suffer restricted opportunities, discrimination and harassment at work despite the existence of anti-discrimination and equalities legislation. It is estimated that up to 40% of people with gender dysphoria may not be receiving appropriate help.
Objective Review of UK policies, guidelines, legislation and research on challenges faced by gender-variant people and ways to improve their care and lives.
Aims To improve gender-variant people access to care and ways to fight inequalities.
Methods MEDLINE, PsycINFO databases were searched for articles published between 2005–2015 containing the keywords "gender dysphoria", "gender-variant people" and "transgender people". Relevant policies, guidelines and legislations were also reviewed.
Results Transgender people still face major health inequalities and discrimination. National statistics show that 80% have experienced harassment, 62% suffered discrimination at work or home and 54% reported being denied access to NHS care due to lack of cultural competency from staff. Guidelines, research, policies and equality legislation have begun to be implemented to protect transgender people from discrimination and accord rights.
Conclusions Many areas need attention and improvement including not only healthcare but also employment, education, housing and media perception. Promotion of equality in the general population with the aim of achieving cultural change and improvement of cultural competency of health professionals is needed.
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EV1206

Personality traits and personality disorders in gender dysphoria

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Investigations in the field of gender dysphoria (GD) have been mostly related to psychiatric comorbidity and severe psychiatric disorders, but have focused less on personality traits and personality disorders (PDs).
We aimed to assess personality and the presence of PDs in a sample of 25 persons with GD attending the Psychiatric Clinic or the Department of Endocrinology of the University of Cagliari requesting sex reassignment therapy. They were assessed through the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and the Structured Clinical Interview for DSM-IV Axis II (SCID-II).
The sample consisted of 14 MtF and 11 FtM, with a mean age of 29.6 ± 9.5. Overall, 39.1% of the sample met the criteria for at least one PD, more frequently cluster-B PD (21.7%). MtF met a higher number of SCID-II criteria than FtM, especially regarding histrionic personality traits ($P = 0.001$). A total of 20 persons (9 MtF and 11 FtM) completed the MMPI-2. Mean T scores did not differ from the general population, except for the Psychopathic Deviate (Pd) scale (mean $T = 66.2 \pm 11.2$). The Masculinity-Femininity (Mf) scale was slightly increased, and its score reduced after correction for perceived sex ($P = 0.037$). MtF scored significantly higher at the Family Problems (FAM) scale ($P = 0.052$) and lower at the Social Discomfort (SOD) scale ($P = 0.005$) compared to FtM.
The high prevalence of PDs confirms that this kind of assessment in GD is of great importance, as a key part of personalized treatment plan tailoring. The high scores on the Pd scale suggest misidentification with societal standards.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV1207

Body image and gender role perceived in gender dysphoria: Cross-sex hormone therapy effects

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The gender dysphoria (GD) refers to the distress caused by the incongruence between gender identity and biological sex. This occurs, especially in pre-treatment cross-sex hormone therapy (CHT), with a marked dissatisfaction with their body image.
The purpose of this study is to evaluate the role of perceived gender in a total of 20 subjects (9 MtFs and 11 FtMs), presented for initiation of CHT at the Psychiatric Clinic or Department of Endocrinology of University Hospital of Cagliari and deemed appropriate to take the transition path aimed at sex reassignment. On a subsample of 7 patients (2 MtFs and 5 FtMs) were then evaluated changes, in terms of improving the acceptance of body image, at 2 months after initiation of CHT, using the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) (focusing on MF, Gm and Gf scale), the Bem Sex Role Inventory (BSRI), and the Body Uneasiness Test (BUT).
The MF scale shows a moderate elevation, which is reduced significantly as a result of correction for perceived gender rather than biological sex. MtFs get higher scores on the Gf scale and lower scores on the Gm scale than FtMs. This trend is confirmed by the average scores of BSRI: MtFs are more "feminine"; while the FtMs are less "masculine". This denotes an excessive identification by MtFs with the female gender role. Before initiating the CHT, the BUT score was indicative of clinically significant distress, which decreased during the CHT.
In conclusion, CHT reduces evidently body discomfort, due to the progressive reduction of the discrepancy between biological and desired gender.
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EV1208

Clinical characteristics of gender identity disorder

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Traditionally, gender identity disorder (GID) is associated with high level of psychiatric comorbidity, particularly psychotic and affective disorders. The aim of this study is to evaluate clinical aspect of GID in a sample of patients in charge of the Operative Unit for Diagnosis and Therapy of GID, Psychiatric Clinic and the Department of Endocrinology, University of Cagliari.
Assessment was made by SCID-I, for Axis I comorbidity, GAF, for global functioning, BUT for body discomfort (BUT-A measures different aspects of body image, BUT-B looks at worries about particular body parts).
The sample comprised 14 MtF (56%) and 11 FtM (44%), of age between 17–49 years; a diagnosed psychiatric disorder was reported in 32%: 16% mood disorders, 12% anxiety disorders, 4%

psychotic disorders. Among subject with GAF < 85, 58.3% were identify to have a Axis I disorder compare to 7,7% patients with GAF ≥ 85 ($P = .011$), especially for mood disorders ($P = .039$). Main score of Global Severity Index (GSI) for BUT-A was 2.45 ± 883; all subjects had a score GSI > 1.2 (clinically relevant discomfort index).
Regarding BUT-B, MtF have higher scores in PSDI global scale (3.37 ± .577; $P = 0.019$) and subscale VI (4.38 ± 1.496 vs. .81 ± 1.864; $P = 0.006$): there are not significant gender differences in the others subscales, although discomfort regards different aspects of both sexes.
According to literature, we observed a slightly higher prevalence of Axis I psychiatric disorders compare to general population, with functioning level statistically significant.
Generally, GID was not associated with higher level of psychopathology, appearing as specific diagnostic aspect, where the main origin of discomfort is dissatisfaction toward self-body imagine.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV1211

Military culture and sexual issues: The sex-stress phenomenon

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Introduction Sex abuse within the military has long been an open-secret afflicting both male and female veterans whose etiology is often attributed to character deficits (personality disorders or paraphilic disorders). Few studies look at the sex-stress phenomenon as a feature of military life itself and the role this plays in sex abuse within the military milieu. While much attention is focused on US forces, this problem in endemic within military cultures per se. The recent sex abuse scandal involving the French military in the Central African Republic illustrates the pervasiveness of the problem.
Objectives/aims To explore the psycho-cultural mechanisms of stress and its sexual expression and how certain scenarios within the military milieu exacerbates this impulse-control reaction. To address the relationship of the availability of sex-release options – without and/or without the military population (and how increased enlistment of women has changed the nature of the target population in today's military).
Methods Look at the problem historically (from WWII – present) with particular illustrations. Evaluate common (often failed) approaches to addressing the problem, including the fallacy that superior officer know best how to handle these cases. Explain the psycho/physiology of the sex-stress phenomenon – mechanism of the hypothalamic-pituitary-adrenal-gonad axis. Look at the relationship between sex-trauma and suicides among veterans.
Results/conclusions Offer a viable assessment/diagnostic of sexual problems within the military culture along with a treatment model that offers both psychotherapeutic (cognitive-behavioral protocols. . .) as well as identifying acute clinical symptoms that may respond to psychotropic medications.
Disclosure of interest The author has not supplied his declaration of competing interest.

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EV1214

I am trapped in a wrong body

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Introduction Gender dysphoria is incoherence between the sex a person feels or expresses and the biological.
Objective Revise the inclusion criteria for hormone therapy and sex reassignment surgery in gender dysphoria. Expose the multidisciplinary approach. Make differential diagnosis with other psychological disorders.
Methodology A 45 years old male patient (biological female), who was sent from Endocrinology Unit for a psychiatric evaluation before restart a hormonal treatment. Since his childhood, he has presented dissatisfaction with his sexual characteristics; he has had fantasies and dreams, in which he belonged to the other sex. He has always chosen male activities and male stereotypes companies. He has presented preference for cross-dressing from 9 years. Always felt the sexual attraction for women. He first consulted for this reason in 1995.
Results It reported favorably to start hormone treatment after completing the eligibility criteria: > 18 years old; knowledge of the effects of hormones; and more 3 months documented real-life experience. The hormone therapy caused the growth of microprolactinoma, which was treated with dopamine agonists until it disappeared and the cessation of galactorrhea. Testosterone treatment is restarted. Laboratory tests are done every 3 months during the first year and then, every 6 months.
Conclusions Is the gender disphoria a pathology? The EU recommends a reclassification as no pathological disorders in ICD-11. The treatment of gender dysphoria is necessary, and there is no reason to postpone it. The main difficulty is the differential diagnosis; there may be comorbidity with others mental disorders which are not exclusive (psychotic disorder, OCD, personality disorders and other disorders of gender identity).
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EV1215

Primary and secondary transsexualism, really?

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Introduction Transsexualism suffers from several definitions that evolve across time. Therefore, some discrepancies appear progressively in regard of evidence-based medicine and psychological approaches as sexo-analysis.
Objectives In our present study, we test if "primary" or "secondary" transsexualism defines in accordance with sexo-analysis definitions will be reliable with the pathology course.
Aims Clarify the definition of transsexualism to obtain a better understanding of this trouble and perhaps to change psychological approaches of gender disorders.
Methods Nine transsexual male-to-female (MtF) aged between 25 to 65 were voluntary recruited. They were diagnosed by a psychiatrist. We adapted the GID scale to measure the lifetime process. Descriptive statistics were reported. Results are expressed as mean ± standard deviation.
Results Age of the group is 41 ± 12. All subjects were treated by hormone therapy. One of them was surgical reassigned. All subjects reported a persistent feeling to be a woman across their entire life. None showed a decreased female feeling during a part of their life or a brutal apparition of this trouble during the adult period.