Gender dysphoria

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Background

Gender dysphoria is the distress or discomfort that may occur when a person's biological sex and gender identity do not align. The true prevalence of gender dysphoria is unknown in Australia because of varying definitions, different cultural norms and paucity of data. Individuals who identify as transgender are vulnerable, and have higher rates of discrimination, depression and suicidality, compared with the general population.

Objective

The aim of this article is to familiarise general practitioners (GPs) with the principles of transgender care so they may provide a safe and supportive environment for patients presenting with concerns.

Discussion

It is important to have a basic understanding of how to conduct an initial consultation of gender dysphoria even if it is an uncommon presentation in general practice. Management should be individualised and may involve a combination of social work, education, counselling, hormone therapy and surgery.

Epidemiology

The prevalence of transgenderism varies internationally because of cultural and societal norms, and differences in definitions. The prevalence in Australia is unknown as there is a paucity of studies in this area. New Zealand reported an estimated prevalence of 1 in 6000, with a natal male-to-female ratio of 6 to 1.[1] However, research suggests the prevalence is much higher than previously thought.[2]

Sex and gender defined

'Biological sex' refers to our reproductive organs, 'gender identity' to our inner sense of being a 'man' or a 'woman', and 'gender presentation' to how we express gender on a 'feminine' to 'masculine' scale. This is defined by local culture and opinion.

It is generally accepted that babies born of the female sex will later view themselves as 'women', and male babies will develop into 'men' and dress accordingly. However, sex and gender are more likely to fall on continuums rather than in neat, dichotomous categories (Figure 1). Variation in how people position themselves on these continuums depends on factors such as developmental stage, past and present environment and experience, and nature of relationship with self and others.

Gender dysphoria

Perceived inconsistencies between one's biological sex and gender identity are often accompanied by significant distress and the onset of gender dysphoria. In the fifth edition of the *Diagnostic and statistical manual of mental disorders* (DSM-5), the term 'gender dysphoria' has replaced gender identity disorder. This change in terminology removes the 'pathology' from being transgender, which is not a mental health condition.[3]

Symptoms of gender dysphoria manifest at different developmental stages, but reliably become more debilitating when secondary sexual characteristics develop during puberty (DSM-5).[4]

The prognosis of gender dysphoria is generally positive and improves with treatment, which may include a combination of psychotherapy, hormones and surgery.[2] These treatments are

safe and effective in the long term, and very few people who chose surgical genital reassignment have regrets about their decision later in life.[5,6]

The initial assessment should begin with a history, assessment of risks and supports, and appropriate examination. Later consultations should focus on a discussion of the patient's short-term and long-term goals, which provide a framework for ongoing care.

Assessment

Establishing a relationship

The consultation should begin by establishing the individual's preferred name and gender. For example, Ms Rachael Smith may prefer to be called Mr Ross Smith, and prefer 'him/his' to 'her/hers'. These simple, initial questions will establish understanding and trust in the therapeutic relationship.

Establishing a diagnosis

The DSM-5 has diagnostic criteria for gender dysphoria in adults and adolescents. There is also a criterion for children, but this will not be covered in this article. It is best to begin by establishing the age of onset and duration. Were they very young? If there was a change point, did it correspond to a significant event? For many, the desire to wear the 'other gender's' attire may be among their first memories. For others, it may have developed much later.

For gender dysphoria to be present, a patient must have had at least two DSM-5 criteria for at least six months, and it must cause significant distress to the patient. This generally includes any of the following:

- a significant difference between their own experienced gender and their secondary sexual characteristics
- strong desire to be rid of their secondary sexual characteristics or prevent their development
- wanting secondary sexual characteristics of the opposite gender
- wanting to be treated as the other gender
- the strong belief that they have the feelings/reactions of the opposite gender.

Patients' feelings about their own and opposite gender's secondary sexual characteristics may be marked. For many, the physical maturation and growth of their misaligned secondary sexual characteristics are highly distressing, a cause of disgust, and may lead to mutilation. For example, it is common for female patients who identify as male (female-to-male) to dress in loose-fitting clothes and wear a binder to hide breast development. Therefore, it is common in our experience for people with gender dysphoria to present during adolescence.

Risk and support assessment

To make a diagnosis of gender dysphoria, there must be significant distress that impairs social, occupational, or other areas of function. The best way to assess this is to conduct a HEADSS (home, education/employment/eating/exercise, activities/relationships, drug use, sexuality/suicide/depression/mental health) assessment. Although primarily used in adolescence, the HEADSS assessment is a good way to cover all the bases of a psychosocial assessment. The assessment in this context allows identification of the patient's support network and any risks that may need to be addressed in future consultations.

Mental illness is common in the transgender population. The prevalence of depressive disorders is double, compared with the general population.[7] Whether this is associated with gender dysphoria or a separate issue should be explored and managed accordingly. Furthermore, rates of abuse, harassment, discrimination, isolation and suicidality are significantly higher in individuals who identify as transgender.[8,9]

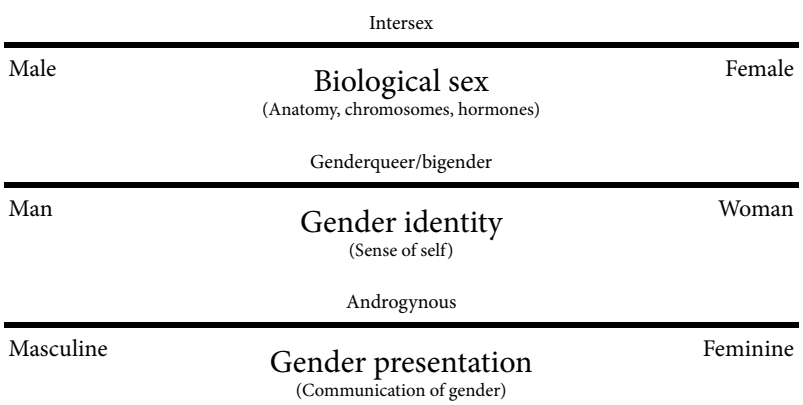

Figure 1. Biological sex, gender identity and gender presentation spectrum

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Medication and drug history are important. Substance misuse data in Australia's transgender population are scarce. Anabolic steroids were the most frequently misused substances. However, this is predominantly related to a desire to transition rather than the classical reasons for misuse.[8] In our experience, these substances are obtained illegally because of fears they will be withheld by their doctor or lack access.

A comprehensive sexual history should be obtained. It is common for younger clients to report little or no sexual history. However, other individuals may be at risk of sexually transmissible infections (particularly those who may engage in receptive anal sex or sex work). A few simple questions would avoid the possibly intrusive experience of blanket testing.

Support networks are vital during transition and should be identified, especially during the early stages. It cannot be assumed that family and friends will be supportive but they should be encouraged to seek counselling and access support groups to help educate them to the process of transition (eg

Table 1. Differential diagnosis of gender dysphoria

Transvestic disorder involves cross-dressing as a sexual urge or fantasy. Individuals do not consider themselves the opposite gender, and do not want surgery or hormones. Outside these times, they will dress and act congruent to their biological sex and gender.
Body dysmorphic disorder involves a distressing or impairing preoccupation with an imagined or slight defect in appearance. Individuals do not consider themselves a different gender, but find a part of their body (possibly the genitalia or breasts) to be abnormal and want them removed.
Psychotic patient may report gender dysphoria as related to a delusion telling them they are a different gender. However, this is uncommon in practice and the individual may have a history of psychotic disorder.
Borderline personality disorder is defined as disturbance in self-identity, which could include sexual orientation and/or gender dysphoria. If a patient shows symptoms of borderline personality disorder, or is known to have the disorder, a mental health professional should be involved to aid in assessment.
Individuals with **Asperger's syndrome** are prone to obsessive preoccupations that could include gender dysphoria. If Asperger's syndrome is previously diagnosed or suspected, review by an appropriate mental health professional may be warranted to differentiate true gender dysphoria from a manifestation of Asperger syndrome.
Rarely, individuals with **dissociative identity disorder** may experience gender dysphoria as one of their identities. Consultation with a mental health professional will help elucidate whether gender dysphoria is distinct from dissociative identity disorder in this setting if the patient has a history of the disorder.

Table 2. Support and services in Australia for transgender persons

	Services	Support
National	• Headspace	• Ausgender • Gender Agenda • Gender Centre • Transhealth Australia
Victoria	• Southern Health Gender Clinic • The Royal Childrens' Hospital – Gender Clinic	• Transgender Victoria • Seahorse Victoria • ButchFemmeTrans Melbourne • Rainbow Network Victoria
NSW	• The Gender Centre • Taylor Square Private Clinic	• Twenty10
QLD	• Cairns Sexual Health Service • Brisbane Gender Clinic • Goldcoast Sexual Health	• The Australian Transgender Support Association Queensland • PFLAG • Transbridge – Townsville
TAS	• Sexual Health Service Tasmania	• Working It Out • Rainbow Tasmania
ACT	• Canberra Sexual Health Service	• Gender Agenda
NT	• Royal Darwin Hospital – Endocrine unit	• Nil specifically identified for transgender
WA	• Not available	• WA Gender Project • Living Proud • Freedom Centre
SA	• South Australia Gender Dysphoria Clinic	• Bfriend

Parents and Friends of Lesbians and Gays [PFLAG]) if needed. Further consultations with the family and the patient at a later date may be helpful.

Examination

Transgender individuals with gender dysphoria are often uncomfortable with their body, particularly their secondary sexual characteristics. They may avoid seeking healthcare to avoid a genital and/or breast examination. A genital examination is not part of the routine assessment unless there is suggestion or evidence of intersex or genital mutilation.[2] Avoiding this examination may be valuable in initial consults, until the patient is comfortable and trusting of the doctor.

Individuals who identify as transgender may prefer to appear androgynous or to match their desired sex. Preconceived ideas of appearance from the doctor are unhelpful.

Differential diagnosis

Being an individual who identifies as transgender is not in itself pathological. However, gender dysphoria may occur as part of another mental health disorder and should be investigated if it is clinically suspected (Table 1).

Investigations

Investigations are only important to provide a baseline for patients who are intent on hormone replacement therapy, and are not part of the diagnostic process.[2]

Management

Some patients may be happy to live in their desired gender role, but many will want to physically transition with the use of hormones, with or without surgery. A large Australian study found 86% of individuals who identified as transgender were using or intended to use hormone therapy. Thirty-nine percent of this group also had had some form of surgery. Only 12% were living in their desired gender role without hormones or surgery.[7]

Psychological counselling

We recommend counselling by a mental health professional with experience or interest in transgender health in the vast majority of cases. Psychologists fulfil an important support role to patients and families during transition. They may also aid in the diagnosis of comorbid mental health conditions and can provide reports on the suitability of the individual for surgery.[2] Finding a suitably experienced psychologist may be difficult, especially in rural areas. A psychologist skilled in the management of anxiety and depression may be the best alternative.

Changing documents

Successfully changing one's identity on documents is an affirmation of gender for patients, but it is often an area of confusion for doctors.[7] The Federal Government's *Australian guidelines on the recognition of sex and gender* in 2013 states specifically that 'sex reassignment surgery and/or hormone therapy are not prerequisites for the recognition of a change of gender in Australian Government records'.[10] This means legal documents from Centrelink, Medicare, passports, Australian Tax Office, driver's licence, birth certificate, and any other government agency cards and records can be changed to a preferred gender.

A letter from a registered medical practitioner or registered psychologist is all that is required to change the sex. The guidelines include a section on what should be included in the letter. The forms to change the documents are easily downloaded from government websites.

Hormone therapy

Hormone therapy has been demonstrated to reduce distress without significant adverse psychological or physical effects.[2] As with any medication, it is important to be aware of the reversible and permanent side effects of hormone therapy to ensure patients are fully informed. This is described well in the Endocrine Society Treatment of Transsexual Persons' Guidelines.[11]

GPs may feel uncomfortable treating patients who identify as transgender due to inexperience. A referral to a specialist (eg endocrinologist, sexual health physician) may be pertinent in the early stages for the initiation of hormone therapy. It is best to first contact the specialist to ensure they are happy to be part of the management team as not all are experienced in this field.

There are limited specific gender clinics in Australia. Some sexual health practices may be experienced in the management of transgender health (Table 2).

Ongoing care, including monitoring hormone therapy, is best managed by the GP as they know the patient well. They can provide preventive and holistic care, and act as the point of contact between other healthcare providers.

Surgical reassignment therapy

Surgical options for individuals who identify as transgender often refer to 'top' procedures (eg chest reconstruction or breast augmentation) and 'bottom' procedures (eg removal and creation of new genitalia). Surgical reassignment is often performed overseas due to greater expertise and lower cost. Genital surgery is often reserved for patients who have been on hormone therapy for at least one year and living in their desired role, given the permanency of the procedures.[12]

Conclusion

It is important for GPs to have a basic understanding of gender dysphoria as they will often be the first point of contact for these patients. While gender dysphoria is an uncommon presentation, these individuals are often isolated and have higher rates of depression and suicide. It is important to validate and engage with the patient. Gender dysphoria often involves a multidisciplinary team and at the very heart of the team is the

therapeutic relationship between the GP and the patient. The GP is best placed to provide holistic and ongoing care for a person with gender dysphoria.

Resources

- The World Professional Association of Transgender Health (WPATH). Standards of care, www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351
- The Endocrine Society. Endocrine treatment of transsexual persons, http://press.endocrine.org/doi/pdf/10.1210/jc.2009-0345
- The Center of Excellence for Transgender Health, transhealth.ucsf.edu

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