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# Gender dysphoria

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Gender dysphoric disorders are currently attracting a great amount of attention. Generally, this attention is appropriately scientific and not condemnatory. This is possibly because of changing attitudes, but also because of the dissemination of information about what may be done to help people with these disorders. People are coming forward to request such help. Whether the surge of applicants to gender identity clinics (GICs) is due entirely to the change in attitude or whether there is a true increase in incidence of these disorders is at present undetermined. The fact, however, remains that prior to the second half of the present century little professional attention was paid to gender dysphoria (Bullogh, 1975).

## Definitions

Gender dysphoria is the appropriate term for those disorders in which, while physically congruent with the gender allotted by chromosomal endowment, the individual experiences a pervasive sense of discomfort. The terms 'core gender identity' and 'gender role behaviour' (Money & Ehrhardt, 1972) have been introduced with clear distinction between these concepts and sexual orientation. The core gender identity is the individual's innate sense of appropriateness of anatomical gender; in a small proportion of people this is seriously skewed so that, while not denying the incontrovertible fact of their anatomical gender, there is a sense of belonging to the opposite gender. This affects their behaviour. The individual may strive, under perceived parental and societal pressures, to behave appropriately, but all the time wishes for the contrary: the young boy feels more comfortable in the company of girls, wishes to play with dolls, be allowed to wear dresses and rejects typically masculine play activity such as football. For the dysphoric female child, the 'tomboy', the reverse is the case. It is now becoming accepted that the supposition that the behavioural repertoires of men and women are mutually exclusive cannot be upheld (Reinisch *et al*, 1991). A more appropriate model to replace this is the orthogonal model in which all individuals have degrees of both masculine and feminine core identity, the androgynous person having both to a high degree. The concept of gender orientation must be separated from the orientation of sexual drive, that is, the hetero- or homosexual dimension.

Gender identity disorders are conventionally separated into two major types: 'transvestism' and 'transsexualism'. The separation of these disorders is authorised in the definitions of both the ICD and DSM systems. In clinical practice this separation appears dubious and a better construct is that of a spectrum of disorder. An individual may experience a state of gender dysphoria at any point between strictly defined transvestism and transsexualism. Over a long time span there may be progress from the one to the other state. Transvestism is the state in which the individual experiences a sense of appropriateness by wearing clothes of the other gender. This is not in order to increase sexual arousal which would be a 'clothing fetishism'. The statement is usually made by the individual that, however inappropriate their appearance may be to others, there is a sense of being dressed appropriately. The transsexual state is more extreme than the matter of dress: the individual wishes to lead life in the role of the opposite gender and, usually, requests medico-social help to be enabled to do so even though the cost may be high in terms of loss of esteem by others, financial security and the medical and surgical discomfort. Gender dysphoric disorders are not an aspect of mental illness or personality disorder. The distortion of self-image is not of a kind to qualify as a delusion or even as an overvalued idea. However,

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it may be observed that some individuals, prone to recurrent major depression, experience a marked intensification of a low-grade gender dysphoria while in a depressive episode, to a degree which does not cause undue distress while in a mentally healthy state. There is no single type of personality trait although there is a tendency to introversion. The individual is usually not homosexual and a high proportion enter into heterosexual relationships, even to the extent of marrying and having children, although if later coming to the GIC's attention the account is invariably given by transsexual people of a persisting sense of being in the wrong gender, and hence sexual, role.

## Aetiology

Little is known about the aetiology of gender dysphoria. An attempt has been made (Stoller, 1968) to attribute the disorders to distortions of attitudes of parents towards their child, but in discussion with many individuals and their families this explanation appears to be forced and inconsistent. No convincing psychodynamic formulation has been put forward. Recently there has been interest in the sexually dimorphic nucleus of the pre-optic area. The area is significantly larger in males than females and it has been shown (Swaab & Hofman, 1990*a*) that in humans the size differentiation increases after birth, reaching a maximum at five years of age. In a review of their findings the authors (Swaab & Hofman, 1990*b*) were cautious in their interpretation. However, there has been an isolated report (Zhou *et al*, 1995) of six male-to-female transsexuals who, after death and inspection of the brain, were found to have a cellular size of the central subdivision of the stria terminalis which approximated to the size normal for females and was significantly lower than that for both heterosexual and homosexual males. They considered that the finding could not be explained either by age, sex hormone level resulting from orchidectomy or administration of cyproterone.

If there is a genuine increase in the prevalence of gender dysphoria it is tempting to consider an ecological explanation. Something of the sort appears to be occurring in fish and reptiles in heavily polluted waters. Certainly, the experimental administration before birth of oestrogens to rhesus monkeys leads to female-type behaviour in males. Reinisch *et al* (1991) have reviewed 19 studies in which observation (often with matched controls) had been made on gender role behaviour of subjects, varying in age from 2–30 years, in which there had been prenatal exposure to progestins or oestrogens (the substances were at one time used to control threatened abortion and 'save' the pregnancy). They come to a tentative conclusion that exposure to androgen-based progestin had a masculinising, or at least defeminising, influence on behavioural development of the child. However, this does not lead to an easy conclusion; gender dysphoria may be in either direction, is worldwide in distribution and is not confined to any ethnic or social group. None the less, oestrogenic substances are probably a by-product of 'civilisation': the insecticide DDT, which used to be sprayed over cities, has a breakdown product with oestrogenic effect, as do certain chemicals used in the plastics industry; and of course there are the sex steroids used in contraception.

Gender dysphoric disorders appear to be enduring and the adult individual usually traces experience of a cross-gender nature back to the early days of childhood. In childhood they may lead to behavioural and scholastic difficulties, often arising because of peer group taunts over cross-gender behaviour. Also, the child's perception is that the behaviour, especially the wish to cross-dress, is somehow wrong and will not be tolerated, and is therefore conducted alone in an attempt at secrecy.

## Management

There is no curative treatment. Behavioural aversion therapy has been reported to be successful in transvestism but there is little in the way of prolonged, independently reported observation to convince of this.

Recognition and open discussion of the dilemma is helpful and the individual may find professional counselling helpful; if so, the emphasis will be on methods of coping, gaining acceptance from kindred and limiting gender role behaviour to produce the minimal amount of social and personal disruption. An individual may find a support group helpful, especially in decreasing the sense of isolation. People who are transvestites may find attendance at a local branch of the Beaumont Society to be helpful and information on this must be made available.

People who are transsexual by definition wish for the procedures of gender reassignment which are likely to comprise initial prolonged assessment of ability to live in, and be more content in, the opposite gender role. Immediate prescription of sex steroid medication and early progress to surgical procedures, as is advocated in some clinics, is the road to disaster. This fact has been recognised by the international gender dysphoria association

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(Harry Benjamin International Gender Dysphoria Association, 1985). Principal among the guidelines issued by this group for gender reassignment is the condition that the individual will attend regularly at a properly constituted GIC for a period of about a year before undertaking any procedure to alter the body. During this prolonged period of assessment the individual should change name to that appropriate to the desired gender (this may be done quite readily without recourse to legal fee). This also involves change of all personal documents, except the birth certificate in Britain, to the new name. The individual therefore demonstrates the ability to live in and gain a degree of acceptance in the aspired gender.

At the Yorkshire Regional Gender Identity Clinic we have adhered to the principle that the work of the Clinic, and of any ultimate gender reassignment, should be undertaken as an aspect of the National Health Service. Urgent requests for immediate gender reassignment procedures must be resisted; the early literature on gender reassignment outcome was littered with accounts of request for reversal of procedures and of suicide. It has therefore been our firm policy that initial referral is only accepted after careful assessment by a psychiatrist who not only vouches for the absence of mental illness and personality disorder, but agrees to resume responsibility for management should a mental illness become apparent during the course of assessment and management at the GIC. Another ruling of the Yorkshire GIC, and one which is now even more important in view of decision on funding provisions, is a clear statement from the individual's general practitioner that the procedures of gender reassignment, should they ultimately be recommended, would not be opposed. It is obviously a poor professional practice to expect a general practitioner, who has the ultimate responsibility for health care, to commence prescription of drugs with profound effect and potential serious side-effects on dictation from a GIC.

Full details of the recommended procedure for gender reassignment have been provided in a series of articles from the Yorkshire GIC (Smith, 1991; Snaith, 1996; Bromham & Pearson, 1996; Donnelly, 1996). If gender reassignment is to be undertaken, some degree of surgical intervention is usually necessary. It is, therefore, essential to have the interested services of a surgeon in an appropriate speciality, that is, plastic surgery or urology.

Reported outcome of gender reassignment varies according to the care with which reassignment proceeds and the type of questions required to be answered; for instance, one American study reported adversely – largely because the reassigned individuals had not reached a higher socio-economic status! The interested reader may wish to read the account of the independently audited reassignments at the Yorkshire Regional GIC (Snaith *et al*, 1994).

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## Multiple choice questions

1. Transsexualism:
   - a is a form of regression to infantile wish fulfilment
   - b is associated with personality disorder (dependent type)
   - c is more common in females than males
   - d is a condition which usually fluctuates in severity
   - e is a form of body dysmorphic disorder.

2. Standards of care for persons requesting gender reassignment:
   - a require a one-year attendance at a gender identity clinic prior to intervention
   - b require consent from a near relative
   - c in case of a married person require prior divorce

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d require agreement of two professional people prior to intervention
e require assay of sex steroid levels.

3. Transvestism:
   a can usually be successfully treated by cognitive therapy
   b is a form of fetishistic behaviour
   c is an impulsive behaviour
   d is not recognised before the age of puberty
   e usually occurs in those with marked physical characteristics of the opposite gender.

4. The following have been found to be associated with gender dysphoria:
   a foetal exposure to administered sex steroids
   b parental conflict regarding wish for gender of unborn child
   c Klinefelters syndrome
   d early history of cerebral trauma
   e a tendency to dissociation manifest in other aspects of experience.

5. Gender dysphoric disorder:
   a may become manifest in a phase of major depression
   b can be clearly differentiated into two major types
   c is associated with homosexual orientation
   d was first described by Harry Benjamin
   e is preferably treated under the National Health Service.

MCQ answers

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| a F | a T | a F | a T | a T |
| b F | b F | b F | b F | b F |
| c F | c F | c F | c T | c F |
| d F | d T | d F | d F | d F |
| e F | e T | e F | e F | e T |

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