Diagnosis and Treatment of Gender Dysphoria

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Outline

• Definitions of sex and gender
• Diagnosis of gender dysphoria
• Barriers & challenges for transgender people
• Treatment of transgender people
Disclaimer

- Euro-american
- Cisgender male
- Psychiatrist
Bracelet on Man = Gay
Sex:  male, female, or...

• contributions from
  – anatomy
  – physiology
  – genetics
  – endocrinology
  – psychology

• objective, scientific, but...

• In sum: no absolute definition
Gender: *masculine, feminine, or...*

- **(core) gender identity**
  - inborn sense of basic maleness, femaleness
    - well-established by age 3 for self, others
    - subjective, personal

- **gender behavior**
  - societal assignation of gender at birth
  - societal expectations for how assigned boys, girls act
    - culturally based, historically specific, variably rigid vs fluid
  - taught by demonstration, learned by emulation

- **In sum:**
  - bio-psycho-sociocultural construction
  - mashup of genetics + psyche + society
Gender as Social Construction

“Gender is so pervasive that in our society we assume it is bred into our genes. Most people find it hard to believe that gender is constantly created and re-created out of human interaction, out of social life, and is the texture and order of that social life. Yet gender, like culture, is a human production that depends on everyone constantly ‘doing gender’.”

Lorber 1994
Keeping terms straight...

• Sex: What science says you are
• Gender: Who you believe you are and how you express it
  – Binary vs. fluid, queer
• Sexual orientation: Whom you desire
  – independent of sex
  – gender-atypical boys, girls more likely to have same-sex attractions
The John/Joan Case
Sex Hormones Organize the Prenatal Brain

• 16 chromosomal males with cloacal extrophy
  – normal internal testes, disrupted external genitalia
  – 16/16 demonstrated male-typical gender behaviors
  – 2/16 raised as males
  – 14/16 surgically altered to phenotypic females
    • 8/14 started living as males in adolescence
      – 6/8 had sexual reassignment surgery
    • 5/14 continued to live as females
      – 3/5 had unclear gender identity, though tending toward male
    • 1/14 refused to talk about it

• challenge to “optimal gender” doctrine

Reiner 2004
Unpredictable Identifications

• “Routine neonatal assignment of genetic males to female sex because of severe phallic inadequacy can result in unpredictable sexual identification. Clinical interventions in such children should be reexamined in the light of these findings.”

Reiner 2004
Sex Hormones Organize the Prenatal Brain

“Future sex reassignment decisions should be made with maximum sophistication in regard to the implications, psychosocial and psychosexual, of brain development as it is influenced by the intrauterine hormonal milieu. In turn, such brain development influences postnatal psychosexual development.”

Reiner 1997
In Utero Masculinization

“There is good evidence that exposure to high levels of androgens during prenatal development results in masculinization of activity and of occupational interests, sexual orientation, and some spatial abilities; prenatal androgens have a smaller effect on gender identity.”

Berenbaum 2011
The Brain Knows

“The clinical decisions must ultimately be based not on anatomical predictions, nor on the ‘correctness’ of sexual function . . . but on that path most appropriate to the likeliest psychosexual developmental pattern of the child. In other words, the organ that appears to be critical to psychosexual development and adaptation is not the external genitalia but the brain.”

Reiner 1997
Clinical Threshold

“A clinical threshold is passed when concerns, uncertainties, and questions about gender identity persist in development, become so intense as to seem to be the most important aspect of a person’s life, or prevent the establishment of a relatively unconflicted gender identity.”

HBIGDA Standards of Care/ WPATH
Gender Identity Struggles

“Such struggles are known to be manifested from the preschool years to old age and have many alternate forms. These forms come about by various degrees of personal dissatisfaction with sexual anatomy, gender-demarcating body characteristics, gender roles, gender identity, and perceptions of others.”

HBIGDA Standards of Care/WPATH
Intersexuality

• Pseudohermaphrodite = disagreement between phenotypic and gonadal sex
  – male p. – testicular tissue, female external genitalia
  – Female p. – ovarian tissue, male external genitalia

• Hermaphrodite = possession of both testicular, ovarian tissue
  – male, female, ambiguous phenotypes possible

• Diversity, not pathology
In Sum: **Sex vs. Gender**

- **Sex**
  - chromosomal
  - anatomic
- **Gender Identity**
  - intrapsychic
- **Gender Role**
  - Interpersonal/sociocultural
- **Sexual Orientation**
  - intrapsychic and interpersonal/sociocultural
Binary – The Status Quo

ONE OR THE OTHER

- how you looked at birth
- how you feel inside
- how you present yourself to others
- what you do, who you do it with
- how you receive social endorsement
Gender, gender identity & sex exist on a spectrum.

**Sex**
- Male
- Intersex
- Female

**Gender Expression**
- Masculine
- Androgynous/Neutral
- Feminine

**Gender Identity**
- Man
- Genderqueer/Genderfluid/Neutral-gender
- Woman
- Agender/Genderless
One TG Term Does Not Fit All

• Transgender – umbrella term
  • gender identity (GI) different from birth-assigned sex (BAS)
  • gender expression (GE) different from stereotypical M/F norms
    – Transman – masculine GI, female BAS
    – Transwoman – feminine GI, male BAS
    – Genderqueer – fluid GI, male or female BAS
    – Transsexual – dated, clinical, patients seeking med/surg interventions to change BAS, affirm GI
Evolving Diagnosis

- DSM-III, III-R, IV: Gender Identity Disorder
  - Identity is the problem needing treatment.
  - Resolving incongruence is the treatment.
    - transsexual vs. non-transsexual types

- DSM-5: Gender Dysphoria
  - Identity *per se* is not the problem.
  - Incongruence between identity and anatomy is.
  - Distress stems from incongruence between self-perception and societal perception
  - Addressing distress is the treatment
    - may/may not involve social transition
    - may/may not involve hormones, surgery
  - Fluidity without distress is neither diagnosis or disorder.
Diagnosing Gender Incongruence

• Criteria:
  – persistent discomfort with external sexual anatomy, with a sense of incongruence between anatomy and gender identity
  – absence of confounding mental disorders other than gender dysphoria (GD), e.g. psychosis
  – interference with relational life, work/school performance

• Timing:
  – most cases present in adulthood in the context of longstanding GD
  – children, adolescents increasingly diagnosed with GD
  – diagnosis should be made prior to starting medical or surgical therapies
Diagnosing Gender Dysphoria in DSM-5

• Six Symptoms of Incongruence
  – Incongruence between experienced gender & assigned sex
  – Desire to be free of incongruent sex characteristics
  – Desire for sex characteristics of experiencing gender
  – Desire to be other than assigned sex
  – Desire to be treated as other than assigned sex
  – Conviction of having feelings, reactions of other than assigned sex

• Diagnosis requires
  – meeting > two criteria for > six months
  – significant distress affecting relationships, work
The Caitlyn Effect?
An Emerging Clinical Population

• 2014: ~1.4 million (0.6%) Americans identify as transgender (TG), double the 2011 prevalence.
  – Willingness of TG individuals to self-disclose rather than increasing incidence is probable explanation.
  – 1.4 million likely underestimates actual number.

• Significant health care disparities stem – in part – from provider discomfort and lack of knowledge.
  – TG patients report having to educate their treaters.
  – Limited TG specialists means PCPs should develop expertise in treating this emergent patient group.
  – Increased mortality rates may result from non-hormone-related causes, including suicide, murder, drug abuse, HIV, and CVD.
Living on the Margins

• “The transgender community is arguably the most marginalized and underserved population in medicine.”
  • Roberts & Fantz 2014

• “Many transgender people live on the margins of society, facing stigma, discrimination, exclusion, violence, and poor health.”
  • Winter 2016
Historical Stigmatization

• Reluctance to disclose
  – fear and anxiety about consequences
  – delay or avoidance of mainstream care
  – resort to alternative care (e.g. internet hormones, under-the-radar surgeries)

• Gender nonconformity dismissed as psychopathology

• Refusal of care (“I’m not an expert in that....”)

• Macro- and micro-aggressions
  – verbal and physical assault
  – dismissive and demeaning interactions
Structural Barriers in a Binary M/F World

• Sex-segregated health care system
  – absence of trans-focused/trans-friendly care models
  – deficient cultural competence, cultural humility

• Challenges in proving who you are
  – birth certificates, driver’s licenses, passports
  – preferred pronouns

• Varying definitions of “family”
  – Who can visit
  – Who can marry
  – Who can speak for the patient
Structural Barriers in a Binary M/F World

• Electronic health records
  – two options only

• Medical procedures and laboratory tests
  – both/and
  – incompatibility with identified gender
    • failure to decouple sex and gender
    • absence of gender-specific reference intervals

• Restroom access

• Inpatient room assignment
  – failure to decouple sex and gender
  – the value of private rooms
Financial Barriers

• Failure to seek care
  – high costs of surgical procedures
  – high rates of unemployment in trans populations
  – lack of employer-provided insurance
Insurance and Medical Necessity

Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury, or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

Medical Necessity Statement, WPATH 2016
Not Elective, not Cosmetic

In addition to hormonal balancing, medically necessary gender affirming/confirming procedures and treatments, as appropriate to the patient, include:

• complete hysterectomy, bilateral mastectomy,
• chest reconstruction or augmentation, including nipple resizing or placement of breast prostheses
• genital reconstruction by various techniques, including, for example, skin flap hair removal, scrotoplasty, and penile and testicular prostheses
• facial hair removal, certain facial plastic reconstruction, voice therapy and/or surgery
• gender affirming counseling or psychotherapeutic treatment

Medical Necessity Statement, WPATH 2016
Insurance Discrimination

• Trans as pre-existing – and thus disqualifying
• Exclusion of transition-related care
• Coverage variances from state to state
  – what is covered, whether it’s covered at all
• Selective coverage: required vs. elective
• Exclusion of cross-gender care
  – lab tests
  – preventative screening and treatment
Provider Inexperience = Unequal Health Care

• Global lack of knowledge
  – deficient curricula in medical training
  – rarity of post-training CME options
  – failure to prioritize knowledge acquisition

• Confusion/conflation of terms/concepts
  – sex (anatomy) vs. sexuality (attraction) vs. gender (identity, self-image)
Unique Trans Health Concerns

• Lack of awareness of:
  – four-fold higher HIV risk
  – higher rates of
    • alcohol, tobacco, drug abuse
    • anxiety, depression
    • suicide attempts (26x GP rate)

• Lack of familiarity with practice guidelines
  – WPATH
  – Endocrine Society

• Failure of imagination, extrapolation
General Principles of Trans-care

• Require patients to undergo mental health assessment, appropriate psychotherapy throughout transition.
• Assure patients have capacity to make well-informed decisions.
• Monitor the health of remnant as well as new anatomy.
• Recognize and manage potential medical and surgical complications of gender-affirming therapies.
• Understand what hormonal & surgical tx can – and can’t – accomplish.
• Expect patients to choose some – and not other – available therapies.
• Know that physical exams may be uncomfortable, even traumatic.
• Follow standard age- and sex-related guidelines for preventive care, management of chronic illness, detection of new-onset disease.
• Appreciate that health disparities and marginalization may be at play in patient presentations.
• Remember that everything going on doesn’t stem from TG status.
It takes a team.

• Access barriers
  – deficiencies in specialized expertise
    • inadequate numbers of specialists
    • geographic isolation from specialists
    • inadequate training opportunities for generalists

• Incomplete teams

• Routine primary care still needed!
The (Ideal) TG Health Care Team

• Primary Care Provider
  – coordinates overall individualized care, seeks specialist consultation where possible
  – expects administrative, clinical staff to create trans-friendly office environment

• Mental health providers
  – diagnose, treat gender dysphoria, pre-existing psychopathology
  – provide support during transition
  – attest to readiness for gender-affirming surgery: “gatekeeper” role

• Endocrinologists
  – develop regimens to suppress natal, augment preferred hormones

• Surgeons
  – perform gender-conforming operations
    • MTF: breast augmentation, facial feminization, orchiectomy, vaginoplasty
    • FTM: mastectomy, hysterectomy/oophorectomy, metoidioplasty, phalloplasty

• MTF specific services
  – Speech therapists assist in acquiring feminine speech styles.
  – Aestheticians remove facial, body hair to enhance female appearance.
  – Physical therapists working with pelvic floor issues.
Mental Health Assessment

• Is gender dysphoria present?
• Are depression and anxiety prominent?
  – medication-responsive
  – therapy-responsive
• What substances are used/abused?
  – recreational
  – non-prescribed internet-acquired hormones
• Is there PTSD originating in sexual, physical, or emotional abuse?
• Does marginalization, bullying shape personality?
• Is there suicidal ideation, self-injurious behavior?
Sexual History Principles

- Practices vary widely; avoid assumptions.
  - partners may be M, F, TG (GI ≠ SO)
  - natal organs may be used when present
  - gender identity assertion may drive activities
- Ask about high-risk behaviors
  - unprotected anal or vaginal intercourse
    • gauge risk of sexually transmitted infections
      - target screening to specific anatomy & sexual practices
    • consider possibility of unintended pregnancy
    • Inquire about # of partners/history of sex work
  - social marginalization may underpin sex work
  - trans-specific needle-sharing
Fertility Preservation

• Address FP before hormonal or surgical interventions
  
  – MTF:
    • Bank semen pre-treatment
    • If testes are retained viable sperm may develop after feminizing hormone interruption. (Don’t count on it!)
  
  – FTM:
    • Store eggs, embryos, ovaries
    • With retained ovaries, viable eggs may develop after masculinizing hormone interruption. (Don’t count on it!)
    • With retained uterus, pregnancy may be possible after masculinizing hormone interruption. (Don’t count on it!)
Provisional Hope; Problematic Data

• TG Treatment Improves QOL
  – 1833 subjects (1093 MTF, 801 FTM) receiving hormonal therapy reported significant improvement in:
    • gender dysphoria 80%
    • psychological symptoms 78%
    • quality of life 80%
    • sexual function 72%
  – meta-analysis of 28 studies; Murad et al reported that their findings were based on “very low quality evidence.”
Treatment Goals for All Transpeople

• to induce or create physical changes that match and affirm gender identity
• to achieve and maintain normal physiological levels of sex hormones for target gender
• to support healthy psychological adjustment during the “coming out” process of transition
QUESTIONS?
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