MANUAL ON MENTAL HEALTH CARE OF TRANSGENDERED PERSONS IN INDIA

FOR PRACTISING PSYCHIATRISTS

FIRST EDITION

2021

Naveen Manohar Pai

Shalini S Naik

C. Naveen Kumar

Suresh Bada Math

National Institute of Mental Health and NeuroSciences
(Institute of National Importance)
Bengaluru-560029

978-93-91300-07-4

NIMHANS Publication No. **205**

EDITORS

Dr. Naveen Manohar Pai, DPM, MD, (PGDMLE)
Senior Resident, Department of Psychiatry,
National Institute of Mental Health and Neuro Sciences,
Bengaluru – 560029

Dr. Shalini S Naik, MD, PDF in Brain Stimulation, (PGDMLE)
Assistant Professor, Department of Psychiatry,
National Institute of Mental Health and Neuro Sciences,
Bengaluru – 560029

Dr. C Naveen Kumar, DPM, MD, MAMS
Professor and Head, Community Psychiatry Unit,
Consultant, Centre for Disaster Management, Forensic Psychiatry, Legal Aid Clinic & Tele-Medicine Centre,
Department of Psychiatry
National Institute of Mental Health and Neuro Sciences,
Bengaluru – 560029

Dr. Suresh Bada Math, MD, DNB, PGDMLE, PGDHRL, PhD in Law (NLSIU)
Professor & Head of Forensic Psychiatry Services, Consultant, Community Psychiatry,
Head of Tele-Medicine Centre and Unit-V (Psychiatry), Department of Psychiatry,
National Institute of Mental Health and Neuro Sciences,
Bengaluru – 560 029

Typesetting: Medscientist Pvt Ltd., India

Citation

Naveen Manohar Pai, Shalini S Naik, C Naveen Kumar, Suresh Bada Math (Eds). Manual on Mental Healthcare of Transgendered persons in India. NIMHANS Publication No: 205; 2021, ISBN: 978-93-91300-07-4

NIMHANS Publication No. **205**

Correspondence

Dr. Suresh Bada Math,
Professor & Head of Forensic Psychiatry Unit,
Head of Tele-Medicine Centre and Unit-V (Psychiatry),
Consultant, Community Psychiatry,
Department of Psychiatry,
National Institute of Mental Health and Neuro Sciences,
Bengaluru – 560 029, INDIA
Email: sureshbm@gmail.com , nimhans@gmail.com , sbm@nimhans.ac.in
Phone: +91 080 2699 5276

Authors

Dr. Naveen Manohar Pai, DPM, MD, (PGDMLE)
Senior Resident, Department of Psychiatry,
National Institute of Mental Health and Neuro Sciences,
Bengaluru - 560029

Dr. Shalini S Naik, MD, PDF in Brain Stimulation, (PGDMLE)
Assistant Professor, Department of Psychiatry,
National Institute of Mental Health and Neuro Sciences,
Bangalore - 560029

Dr. Guru S Gowda, MD, PGDMLE
Assistant Professor, Department of Psychiatry,
National Institute of Mental Health and Neuro Sciences,
Bengaluru – 560029

Dr. Rajendra K M, DPM, MD, DM
Assistant Professor
Department of Child and Adolescent Psychiatry
National Institute of Mental Health and Neuro Sciences,
Bangalore – 560029

Dr. Dinakaran D, MD, PDF
Assistant Professor, Centre for Disaster Management
National Institute of Mental Health and Neuro Sciences,
Bengaluru – 560029

Dr. Malathesh BC, MD, PDF
Assistant Professor, Department of Psychiatry,
National Institute of Mental Health and Neuro Sciences,
Bengaluru – 560029

Dr. Chethan Basavarajappa, DNB, FIPsyR, DDM, (PGDMLE), MANBD
Assistant Professor, Department of Psychiatry,
National Institute of Mental Health and Neuro Sciences,
Bengaluru – 560029

Dr. C Naveen Kumar, DPM, MD, MAMS
Professor and Head, Community Psychiatry Unit,
Consultant, Centre for Disaster Management, Forensic Psychiatry, Legal Aid Clinic & Tele-Medicine Centre,
Department of Psychiatry
National Institute of Mental Health and Neuro Sciences,
Bengaluru – 560029

Dr. Suresh Bada Math, MD, DNB, PGDMLE, PGDHRL, PhD in Law (NLSIU)
Professor & Head of Forensic Psychiatry Services, Head of Tele-Medicine Centre and Unit-V (Psychiatry),
Consultant, Community Psychiatry, Department of Psychiatry,
National Institute of Mental Health and Neuro Sciences,
Bengaluru – 560029

NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES

INSTITUTE OF NATIONAL IMPORTANCE

P.B. 2900, Bengaluru - 560 029 (India)

Dr. Pratima Murthy
MBBS, DPM, MD, FRCP (Glasgow)
Director

Off : 91-80-26564140, 26561811
26565822, 26995001 / 2
Res : 91-80-22239127
Fax : 91-80-26564830 / 26562121
Email : pratimamurthy@gmail.com
pra0041@nimhans.ac.in

From the Director's Desk

The principles of Indian democracy rests on the fundamental right of all citizens to be free from discrimination in every sphere of public life. Every individual has a right to self-perceived identify. No individual should face any discrimination with regard to their gender in any sphere, including education, employment or housing. Transgenders constitute a vulnerable section in society, who have long strived for their rights to equal status and opportunity in society. Given the heterogeneity and needs of transgenders, there has been a need for a local guideline for effective medical and psychological management of transgenders. The Forensic team of the Department of Psychiatry at NIMHANS has taken a first step towards bringing out a manual focusing on the mental health assessment for the Transgenders. The manual highlights the various mental health issues among Transgenders and serves as a guide for their assessment and treatment. The manual also aims at increasing awareness among psychiatrists and may be useful for other mental health professionals.

I would like to congralute the entire team for coming up with this manual and taking an initiative towards the promotion of mental wellbeing of these individuals.

Prof. Pratima Murthy
Director
NIMHANS
Bengaluru-560029

CONTENTS

Chapter 1

Purpose, scope and applicability of the manual on mental healthcare for transgender

TRANSGENDER PERSON is often used as an umbrella term for identifying all those individuals who have discordance or discomfort between expressed gender and gender assigned at birth. (1) Being identified as transgender person or gender diverse is considered being a matter of human diversity and not pathology. (2) However, The International Classification of Diseases 10th edition (ICD 10) classifies transgender under the subcategory of Transsexualism. (3) This category has attracted a lot of criticisms over the years from various organisations which have called upon the World Health Organisation (WHO) to retract this diagnosis. While experts in transgender health say that this diagnostic category pathologize a variant of the normal behaviour, few others have framed it as a more fundamental issue of human rights. (4) However, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) have removed this classification while retaining the diagnosis of Gender identity disorder (GID) of childhood. The argument for this diagnosis being retained is the concern that removal of GID from the classification may further worsen the difficulties of transgender adults already struggling with inadequate access to private and/or public healthcare for medical and surgical care. (4) Considering these issues, the ICD-11 working group on sexual disorders and sexual health has recommended keeping the 'Gender Incongruence of Adolescent and Adulthood' under the category of conditions related to sexual health. (5) The primary focus of this category is on the experience of incongruence between the gender role and assigned sex. The never-ending challenge of reducing stigma and maintaining access to health care for these individuals emphasizes the need for the development of a manual for mental healthcare of transgender persons in India.

1.1: Proportion of transgender and gender non-conforming individuals in the population

It is essential to determine the size and distribution of Transgender and Gender Non-Conforming individuals (TGNC) in a population as it helps us in understanding the needs of

these individuals, aids in framing health policies to address their health care needs and plan research accordingly. Decuypere *et al* in their review of 10 studies spanning across 39 years and 8 countries found that the proportion of male-to-female individuals (MtF) was **1:11,900 to 1:45,000** and of female-to-male (FtM) individuals was **1:30,400 to 1:200,000.** (6) A recent review shows that people who self-identify as TGNC represent a sizable proportion of the general population with realistic estimates ranging from **0.1% to 2%**, depending on the inclusion criteria and geographic location. (7) But these numbers are subject to a wide variation in terms of differing clinical presentations, discrepancies in inclusion of the definition of transgender person, cultural diversity specific to this population, and wide variations in the time periods covered in different studies. Scientific studies estimating the proportion of transgender persons in the Indian population are lacking. (8) In the Census of 2011 for the first time in India, data was collected on transgender persons. Around **4.88 lakhs** adults and **54,845** children were estimated to be transgender individuals. (9) However, these estimates were collected prior to legal recognition of transgender persons and were based on self-reporting of individuals as transgender person and compiled under the gender category of males, further making it difficult to understand the socio-economic condition and distribution of these individuals in the population.

1.2: Purpose of the manual

Majority of the literature on the care and needs of these individuals comes from World Professional Association for Transgender Health (WPATH), formerly known as the 'Harry Benjamin International Association for Gender dysphoria' which released The Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7 in 2012. (10) The recent Indian legislation on Transgender individuals, The Transgender Persons (Protection of rights) Act, 2019, (11) states the various healthcare provisions which need to be provided to these sexual minority groups in order to attain overall physical and mental wellbeing. Section 15, subsection (d) of this Act further stresses on the need for a health manual related to 'sex reassignment surgery and care of transgenders' under the World Professional Association for Transgender Health guidelines. (11) The larger goal of the manual is to provide psychiatrists who work in the area transgender health with the required clinical guidance, which would help them promote the highest standards of mental healthcare while dealing with TGNC individuals. The manual also attempts to facilitate safe and effective pathways to care and help to attain maximum benefits that help them achieve overall health and psychological well-being.

1.3: Scope of the manual

The manual is intended to provide assistance in delivering mental health services (e.g.- assessment, counselling, psychotherapy), and serve as a guidance document for Psychiatrists

for referring TGNC individuals for hormonal therapy and sexual reassignment surgery. The various standards recorded in this document are merely clinical guidelines and may be modified as per the clinical needs and individual goals of gender expression for these diverse groups of individuals. If in case, because of the wide variations in clinical presentations, or due to lack of resources, a clinical situation arises leading to a departure from the standard of care the same should be identified, explained to the patient, documented in the case records via an informed consent in order to ensure the highest quality of care and protection against legal proceedings. (10) The documentation of all such clinical departures may provide valuable data, which may provide evidence for further research and future practices. This is primarily a document for psychiatrists but may be used by other mental health, medical, and health care professionals to understand and promote the health care needs of these individuals. It is the duty of every health care professional to uphold the autonomy of these individuals and make informed choices. True beneficence should always be promoted and health care professionals should strive towards the best interests of transgender persons and make efforts to avoid pain, injury, offense, or negligence towards these individuals. (12)

1.4: Applicability of the manual

The manual is a synthesis of the existing literature in the healthcare of transgender and gender non-conforming individuals in accordance with the WPATH guidelines and is intended for use in the Indian health care and legal context. While most of the literature that is available is from elsewhere, it has been synthesized in a way to best suit the needs of the psychiatrists while dealing with the various challenges and health care needs of these individuals in the Indian setting. It is also essential for clinicians to recognize the wide variation in the clinical presentation of these individuals, the cultural diversity and prevailing stigma and social attitudes towards these individuals. (10) While it is difficult to address all of these issues, the manual is intended to provide information regarding the best practices available in the mental healthcare of these individuals.

The psychiatrist, while dealing with these individuals, is expected to exhibit utmost respect for their autonomy in a way that does not pathologize or label expressions of gender variance as symptoms of a mental illness which would further stigmatize and cause harm to these individuals. The psychiatrist should become knowledgeable about the health care needs of transsexual, transgender, and gender-nonconforming people. The psychiatrist must be culturally competent and apply evidence-based interventions in the best possible way that reduces the distress of gender dysphoria and helps them express their gender identities. (12) whenever there is a disparity between the practitioner's and patients' ethics and perspectives, the practitioner should, with utmost respect, explain the same and suggest alternative sources of consultation for the same. (12) Both the patient and the practitioner should not feel coerced to

give up one's moral views nor impose them onto the other, which would otherwise lead to conflict. (13) The psychiatrist must always help patients weigh the benefits and risks of any treatment option for gender dysphoria and assist them in making an informed treatment decision that matches their specific needs. (13) Finally, the psychiatrist should also be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings). (10) It would be recommended that mental healthcare can be provided at district level through district mental health programme.

1.5: Position statement of the American Psychiatric Association

Discrimination and lack of equal civil rights is damaging to the mental health of transgender and gender diverse individuals. In May 2012, American Psychiatric Association (APA) released a position statement on discrimination against transgender and gender diverse individuals stating "Being transgender or gender diverse implies no impairment in judgment, stability, reliability, or general social or vocational capabilities; however, these individuals often experience discrimination due to a lack of civil rights protections for their gender identity or expression. As a result, transgender and gender diverse persons face challenges in their marriage, adoption and parenting rights, are regularly discharged from uniformed services and/or rejected from enlisting due to their gender identity, and have difficulty revising government identity documents. Incarcerated transgender and gender diverse persons suffer risks to their personal safety and lack access to comprehensive healthcare. Furthermore, transgender and gender diverse individuals may be inappropriately assigned space in gender-segregated facilities such as inpatient psychiatric units, homeless shelters, and residential treatment programs. Transgender and gender diverse people are frequently harassed and discriminated against when seeking housing or applying to jobs or schools and are often victims of violent hate crimes."(14,15)

1.6 Position statement of the Indian Psychiatric Society

The Indian Psychiatric Society (IPS) stands in solidarity with WPATH and other international and national organisations involved in the health, rights and wellbeing of transgender and gender diverse individuals and is committed towards creating and providing gender-affirming practice towards the TGNC individuals. The IPS forbids practitioners form promoting, delivering or referring to any and all forms of conversion 'treatment/therapy' (including individual psychotherapies, behaviour therapies like aversive conditioning etc., hypnotherapy, group therapies, pharmacotherapy, physical treatment methods like ECT etc. or milieu treatments) which aims at suppressing or forcefully altering individual's gender expression to bring about a change of gender identity. (16) The Indian Psychiatric Society in their totality disapproves of any such treatments which result in pain, injury, offense, or negligence towards these individuals and urges that such therapies must cease forthwith.

Chapter 2

Definition of transgender/ gender dysphoria

GENDER IDENTITY is popularly defined as one's persistent inner sense of belonging to either a male or female gender category. (17) **Gender role** is described as the outward expression of the inner sense of gender identity. (17) While both Gender identity and Gender role is an important human attribute, it has a profound impact on personal well-being. (18) The terms experienced Gender and expressed gender are more commonly used in the vocabulary and are used interchangeably while referring to gender identity and gender role respectively in legal and political sense. (17) The initial descriptions of gender identity and gender role discretely implied to two gender categories, either male or female. More recent descriptions of Gender approach the concept as a more fluid entity which lies on a spectrum between masculinity and femininity as opposed to the earlier dichotomy (i.e. male or female). (17) There is a vast diversity in individual and cultural notions of what is masculine and what is feminine and the concept has evolved over time. Hence experienced Gender/ Gender identity may be either male, female, somewhere in between or neither, and gender expression/ gender role may be categorized into masculine, feminine, or mixed.

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex. (10) Only a proportion of people with Gender non-conformity experience Gender dysphoria at some point in their lifespan. While differences exist between Gender nonconformity and gender dysphoria, they are considered to be a part of the spectrum that lies between masculinity and femininity. ***Gender dysphoria/ Transgender*** refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). (10) The distress associated with gender dysphoria can be reduced via treatment which is aimed at providing a gender role and expression which is comfortable for them even if they differ from the prevailing norms and expectations of the sex assigned at birth. (10) Comparative description the diagnosis of transgender between ICD-10 and DSM 5 diagnostic criteria have been highlighted in Table 2.1.

The Transgender Persons (Protection of rights) Act, 2019 defines a **transgender person** as any person whose expressed gender does not match with the gender assigned to that person at birth and includes trans-man or trans-woman (whether or not such person has undergone Sex Reassignment Surgery or hormone therapy or laser therapy or such other therapy), a person with intersex variations, genderqueer and person having such socio-cultural identities as *Kinner, Hijra, Aravani* and *Jogta.* (11) This definition is slightly different from the ICD-10 and DSM-5 definitions as it also includes individuals with disorders of sexual development and the definition shall be used for all issues and matters related to the law.

Table 2.1: Salient features and comparison of ICD-10 and DSM-5 diagnostic criteria of transgender (3,19,20)*

Features	ICD-10	DSM-5
Concept of Gender	Gender is binary	Gender is fluid
Diagnostic category	Gender identity disorder	Gender dysphoria
Name of the diagnosis	Transsexualism	Gender dysphoria in adolescents and adults
Overlap with diagnosis of Disorders of Sexual Development (DSD)	Not specified	If an individual with a DSD also satisfies the diagnostic requirements for gender incongruence, both diagnoses should be assigned
Time duration required to establish the diagnosis	Minimum of 2 years	Minimum of 6 months
Diagnostic criteria	a) Desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make one's body as congruent as possible with one's preferred sex through surgery and hormonal treatment	Criterion A: Two of the following must be present a) A marked incongruence between one's experienced/ expressed gender and primary and/or secondary sex characteristics b) A strong desire to be rid of one's primary and/or secondary sex characteristics c) A strong desire for the primary and/or secondary sex characteristics of the other gender d) A strong desire to be of the other gender e) A strong desire to be treated as the other gender f) A strong conviction that one has the typical feelings and reactions of the other gender
Associated distress or impairment in important areas of functioning	Evidence of significant distress or impairment in social or other important areas of functioning must be present	Criterion B: Evidence of the condition being associated with clinically significant distress or impairment in social, school, or other important areas of functioning must be present

**Source: Soll BM, Robles-García R, Brandelli-Costa A, Mori D, Mueller A, Vaitses-Fontanari AM, et al. Gender incongruence: a comparative study using ICD-10 and DSM-5 diagnostic criteria. Brazilian Journal of Psychiatry. 2018;40(2):174–80*

Chapter 3

Transgender rights movement: Evolution and History in the world & India

3.1: Recognising the legal rights of the third gender: an international perspective

IN RECENT YEARS, TG persons around the world have made tremendous strides toward achieving legal recognition. The Trans Murder Monitoring Project, an initiative that collects and analyses reports of transgender homicides worldwide, recorded 1,731 murders of TG persons globally between 2007 and 2014. (21) Many were of a shockingly brutal nature, sometimes involving torture and mutilation. Outright violence is not the only threat to the lives of TG persons. They are as much as 50 times more likely to acquire HIV than the general population because stigma and discrimination create barriers to accessing health services. Systematic marginalization and have led to higher suicidal rates as per the studies done in United States, Canada and Europe.

In 2012, Argentina formed a law that is considered the gold standard for legal gender recognition. It says anyone aged over 18 years can choose their gender identity, undergo gender reassignment, and revise official documents without any prior judicial or medical approval, and children can do so with the consent of their legal representatives or through summary proceedings before a judge. In the subsequent three years, four more countries—Colombia, Denmark, Ireland, and Malta explicitly eliminated significant barriers to legal gender recognition.

To date, 24 countries (includes India and Pakistan in Asia) recognise third gender/ transgender identity, while Poland had vetoed the gender identity law and rest countries continue to derecognize the third gender/ transgender identity

3.2: Recognising the legal rights of the third gender: an Indian perspective

The census data of 2011 reports that over 66% of the population identified as third gender lived in rural areas. They had lower literacy rates compared to the general population (46% compared to 74% literacy in the general population). (9) They had lower rates of successful employment

and the majority of them were unable to sustain work beyond 6 months. The reasons for the same were manifold–discrimination in the society, educational facilities and workplace; high prevalence of HIV, substance use disorders, depression and suicide; and lack of medical facilities catering to the needs of these individuals. (22) The monograph published by the Peoples Union for Civil Liberties, Karnataka (PUCL-K) have given comprehensive accounts on violent stories of abuse and sexual violence and the embedded fear of sexual and gender non-conformity in the mainstream society, thus, negating the claims of equal citizenship and protection for all according to the Constitution of India. (23)

Article 15 and 16 of the Indian Constitution explicitly prohibits discrimination on the grounds of "sex" and provides all individuals with the fundamental right to equality and equal protection under the law. (24) Further, Article 21 of the Indian Constitution states that every person is allowed to lead a dignified life, including diversity in self-expression. (24) However, the Indian Penal Code (IPC), Sec 377 criminalized consensual sexual acts among 2 consenting adults in private and was presumed to be in violation of these fundamental rights. In the first of a series of noteworthy cases, Naz Foundation filed a writ petition (a public interest action taken before the government) to decriminalize Sec 377 IPC in the high court of Delhi. (25) In a historic judgment that spearheaded the Lesbian, Gay, Bisexual, and Transgender (LGBT) activist movement, the Delhi high court in 2009 ruled in the favour of decriminalizing IPC Sec 377. However, as per the judgement, the provisions of IPC Sec 377 would still continue to govern non-consensual penile non-vaginal sex and penile nonvaginal sex involving minors. It was challenged by a civil appeal by Suresh Kumar Kaushal and others vs Naz Foundation and others in the honourable supreme court. A two judge supreme court bench said that the 2009 order of the Delhi High Court is "Constitutionally unsustainable as only Parliament can change a law, not courts" and overturned the judgement of the Delhi high court and reinstated Sec 377 of the Indian Penal Code in 2014. (26)

Challenging the decision given by the honourable Supreme Court in Suresh Kumar Kaushal and others vs Naz foundation and ors. Navtej Singh Johar, a dancer who identified as part of the LGBT community, filed a Writ Petition in the honourable Supreme Court in 2016 stating Sec 377 of the Indian Penal Code of 1860 was unconstitutional as it violated Article 14 and Article 21 of the Indian Constitution which guarantees right to sexuality and sexual autonomy to be a part of these fundamental rights and further demanding for a reasonable classification between natural and unnatural consensual sex. An emphasis was also made on the judgment given by the honourable supreme court in Justice K. S Puttaswamy vs Union of India which delivered a unanimous verdict in 2017 stating the Constitution of India confers each individual with a fundamental right to privacy under Article 21 which suggested that autonomy and privacy are inextricably linked. (27) After hearing the arguments, the five-judge bench of the Indiana Supreme Court unanimously held that Sec 377 of the Indian Penal Code, 1860, in so

far as it applied to consensual sexual conduct between adults in private, was unconstitutional. (28) With this, in 2018, the honourable supreme Court overruled its decision in Suresh Kumar Kaushal v. Naz Foundation that had upheld the constitutionality of Sec 377.

It was in this pretext the National Legal Services Authority (NALSA) filed a civil petition in the honourable Supreme Court demanding legal provisions to recognize persons who fall outside the binary gender (male/female), including persons who identify as "third gender". (29) It drew attention to the fact that transgender persons were subject to "extreme discrimination in all spheres of society" which was a violation of their right to equality. After much deliberation about the breach of fundamental rights to non-binary gender and consultation with the "expert committee on issues relating to transgender persons" constituted under the Ministry of Social Justice and Empowerment, the honourable Supreme Court in a landmark judgement dated 15th April 2014 granted legal recognition for "third gender". It placed one's gender identity within the framework of the fundamental right to dignity under Article 21 and held that all individuals including transgender persons were entitled to fundamental rights under Articles 14, 15, 16, 19 (1) (a), and 21 of the Constitution. (29)

This was an important milestone because it not only gave legal recognition to non-binary gender identities but also upheld their fundamental rights as per the Constitution of India. As per this judgement, Central and State governments were deemed to take proactive action towards securing transgender persons' rights. It highlighted the fact that Article 14 and 19 (1) (a) of the Constitution which talks about the right to equality and freedom of expression was outlined in gender-neutral terms ("all persons") and by default these would also apply to transgender persons. (29) It further clarified gender identity as "an innate perception of one's gender" and not restricting it to biological characteristics (such as chromosomes, genitalia and secondary sexual characteristics). The court upheld the right of all persons to self-identify their gender and declared that *hijras* and eunuchs can legally identify as "third gender". (29) No third gender persons should be subjected to any medical examination or biological test which would invade their right to privacy in addition to directing the state and central governments to develop mechanisms for realising and making legal provisions for "third gender"/transgender persons. (29)

These landmark judgments paved the way for the legislation, which is now known as **The Transgender Persons (Protection of rights) Act, 2019,** and came into effect on 5th December 2019. (11) The legislation highlights the need for formulating welfare schemes and programmes, including healthcare provisions, to facilitate and support livelihood for transgender persons, including their vocational training and self-employment. It safeguards the fundamental rights of these transgender and gender diverse individuals and aims at providing a safe space for them to function in society. Section 3 of the Act prohibits any and all forms of discrimination against

Transgender individuals either in public or private, Educational institutes, offices, healthcare facilities or public places, and any individual who is found to be guilty of the same, directly or indirectly leading to harm or endangerment to the life of transgender individuals shall be liable to punishment with imprisonment for a term not less than six months and may extend to 2 years with fine. (11)

Under Sections 4-6 of the Act, a transgender person who is a major (age of 18 years and above) can apply for obtaining the certificate of gender identity as transgender or third gender along with an affidavit stating they are transgender person and a clinical psychologist report (see figure 3.1). Upon receipt of this application, the District Magistrate shall grant the Transgender certificate and identity card within 60 days of receipt of this application. (11) The Transgender certificate shall serve as a proof of recognition which shall be recorded in all official documents pertaining to the individual and can be used to avail all welfare measures available for the benefit of these individuals. Upon completion of the sex reassignment surgery (SRS) the transgender person, under Section 7 of this Act shall be eligible to apply for gender change certificate (as per their expressed gender) along with the medical certificate from the Medical Superintendent or Registered Medical Officer of the hospital from where they have undergone the SRS. The district magistrate under whose jurisdiction the transgender person has been residing for the past one year upon receipt of the application shall grant the gender change certificate and identity card. (11)

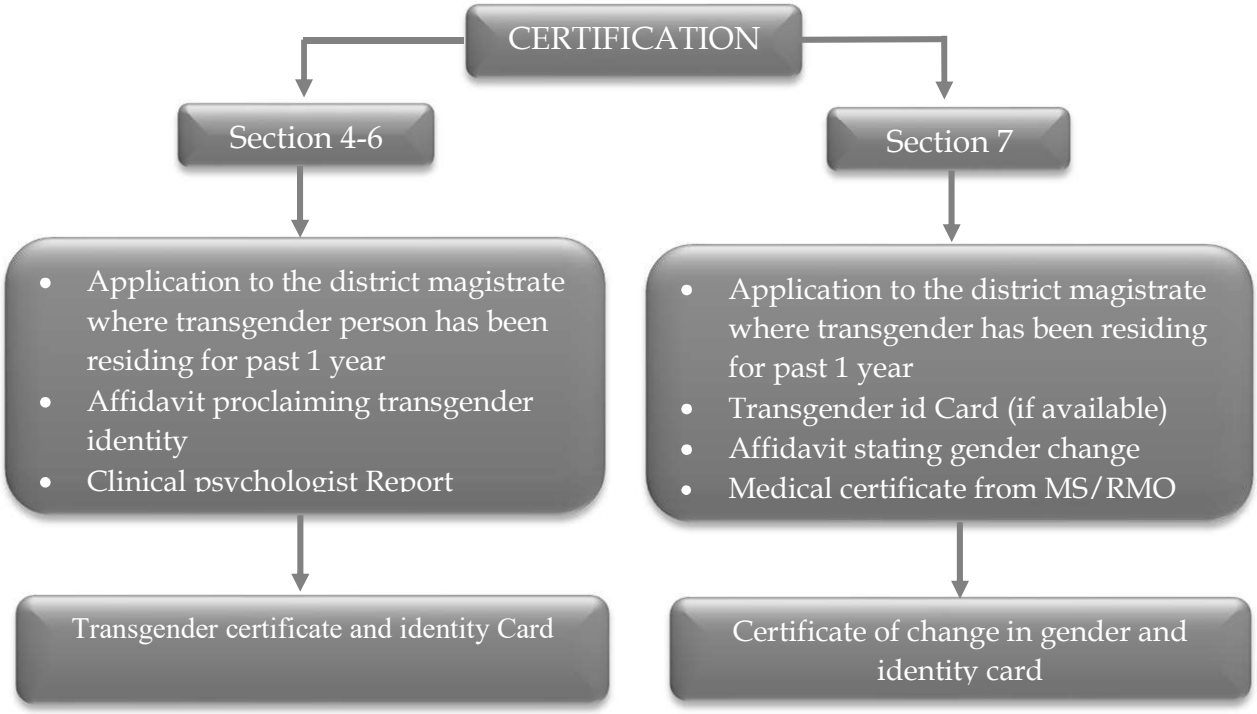

Figure 3.1: Flow chart illustrating certification procedure for transgender and change in gender as per The Transgender Persons (Protection of Rights) Act, 2019

Section 15 of this Act insists the appropriate Governments to set up a separate HIV sero-surveillance centre for these individuals, facilities for medical and surgical care which provide gender affirmation surgeries, hormonal therapy. (11) In addition, it also directs the appropriate governments to bring out a manual for healthcare of transgender persons in India in accordance with the World Professional Association for Transgender Health (WPATH) guidelines. The Act also provides for inclusion of health education of sexual minorities in both undergraduate and postgraduate medical curriculum and provision of comprehensive health insurance schemes for the benefit of transgender persons. As per Section 16 of the Act, a national council for transgender persons has been formulated on 21 August 2020 which shall oversee all the social welfare measures and policies related to transgender persons.

Chapter 4

Health issues among transgenders in India

THE EXISTING LITERATURE on TGNC individuals have increasingly shown that being or identifying oneself as a transgender is not a Mental illness or Medical condition. However, transgender individuals have very high rates of both psychiatric and medical comorbidities. The majority of our knowledge in this regard arises from studies that have focussed mainly on the prevalence of HIV/AIDS, suicide, and abuse among this population. This section provides a summary of the various medical and mental health problems faced by these individuals. A summary of various health issues among transgender individuals have been provided in Table 4.1.

4.1: Mental health issues among transgender persons:

TGNC population is subjected to a variety of social adversities including violence, stigma, discrimination in the healthcare systems which makes these individuals more vulnerable to the risk of mental illness. (30) The Virginia transgender health study reported nearly one-third of the individuals enrolled in their study reported not having families that are very supportive of their gender expression or transgender status and another one-third of the study individuals reported having faced some adverse experience in the form of bullying, hostility from peers and teachers in the school. (31) A TGNC child who acts against the binary gender norms of the society, face culturally infused transphobia and psychological trauma within the family. Family rejection and violation of the right to education and employment were one of the major causes that hinder their progress in the society, as reported by The Joint united nations programme on HIV/AIDS (UNAIDS) on transgender health. (32) The UNAIDS survey also reported that 65% to 85% of transgender people experienced verbal abuse, 25% to 45% faced physical abuse and almost 20% were sexually abused. (32) The Los Angeles Transgender Health Study has also shown that overall, 80% transgender people being verbally abused and nearly 50% of them faced physical abuse. (33)

A review on mental health issues related to transgender youth reported increased rates of psychiatric morbidity including higher rates of suicidality and self-harm, depression, and eating disorders when compared with their peers. (34) The risk of anxiety, depression, self-harm, and suicide were increased by twofold to threefold among transgender youth when compared to cisgender matched controls in both outpatient and inpatient mental health care settings. (35) Among all other psychiatric morbidities, the risk of suicide was 20 times higher among

transgender individuals when compared to the general population. (36) Transmen where twice as likely to commit suicide as transwomen, however, the rates of suicide among both the groups were significantly higher when compared to the general population. (37)

Indian studies in this regard, even though limited, have consistently shown higher rates of abuse. Naskar P *et al* reported that in their study around 98.6% of individuals were verbally abused, 79.2% were physically abused, 33.3% sexually abused and 18.1% faced childhood abuse at least once in their lifetime. (38) Poguri M *et al* in a study from south India reported almost all of the study subjects experienced some form of childhood sexual abuse. (39) George A *et al* reported better quality of life among those individuals who had some form of contact with their families when compared to those who were excluded from their families. (40) Thus, based on the available literature one may assume that TGNC individuals are socially excluded and marginalised because of the way in which they express their gender identities thus making them vulnerable to develop mental illness. These difficulties have led them to often depend on others for their livelihood which makes them vulnerable for exploitation, because of which they engage in commercial sex work, by performing in ceremonies, generate income by petty extortion which has a negative impact on their quality of life. (22,41)

4.2: Medical issues among transgender persons:

Globally, around 19% of transgender women are living with Human Immunodeficiency Virus (HIV). Indian studies have shown varied prevalence between 17.5% to 41% of transgender women have HIV positive status. (32) They also have an increased risk of contracting other sexually transmitted infections (STI) such as syphilis, Hepatitis C and Human papilloma virus infection. Transgender women have approximately 50 times higher risk of contracting HIV than all other adults in the reproductive age. (32) Stigma, discrimination, gender-based sexual violence, social and economic exclusion, including from education and employment opportunities, represent the fundamental drivers of HIV vulnerability and risk among transgender women worldwide and in India. (32) The transgender legislation is supposed to address some of these issues as there are provisions in the law that prohibit discrimination towards these sexual minority individuals. There is also a provision in the legislation for setting up separate HIV sero-surveillance centre for better screening, identification, and treatment of STIs these individuals. (11)

Transgender individuals have an increased propensity to develop obesity which predisposes them to metabolic syndrome and diabetes. (42) Transgender men receiving masculinizing hormone therapies have shown a high association with elevated liver enzymes, loss of bone mineral density, and increased risk of developing ovarian cancer. (43) Transgender men were more likely to miss the routine pap smear screenings when compare to cisgender women which may additionally pose risk to develop endometrial, cervical and vaginal cancer although rare, compounded with the additional risk of hormonal therapy. (44) Studies have reported no increased risk of breast cancer among transgender women as compared to cisgender women thus not recommended for screening mammography. (44) American endocrine society guidelines recommend for routine screening of these risk factors for all transgender individuals undergoing hormonal therapy. (43)

Table 4.1: Summary of prevalence of various health issues among transgender persons *

Depression and anxiety (45,46)	➢ Approximately 30-70% of the individuals had a lifetime diagnosis of Depression. * ➢ Approximately 3-30% of the individuals had a current diagnosis of Anxiety disorder. * ➢ Two- to threefold increase the risk of depression and anxiety compared to the general population. ➢ The majority of the individuals had some form of Psychological distress or adjustment issues.
Schizophrenia and bipolar disorder (46)	➢ Risk no more than the general population
Suicide (36,37,47)	➢ Rates of suicide range from 32-50% across studies. ➢ Risk of suicide 20 times higher than in the general population. ➢ 50% of the individuals had attempted suicide at least once by their 20th birthday. ➢ In India, the rate of completed suicide among Transgender's is around 30%.
Substance Use disorder (40,42–44)	➢ The prevalence of substance use was 2.5–4 times higher for transgender youth compared with their non-transgender peers. ➢ Approximately 10-66% of transgender individuals had a lifetime diagnosis of Substance use disorder. * ➢ Strong correlation between a history of abuse and substance use disorder.
Infection (32,33,48,49)	➢ 17.5- 41% of transgenders were HIV positive. ➢ Transgender women had a 50 times higher risk of contracting HIV than others. ➢ Studies have also shown an increased risk of other Sexually transmitted infections.* • Syphilis (3%–79%) • Gonorrhoea (4%–14%) • Chlamydia (2%–8%) • Herpes (2%–6%) • Human papillomavirus (3%–7%)
Violence (31,33,38,39)	➢ 65-98% had faced verbal abuse. ➢ 25-79% had faced some form of Physical abuse. ➢ 20-33% had a history of sexual abuse. ➢ Social stigma and other factors may lead to under-reporting of acts of violence committed towards Transgender individuals.
Medical comorbidities (42,43)	➢ Increased propensity to develop obesity, metabolic syndrome, and diabetes. ➢ Hormone therapy in transgender men associated with increased risk of- • Elevated liver enzymes, • Decreased Bone mineral density • Increased risk of ovarian cancer.

*Majority of the studies were methodologically weak, small sample size, had differing definitions of transgender and inclusion criteria.

Chapter 5

Strengthening transgenders access to healthcare

5.1: Barriers to access healthcare

TRANSGENDER AND GENDER DIVERSE INDIVIDUALS seeking healthcare were often faced with stigma and maltreatment, which ranges from refusal to care and treatment on one end to verbal abuse, harassment, and violence on the extreme. National Transgender survey including 6450 participants comprising transgender and gender-nonconforming individuals conducted in the United States of America (USA) reported that 19% of the individuals were refused any form of treatment and 2% of the individuals encountered some form of violence in the medical settings, 28% of the participants postponed medical care owing to past negative experiences. (51) A study conducted by Kosenko *et al* focussing on subjective experiences of transgender individuals attending health care identified issues faced by transgender individuals in healthcare mainly centred around the themes of insensitivity towards expressed gender, lower standards of care and sometimes being denied of services, displays of discomfort by healthcare professionals, and verbal abuse. (52) Some of the other factors contributing as barrier to access of healthcare were most of these individuals were not covered under any insurance schemes compounded by the lack of culturally competent and knowledgeable professionals. A study on students from a health sciences university and applied mental health programs in Georgia, USA looking at how health professionals from different specialties could show respect for, and appreciate patient diversity concluded that professional students with pre-existing notions on sex and sexuality, and higher levels of religiosity had a discouraging attitude towards the sexual minority individuals. (53) Homophobia and transphobia continue to persist in some health care settings, with limited emphasis during training on cultural empathy or understanding among mental health care professionals, which presents challenges for the provision of appropriate delivery of mental health care. (53) Access to knowledgeable providers willing to care for transgender persons were limited. (54,55) It is important to note that some of these barriers to care also apply towards all sexual minority individuals, including the Lesbian Gay Bisexual and Transgender (LGBT) community.

The medical record or electronic health records (EHR) may serve as a barrier to care for transgender persons if they don't have facilities to appropriately capture information regarding gender identity and sexual orientation. (56) Ideally, for data collection about gender identity and sexual orientation, it must capture the patient's preferred name, gender at birth, sexual orientation, and gender identity. If the providers are using EHR and the system cannot collect these details at registration it may result in wide-ranging difficulties from patients being called by the wrong name, identified by inappropriate pronouns, or treated incorrectly based on provider or staff assumptions about sex, gender identity, and sexual orientation and behaviours. (57) Laboratory tests that are appropriate for the patient's gender identity may be reported with the incorrect reference ranges based on gender as reported in the EHR. (56) Currently gender reassignment services are not covered by any medical insurance schemes and the majority of the costs have to be borne by the individuals themselves. Also, hospitals need to have a separate restroom facility for transgender persons and should have a separate inpatient facility for transgender patients for admission and care for these individuals. Unavailability of most of these facilities can be gendered non-affirming experience for the patient and may hinder the delivery of effective mental healthcare services.

5.2: Role of psychiatrist in care of transgender persons

A psychiatrist must familiarize themselves with gender-nonconforming identities and expressions, and be knowledgeable about the assessment and treatment of gender dysphoria, sexual health concerns, and the assessment and treatment of sexual disorders. (10) Psychiatrists must develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender-nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. (10)

It is crucial for psychiatrists working with the TGNC population to create a gender-affirming environment, as often these individuals look for subtle clues in the healthcare settings to determine if they would have a positive mental healthcare experience. (58) All mental healthcare staff must be trained and must familiarize themselves to refer to such patients with their preferred pronouns and their correct gender identity. It would be preferable to have transgender person and other sexual minority friendly photographs, stickers, symbols and posters representing a diverse patient population. (49) Reading materials and brochures in the waiting rooms may include some of the information and materials pertinent to the transgender community. (49) While examination, the clinician should begin by asking open-ended questions and have a non-judgmental attitude throughout the interview to nurture a warm and friendly environment where they can discuss their issues. (58) The provider should ask about the

patient's gender identity and their preferred pronoun (s), which should be used when addressing the patient throughout the visit. (58)

Whenever there is a disparity between the practitioner's and transgender person's ethics and perspectives, the practitioner should, with utmost respect, explain the same and suggest alternative sources of consultation for the same. Both the patient and the practitioner should neither feel coerced to give up one's moral views nor impose them onto the other, which would otherwise lead to conflict. There may be circumstances where a professional may presume what is right for these individuals as per their judgement and provide with treatment options that are suitable as per them without providing other reasonable options. In extreme cases, they may initiate treatment for these individuals without their consent. This has to be avoided; true beneficence should always be upheld. (13) The practitioner must always follow the principle of 'do no harm' and act in the best interests of patients without imposing any burden (either personal or economic) upon them. (12) In simple terms, practitioners must always help these individuals weigh the benefits vs risks of any treatment option, assist them in making an informed treatment decision.

Many transgenders desire for hormonal therapy and sex reassignment surgery (SRS). Unfortunately, these services are only available free of cost in public health establishments in a few states like Tamil Nadu, Kerala, New Delhi. Section 15 of the Act directs appropriate governments to provide for medical care and counselling facilities pre and post hormonal therapy and SRS. In order to achieve this goal mental healthcare facilities for transgender individuals maybe incorporated in the District Mental Health Programme, thereby enhancing the access to mental healthcare facilities for these individuals

Chapter 6

Psychiatric assessment of gender dysphoria among Children and Adolescents

THE DEVELOPMENT of gender identity is a complex and multifactorial process related to genetic, environmental and hormonal factors. (59) The development of gender identity is influenced by prenatal exposure to specific hormones which ultimately influence the sexual differentiation of the foetus and also assist in gender differentiation of brain. However, the core gender identity is only formed by age of 3 years and it becomes evident between the ages of 6 years and 8 years along with the development of cognitive abilities through which a child is able to differentiate between a male and female. (60) Most of the secondary sexual characteristics develop during preadolescence period for boys and in latency for girls which matures after puberty.

Preliminary reports suggest that atypical sexual differentiation of the brain occurs in individuals which differs from the body phenotype and results in gender dysphoria in these individuals. (2) A percentage of people may have an intense desire to shift identities after puberty leading to gender dysphoria. (60) Depending on the degree of distress between one's experienced gender and gender assigned at birth the manifestations of gender dysphoria are ascertained. Gender dysphoria of childhood and adolescence differs from disorders of sexual development (DSD) in which the latter encompass a group of congenital conditions associated with variations in genes, developmental programming and hormones which result in atypical development of internal and external genital structures. (61)

The existing evidence from high income countries suggests that number of adolescents and children with gender identity issues being referred to specialised gender clinics and programmes have seen a substantial increase over the last two decades. (62) Increased awareness towards transgender persons issues via internet and mass media, reduction in stigma towards these children could be few possible explanations for the same. There are considerable differences in the manifestations of gender dysphoria in children, adolescents, and adults in

terms of the phenomenology, development, course, and outcomes and treatment approaches. (63)

Young children who identify themselves as gender nonconforming or transgender persons as they progress into adolescence and adulthood may or may not continue to identify as transgender person. (64) Children may express a wish to be of the other sex and/or express displeasure about their physical appearance and sex as early as two years of age. They may prefer playing with children of other sex and may demonstrate an unusual liking towards the toys, games and clothes usually related with the other sex. The intensity of these symptoms may vary and sometimes may keep fluctuating. There is some evidence to suggest in a minority of these individuals the gender incongruence of childhood usually disappears as they enter adolescence.

There is a wide variation in the prevalence of gender dysphoria in children and adolescence. Approximately 10-39% of the children who present with gender dysphoria may continue to have gender dysphoria of adolescence. (65) The dysphoria associated with the assigned gender usually intensifies with the onset of puberty and the appearance of secondary sexual characteristics. The average age at presentation to the clinics is usually in mid-adolescence (between 14-16 years of age). (65) Studies have examined that children who have more persistent and more severe symptoms of GID in childhood, who are cognitively able to assert their gender (e.g.- 'I am a boy' vs 'I feel like a boy'), and consistent use of cross-gender statements in childhood, have higher associations with persistence of gender dysphoria/ transgender identity in adolescence and adulthood. (64) As observed in children adolescents with gender dysphoria also have higher comorbid anxiety and depression along with externalising spectrum disorder such as Oppositional defiant disorder, etc.

Children with gender dysphoria have higher rates of mental health difficulties and greater psychological problems. (65) Transgender youth between the ages of 14 to 18 years old had 5-fold higher risk of suicidality. (66) These individuals also had 2-3-fold higher risk of developing depression and anxiety disorders. (66) There is growing evidence concerning co-occurrence and/or overlap between GD and Autism Spectrum Disorder (ASD). Even though the link between these two remain weak studies report a bidirectional assumption between GD and ASD, not only children and adolescents with GD show more symptoms of ASD, but also that children with ASD show a higher level of reported GD. It is highly recommended to screen for ASD among gender referrals and vice versa. (66)

The following approach may be useful for psychiatrists working with children and adolescents with gender dysphoria (10,18,63)

- Diagnostic assessment of gender dysphoria based on using DSM-5 or ICD-10 codes which should include the developmental assessment including gender identity, sex, orientation and cognitive/ emotional functioning.
- Assessment and treatment of any and all coexisting mental health problems such as anxiety, depression, or autism spectrum disorders. Assessment of risk for self-harm and suicide, if any, should also be performed.
- Endocrinological/ Gynaecological evaluation should be performed for all patients in order to rule out Disorders of sexual development.
- The Psychiatrist should not dismiss or express a negative attitude towards children and adolescents with nonconforming gender identities or gender dysphoria.
- A psychiatric assessment covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement should be performed.
- Individual therapy which is appropriate to the development of the individual to assist children and adolescents to explore gender identity, reduce the distress associated with gender dysphoria, facilitating the coming out process when ready and addressing any other psychosocial difficulties should be offered.
- They should be a minimum of 18 years for applying for a certificate for legal recognition of transgender.
- Identification of support groups and provision of support for carers, education, and advocacy on behalf of transgender children and adolescents to promote gender-affirming environment at both home, school, and social situations.

Majority of the clinical guidelines for the management of children with a diagnosis of gender dysphoria suggest psychological interventions as the first line of management before any other physical intervention. (67) Physical interventions such as hormone replacement therapy should be considered only after a careful consideration where benefits outweigh the risk and after parental consent if the individual is below 18 years of age. Majority of the clinical guidelines suggest a delay in gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old.

Chapter 7

Psychiatric assessment of gender dysphoria among Adults

AS DESCRIBED EARLIER there is a very high prevalence of mental health issues and substance use disorders among transgender individuals (table 4.1). Taking into account a wide variety of barriers to health care in accessing general and specialist services including Anti-retroviral treatment, there is also a dearth in availability and access to specialist health services including gender transition services in India. (68) The available information about the social functioning and mental health needs of these individuals is also limited which further makes this population a vulnerable one. The Transgender Persons (Protection of Rights) Act of 2019 acknowledges these limitations and under Section 15 of the Act urges for appropriate measures to be taken in this regard including the provision of specialist mental health services and medical care facilities for sexual reassignment surgery and hormonal therapy to address the needs of these individuals. (11)

The management of transgender or gender diverse individuals requires a multidisciplinary team approach. The multidisciplinary team along with the psychiatrist may include general practitioner or sexual medicine practitioner, endocrinologist, general surgeon, urologist or gynaecologist or a plastic surgeon with expertise in sexual reassignment surgery, a speech pathologist, depending on the individual patient requirements. (69) It is often the psychiatrist who is called upon to take a lead clinician role in order to ascertain the gender dysphoria and rule out any secondary causes of gender dysphoria. The lead clinician often must undertake a detailed assessment and document an elaborate treatment plan and facilitate referrals to all other members of the multidisciplinary team.

Psychiatrists may often find a referral from primary care physicians or endocrinologists or other medical specialties to establish gender dysphoria. (69) It is of utmost importance to maintain a good rapport and establish a therapeutic alliance with these individuals and minimise the frequent change in the person in order to retain these individuals in the treatment loop. Psychiatrists should bear in mind that transgender individuals who seek consultations are in different stages of transition, some of them may have clear views about the kind of interventions and treatments that they would want to have, for e.g.- individuals may seek

consultation for assessment and obtaining referral for hormonal or surgical interventions; psychotherapy unrelated to gender concerns; or other professional services such as to seek psychological support for family members (partners, children, extended family). (10) While some individuals may need help for psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming-out process. It is of utmost importance to identify the individual's reason for seeking professional or health care assistance and mental health professionals should ascertain the purpose of help-seeking before carrying out further assessments and management. The following approach may be useful for -

7.1: Assessment and management of gender dysphoria along with co-existing mental health issues: (10,69)

- Detailed history including the development of gender dysphoric feelings including assessment of sex, gender and orientation.
- A detailed interview and mental status examination to rule out co-morbid mood and anxiety disorders, substance use disorders and to assess suicidal risk factors
- The examiner should confirm the diagnosis of the gender dysphoria and rule out if it is secondary to or better accounted for by another diagnosis.
- Assessment of family dynamics, various social support systems, stigma faced in the society or at work and educational places.
- Assess for the current stage of transition, whether the individual has completed social or medical/surgical transitioning or both.
- Physical examination (height; weight; blood pressure) and necessary baseline laboratory investigations should be done.
- If the individual does not have gender dysphoria and as a consequence gender incongruence, it shall be communicated to the individual, and referral for alternate services may be advised.
- Upon confirmation of the diagnosis of gender dysphoria, the psychiatrist shall provide necessary information to these individuals regarding various evidence-based options that are clinically appropriate, to encourage these individuals to take active role in determining the best treatment route which suits their needs and preferences.
- The clinician must examine the capacity of these individuals to consent for their treatment.
- Ascertain if the individual has applied for or obtained a certificate of identity as a transgender person from the district magistrate.

TGNC individuals may have complex issues or need, comorbid mental and physical illness, and may require 2 or more consultations for completion of assessments, in such cases each consultation should be planned and should have a defined agenda and the same shall be communicated to the patients (69). The psychiatrists should bear in mind that individuals may also require sufficient time to reflect on the figure 7.1 clinical advice and the potential treatment option before they make any treatment decisions. Before initiating any assessment or intervention, either psychological or medical, and informed consent must be obtained. Thus, enabling these individuals to review the various treatment options, material risks, benefits, and any other alternative options for treatment than those already proposed (including the option of having no treatment) and promoting shared decision making. Whenever there is a doubt in the diagnosis, one should always take an opinion from another psychiatrist who shall make an independent assessment of the patient.

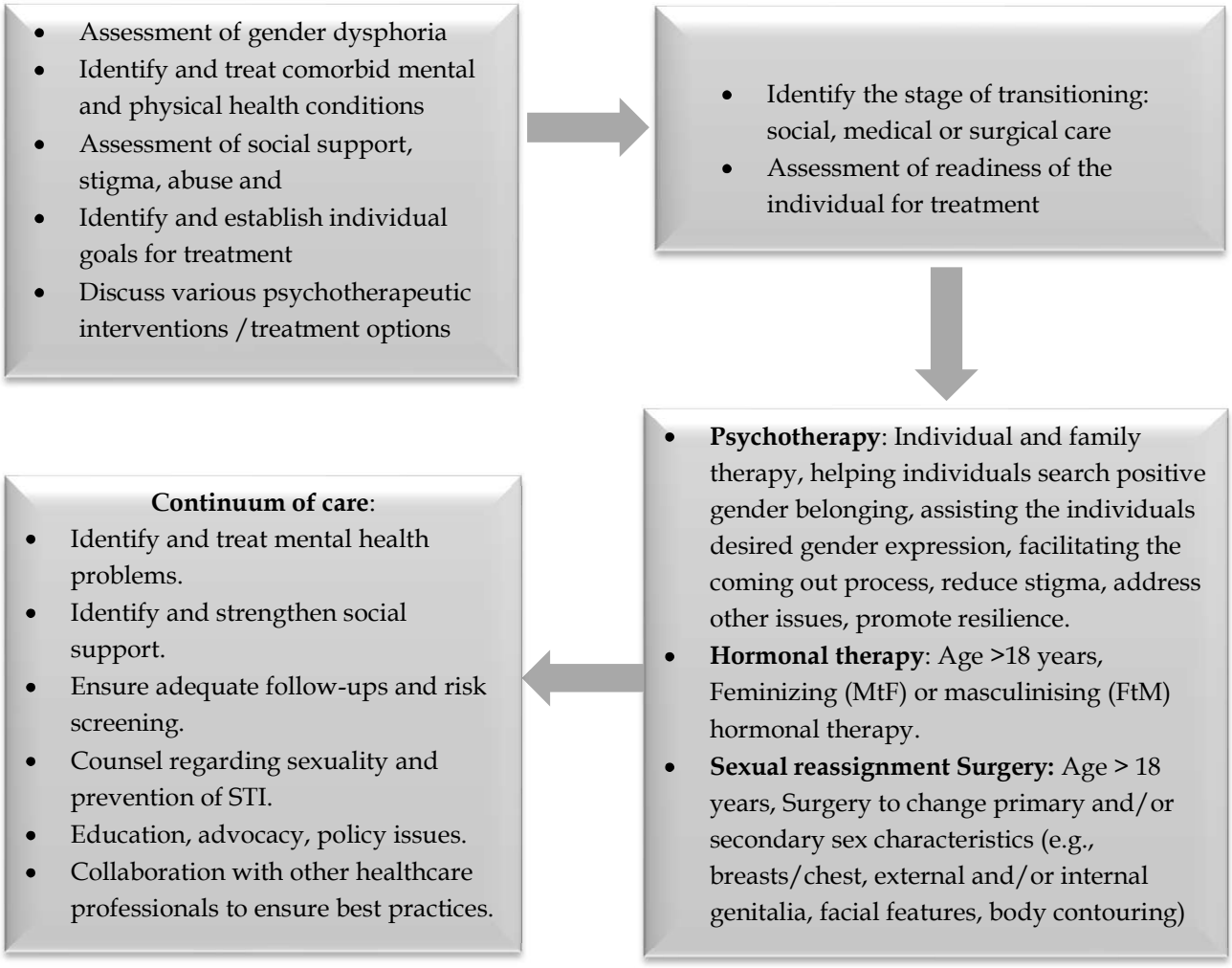

Figure 7.1: Overview of therapeutic approaches for gender dysphoria

Chapter 8

Guidelines for referring an individual for hormonal therapy

IT IS THE DUTY of the psychiatrist, either independently or as a part of the multidisciplinary teams, to assess the readiness of transgender individuals to undergo hormonal therapy. Just expressing a desire to undergo hormonal therapy or mere possession of a gender recognition certificate does not in itself provide all the necessary clinical information required to assess the suitability and readiness for available medical interventions.

8.1: Assessment for the suitability and readiness for masculinizing/ feminizing hormonal therapy: (10,69)

- Assessment of expectations from hormonal or medical interventions and the impact of these interventions on the psychological and social functioning of these individuals
- Detailed psychiatric, medical, or surgical history including any contraindications for medical or hormonal procedures.
- Assessment of understanding about the likely impact of medical interventions on physical health including the loss of fertility.
- Preparing the individuals for the said intervention and plan for aftercare.
- Advice on positive lifestyle behaviours such as encouraging to adopt a healthy lifestyle, regular exercises, advice, and treatment of substance use (depending on the level of motivation of these individuals).
- Discussion of various support strategies and identification of support networks for these individuals to thrive after the said intervention.

8.2: Criteria for hormonal therapy:

a) Persistent, well-documented gender dysphoria for 6 months

b) Psychological preparedness for Hormonal Therapy.

c) Capacity to make a fully informed decision and to consent for treatment, free of any and all forms of coercion.

d) The individual should be of the age of 18 years or above

e) The well controlled medical or mental health condition, if any issues are present.

f) Psychotherapy is not an absolute prerequisite (it is optional) for Hormonal therapy

g) It is recommended that all individuals approaching hormonal therapy should have got transgender certificate/ id card as per the legislation.

8.3: Referral to the endocrinologist or hormone prescribing physician:

For referring a patient for hormonal therapy, a recommendation letter from one psychiatrist is sufficient. The recommended content of the referral letter for feminizing or masculinizing hormone therapy should include the following (10):

- The transgender person's name as per the birth certificate and the individuals chose name along with identifying characteristics.
- Results of the Psychiatric evaluation and psychosocial assessment of transgender person, including any psychiatric diagnoses.
- The duration of the professional's relationship with the transgender person, including the type of evaluation and therapy or counselling to date.
- A statement on transgender persons capacity to make informed consent and a brief description of the clinical rationale for supporting the transgenders request for hormonal therapy
- A statement that the referring psychiatrist is available for coordination of care and can be contacted through established means of professional communication.

A format of the referral letter is attached in the *Appendix C*.

It is the primary duty of the endocrinologist or the hormone prescribing physician to provide information to the individuals regarding the potential risks and possible complications involved, including the impact of hormonal therapy on physical changes and mental health. The endocrinologist or the hormone prescribing physician has to take the prior informed consent for hormonal therapy, before initiating the hormone therapy.

Chapter 9

Role of psychiatrist in sex reassignment surgery

THE PRACTICE OF SURGERY often involves the removal of a pathological tissue and restoring the disturbed functioning of the body part. However, sex reassignment surgery (SRS) involves altering the normal functioning of the body part in order to reduce the sense of gender dysphoria and improve a person's self-image. This has often been questioned and objected citing ethical concerns. While the concept of 'above all do no harm' shall be respected, health care professionals also have a duty to prevent the high number of self-harm attempts and suicide secondary to gender dysphoria seen among the TGNC individuals. (10) There exists a subset of transgender and gender-nonconforming patients for whom surgery is not only essential but medically necessary to reduce the gender Dysphoria thereby preventing harm and promoting life. For this group of individuals modification of primary and secondary sexual characteristics is necessary in order to alleviate gender Dysphoria. (70) Follow up studies post-SRS have shown a positive impact on the life of these individuals in terms of subjective wellbeing and sexual functioning.

Sexual reassignment surgery is often considered the last but the most crucial step in the treatment of gender dysphoria. Genital and breast/chest surgery are not merely another elective procedure, the majority of these procedures are often irreversible. The psychiatrist who receives the referral shall independently assess the patients as following

9.1: Assessments of patients for SRS (10,71)**:**

- Assessment of expectations from the desired surgical procedure and the impact of these interventions on the psychological and social functioning of these individuals
- Psychological preparedness for surgery
- Detailed psychiatric, medical or surgical history, contraindications to the prescribed procedures if any.
- Details of the hormonal therapy, if any, including duration, dosing, any adverse effects.

- Knowledge and information about the different surgical techniques (as discussed by the surgeon), limitations of the procedure to achieve the ideal or desired result and the likely benefits
- Preparing the individuals for the prescribed surgical intervention and plan for aftercare.
- Discussion of various support strategies and identification of support networks for these individuals to thrive after the said intervention.
- Ascertain if the individual has applied for or obtained a certificate of identity as a transgender person from the district magistrate.

9.2: Criteria for non-genital (chest/breast) & genital surgery:

a) Persistent well-documented gender Dysphoria

b) Capacity to make fully informed decisions and consent for treatment. *

c) The individual should be of the age 18 years or above

d) The individual should possess a transgender certificate/id card issued by the district Magistrate.

e) If physical and mental health problems are present should be well controlled in past one year.

f) Has lived full time in his/ her desired gender role for the past 12 months.

g) Psychotherapy or hormone therapy is not an absolute prerequisite (it is optional) for genital or non-genital surgery. ^

^ *However for individuals undergoing feminising surgery or breast augmentation procedures, hormonal therapy for a minimum duration of 12 months is advisable.*

9.3: Referral for sexual Reassignment Surgery:

For persons requesting genital surgery, (e.g.- orchidectomy, salpingo-oophorectomy/ hysterectomy, genital reconstructive surgeries), non-genital breast/ chest surgery (e.g.- chest reconstruction, mastectomy or augmentation mammoplasty) one referral from a qualified psychiatrist is sufficient along with transgender certificate issued by the district Magistrate. However, WPATH recommends individuals to be evaluated by two psychiatrists (preferably one of the psychiatrists not be involved in the care of the individual who is requesting for SRS) independently who shall undertake their assessments and then give two separate referrals. However, in the Indian context due to the shortage of psychiatrists and mental health professionals who provide care for transgender persons, we would recommend evaluation from one psychiatrist to be sufficient.

The recommended content of the referral letter for feminizing or masculinizing hormone therapy includes the following (10):

- The transgenders name as per the birth certificate and the individuals chose name along with identifying characteristics.
- Results of the Psychiatric evaluation and psychosocial assessment of transgender person, including any psychiatric diagnoses.
- The duration of the professional's relationship with the transgender person, including the type of evaluation and therapy or counselling to date.
- A statement that capacity to make a informed consent by the patient and a brief description of the clinical rationale for supporting the transgender persons request for sexual reassignment surgery
- A statement that the referring psychiatrist is available for coordination of care and can be contacted through established means of professional communication.

A format of the referral letter is attached in Appendix B.

It is the surgeon's responsibility to determine that an individual is sufficiently healthy, physically and psychologically, to undergo surgery. It is the primary duty of the surgeon to provide information to the individuals regarding the potential risks and possible complications of the various techniques, including the impact of surgical procedure to physical health including the loss of fertility and the surgeon has to take a prior informed consent for the surgery.

9.5: post-operative care:

Patients who follow-up regularly after surgical treatments for gender dysphoria had better surgical and psychosocial outcomes. (10) It is equally important for these patients to follow-up with psychiatrists as patients may have spent maximum time in consultation and the psychiatrists can provide assistance in post-op adjustment difficulties.

Upon completion of the SRS (genital surgery) a medical certificate from the Medical Superintendent (MS) or Registered Medical Officer (RMO) [as per The Transgender Persons (protection of rights) Rules, 2020] of the hospital from where they have undergone the SRS shall be provided which will help the individuals to apply for certificate of gender change from the district Magistrate. MS or RMO can issue the certificate alone or form a medical board including psychiatrist for issuing the certificate.

Chapter 10

Psychotherapy/Counselling for transgender persons

PSYCHOTHERAPY is not an absolute prerequisite for hormone or surgical therapy. The main aim of psychotherapy is to offer support to these transgender individuals throughout the process of transition from an unsatisfying life to a more satisfying life. (72) There are no recommendations available regarding the minimum number of psychotherapy sessions prior to hormone or surgical therapy, as both clients and therapists differ in their abilities to achieve similar goals in a specified time period; and hence, a minimum number of sessions may appear as a hurdle hindering true opportunities for personal growth. (73) The meaning of transitioning from one's experienced gender to express gender is complex and differs from each individual. Hence, the goals of the therapy can be realised under the premise of two basic principles (72) -

- Offering optimal options for assisting the individuals search for positive (or desired) gender belonging, desired gender expression including assistance in the coming out process.
- Improving the psychological and psychosocial wellbeing of TGNC individuals.

In order to make a treatment decision with regard to transitioning it is important to identify one's sex and gender roles assigned at birth and the acknowledgment of the dysphoria w.r.t same and desire to be seen by oneself and/or others as a different gender and/or sex. Transgender individuals who are enrolled in therapy may have completed some, all or none of the components of the 3 broad categories of transitioning, i.e.- social, medical, and surgical. The therapies must aim at (71,74):

a) Creating opportunities for individuals to access, information, resources, and skills to help them to adapt to the psychological, social, physical and relationship changes
b) Providing evidence-based psychological interventions that are personalised to specific individual needs.

c) Providing clarity and hope to these individuals by validating their personal experience and ensuring gender-affirming practice.

d) Overall, promote the psychological and psycho social wellbeing of these individuals.

Psychotherapy or counselling may be offered as a primary intervention or in concurrence with medical or surgical treatments or following medical or surgical treatment and should be planned accordingly. It is also the duty of the mental health professionals to provide adequate training and supervision that promotes confidence and competence among therapists to deal effectively with the problems and difficulties presented to them in the therapy sessions.

10.1: Tasks related to psychotherapy (72–75)**:**

i. Educating and providing insights regarding optional gender belongings

The strongest sense of gender rests in the minds of the presenting individual and the role of the therapist to facilitate the process of transitioning into expressed gender. This has to be explored during the early stages of treatment, and therapists should work in association with the patient to achieve the same. In addition to the binary gender (male and female), the therapist should provide options about other possible options for gender expressions such as non-gender /agender, gender queer or intersex genders, etc. This should also include identifying and assisting their sexual needs (including after SRS).

ii. Facilitate social transitioning and coming-out process

The process of social transitioning includes the decisions related to public presentation of one's gender identity, how they wish to appear in public, preferred name, desired pronouns, and their sexual orientation and behaviours. Behavioural interventions that focus on bringing about desired social change may include learning the communication and interaction styles, various mannerisms of the preferred gender, resocialisation, voice training.

The process of coming out is not a onetime thing and, in most cases, is a recurring process. The decision of coming out should be made by the individuals and the role of the therapist is to assist and support them during the process. In majority of the cases, coming out is most comfortable when one is confident and is ready. During this process, the therapist should actively screen for any mental health problems such as depression or anxiety, etc., also assess for the readiness of the individual to begin medical/ hormonal transition if not undergone before.

iii. Addressing stigma

Therapists should assess the stigma faced by these individuals in the society, in schools or at work, and the impact of stigma on the mental health of these individuals and address these

issues. Identify strong social support or network and strengthen the support and help in promoting a friendly environment where these individuals thrive.

iv. Promote a sense of satisfaction with their expressed gender

The most important long-term goal of psychotherapy is to help the TGNC individuals to achieve a sense of comfort in their gender expression. The therapist must direct their efforts towards achieving this and provide them with realistic chances for success in their education work and relationships.

v. Provide support to the family members

The distress associated with gender dysphoria is not only limited to the individuals, but also has a significant impact on the family or partner. Family members may face significant guilt, difficulties associated with role transitioning, stigma, etc. Alternatively, individuals with gender dysphoria may need help to communicate the diagnosis or various treatment decisions to the family members. Family therapy should focus on addressing these issues.

The role of family becomes even more important while dealing with children and adolescents with gender dysphoria. Parental consent is a must before initiating any form of psychological intervention among children and adolescents below the age of 18 years. The most important goal of the family interventions should be to provide a safe home environment for these individuals while addressing the concerns of the family members.

Don'ts in therapy:

- The Indian Psychiatric society forbids promoting, delivering, or referring individuals for conversion therapy.
- Avoid attitudes and practices which foster gender non affirming experience.

Chapter 11

Continuity of care of transgender persons

TGNC INDIVIDUALS require health care throughout their lives, although their needs and requirements may vary depending on the life stage and stage of transitioning. There is merit in maintaining the continuity of care in order to address any mental health issues or stigma faced by these individuals, possible consequences of life-changing surgeries and any other issues that hinder the psychological wellbeing and progress of these individuals. (10) Engagement in the treatment process is absolutely essential and the duration and frequency of contact may be decided based on a case-by-case basis and can be flexible based on the needs of the individual. (71) Mental healthcare services which incorporates the views and needs of the patient, which are appropriate and sustainable with good liaising with other psychiatrist and mental health professionals and healthcare service providers (e.g.- endocrinologist/ surgeon, etc.) will not only benefit these individuals but promote dignity, respect and equality for trans people.

Alternative means of consultation via telemedicine may also be provided as per the individual circumstances. In person, face-to-face consultations may be considered as per the professional discretion during the initial phases of the treatment and for certification purposes(76). Suitability of patient for online therapeutic alliance to be taken into account before considering and also during tele-therapy. Psychiatrist providing teletherapy should abide by the same professional standards, ethical norms and laws as applicable to traditional in-person therapy. The Psychiatrist should exercise their professional judgment to decide whether a teletherapy consultation is appropriate in a given situation or an in-person therapy is needed and can be referred in the interest of the patient. (76)

11.1: Duties of a psychiatrist (10,18,69)

- Identify and manage mental health problems that may arise during the process or after the completion of transitioning.
- Ensure patients have adequate social support by identifying social networks in which the individuals can thrive

- Ensure regular follow-ups with the endocrinologist or hormone prescribing physician for general care and monitoring the cardiovascular risk, risk of osteoporosis, or development of cancers
- Ensure regular follow-ups with the general surgeon/ gynaecologist/ urologist and other specialists for postoperative uro-genital care and counsel regarding sexuality, genital hygiene, and prevention of sexually transmitted infections.
- Psychiatrist whenever applicable, shall play the role of an educator for these individuals and shall advocate for the rights of these individuals.
- Collaborate with other psychiatrists both at a national and international level to share best practices, peer review and contribute to the development of innovation and research in the field
- Ensure best practices in the diagnosis and management of gender dysphoria through increasing awareness, educating healthcare professionals, and engaging them in healthcare and support of transgender people.

Frequently Asked Questions (FAQs)

Q1. Is it advised to perform any list of standard psychological tests in transgender persons as sometimes patients come and state that "they are confused about their gender"?

A1: There is no standard, validated psychological test available to confirm someone is a 'transgender'. Moreover, being a transgender person is not a diagnosis. Hence, it is not advised.

Q2. Would a team of psychiatrists, psychologist, urologist and endocrinologist together be better to certify for sex reassignment surgery (SRS)?

A2: It is ideal to have a team. However, this manual this manual is intended for psychiatrists who carry out evaluation and certification of transgender persons, even in a standalone psychiatric clinic settings.

Q3: Should psychiatrists carry out a physical examination of transgender persons during consultation?

A3: Yes, psychiatrists must examine for ID purposes, general medical examination, and to look for age-appropriate secondary sexual features development. Endocrinological/ Gynaecological evaluation should be performed for all patients in order to rule out Disorders of sexual development. Gender-neutral policy must be adapted in consultation rooms as much as possible.

Q4: Can a psychiatrist certify gender dysphoria in adolescents between 15-17 years for any medical or surgical interventions?

A4: No, psychological interventions as the first line of management in individuals below 18 years of age. Hormone replacement therapy can be considered only after outweigh benefits over the risks and mandatorily after seeking parental consent. Gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient are advised to be delayed until the adolescent reaches at least 18 years of age.

Q5: A mention of pronouns to be used when addressing such patients in therapy and clinical settings.

A5: Till the person is a certified transgender, pronouns of the former gender may be used in all medical documents. However, in therapy and clinical consultation visits, psychiatrists must ask about the person's gender identity and their preferred pronoun(s), and the same should be used when addressing the patient throughout.

Q6. If a transgender person wishes to wishes to preserve sperms for future use in surrogacy prior to male to female sex-reassignment surgery?

A6: It is outside the purview of Transgender Persons (Protection of Rights) Act, 2019.

Q7: What about the concept of gender fluidity and certification in such patients?

A7: It is outside the purview of Transgender Persons (Protection of Rights) Act, 2019.

Q8: What is the role of a psychiatrist surgery when the TG is dissatisfied after Sex reassignment surgery (SRS)?

A8: Supportive psychotherapeutic approach must be adapted in assisting them to deal with problems effectively. Advise them to contact the operating surgeon about the dissatisfaction with SRS

Q9: Is there any specific psychotherapy training to be undertaken for this population?

A9: The Transgender Persons (Protection of Rights) Act, 2019 does not recommend it. However, sensitization programmes for all mental health professionals will be needed. Section 15, subsection (d) of this legislation further stresses on the need for a health manual related to 'Sex reassignment surgery and care of transgender persons' in accordance with the World Profession Association for Transgender Health (WPATH) guidelines

Q10. Can a psychiatrist provide videoconference-based teleconsultation for those transgender persons residing in remote areas?

A10: Telemedicine practice guidelines and telepsychiatry operational guidelines are in place since March, 2020. Technology can be utilized as and when required for providing care.

Q11: If a transgender person has psychiatric disorders such as BPAD, Psychosis, OCD, Substance Abuse, Anxiety disorders, Personality Disorders, Depression, etc, how can their treatment be planned?

A11: Appropriate psychopharmacological management must be considered. Capacity assessment for their treatment, admission, discharge and surgical intervention must be performed whenever indicated, as per the Mental Healthcare Act 2017.

Appendix A

PROFORMA FOR OUTPATIENT PSYCHIATRIC EVALUATION OF TRANSGENDER PERSON

Hospital Number: _____

Name (*Hospital registration should be done in person's name and biological gender*): _____

Patients chosen name (if any, as per the gender recognition certificate): _____

Occupation: _____

Age: _____

Sex – Male /Female/ Transgender Male – female / Transgender Female – male/ others

Marital status: Single/Married/Widowed/Separated

Education (years): _____

Phone No: _____

Informants: _____

Reliability: Yes/No

Referred by: Self/GP/Psychiatrist/ Endocrinologist / Plastic Surgeon / Others

Identification marks: a) b)

Presenting complaints (In chronological order, with duration):

Age at onset: _____ Duration: _____

Mode of onset: Acute/ insidious/other

Course: Continuous /Episodic/Progressive/Stable/ Others (specify)

Precipitating factors: Present/Absent If present, specify:

HOPI: (Mention only salient points. Draw a life chart where appropriate)

Any evidence of organicity: No/Yes if Yes, specify

Comorbid substance abuse (alcohol/nicotine/cannabis/opioids/others)

Specify

Biological functions; Appetite_____; Sleep_____; Sex_____

Current social and occupational functioning:

If undergoing Psychotherapy (relevant details):

Details regarding Hormonal Therapy (if any masculinising/ feminizing hormone therapy): No (drug-naive)/Yes

Name of the drug	Maximum dose	Duration	Efficacy	Side effects
Mention Combinations				

Details regarding Surgical Therapy (if underwent any genital/ breast surgery/ others):

Relevant Past history (Medical /psychiatric):

Family history:

a. Genogram:

b. Family history of (Schizophrenia/bipolar disorder, depressive disorder, Other psychotic disorders/ suicide/ substance use disorders /others (specify);

c. Any significant pathology (mention if present):

Personal history:

a) Developmental and educational history:

b) Sexual and marital history:

c) Occupational history:

d) Substance use history:

Premorbid personality: Well-adjusted /Maladjusted (describe. Below)

Mental status examination:

General appearance and behaviour (describe):

Psychomotor activity: increased/ decreased/ agitation/ normal

Speech:

Thought:

Stream: flight of ideas/thought block/retardation/circumstantiality

Formal thought disorder: Present/absent

Possession: Obsession/compulsion/thought alienation

Content:

Delusion/overvalued ideas:

Depressive cognitions, suicidal ideations, and any other thought content:

Mood:
Subjective:

Objective: Depressed/ Anxious/ Irritable/ Euphoric/ Elated/ Blunted/ Agitated / Normal;

Range: Normal/ Restricted/ Increased;

Reactivity: Normal / Reduced/ Increased;

Appropriate to situation: Yes/No;

Lability: Yes/No

Perception: Hallucinations- Auditory/ Visual/ Somatic/ Others (specify if present)

Cognition:

Orientation: Time/Place/ Person

Digit span—Forward: _____ backward: _____

Memory:

Intelligence:

Judgement:
Personal-Intact/Impaired;
Social—Intact/Impaired;
Test-intact/impaired

Insight:
Present/Absent/Partial

Diagnosis:

Management Plan:

Name and Signature of the Psychiatrist:

Date:

Place:

Appendix B

THERAPY REPORTING FORM

1) Socio-demographic details
    a) Name (*Registration should be done in person's name and biological gender)*) -
    b) Name change (if any as per gender recognition certificate) -
    c) Age / Date of Birth –
    d) Gender –

2) Psychiatric Diagnosis –

3) Session No and date –

4) Duration of session

5) Session Participants

6) Therapy Method –
    - Individual
    - Couple / Family
    - Group
    - Other
7) Type of Therapy –
8) Objective of Session –

9) Key Issue / Theme Discussed –

10) Therapy Technique Used –

11) Therapist Observation /Reflections

12) Plan for Next Session –

13) Date of Next session –

Therapist

Name:

Date:

Qualification:

Signature:

Therapy Supervised by (if applicable)

Name:

Date:

Qualification:

Signature:

Appendix C

Format for issuing referral letter for endocrinologist or hormone prescribing physician

Hospital/ Institution / Organisation/ Clinic/ Personal/ Letter Head

Date

Name of the person *(Hospital registration should be done in persons name and biological gender)*

Chosen name,

Transgender ID,

Hospital ID,

Identification Mark

[Person's name] is under my care at [your practice name]. [Person's name] has been under my care here since [date]. Their biologically assigned gender is …… but they identify as [expressed gender identity] and [chosen name]

They have been successfully and consistently living in a gender role congruent with their affirmed gender since [date].

Despite these, they report significant anxiety, depression, and distress due to their experience of dysphoria. During my independent evaluation of [Person's name], I diagnosed them with gender dysphoria.

[Person's name] are capable of making an informed decision about undertaking hormonal therapy.

Therefore, I hereby refer [Person's name] for hormonal therapy.

If you have any questions or concerns, please do not hesitate to contact myself or my office
Sincerely,

[your name],

[your license registration number under state / Indian Medical Council]

Appendix D

Format for issuing referral letter for sex reassignment surgery

Hospital/ Institution / Organisation/ Clinic/ Personal/ Letter Head

Date

Name of the person *(Hospital registration should be done in person's name and biological gender)*

Chosen name,

Transgender ID,

Hospital ID,

Identification Mark

[Person's name] is under my care at [your practice name]. [Person's name] has been under my care here since [date]. Their biologically assigned gender is …… but they identify as [expressed gender identity] and [chosen name]

[Person's name] has been successfully and consistently living in a gender role congruent with their affirmed gender since [date]. [Person's name] has undergone .... (number) of sessions. [Person's name] have socially transitioned by [list how - change name, pronoun, dress, hair, tuck, pack, binding, coming out, etc)

Despite these, they report significant anxiety, depression, and distress due to their experience of dysphoria. During my independent evaluation of [Person's name], I diagnosed them with gender dysphoria.

[Person's name] expressed a persistent desire for sex reassignment surgery.

[Person's name] are capable of making an informed decision about undertaking sex reassignment surgery.

Therefore, I hereby refer [Person's name] for sex reassignment surgery.

If you have any questions or concerns, please do not hesitate to contact myself or my office

Sincerely,

[your name],

[your license registration number under state / Indian Medical Council]

The following forms are as per the Transgender Persons (protection of rights) Rules, 2020

Form – 1

[See rules 2(d), 3(1) and 6(1)]

Application form for issue of transgender certificate of identity under Rule Transgender Persons (Protection of Rights) Rules, 2020 read with Section 6* / 7* of the Transgender Persons (Protection of Rights) Act, 2019

*** Strike out whichever is not applicable**

State Emblem State Government of (name of the State) Office of the District Magistrate		
Application form for issue of a transgender certificate of identity under Rule Transgender Persons (Protection of Rights) Rules, 2020 (read with Section 6* / 7* of the Transgender Persons (Protection of Rights) Act, 2019 * Strike out whichever is not applicable)		
1	**Name**	
(i)	Given name (in capital letters)	
(ii)	Changed/Chosen name (in capital letters)	
(iii)	Out of (i) and (ii), name to be printed in the certificate of identity and in the identity card	
2	**Gender**	
(i)	Assigned at birth	
(ii)	Requested in the application	
3	**Date of birth**	dd/mm/yyyy
4	**Educational qualification**	
5	**Present address**	
6	**Permanent address**	
7	**If there is a source of income, the annual income:**	
(i)	Under Rs 1,00,000	YES / NO
(ii)	Between Rs 1,00,001 and 3,00,000	YES / NO
(iii)	Above Rs 3,00,000	Please specify the amount:
8	**Do you have any of the following documents? If so, please submit self- attested photocopies of the certificates stated below.**	
(i)	Date of birth certificate	YES / NO
(ii)	Aadhaar card	YES / NO
(iii)	PAN card	YES / NO
(iv)	Election Voter Identity Card	YES / NO
(v)	Ration card	YES / NO
(vii)	Passport	YES / NO
(viii)	Bank passbook	YES / NO
(ix)	MNREGA Card	YES / NO
(x)	Caste certificate (SC/ST/OBC/Others)	YES / NO

9	**Medical history (for those applying under section 7 of the Transgender Persons (Protection of Rights) Act, 2019**	
(i)	Have you undergone any medical intervention in the context of transgender transition?	YES / NO
(ii)	Please give details	
(iii)	Name and complete address of the Hospital or medical institute	
(iv)	Name of the issuing authority along with the date	
(v)	Any other medical status you would like to share	
(vi)	Have you been issued any certificate of identity under Section 6 and Section 7 under the Act, or any other ID Card issued by the State Authority before the commencement of these Rules? If so, enclosed the same.	
10	Any other information you would like to give	
11	Have you attached affidavit prescribed in Form – 2 of the Transgender Persons (Protection of Rights) Act, 2019 under Rule--Transgender Persons Protection of Rights) Rules, 2020	
12	Have you attached the passport size photographs?	Yes/No

Enclosed:_____documents as mentioned in the application

Declaration

1. I declare that the particulars furnished by me are true and correct.
2. Information provided in this application will be treated as confidential and shall not be shared with any person or organisation save the Central and / or State security agencies, any other agency as provided by Law; and for statistical and policy framing purposes.

Place: Date:	Signature or left hand thumb impression of the applicant given name of the applicant

Form – 2

[See rules 2(b) and 4(1)]

Format of affidavit to be submitted by a person applying for certificate of identity for transgender persons under Rule 4 of the Transgender Persons (Protection of Rights) Rules, 2020 read with Section 6 of the Transgender Persons (Protection of Rights) Act,2019

(Affidavit should be on Non-judicial stamp paper of Rs.10/-)
Competent Notary Civil, District (Name of the District), (Name of the State)

I, (Name), son/daughter/ward/spouse of (name of the parent/guardian/husband), aged

(in completed years), residing at (address), (Tehsil), (District), (State) (Pin code) do hereby solemnly affirm and declare as under:

1. I am currently residing in the above address.
2. I perceive myself as a transgender person whose gender does not match with the gender assigned at birth.
3. I declare myself as transgender.
4. I am executing this affidavit to be submitted to the District Magistrate for issue of certificate of identity as transgender person under Section 6 of the Transgender Persons (Protection of Rights) Act, 2019 under Rule Transgender Persons (Protection of Rights) Rules, 2020.

.* strike out whichever is not applicable.

Deponent (Signature of the Applicant)

Verification

I, (Name), hereby state that whatever is stated here in above serial Nos. 1 to 4 are true to the best of my knowledge.

Deponent

(Signature of the Applicant)

Tehsil Date

Identified by me

Advocate

Public

Before Me

Notary

Form – 3

[See rules 2(e) and 5(1)]

Form of certificate of identity to be issued by District Magistrate under Rule 5 Transgender Persons (Protection of Rights) Rules, 2020 read with section 6 of the Transgender Persons (Protection of Rights) Act, 2019

Photograph of the certificate holder District Magistrate to attest the photograph

1. On the basis of the application dated dd/mm/yyyy to the undersigned it is certified that Shri / Smt./ Km/ Ms (name) son / daughter / ward of Shri/ Smt. (name of the parent or Guardian) of (complete residential address of the applicant) is a transgender person.
2. His / her birth name is_____.
3. This certificate is issued in terms of the provisions contained under Rule 5 Transgender Persons (Protection of Rights) Rules, 2020 read with section 6 of the Transgender Persons (Protection of Rights)Act, 2019.
4. It is also certified that Shri/Smt/Km/Ms._____is ordinarily a resident at the address given above.
5. This certificate entitles the holder to change name and gender in all official documents of the holder.

Date Signature of the District Magistrate

Place Seal

Form – 4

[See rules 2(e) and 7(1)]

Form of certificate of identity for change of gender to be issued by District Magistrate under Rule 6 of the Transgender Persons (Protection of Rights) Rules, 2020 read with section 7 of the Transgender Persons (Protection of Rights) Act, 2019

Photograph of the certificate holder District Magistrate to attest the photograph

1. On the basis of the application submitted to the undersigned along with a medical certificate from the Medical Superintendent or Chief Medical Officer (name of the Hospital and complete address), it is to certify that Shri / Smt./ Km/ Ms. (name) son/ daughter / ward of Shri/ Smt. (name of the parent or Guardian) of (complete residential address of the applicant) has undergone medical intervention to change gender.
2. His/ Her birth name is_____.
3. This certificate is issued in terms of the provisions contained under Rule 6 of the Transgender Persons (Protection of Rights) Rules, 2020 read with section 7 of the Transgender Persons (Protection of Rights) Act, 2019.
4. It is also certified that Shri / Smt/ Km/ Ms. is ordinarily a resident at the address given above.
5. This certificate entitles the holder to change name and gender in all official documents of the holder.
6. Such change in name and gender and the issue of this certificate shall not adversely affect the rights and entitlements of the holder of this certificate.

Date — Signature of the District Magistrate:

Place — Seal

Form – 5

[See rules 2(g) and 5(4)] Form of Identity Card Front side of identity card

State Emblem

State Government of (name of the State) Office of the District Magistrate

Transgender Identity Card

Identity card number

Photograph of the Card holder

Name

Mother's name@

Father's or Guardian's name @

Gender Transgender

Date of birth **or** dd/mm/yyyy

Age as on the date of application for issue of

_____years

Identity card

Reference number of certificate of authority on the basis of which this card is issued

Back side of the identity card

Present address

Card issue date

Signature of the issuing authority Designation

Seal of the issuing authority

Issued under Section 6*/ 7* of the Transgender Persons (Protection of Rights) Act, 2019 and under Rule_____of Transgender Persons (Protection of Rights) Rules, 2020

*** Strike out whichever is not applicable**

@ only in case the applicant is a minor child

Form – 6

[See rules 2(g) and 7(4)] Form of Identity Card Front side of identity card

State Emblem

State Government of (name of the State) Office of the District Magistrate

Identity Card

Identity card number

Photograph of the Card holder

Name

Mother's name@

Father's / Guardian's name@

Gender Male /Female

Date of birth **or** dd/mm/yyyy

Age as on the date of application for issue of identity card _____years

Reference number of certificate of authority on the basis of which this card is issued

Back side of the identity card

Present address

Permanent address

Card issue date Signature of the issuing authority

Designation

Seal of the issuing authority

@ Only in case of a minor child

Glossary of various terminologies used in transgender care

- **Agender:** a term to describe someone who does not identify with any gender.
- **AIDS:** Acquired Immune Deficiency Syndrome.
- **Assigned female at birth:** a person who was female when born and initially raised as a girl.
- **Assigned male at birth:** a person who was male when born and initially raised as a boy.
- **Cisgender:** a term for someone whose gender identity aligns with their sex assigned at birth.
- **DSM- V:** Diagnostic and Statistical Manual of Mental Disorders, Fifth edition.
- **Gender Diverse:** a term to describe people who do not conform to their society or culture's expectations for males and females. Being transgender is one way of being gender diverse, but not all gender diverse people are transgender.
- **Gender dysphoria:** a discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics).
- **Gender fluid:** a person whose gender identity varies over time.
- **Gender nonconformity:** refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex.
- **HIV:** Human Immunodeficiency Virus.
- **HT:** Hormonal therapy.
- **ICD 10:** International Statistical Classification of Diseases and Related Health Problems, 10th Revision.
- **IPC:** The Indian Penal Code, 1860.
- **IPS:** Indian Psychiatric Society.
- **LGBT:** Lesbian Gay Bisexual and Transgender.
- **Medical transition:** a process by which a person changes their physical sex characteristics via hormonal intervention and/or surgery to more closely align with their gender identity
- **MHA:** The Mental Healthcare Act of 2017.
- **MHP:** Mental Health professionals.
- **NALSA:** National Legal Services Authority.
- **Non-binary:** a term to describe someone who doesn't identify exclusively as male or female.
- **Person with intersex variations** means a person who at birth shows the variation in his or her primary sexual characteristics, external genitalia, chromosomes, or hormones from the normative standard of male or female body. (11)

- **Social transition:** a process by which a person changes their gender expression to better match their gender identity.
- **SRS:** Sexual Reassignment Surgery.
- **TNGC:** Transgender and Gender Non-conforming Individuals.
- **Trans boy/male/man:** a term to describe someone who was assigned female at birth who identifies as a boy/male/man.
- **Trans girl/female/woman:** a term to describe someone who was assigned male at birth who identifies as a girl/female/woman.
- **Transgender person:** any person whose expressed gender does not match with the gender assigned to that person at birth and includes trans-man or trans-woman (whether or not such person has undergone Sex Reassignment Surgery or hormone therapy or laser therapy or such other therapy), a person with intersex variations, genderqueer and person having such socio-cultural identities as *kinner, hijra, aravani* and *jogta.* (11)
- **Transitioning:** a process by which an individual begins living in their affirmed gender role (may or may not include hormonal and/ or surgical treatment).
- **WPATH:** World Professional Association for Transgender Health (WPATH), it was formerly known as the 'Harry Benjamin International Association for Gender dysphoria

References

1. Papoulias C. Transgender. Theory, Culture & Society. 2006;23(2–3):231–3.
2. Saraswat A, Weinand J, Safer J. Evidence supporting the biologic nature of gender identity. Endocrine Practice. 2015;21(2):199–204.
3. ICD-10 Version: 2019 [Internet]. Available from: https://icd.who.int/browse10/2019/en. [Accessed 14 Dec 2020]
4. Drescher J. Controversies in gender diagnoses. LGBT health. 2014;1(1):10–4.
5. ICD-11 and the depathologisation of the transgender condition [Internet]. Available from: https://www.elsevier.es/en-revista-revista-psiquiatria-salud-mental-486-pdf-S2173505019300214. [Accessed 14 Dec 2020]
6. De Cuypere G, Van Hemelrijck M, Michel A, Carael B, Heylens G, Rubens R, et al. Prevalence and demography of transsexualism in Belgium. European psychiatry. 2007;22(3):137–41.
7. Corneil T, MHScc BK. Size and Distribution of Transgender and Gender Nonconforming Populations. Transgender Medicine, An Issue of Endocrinology and Metabolism Clinics of North America Ebook. 2019;48(2).
8. Sawant NS. Transgender: status in India. Annals of Indian Psychiatry. 2017;1(2):59.
9. THE TRANSGENDER PERSONS (PROTECTION OF RIGHTS) ACT, 2019 [Internet]. Available from: http://socialjustice.nic.in/writereaddata/UploadFile/TG%20bill%20gazette.pdf. [Accessed 14 Dec 2020]
10. TransGender/Others - Census 2011 India [Internet]. Available from: https://www.census2011.co.in/transgender.php. [Accessed 14 Dec 2020]
11. Standards of Care version 7 - WPATH World Professional Association for Transgender Health [Internet]. Available from: https://www.wpath.org/publications/soc. [Accessed 14 Dec 2020]
12. Wagner G, Bondil P, Dabees K, Dean J, Fourcroy J, Gingell C, et al. Ethical Aspects of Sexual Medicine. The Journal of Sexual Medicine. 2005 Mar 1;2(2):163–8.
13. Holm S. Principles of Biomedical Ethics, 5th edn.: Beauchamp T L, Childress J F. Oxford University Press, 2001, pound19.95, pp 454. ISBN 0-19-514332-9. Journal of Medical Ethics. 2002 Oct 1;28(5):332-a-332.
14. Drescher J, Haller E, Lesbian G. Position statement on access to care for transgender and gender variant individuals. Washington, DC: American Psychiatric Association. 2012;
15. Drescher J, Haller E, Lesbian G. Position statement on discrimination against transgender and gender variant individuals. American Journal of Psychiatry. 2012;12:37–8.
16. Dalal DPK, Bhide DA. Position statement of Indian Psychiatric Society regarding LGBTQ. :1.

17. Graham R, Berkowitz B, Blum R, Bockting W, Bradford J, de Vries B, et al. The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. Washington, DC: Institute of Medicine. 2011;10:13128.

18. australian-standards-of-care-and-treatment-guidelines-for-trans-and-gender-diverse-children-and-adolescents.pdf [Internet]. Available from: http://auspath.org/wp-content/uploads/2019/05/australian-standards-of-care-and-treatment-guidelines-for-trans-and-gender-diverse-children-and-adolescents.pdf. [Accessed 14 Dec 2020]

19. Soll BM, Robles-García R, Brandelli-Costa A, Mori D, Mueller A, Vaitses-Fontanari AM, et al. Gender incongruence: a comparative study using ICD-10 and DSM-5 diagnostic criteria. Brazilian Journal of Psychiatry. 2018;40(2):174–80.

20. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth edition [Internet]. Fifth Edition. American Psychiatric Association; 2013. Available from: http://psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596. [Accessed 14 Dec 2020]

21. Pillay N. Every 3 rd day the murder of a trans person is reported. Preliminary results of a new Trans Murder Monitoring Project show more than 200 reported cases of murdered trans people from January 2008 to June 2009.

22. Raju DDV. A Study on Socio- Economic Issues of Third Genders in Tamilnadu. International Journal of Science and Research (IJSR). 2013;4(7):4.

23. People"s Union for Civil Liberties, Karnataka (PUCL-K), Human Rights Violations against the Transgender Community: a Study of Kothi and Hijra Sex Workers in Bangalore, Bangalore: PUCL-K, 2003. [Internet]. Available from: http://pucl.org/sites/default/files/reports/Human_Rights_Violations_against_the_Transgender_Community.pdf. [Accessed 14 Dec 2020]

24. THE CONSTITUTION OF INDIA [Internet]. Available from: https://www.india.gov.in/sites/upload_files/npi/files/coi_part_full.pdf. [Accessed 14 Dec 2020]

25. WP(C) No.7455/2001 Naz-Foundation-v.-Government-of-NCT-of-Delhi-and-Others.pdf [Internet]. Available from: https://cjp.org.in/wp-content/uploads/2017/12/Case-Summary-Naz-Foundation-v.-Government-of-NCT-of-Delhi-and-Others.pdf. [Accessed 14 Dec 2020]

26. CIVIL APPEAL NO.10972 OF 2013, Suresh Kumar Kaushal and others vs Naz foundation.pdf [Internet]. Available from: https://main.sci.gov.in/jonew/judis/41070.pdf. [Accessed 14 Dec 2020]

27. WP (civil) No.494/2012. Justice K. S Pusttaswamy (retd)VS. UNION OF INDIA.pdf [Internet]. Available from: https://main.sci.gov.in/supremecourt/2012/35071/35071_2012_Judgement_26-Sep-2018.pdf. [Accessed 14 Dec 2020]

28. WP (criminal) No.76/2016. Navtej Singh Johar & Ors. vs Union of India [Internet]. Available from: https://main.sci.gov.in/supremecourt/2016/14961/14961_2016_Judgement_06-Sep-2018.pdf. [Accessed 14 Dec 2020]

29. WP (civil) No.400/2012. National Legal Services Authority (NALSA) VS. UNION OF INDIA [Internet]. Available from: https://main.sci.gov.in/jonew/judis/41411.pdf. [Accessed 14 Dec 2020]

30. Radix AE, Lelutiu-Weinberger C, Gamarel KE. Satisfaction and healthcare utilization of transgender and gender non-conforming individuals in NYC: a community-based participatory study. LGBT health. 2014;1(4):302–8.

31. Bradford J, Reisner SL, Honnold JA, Xavier J. Experiences of transgender-related discrimination and implications for health: results from the Virginia Transgender Health Initiative Study. American journal of public health. 2013;103(10):1820–9.

32. Joint United Nations Programme on HIV/AIDS (UNAIDS). The Gap Report: Transgender People. 2014;

33. Reback CJ, Simon PA, Bemis CC, Gatson B. The Los Angeles transgender health study: Community report. Los Angeles: Authors. 2001;

34. Connolly MD, Zervos MJ, Barone II CJ, Johnson CC, Joseph CL. The mental health of transgender youth: Advances in understanding. Journal of Adolescent Health. 2016;59(5):489–95.

35. Reisner SL, Vetters R, Leclerc M, Zaslow S, Wolfrum S, Shumer D, et al. Mental health of transgender youth in care at an adolescent urban community health center: a matched retrospective cohort study. Journal of Adolescent Health. 2015;56(3):274–9.

36. Maguen S, Shipherd JC. Suicide risk among transgender individuals. Psychology & Sexuality. 2010;1(1):34–43.

37. Blosnich JR, Brown GR, Shipherd P Jillian C, Kauth M, Piegari RI, Bossarte RM. Prevalence of gender identity disorder and suicide risk among transgender veterans utilizing Veterans Health Administration care. American Journal of Public Health. 2013;103(10):e27–32.

38. Naskar P, Roy S, Naskar S, Gupta I. An assessment of quality of life of transgender adults in an urban area of Burdwan district, West Bengal. International Journal of Community Medicine and Public Health. 2018;5(3):1089.

39. Poguri M, Sarkar S, Nambi S. A pilot study to assess emotional distress and quality of life among transgenders in South India. Neuropsychiatry. 2016;6(1):22–7.

40. George A, Janardhana N, Muralidhar D. Quality of life of transgender older adults. Int J Soc Sci Humanit Invent. 2015;4:7–11.

41. Chettiar A. Problems faced by Hijras (male to female transgenders) in Mumbai with reference to their health and harassment by the police. International Journal of Social Science and Humanity. 2015;5(9):752.

42. Hafeez H, Zeshan M, Tahir MA, Jahan N, Naveed S. Health care disparities among lesbian, gay, bisexual, and transgender youth: a literature review. Cureus. 2017;9(4).

43. Gooren LJ. Management of female-to-male transgender persons: medical and surgical management, life expectancy. Current Opinion in Endocrinology, Diabetes and Obesity. 2014;21(3):233–8.

44. Quinn GP, Sanchez JA, Sutton SK, Vadaparampil ST, Nguyen GT, Green BL, et al. Cancer and lesbian, gay, bisexual, transgender/transsexual, and queer/questioning (LGBTQ) populations. CA: a cancer journal for clinicians. 2015;65(5):384–400.

45. Valentine SE, Shipherd JC. A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. Clinical Psychology Review. 2018;66:24–38.

46. Dhejne C, Van Vlerken R, Heylens G, Arcelus J. Mental health and gender dysphoria: A review of the literature. International Review of Psychiatry. 2016;28(1):44–57.
47. Virupaksha H, Muralidhar D, Ramakrishna J. Suicide and suicidal behavior among transgender persons. Indian Journal of Psychological Medicine. 2016;38(6):505.
48. Chakrapani V. Hijras/transgender women in India: HIV, human rights and social exclusion. 2010;
49. Lapinski J, Covas T, Perkins JM, Russell K, Adkins D, Coffigny MC, et al. Best Practices in Transgender Health: A Clinician's Guide. Primary care. 2018;45(4):687.
50. Keuroghlian AS, Reisner SL, White JM, Weiss RD. Substance use and treatment of substance use disorders in a community sample of transgender adults. Drug and Alcohol Dependence. 2015;152:139–46.
51. Grant J, Mottet L, Tanis J, Herman JL, Harrison J, Keisling M. National transgender discrimination survey report on health and health care. 2010;
52. Kosenko K, Rintamaki L, Raney S, Maness K. Transgender patient perceptions of stigma in health care contexts. Medical care. 2013;819–22.
53. Wilson CK, West L, Stepleman L, Villarosa M, Ange B, Decker M, et al. Attitudes toward LGBT patients among students in the health professions: Influence of demographics and discipline. LGBT health. 2014;1(3):204–11.
54. Shipherd JC, Green KE, Abramovitz S. Transgender clients: Identifying and minimizing barriers to mental health treatment. Journal of Gay & Lesbian Mental Health. 2010;14(2):94–108.
55. Reisner SL, White JM, Bradford JB, Mimiaga MJ. Transgender health disparities: comparing full cohort and nested matched-pair study designs in a community health center. LGBT health. 2014;1(3):177–84.
56. Sausa L, Sevelius J, Keatley J, Iniguez J, Reyes M. Recommendations for Inclusive Data Collection of Trans People in HIV Prevention, Care & Services. San Francisco, CA: Center of Excellence for Transgender Health; 2009.
57. Collecting sexual orientation and gender identity data in electronic health records. National LGBT Health Education Center. The Fenway Institute, Boston, MA. [Internet]. [cited 2020 Jul 23]. Available from: https://www.lgbtqiahealtheducation.org/wp-content/uploads/2017/05/SOGI-Office-Hours-Update-Final.pdf
58. Eliason MJ, Schope R. Does "don't ask don't tell" apply to health care? Lesbian, gay, and bisexual people's disclosure to health care providers. Journal of the Gay and Lesbian Medical Association. 2001;5(4):125–34.
59. Apeiranthitou V, Thomas G, Louka P. Gender dysphoria: A critical discussion of the understanding and treatment of gender dysphoria. Dialogues in Clinical Neuroscience & Mental Health. 2019;2(1):72–80.
60. Pleak RR. Gender-Variant Children and Transgender Adolescents. Child and Adolescent Psychiatric Clinics. 2011 Oct 1;20(4):xv–xx.
61. Hughes IA. Disorders of sex development: a new definition and classification. Best practice & research Clinical endocrinology & metabolism. 2008;22(1):119–34.
62. Zucker KJ. Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. Archives of Sexual Behavior. 2019;48(7):1983–92.

63. Martinerie L, Condat A, Bargiacchi A, Bremont-Weill C, de Vries MC, Hannema SE. MANAGEMENT OF ENDOCRINE DISEASE: Approach to the management of children and adolescents with Gender Dysphoria. European Journal of Endocrinology. 2018;179(5):R219–37.

64. Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT. Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. Clinical child psychology and psychiatry. 2011;16(4):499–516.

65. Ristori J, Steensma TD. Gender dysphoria in childhood. International Review of Psychiatry. 2016;28(1):13–20.

66. Baetens L, Dhondt K. Psychosocial challenges and hormonal treatment in gender diverse children and adolescents. A narrative review. International journal of impotence research. 2020;1–11.

67. Horowicz E. Transgender adolescents and genital-alignment surgery: Is age restriction justified? Clinical Ethics. 2019;14(2):94–103.

68. Singh Y, Aher A, Shaikh S, Mehta S, Robertson J, Chakrapani V. Gender Transition Services for Hijras and Other Male-to-Female Transgender People in India: Availability and Barriers to Access and Use. International Journal of Transgenderism. 2014 Jan 2;15(1):1–15.

69. Gender Identity Services for Adults (Non-Surgical Interventions), NHS,UK [Internet]. Available from: https://www.england.nhs.uk/wp-content/uploads/2019/07/service-specification-gender-dysphoria-services-non-surgical-june-2019.pdf. [Accessed 14 Dec 2020]

70. Hage JJ, Karim RB. Ought GIDNOS get nought? Treatment options for nontranssexual gender dysphoria. Plastic and Reconstructive Surgery. 2000;105(3):1222–7.

71. Gender Identity Services for Adults (Surgical Interventions), NHS,UK. [Internet]. Available from: https://www.england.nhs.uk/wp-content/uploads/2019/12/nhs-england-service-specification-gender-identity-surgical-services.pdf. [Accessed 14 Dec 2020]

72. Benestad E. From gender dysphoria to gender euphoria: An assisted journey. Sexologies. 2010;19(4):225–31.

73. Fraser L. Psychotherapy in the world professional association for transgender health's standards of care: Background and recommendations. International Journal of Transgenderism. 2009;11(2):110–26.

74. Fraser L. Depth psychotherapy with transgender people. Sexual and relationship therapy. 2009;24(2):126–42.

75. Emerson S. Stages of adjustment in family members of transgender individuals. Journal of Family Psychotherapy. 1996;7(3):1–12.

76. Math S, Manjunatha N, Naveen Kumar C, Basavarajappa C, Gangadhar B. Telepsychiatry operational guidelines-2020. 2020;

Acknowledgments

The authors would like to express their gratitude to Prof. Shekhar P. Seshadri, senior professor of psychiatry at NIMHANS for all his guidance and suggestions that helped us in preparing the manual. The authors would like to express special thanks to the reviewers: Dr Avinash De Sousa, Consultant psychiatrist, Lokamanya Tilak municipal medical college, Mumbai; Dr Darpan Kaur, Associate professor of psychiatry, Mahatma Gandhi Mission Medical college, Maharashtra; Dr Prasad Raj Dandekar, Head of radiation Oncology, reliance foundation hospital, for their critical review of the manual. This has helped in making the manual more robust and applicable to the current clinical practise in India. The authors would also like to acknowledge Ms. Madhura Bojappa and Dr Naveen Manohar Pai for designing the cover page. The authors would also like to acknowledge all the help and support provided by Dr Bhavika Vajawat and Dr Prakyath Hegde, senior residents in Forensic Psychiatry at NIMHANS. Finally, we are indebted to the constant support and approval provided by the department of psychiatry at NIMHANS.