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Gender Dysphoria challenges: Diagnosis and Care

Maedeh Parvizi
Child and Adolescent Psychiatrist
Iran University of Medical Sciences

Gender Dysphoria- DSM-5

A.

A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following:

1. A strong desire to be of the other gender or an insistence that one is the other gender.

2. In boys, a strong preference for cross-dressing or simulating female attire; in girls, a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.

3. A strong preference for cross-gender roles in make-believe play or fantasy play.

Gender Dysphoria- DSM-5

4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.

5. A strong preference for playmates of the other gender.

6. In boys, a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; in girls, a strong rejection of typically feminine toys, games, and activities.

7. A strong dislike of one's sexual anatomy.

8. A strong desire for the primary and/or secondary sex characteristics of the other gender.

Gender Dysphoria- DSM-5

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

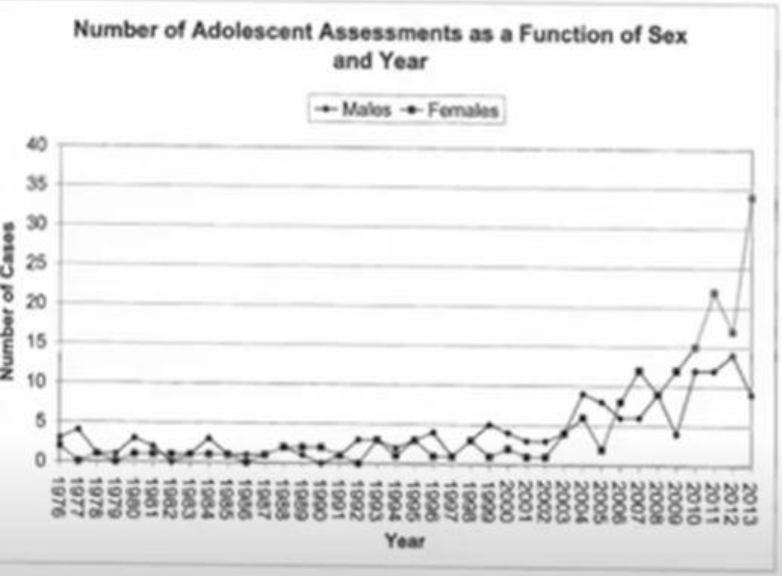
Rcent Years…

An Explosion

Source: Komodo Health Inc

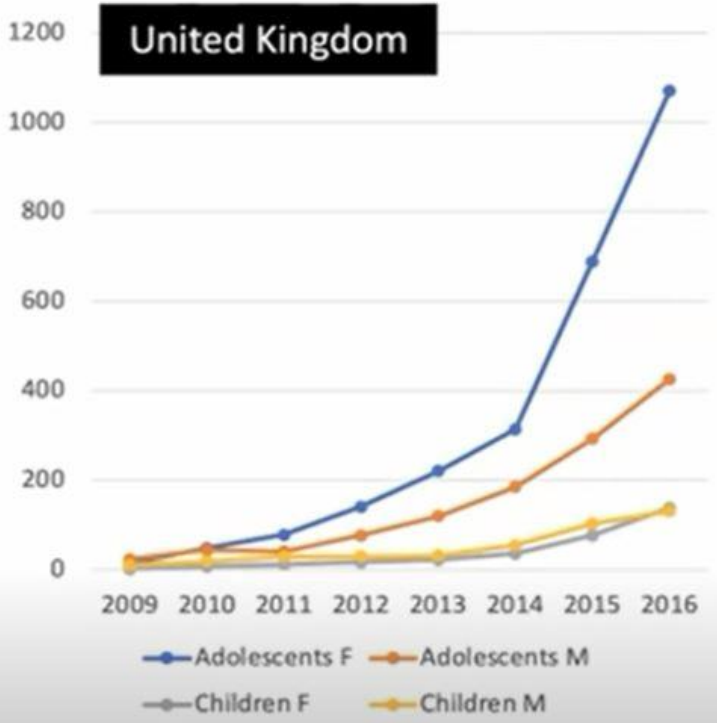
Changes population

Canada



(Aitken et al., 2015a; de Graaf, Giovanardi, et al., 2018a)
Graph (L) with permission from Ken Zucker

United Kingdom



Gender clinics:

- Canada: Center for Addiction and Mental Health (CAMH)
- United Kingdom: the National Gender Identity Development Service (GIDS)

Natal female Adolescents GD- rising issue

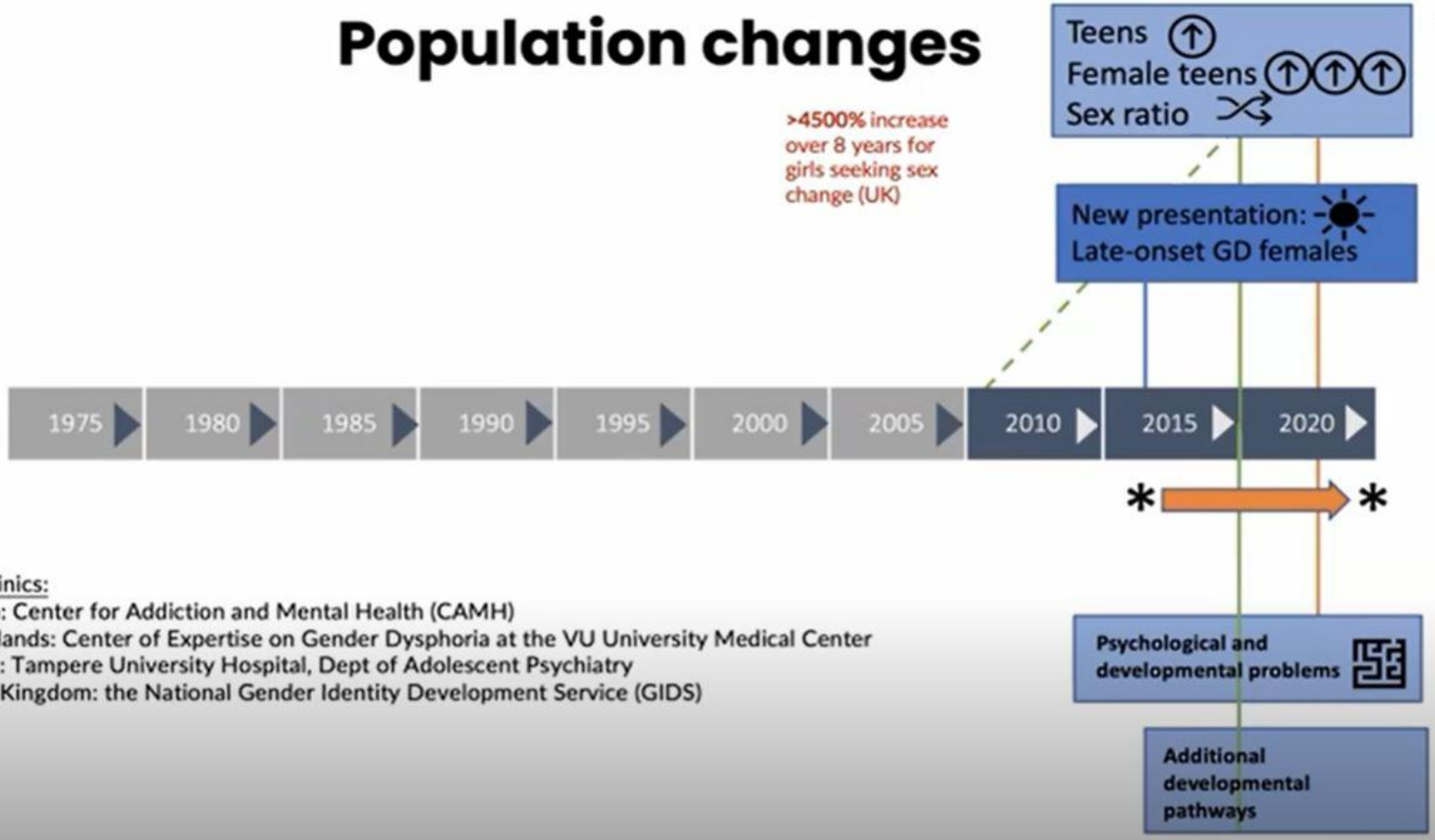
The predominance is a reversal from the past. (Amsterdam Cohort – 2023)
2.5 to 7.1 times more than natal male (WPATH) (CDC-2017-2020)
Increased 1,000% natal males and 4,400% natal females. (UK-Ministery for Women & Equalities-2009-2019)
Subset of transgender youth, typically natal females, suddenly dysphoric, shortly after puberty.

Adolescent girls' susceptibility to peer influence?
On social media?
More accessible care?
Increasing social acceptance?
Culture of internalized misogyny
Body hatred and early sexualization of girls.

"Girls have a harder time with the physical and emotional changes that come with the onset of puberty,". "And I think there is an element of truth that males have it better in many quarters of society than females." "Kids do try things on and not everything sticks. They experiment," "I do not believe that we have an obligation to accept at face value everything a young person says to us."
Erica Anderson, former WPATH president

Population changes

>4500% increase over 8 years for girls seeking sex change (UK)



Gender clinics:

- Canada: Center for Addiction and Mental Health (CAMH)
- Netherlands: Center of Expertise on Gender Dysphoria at the VU University Medical Center
- Finland: Tampere University Hospital, Dept of Adolescent Psychiatry
- United Kingdom: the National Gender Identity Development Service (GIDS)

(Aitken et al., 2015b; Bonfatto & Crasnow, 2018; Cohen-Kettenis & Klink, 2015; de Graaf, Giovanardi, et al., 2018b; de Graaf & Carmichael, 2019; Edwards-Leeper & Spack, 2012; Kaltiala-Heino et al., 2015, 2018; McGrath, 2018)

Psychosocial factors?

Psychological

- Higher than expected psychological issues
- Severe psychiatric and developmental issues pre-dating the GD onset

Social

- Social contagion
- Peer contagion
- Adolescents susceptible to peer influence
- Pattern of distribution
- Social media content and dynamics

(Brechwald & Prinstein, 2011, Dishion & Tipsord, 2011)

Detransition

Although transgender and gender-diverse (TGD) people have been receiving hormone therapy and surgical interventions for several decades, information and public discourse on discontinuation rates of hormones, detransition, and regret were sparse until around 2016.

Detransition refers to the stopping or reversal of transitioning which could be social (gender presentation, pronouns), medical (hormone therapy), surgical, or legal.

Although they are sometimes mistakenly viewed as synonymous, detransition and regret are different concepts that may overlap in some people.

Roberts et al

examined rates of continuation of gender affirming hormones among TGD adolescents and adults in the U.S. Military Healthcare System.

627 transmasculine and 325 transfeminine individuals who were children or spouses of active-duty, retired, or deceased military members. ICD codes were used for diagnoses and pharmacy records determined hormone use.

Discontinuation of hormones was defined as failure to obtain another prescription > 90 days following completion of the most recent prescription.

This study found that the 4-year gender-affirming hormone continuation rate was 70.2% with 81% for the transfeminine group and 64% for the transmasculine group. 2022

Roberts et al

Using a Cox regression model, increased discontinuation rates were independently associated with transmasculine gender identity (hazard ratio 2.4) and starting hormones ≥ age 18 (hazard ratio 1.69).

Important limitations

unable to assess the reasons why 30% discontinued hormonal therapy for more than 90 days, the short period of 90 days, and the inability to capture prescriptions filled outside of the military healthcare system.

It would be interesting to know what proportion discontinued due to detransition versus other reasons such as

Of note, the mean agan adverse effect of a medication or cost. e in this study was 19.2 years.

James SE, 2016

The largest study to look at detransition was the U.S. Transgender Survey from 2015 which was a cross-sectional non probability study of 27 715 TGD adults.

This survey included the question

"Have you ever de-transitioned? In other words, have you ever gone back to living as your sex assigned at birth, at least for a while?"

8% had detransitioned temporarily or permanently at some point and that the majority did so only temporarily.

Rates of detransition were higher in transgender women (11%) than transgender men (4%).

The most common reasons: pressure from a parent (36%), transitioning was too hard (33%), too much harassment or discrimination (31%), and trouble getting a job (29%).

Wiepjes CM et al

Historically, rates of regret in TGD people following hormone therapy and surgical interventions were thought to be quite rare. From 1972-2015, 6793 people sought gender affirming services at the multidisciplinary gender identity clinic at the VU Medical Center in Amsterdam.

All patients were screened by mental health specialists who determined whether patients were eligible for hormone therapy. 70% were started on hormone therapy and 78% of this group went on to have gonadectomy. Among gonadectomy, rates of regret were 0.6% for transwomen and 0.3% for transmen with an average time to regret of 10.8 years.

The rate of regret may be an underestimate due to a high rate (36%) of loss to follow-up.

Wiepjes CM et al

The reasons for regret were:
true regret (n = 7),
social acceptance (n = 5)
feeling nonbinary (n = 2)

Pazos Guerra M et al

Reported 8 cases of detransition and/or regret among 796 patients seen from 2008-2018 at a multidisciplinary gender identity clinic in Valencia, Spain .

the study by *Roberts et al* highlights the important issue that a proportion of our TGD patients elect to discontinue hormonal treatment.

As clinicians, we may overlook this aspect of care as many patients who detransition no longer present to our clinics for follow-up.

Littman 2023

In fact, one study of 100 detransitioners:
only 24% of respondents informed their clinicians that they had detransitioned.

Littman study (2021)
A survey of 100 detransitioners

69 were natal female (31.0% were natal male)

- **Becoming more comfortable identifying as their natal sex (60.0%)**
- **concerns about potential transitioning medical complications (49.0%)**
- **GD was caused by specifics (trauma, abuse, or mental health condition) (38.0%)**
- **Homophobia or difficulty accepting themselves as lesbian, gay, or bisexual was expressed (Experiencing discrimination) (23.0%)**

Majority (55.0%) felt they did not receive adequate evaluation before transition
Only 24.0% informed their clinicians that they had detransitioned.

40% said their GD was caused by a mental-health condition
62% felt professionals did not investigate trauma as factor in transition decisions.

We have an important role to play when it comes to the medical management of TGD patients who transition or detransition.

Because the informed consent model has made it easier for people to access gender affirming therapies, we should ensure that our patients have received adequate and comprehensive information on the potential benefits and risks of gender-affirming therapies, especially regarding irreversible changes such as voice deepening with testosterone and hypogonadism after gonadectomy.

Vandenbussche E, 2022

A cross-sectional online survey of 237 detransitioners found important psychological needs and needed accurate information on stopping/changing hormonal treatment.

This particular study recruited participants through social media, particularly through websites and groups for female detransitioners.
The average age was 25 years

92% were assigned female at birth,
65% transitioned both socially and medically,
46% of medically transitioned underwent GAS,

The average duration of transition was 4.7 years.

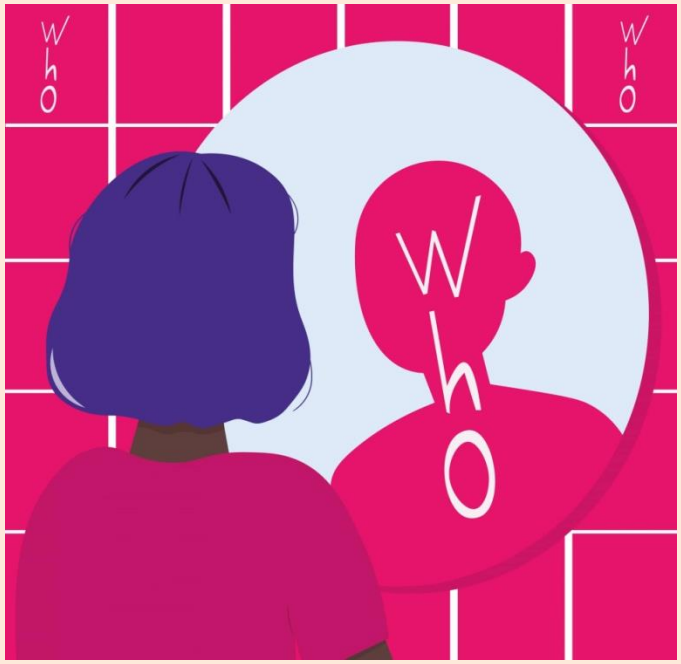
Vandenbussche E, 2022

The most common reason for detransitioning:

realization that their GD was related to other issues (70%).

high rates of MH comorbidities:

- **Depressive disorder (70%)**
- **Anxiety (63%)**
- **PTSD (33%)**
- **ADD (24%)**
- **ASD(20%)**
- **ED (19%)**
- **PD (17%)**



Vandenbussche E, 2022

Most described their detransition as a very isolating experience in which they did not receive adequate psychological or medical support.

Many lost support and friendships from the LGBT community and some experienced hostility after announcing their decision to detransition. This study has the major limitation of selection bias.

With the increase in numbers of persons presenting for gender-affirming care, shift to informed consent, likely reduced proportion of receiving an adequate MH evaluation, and a change in the distribution of TGD people to more assigned female at birth and nonbinary individuals, there is reason to believe that the numbers of detransitioners may increase.

It is quite possible that low reported rates of detransition and regret in previous populations will no longer apply to current populations.

More research is needed to compare care and outcomes between the
Less restrictive informed consent model
v/s
Stricter interdisciplinary model (pioneered in the Netherlands)

Although the rates of discontinuing hormones and detransition may change over time, our compassionate care can remain a constant.

Gender-affirming Model of Care (GAMC)- Finland 2020

Takes Another Look at Youth Gender Medicine

COHERE/PALKO, agreed for new guidelines
A new cautious set of guidelines 2020
Almost entirely abandoned the controversial WPATH SoC.

Medical Treatment Methods for Dysphoria Related to Gender Variance In Minors 2020:
“in light of available evidence, gender reassignment of minors is still an experimental practice.”

Psychosocial first-line, Even with Dutch protocol profile,
if needed, psychotherapy.

Medical interventions are possible in Finland on a case-by-case basis if, after psychotherapy, the patient’s gender-related anxiety persists, personality development appears stable and no severe mental health disorders would complicate treatment.
Surgery is not offered to under-18s.

Low persistance even in extreme cases.

Gender-affirming Model of Care (GAMC)- Sweden 2022

In February, Sweden's National Board of Health and Welfare

Revised its recommendations
Treatments be given within a clinical trial
Or who fit the original Dutch model (persistent GD- no mental health issues).

Gender-affirming Model of Care (GAMC)- UK- NHS- 2022

The Cass Review In 2020

NHS closed The Gender Identity Development Service (GIDS) at the Tavistock Centre

Classification: Official

NHS England

Interim service specification:

Interim specialist service for children and young people with gender incongruence

9 June 2023

Referrals for assessment for endocrine interventions

Separate but linked NHS England clinical commissioning policies will define the use as part of the NHS commissioned service of i) puberty suppressing hormone treatment; and, ii) masculinising / feminising hormones from around the age of 16 years.

Prescribing from unregulated sources and unregulated providers

Children, young people and their families are strongly discouraged from sourcing puberty suppressing or gender affirming hormones from unregulated sources or from on-line providers that are not regulated by UK regulatory bodies.

If a child or young person has already been started on **puberty suppressing hormones** outside of NHS protocols by the time that they are seen by the NHS, The Service may consider assuming clinical responsibility for prescribing through NHS protocols if The Service's MDT jointly concludes with the related endocrine clinic that this is an appropriate harm reduction measure. In such cases administration of puberty suppressing hormones would need to be stopped for a brief period of time to allow baseline investigations to be undertaken by The Service. If the patient is felt to be appropriate to be restarted on treatment after assessment by The Service treatment may be resumed in accordance with NHS protocols, including the requirement for the patient to be enrolled in the formal research protocol.

If a young person has already been started on **masculinising / feminising hormones** outside of NHS protocols, The Service will consider (jointly with the related endocrine clinic) a continuation of prescribing through NHS protocols as a harm reduction measure where ALL of the following criteria are met:

- Evidence of a comprehensive documented assessment by a multi-disciplinary team that includes a medical practitioner with specialist expertise in gender incongruence in children and adolescents; and
- Evidence of continued psychological support through engagement with the MDT; and
- Administration of puberty suppressing hormones was commenced not before Tanner stage 2; and
- Masculinising / feminising hormones commenced after at least twelve months on puberty suppressing hormones; and
- Masculinising / feminising hormones were commenced not before approximately 16 years of age; and
- Evidence that impact to fertility was discussed with the young person before initiation of the hormones.