

Prior to hormonal treatment, the mental health professional should inform the patient of the potential side effects that may result due to the administration of androgen deprivation treatment. The most commonly experienced side effects reported by genetic males on androgen deprivation treatment are loss of libido, erectile dysfunction,

hot flashes and weight gain (Higano, 2006; Isbarn et al., 2008). Other long term side effects of androgen deprivation treatment include loss of muscle mass and strength, increase in fat mass (usually within the first year of treatment), increase in serum cholesterol and triglyceride levels, decreased penile and testicular size, loss of body hair, anemia, and loss of bone density with an increased risk of bone fractures (reviewed in Saylor, Keating, & Smith, 2009; Saylor & Smith, 2010). Metabolic syndrome, which collectively includes lipid abnormalities, hypertension and insulin resistance leading to increased risk of diabetes and cardiovascular disease, has increasingly been associated with long term androgen deprivation treatment (Basaria, 2008; Levine et al., 2010). Other side effects of androgen deprivation treatment include fatigue and lack of energy. Aches and pains, depression, and cognitive impairments have also been reported by some individuals on androgen deprivation treatment, primarily among prostate cancer patients, many of whom are androgen-deprived as part of their therapy (reviewed in Elliott et al., 2009).

Surgical Therapy

There are two main categories of surgical options that are available to MtE transgendered individuals: castration alone or with a penectomy. There are several eligibility and readiness criteria that the MtE transgendered individual must satisfy prior to surgery.

Eligibility Criteria for Surgical Therapy in Adults

Similar to MtF and FtM transsexuals, the MtE transgendered individual must be at least the age of legal majority in his country and he should have undergone approximately 12 months of hormonal therapy to provide him with a “real-life experience” of the hormonal profile he can expect to have following removal of the testes. In accordance with the criteria set out for MtF and FtM transsexuals in the WPATH SOC (Meyer et al., 2001), MtE transgendered individuals must have a thorough understanding of the costs, lengths of hospitalizations, possible complications, post-surgery rehabilitation requirements,

as well as a sufficient awareness of various competent surgeons available to them.

Readiness Criteria for Surgical Therapy in Adults

The satisfaction of readiness criteria for surgical treatment is a subjective assessment administered by a mental health professional. The MtE transgendered individual must demonstrate progress throughout therapy and hormonal treatment. He must also demonstrate an adequate level of responsibility for handling the implications and possible negative consequences or side effects that may accompany a genital surgery.

Exception to the Eligibility and Readiness Criteria

Harm reduction should be the primary criterion for exceptions to the eligibility and readiness criteria. Surgical therapy may be provided to a patient who has not met the criteria only when, in the therapist's best judgement, the alternative to medical surgery is that:

1. the patient will engage in self-mutilation or irreversible self-harm; or
2. the patient is actively seeking an underground cutter, friend, or lover to perform his genital surgery; and
3. if the patient is suffering from a co-morbid psychological disorder (e.g., schizophrenia), care should be taken to determine that the patient's desire for surgery is not a symptom of the disorder and that surgery will not interfere with the patient's treatment of the disorder.

Real-Life Experience

The WPATH SOC (Meyer et al., 2001) include a "real-life experience" eligibility criterion for medical treatment. While some MtF and FtM transsexuals manage to successfully present as members of their preferred gender without undergoing hormonal therapy, MtE transgendered individuals are unable to engage in the real-life experience of presenting in society as a eunuch as there is no socially accepted "eunuch" role

available for them to publicly fill (McKenna et al., 2010). The therapist should help the patient to envision and articulate what his public presentation could be as a eunuch.

However, short term hormonal treatment will allow MtE transgendered individuals to experience all of the emotional and psychological responses of androgen deprivation, as well as many of the physical effects that accompany actual castration. An MtE transgendered individual who desires surgical castration, should engage in approximately 12 months of hormonal therapy to provide him with "real-life experience" of castration, regardless of any "public presentation" that he may be able to experience. In addition, the patient's response to androgen-depriving hormones will offer insight into the patient's underlying motivation for treatment as well as an indication as to the most appropriate direction for further treatment.

There are four potential outcomes of hormonal treatment:

1. the patient is unhappy with the effects of hormonal treatment, and decides to discontinue hormonal treatment and not proceed with surgery;
2. the patient is pleased with the effects of hormonal treatment and opts to remain on hormones, and not undergo surgery;
3. the patient is unhappy with the effects of hormonal treatment; however he maintains his desire for surgical removal of his testicles and/or penis; or
4. the patient is pleased with the effects of hormonal treatment and maintains his desire for surgical removal of his testicles and/or penis.

Treatment Options

A patient who is unhappy with the effects of hormonal treatment and desires to remain male will not desire to have surgery. This patient may continue psychotherapy to resolve any issues that may have resulted from hormonal treatment. The patient, who is pleased with hormonal treatment and does not maintain a desire for surgery, presumably originally sought treatment for the purpose of libido reduction.

Hormonal treatment will have effectively reduced his libido and thereby reduced the discomfort and stress that he attributed to his genitalia. This patient should continue on hormonal therapy. The patient who is unhappy with the effects of androgen-deprivation hormones, yet maintains a desire for genital amputation, may suffer from BIID or BDD. Additional treatment options should be explored. The patient who is pleased with the effects of androgen-depriving hormones, yet maintains a desire for surgical removal of his testicles and/or penis, likely desires surgery for the purpose of emasculation. This individual will most likely remain dissatisfied with his genitals even with the introduction of androgen-depriving hormones. The optimal treatment direction for this patient is continuation of hormonal treatment and psychotherapy, followed by surgery providing that he has satisfied the eligibility and readiness criteria.

Post-Transition and Follow-Up

Following the surgery, the patient should be provided with appropriate medical and psychological care to ensure a safe recovery. To enhance the likelihood of a healthy transition to the target gender, the mental health professional must be available to the patient in order to provide follow-up services and counselling post-surgery. Mental health professionals must be able and willing to treat any disorders or side effects that may arise as a result of the surgery. For example, data collected by Brett and colleagues (2007) from voluntarily castrated individuals indicated that the most commonly reported side effects following castration were hot flashes and loss of libido. The side effects found to be most bothersome following surgery were hot flashes, weight gain, and depression (although some self-reported that their castration resulted in recovery from previous depression). The duration of psychotherapy will be based on the mental health professional's assessment of the patient's progress throughout therapy and on the patient's individual needs.

Treatment of Adolescents

The effects of hormonal treatment administered to pubescent boys or adolescents will

differ from the effects of hormonal treatment for adult males. The administration of androgen deprivation hormonal treatments among adolescents may result in irreversible physical, psychological, and/or emotional consequences. It is crucial that the mental health professional is thoroughly aware of *all* possible consequences and side effects of any hormonal treatment prior to recommending or prescribing hormones to adolescents. It is also the responsibility of the mental health professional to ensure that the adolescent and his parent(s) or guardian(s) fully understand *all* possible implications of treatment. Finally, the mental health professional must receive informed consent from both the parent(s) or guardian(s) and the adolescent prior to administration of hormonal treatment.

The WPATH *SOC* (Meyer et al., 2001) outline three intervention options for adolescents with gender dysphoria who are seeking treatment. Only two of these treatment options are applicable to MtE transgendered adolescents with some modifications:

1. *Fully reversible interventions:* This involves the administration of puberty-delaying hormones following the onset of pubertal changes. Similar to adolescents who are MtF and FtM transsexuals, MtE transgendered adolescents should not commence hormonal treatment until at least Tanner Stage Two. MtE transgendered adolescents must meet the following eligibility criteria prior to receiving hormonal therapy:
 - a. The adolescent has displayed consistent patterns of disinterest in and detachment from identifying as a member of the male sex and/or of having male genitals throughout his childhood;
 - b. The adolescent has become increasingly uncomfortable and dissatisfied with his gender and/or sex following the onset of puberty, especially if the adolescent has engaged in self-harm directed at his genitals; and
 - c. The adolescent and his family consent to and participate in therapy.

Hormonal treatment options include the administration of LHRH agonists to stop LH and testosterone secretion, or the administration of progestins or anti-androgens to block or neutralize testosterone secretion.

2. *Irreversible interventions*: Irreversible treatment options include surgeries such as physical castration or castration with a penectomy. Surgical options should only be available to individuals who are at least the legal age of majority and have met the eligibility and readiness criteria for surgical treatment. An exception to this age restriction applies to an adolescent who is at serious risk for self-mutilation or who is seeking a non-medical cutter to perform his castration or castration with a penectomy and a medical surgery is the best alternative to a medically unsupervised surgery.

CONCLUSION

SOC for any medical condition are typically drafted in the context of a definable diagnosis. In the absence of a diagnosis, both the development and professional endorsement of SOC are neither necessary nor justified within the medical care system. Indeed, it is only in the context of a definable diagnosis that the efficacy of any treatment program can be assessed.

In terms of a particular diagnosis for MtE transgenerism, there is timeliness about the MtE SOC that we present here. At the moment, an MtE GID falls under GID “Not Otherwise Specified” (GIDNOS) in the *DSM-IV*. Elsewhere, two of the authors have argued that a GIDNOS diagnosis does not adequately open pathways to care for individuals who desire castration without a concomitant desire to present as female (Johnson & Wassersug, 2010). In our studies of the voluntary eunuch community we have come across many individuals who fit the current GIDNOS diagnosis, but who could get neither chemical nor physical androgen deprivation therapy because the GIDNOS diagnosis was not precise enough to initiate treatment.

Currently, all the diagnostic criteria for GID within the *DSM* are under review with a new

edition, the *DSM-V*, due for publication in 2013. The broader definition of GID itself is being reassessed and GID is likely to be renamed in the *DSM-V* (see Cohen-Kettenis & Pfäfflin, 2009). The draft MtE SOC developed here support the formal recognition of MtE as a “GID” outside of GIDNOS and we believe will be consistent with the language in the *DSM-V*. We see MtE GID as a definable condition warranting intervention regardless of how GID itself is labeled in the next edition of the *DSM*.

Lastly, as noted above, SOC and *DSM* diagnoses interact in that a good diagnosis permits evidence-based assessment of intervention. In terms of efficacy of our draft SOC, data in Brett and colleagues (2007) show that androgen deprivation treatments, as proposed here, can indeed improve the lives of men with severe desire for castration.

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