Gender Dysphoria

What is it that makes you think you are a man? Or a woman? Clearly, it's more than your sexual arousal patterns or your anatomy. It's also more than the reactions and experiences of your family and society. The essence of your masculinity or femininity is a deep-seated personal sense called gender identity or the gender you actually experience. Gender dysphoria is present if a person's physical sex (male or female anatomy, also called "natal" sex or “chromosomal sex”) is not consistent with the person's sense of who he or she really is or with his or her experienced gender. While gender dysphoria can occur on a continuum, at the extreme end of the continuum are individuals who reject their natal sex altogether and wish to change it. People with this disorder often feel trapped in a body of the wrong sex. Consider the case of Joe.

> *Joe was a 17-year-old male and the last of five children. Although his mother had wanted a girl, he became her favorite child. His father worked long hours and had little contact with the boy. For as long as Joe could remember, he had thought of himself as a girl. He began dressing in girls' clothes of his own accord before he was 5 years old and continued cross-dressing into junior high school. He developed interests in cooking, knitting, crocheting, and embroidering, skills he acquired by reading an encyclopedia. His older brother often scorned him for his distaste of such "masculine" activities as hunting.*
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> *Joe associated mostly with girls during this period, although he remembered being strongly attached to a boy in the first grade. In his sexual fantasies, which developed around 12 years of age, he pictured himself as a female having intercourse with a male. His extremely effeminate behavior made him the object of scorn and ridicule when he entered high school at age 15. Usually passive and unassertive, he ran away from home and attempted suicide. Unable to continue in high school, he attended secretarial school, where he was the only boy in his class. During his first interview with a therapist, he reported, "I am a woman trapped in a man's body, and I would like to have surgery to become a woman"*

If the natal sex is female but the experienced gender (gender identity) is strongly male, the individual is typically referred to as a transsexual man or "transman," and a natal male would be a transwoman. If the individual has made the transition to full time living in their experienced gender (by interacting with people in their daily lives in a consistent manner in their desired gender) and they are preparing for, or have undergone sex reassignment surgery then they are referred to as "posttransition." Additionally, a chromosomal male who has gender dysphoria and wishes or has gone through the transition is referred to as a male-to-female transsexual. Similarly a chromosomal female with gender dysphoria could be referred to as a female-to-male transsexual.

Transgender: An umbrella term that refers to those with identities that cross over, move between, or otherwise challenge the socially constructed border between the genders. While this can include medical or social transition, it may not.

Transexual: A term referring to a person who does not identify with the sex they were assigned at birth and wishes, whether successful or not, to realign their gender and their sex through use of medical intervention.

Defining Gender Dysphoria

Gender dysphoria must be distinguished from transvestic fetishism, a paraphilic disorder in which individuals, usually males, are sexually aroused by wearing articles of clothing associated with the opposite sex. There is an occasional preference on the part of the male with transvestite patterns of sexual arousal for the female role, but the primary purpose of cross-dressing is sexual gratification. In the case of gender dysphoria, the primary goal is not sexual gratification but rather the desire to live life openly in a manner consistent with that of the other gender.

Gender dysphoria can also occur among individuals with disorders of sex development (DSD), formerly known as intersexuality or hermaphroditism who are born with ambiguous genitalia associated with documented hormonal or other physical abnormalities[1]. Depending on their particular mix of characteristics, individuals with DSDs are usually "assigned" to a specific sex at birth, sometimes undergoing surgery, as well as hormonal treatments, to alter their sexual anatomy. If gender dysphoria occurs in the context of a DSD, this should be specified when making a diagnosis. But most individuals with gender dysphoria have no demonstrated physical abnormalities. (We return to the issue of DSD later.)

Finally, gender dysphoria must be distinguished from the same-sex arousal patterns of a male who sometimes behaves effeminately, or a woman with same-sex arousal patterns and masculine mannerisms. Such an individual does not feel like a woman trapped in a man's body or have any desire to be a woman, or vice versa. Note also, as the DSM-5 criteria do, that gender identity is independent of sexual arousal patterns. Male-to-female transsexuals could be attracted to men (referred to as the homosexual type because they are natal men attracted to men) or attracted to women (referred to as the heterosexual type because they are natal males attracted to females). Research has identified some differences between these 2 types of male-to-female transsexuals and that will most likely be mentioned in class.

Lawrence (2005) studied 232 transwomen both before and after surgery and found that the majority (54%) were mostly heterosexual (attracted to women) before the surgery. This changed after surgery slightly for some and dramatically for a few, such that only 25% remained attracted to women after surgery, thus making them technically gay. This latter group may constitute a distinct subset of transwomen with a different pattern of development called autogynephilia, in which gender dysphoria begins with a strong and specific sexual attraction to a fantasy of oneself (auto) as a female (gyne). This fantasy then progresses to a more comprehensive all-encompassing experienced gender as a female. Individuals in this subgroup of biological males were not effeminate as boys but became sexually aroused while cross-dressing and to fantasies of themselves as women. Over time, these fantasies progress to becoming a woman (Bailey, 2003; Carroll, 2007; Lawrence, 2013). In other words, they may want to become the source of their arousal. [2] They (the heterosexual type) also seem to transition later in life as compared to the homosexual type of male-to-female transsexual. This distinction is controversial, but it is supported by research (Carroll, 2007; see p. 379).

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[1] For example at birth the doctor looks at the infant and can't tell if he sees a little penis or a big clitoris. That is intersexed.

[2] Some have drawn a parallel to men who become aroused to amputees and then want to become an amputee themselves.

Prevalence

Gender dysphoria resulting in a rejection of natal sex is relatively rare. The estimated prevalence in natal males is between 5 and 14 per 1,000 and for natal females between 2 and 3 per 1,000 (American Psychiatric Association, 2013; 2015), occurring approximately 3 times more frequently in natal males than in natal females. Many countries now require a series of legal steps to change gender. In Germany, between 2.1 and 2.4 per 100,000 in the population took at least the first legal step of changing their first names in the 1990s; in that country, the male:female ratio of people with gender dysphoria is 2.3:1. Since 2006 in New York City, people may choose to alter the natal sex listed on their birth certificates following surgery.

Other Facts

In some cultures, individuals with a different gender experience are often accorded the status of "shaman" or "seer" and treated as wisdom figures. A shaman is almost always a male adopting a female role. Stoller (1976) reported on two contemporary feminized Native American men who were not only accepted but also esteemed by their tribes for their expertise in healing rituals. Contrary to the respect accorded these individuals in some cultures, social tolerance for them remains relatively low in Western cultures, although that is changing particularly as individuals such as Kaitlyn Jenner and Chaz Bono forthrightly and openly discuss gender dysphoria. In recent years, actors such as Laverne Cox, books such as "Becoming Nicole", and movies such as The Danish Girl, have also begun to raise awareness about gender dysphoria and encourage more discussion on the topic.

Causes

Research has yet to uncover any specific biological contributions to gender dysphoria or alternative gender experience for that matter, although it seems likely that a biological predisposition will be discovered. Coolidge, Thede, and Young (2002) estimated that genetics contributed about 62% to creating a vulnerability to experience gender dysphoria in their twin sample. Thirty-eight percent of the vulnerability came from environmental events. A study from the Netherlands twin registry suggested that 70% of the vulnerability for cross-gender behavior (behaving in a manner consistent with the opposite natal sex) was genetic as opposed to environmental, but this behavior is not the same as gender identity, which was not measured. Segal (2006) found two monozygotic (identical) female twin pairs in which one twin had gender dysphoria and the other did not; no unusual medical or life history factors were identified to account for this difference. Nevertheless, genetic contributions are clearly part of the picture, but it is a cloudy picture.

Early research suggested that, as with sexual orientation, slightly higher levels of testosterone or estrogen at certain critical periods of development might masculinize a female fetus or feminize a male fetus (see, for example, Keefe, 2002). Variations in hormonal levels could occur naturally or because of medication that a pregnant mother is taking. Scientists have studied girls aged 5 to 12 with an intersex condition known as congenital adrenal hyperplasia (CAH). In CAH, the brains of these chromosomal females are flooded with male hormones (androgens), which, among other results, produce mostly masculine external genitalia, although internal organs (ovaries and so on) remain female. Meyer-B ahlburg and colleagues (2004) studied 15 girls with CAH who had been correctly identified as female at birth and raised as girls and looked at their development. Compared with groups of girls and boys without CAH, the CAH girls were masculine in their behavior, but there were no differences in gender

identity. Thus, scientists have yet to establish a link between prenatal hormonal influence and later gender identity, although it is still possible that one exists. Structural differences in the area of the brain that controls male sex hormones have also been observed in individuals with male-to-female gender dysphoria (Zhou, Hofman, Gooren, & Swaab, 1995; Hannema et al., 2014), with the result that the brains are comparatively more feminine. But it isn't clear whether this is a cause or an effect.

At least some evidence suggests that gender identity firms up between 18 months and 3 years of age (Ehrhardt & Meyer-Bahlburg, 1981; Money & Ehrhardt, 1972) and is relatively fixed after that. But newer studies suggest that possible preexisting biological factors have already had their impact. One interesting case illustrating this phenomenon was originally reported by Green and Money (1969), who described the sequence of events that occurred in the case of Bruce/Brenda. There do seem to be other case studies of children whose gender was reassigned at birth who adapted successfully (see, for example, Gearhart, 1989), but it certainly seems that biology expressed itself in Bruce's case. Richard Green, a pioneering researcher in this area, has studied boys who behave in feminine ways and girls who behave in masculine ways, investigating what makes them that way and following what happens to them (Green, 1987). This set of behaviors and attitudes is referred to as gender nonconformity (see, for example, Skidmore, Linsenmeier, & Bailey, 2006). Green discovered that when most young boys spontaneously display "feminine" interests and behaviors, they are typically discouraged by most families, and these behaviors usually cease. Boys who consistently display these behaviors are not discouraged, however, and are sometimes encouraged.

Other factors, such as excessive attention and physical contact on the part of the mother, may also play some role, as may a lack of male playmates during the early years of socialization. These are just some factors identified by Green as characteristic of gender- nonconforming boys. Remember that as-yet-undiscovered biological factors may also contribute to the spontaneous display of cross-gender behaviors and interests. For example, one recent study found that exposure to higher levels of fetal testosterone was associated with more masculine play behavior in both boys and girls during childhood (Auyeng et al., 2009). In following up with these boys, however, Green discovered that few seem to develop the gender incongruence (although some did). The most likely outcome is the development of homosexual preferences.

We can safely say that the causes of the development of incongruent experienced gender is still something of a mystery.

Treatment

Treatment is available for gender dysphoria in specialty clinics around the world, although much controversy surrounds treatment (Carroll, 2007; Meyer-Bahlburg, 2010). For adults requesting full sex transition treatment guidelines from both the American Psychiatric Association and the American Psychological Association have now been published (American Psychological Association, 2015; Byne et al., 2012). Recommendations from the American Psychiatric Association guidelines, when addressing adult patients with gender dysphoria more specifically, begin with the least intrusive step of full psychological evaluation and education before proceeding to partially reversible steps such as administration of gonadal hormones to bring about desired secondary sex characteristics. It is often very stressful and difficult to complete the transition. Consider the impact on family, friends, and coworkers

and how those relationships could either help or hurt adjustment. The final nonreversible step is to alter anatomy physically to be consistent with gender identity through sex reassignment surgery.

Sex Reassignment Surgery

To qualify for surgery at a reputable clinic, individuals must live in the desired gender for 1 to 2 years so that they can be sure they want to change sex. They also must be stable psychologically, financially, and socially. In transwomen, hormones are administered to promote gynecomastia (the growth of breasts) and the development of other secondary sex characteristics. Facial hair is typically removed through electrolysis. If the individual is satisfied with the events of the trial period, the genitals are removed and a vagina is constructed.

For transmen, an artificial penis is typically constructed through plastic surgery, using sections of skin and muscle from elsewhere in the body, such as the thigh. Breasts are surgically removed. Genital surgery is more difficult and complex in natal females become males. Estimates of satisfaction with surgery indicate predominantly successful adjustment (between 75% and 100% generally satisfied) among those who could be reached for follow ups. Approximately 1% to 7% of individuals who have sex reassignment surgery and were reached for follow-up later regret having the surgery to some extent. This is unfortunate, because the surgery is irreversible. Also, as many as 2% attempt suicide after surgery, a rate much higher than the rate for the general population. One problem may be incorrect diagnosis and assessment. For example, one study of 186 Dutch psychiatrists reporting on 584 patients presenting with gender dysphoria revealed little consensus on diagnostic features or the minimum age at which sex reassignment surgery is safe. Rather, the decision seemed to rest on personal preferences of the psychiatrist. These assessments are complex and should always be done at highly specialized gender clinics. Predictors of regret in addition to misdiagnosis include the presence of comorbid diagnoses such as alcohol use and psychosis, and poor family support (Byne et al., 2012). Nevertheless, surgery has made life worth living for many people who suffered the effects of existing in what they felt to be the wrong body with rates of satisfaction in recent years averaging about 90% (Johansson et al., 2010).

Treatment of Gender Nonconformity in Children

Even more controversial is the treatment of gender-nonconforming children. On the one hand, some segments of society, particularly in more traditionally tolerant areas of the country such as San Francisco and New York, are becoming more open to gender variations in both children and adults. In some schools, children are being allowed and even encouraged to dress and appear in gender- nonconforming ways on the assumption that this gives freer rein to who they "really are" (Brown, 2006). On the other hand, Skidmore and colleagues (2006) examined whether gender nonconformity was related to psychological distress in a community-based sample of gay men and lesbians. Gender nonconformity was measured by self-reports of childhood gender nonconformity, as well as ratings of current behavior. The researchers found that gender nonconformity was related to psychological distress (depression, anxiety), but only for gay men and not for lesbians[3].

[3] This may not be surprising as society gives women more freedom in this area than it gives men.

Although only a minority of gay men report gender nonconformity as boys; research indicates that many of these gender-nonconforming boys defeminize as they reach adulthood, perhaps because of persistent social pressure from their family and peers. Also, interventions exist to alter gender-nonconforming behavior in young children to avoid the ostracism and scorn these children encounter in most school settings (e.g., Rekers, Kilgus, & Rosen, 1990). Other interventions exist to build resilience in children who exhibit gender- nonconforming behavior by strengthening their relationships with peers and caregivers, increasing their sense of self-control, and increasing their sense of belonging within a community or culture (Allan & Ungar, 2014).

Thus, society is faced with a dilemma that requires more research. Should the free expression of gender nonconformity be encouraged knowing that, in most parts of world, gender nonconformity will make for difficult social adaptation leading to substantial psychological distress for decades to come? Or will psychological adjustment be more positive if gender nonconformity is allowed and facilitated? If research confirms that adjustment is more positive if individuals find their own place on a gender continuum, then large-scale campaigns to alter social norms may well occur along the lines of the successful campaigns of the past several decades for gay rights, after a consensus developed in the 1970s that homosexuality was not a disorder. Research will continue on this important and interesting topic.

Treatment guidelines developed by the American Psychiatric Association and the American Psychological Association for gender nonconformity in youth simply outline the options available (American Psychological Association, 2015; Byne et al., 2012). One option would be to work with the child and caregivers to lessen gender dysphoria and decrease cross-gender behaviors and identification on the assumption that these behaviors are unlikely to persist anyway and the negative consequences of social rejection could be avoided and that avoiding later intrusive surgery would be desirable. A second approach could be described as "watchful waiting" by letting expressed gender unfold naturally. This goal requires strong support from caregivers and the community because of the potential social and interpersonal risks and lack of integration with peer groups. Yet a third approach advocates actively affirming and encouraging cross-gender identification, but critics point out that gender nonconformity usually does not persist and that taking this course would increase the likelihood of persistence. There is very little hard scientific information on which course would be the most beneficial for a given child.

More recently, new treatment approaches have been developed in some clinics for children who more clearly identify as transsexual. Given the irreversible nature of many treatments for gender dysphoria, treatment for these children needs to be administered with caution. One specialty clinic for these children at well-known Children's Hospital in Boston, has attracted attention for their treatment approach. In pre-pubescent children, first-line treatments include psychoeducation and therapy to help clarify gender identity and navigate the complex social issues associated with cross-gender identification. In individuals closer to puberty, psychotherapy is also recommended. However, a medical intervention that blocks puberty is also available (if, after detailed assessment, it is determined that such treatment would be in the best interest of the patient based on the severity of the discordance between gender identity and natal sex as well as family and social considerations). This medication allows the adolescent time to continue exploring gender identity issues without the added of stress of beginning puberty in a gender that is inconsistent with their identify (Tishelman et al., 2014). While this treatment

has received some positive press in recent years, it still remains controversial in many parts of the United States.

Treatment of Disorders of Sex Development (Intersexuality)

For a intersexed female with a big clitoris, the treatment of choice in the past had been to cut the clitoris down in order to appear more normal. For intersexed males with a “micro” penis, the treatment of choice had been to remove the penis and raise the child as a female. Doctors thought that going through life as a male with a tiny penis would be too traumatic. Remember these surgeries are usually not medically necessary.

More recently, there has been a push to leave these infants alone and let them decide when they are older, how they want their genitals to be.

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