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Gender dysphoria

Synonym: gender identity disorder

This article refers to the International Classification of Diseases 11th edition (ICD-11) which is normally used as the official classification system by mental health professionals working in NHS clinical practice. The literature also refers to the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system which - whilst used in clinical practice in the USA - is primarily used for research purposes elsewhere.

What is gender dysphoria?

Gender dysphoria is the distress associated with the experience of one's personal gender identity being inconsistent with the phenotype. The term which has replaced gender identity disorder is gender incongruence; this reflects the lack of congruence between someone's personal identity and their phenotypical biological gender The role of health professionals in helping those who are transsexual or transgender is not to treat a disease but to promote health and well-being in this group of people. This involves multidisciplinary care across a wide scope of health professionals. [1]

Definitions of gender dysphoria

The World Professional Association for Transgender Health (WPATH) leads many groups in urging the de-psychopathologisation of gender nonconformity worldwide. The WPATH standards of care state that being transsexual, transgender, or gender-nonconforming is a matter of diversity not pathology.

Gender dysphoria

Gender dysphoria is the term used to describe the distress experienced by an individual about their assigned gender which is in conflict with their internal gender identity. For a DSM 5th edition (DSM-5) diagnosis, there must be a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months.[2] Gender incongruence is manifested in a variety of ways, including strong desires to be treated as the other gender or to be rid of one's sex characteristics or a strong conviction that one has feelings and reactions typical of the other gender. Not everyone with gender incongruence will experience distress but the term gender dysphoria relates to the problems caused by the difference in experienced and assigned gender.

The WPATH standards of care state: "The designation of gender identity disorders as mental disorders is not a license for stigmatization, or for the deprivation of gender patients' civil rights. The use of a formal diagnosis is often important in offering relief, providing health insurance coverage, and guiding research to provide more effective future treatments." In the words of Department of Health policy: "It cannot be overemphasised that being trans is not a mental illness. Trans or gender variant individuals are not necessarily dysphoric.

Gender identity disorder

Gender identity disorder is no longer a diagnosis under the ICD-11 classification. ICD-11 no longer categorises being transsexual as a mental health issue. The term "gender identity disorder" which was defined as: "A desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make one's body as congruent as possible with one's preferred sex through surgery and hormonal treatment." has been replaced with "gender incongruence" and this is further categorised into "gender incongruence of adolescence and adulthood" and "gender incongruence of childhood". It is no longer categorised as a mental illness but a condition associated with sexual health.

"...gender incongruence and gender dysphoria. The terms are not interchangeable. Gender incongruence is where the individual’s experience of their gender identity does not align with their biological sex. Gender dysphoria is present when the gender incongruence causes clinically significant levels of distress to the individual. Not all individuals with gender incongruence will experience dysphoria."[3]

Transsexual
A person who feels a consistent and overwhelming desire to effect a transition and fulfil their life as a member of the opposite gender. Many - though not all - transsexual people actively desire and complete gender reassignment surgery.

Transgender, or trans
An umbrella term for a number of different gender experiences, often used to include transsexual people, transvestites and cross-dressers.

Trans woman/trans man
Trans woman refers to an individual who has been assigned as a male at birth, but who later
identifies as a woman. A trans man is an individual who has been assigned as a female at birth, but later identifies as a male. These are terms used to describe this person prior to having any surgery or obtaining a Gender Recognition Certificate (see below), as after either of these events, they would normally refer to themselves as a woman or a man respectively.

Definitions are evolving, may vary between users and can cause some confusion.

Legalities

The Gender Recognition Act of 2004 in the UK allows transsexual people to change their legal gender. In the UK, individuals may apply to the Gender Recognition Panel for a Gender Recognition Certificate. Those applying under this process have to demonstrate that they have had a diagnosis of gender incongruence and that they have lived in the changed gender role for at least two years. Once a Gender Regulation Certificate has been issued, that person should be identified as a man or a woman and not a 'trans man' or 'trans woman'.

Once individuals have changed their name and formal style of address (ie Mr, Mrs, Miss, etc), their NHS records should be changed accordingly. A formal certificate should not be needed for this change to be affected.

There have been reviews of the Gender Recognition Act in 2018 and 2020 which with a move to streamline it and de-medicalise it.[4]

The Equality Act of 2010 in the UK protects all individuals against discrimination. This includes gender or gender reassignment along with other characteristics such as age, disability, race and religion.

How common is gender dysphoria / gender incongruence? (Epidemiology)

Prevalence figures vary and depend on methodology in studies attempting to establish data.

A survey by the Equality and Human Rights Commission in 2012 of 10,000 people found 1% had some degree of gender variance. This was partly conducted to investigate the most appropriate ways and wording to collect data, and cannot necessarily be assumed representative of the population as a whole.

A Gender Identity Research and Education Society (GIRES) publication in 2011, funded by the Home Office, estimates that prevalence is increasing.[5] Its original report had estimated prevalence in the UK in 2007 as 20 per 100,000 people having sought medical help for gender variance. This represented 10,000 people of whom 6,000 had undergone gender transition. Of these, 80% were birth-assigned males choosing to become females, although this percentage is noted to be dropping. By 2010, 12,500 had presented for treatment. It was estimated that the number presenting for treatment is doubling every 6.5 years. The mean age of those presenting for treatment was previously 42 but is significantly lowering. The GIRES report states currently around 100 children and adolescents were being referred each year to the UK's single specialised gender identity service for this age in 2010. The number of referrals for this age group, however, is said to have been rising by 32% per year in recent years. and, before it was closed, the Gender Identity Service at the Tavistock received over 2,700 referrals in 2019/20.[6]

What causes gender dysphoria? (Aetiology)

There is likely to be a balance of a number of genetic, hormonal and environmental factors involved in gender dysphoria but the cause is essentially unknown. Twin studies indicate genetic factors have at least some role.

Gender dysphoria symptoms (presentation)

Individuals may present to a GP at various stages. They may have been living as a trans individual for some time and want help in accessing medical or surgical treatment. They may present with the symptoms of the stress associated with suppressing feelings, or with lack of acceptance/understanding displayed by friends and family. Depression, self-harm and suicide may be more common in transsexual individuals.[7]

This individual will need their GP to have an understanding, non-judgemental, confidential and supportive attitude in keeping with the duties laid down in the GMC Good Medical Practice guidance.[8] The role of the GP is important in accessing specialist service and in potentially providing ongoing support - and possibly endocrine treatment and monitoring where the individual has been fully assessed by an expert and where good shared care agreements exist.

Some of the issues which it may be appropriate to explore include:

- The timescale of the gender identity issue and any change over time.
- The effect on relationships, job, family and social life.
- The effect on health and well-being. Symptoms of associated depression.
- Future ambitions and plans.
- Any steps taken to live in the identified gender - cross-dressing, hormonal medication, changes to appearance. Specifically ask if there has been self-medication as there can be risks in taking medication without appropriate monitoring or medical advice.
- Sexuality and relationships.
- Perceptions and reactions of others, attitudes of significant others.
- Feelings towards own gender-specific features such as genitals, breasts and body hair.
- Support network.
- Fears.

However, the presentation will differ in every individual and it is appropriate for most of these issues to be explored in secondary or tertiary services rather than in primary care.

Children presenting with gender incongruence may:

- Prefer dressing in clothes usually worn by the opposite gender (although this is also normal for many children who do not have gender incongruence).
- Prefer the type of play usually enjoyed more by the opposite gender (although this is also normal for many children who do not have gender incongruence).
- Have more friends of the opposite gender (although this is also normal for many children who do not have gender incongruence).
- State that they are a gender opposite to that which was assigned to them at birth.
- Express a desire to be rid of their genitals, and find pubertal changes distressing.
- Have experienced bullying at school.
- Find it persists as they enter adolescence, or there may be remission - sometimes going on to homosexuality or bisexuality. - studies suggest that between 6 and 23% have gender incongruence that persists into adulthood.

Referral[9] [10]

Prior to referral, a GP would normally be expected to:

- Take a detailed history.
- Assess whether any self medication is taking place and if so, caution about potential side-effects or harms.
- Assess mental health. Consider a concurrent psychiatric referral if the wait for a gender identity clinic is likely to be a long one and there are significant mental health problems.
- Provide information on support groups such as tranzwiki.[11]

Referral of adults

Swift referral to specialist gender services is the ideal. A number of NHS and private specialist services exist in the UK but waiting times are very long and growing. GPs can refer directly to a gender identity clinic (GIC) in most of the UK. In England, prior approval from the clinical commissioning group (CCG) is not required. Specialist gender services consist of a multidisciplinary team, which may include psychiatrists, psychologists, psychotherapists, counsellors, surgeons of a number of specialities, endocrinologists, speech and language therapists, dermatologists, occupational therapists, nurses and social workers.

Guidelines differ on advice for GPs about bridging prescriptions while the GIC appointment is awaited. The Royal College of Psychiatrists (RCPsych) guidelines advised that GPs consider prescribing of 'bridging' hormonal treatments to alleviate distress, but the British Association of Gender Identity Specialists advised against this, pointing out that GPs are unlikely to have the necessary confidence with prescribing and it is difficult for a GIC to advise before they have seen the person. The GMC advises that in occasional circumstances it may be considered, such as when the person is already self-medicating and involvement by the GP may protect from harmful side-effects or the risk of serious mental ill health.[12] However, it is important that GPs do not prescribe outside of their competence - drug treatment of gender incongruence and dysphoria would be outside of most GPs' competence. Most GPs do not offer bridging hormonal treatments. In these situations, the GP would be expected to screen for risks and possibly arrange blood tests and take advice from a GIC.[12]

Following assessment and treatment from a GIC, it may be that GPs will be asked to take on prescribing and monitoring of hormonal medication on a long-term basis. There will need to be rigorous locally-agreed shared care agreements for this. GPs would normally only share care with NHS providers.

Referral of children and adolescents

Significant concerns were raised about the children referred to the Tavistock GIC which was closed in 2022 due to these concerns and a court case. Two new centres have been set up, one at the Maudesley and one in the North of England. 2023 waiting times were significant and growing.[10]

Gender dysphoria treatment and management[1] [13]

In the UK, good practice guidelines for the assessment and treatment of gender dysphoria are laid down by the RCPsych, and endorsed by a host of organisations involved in management. These guidelines are informed by the Standards of Care set by the WPATH.

Note that it is important to address users of gender services as they would wish to be addressed. Ask which they would prefer, discreetly, as soon as possible. Mistakes in gender address can cause offence and distress.

Management is multidisciplinary and may involve any number of the following:

- Psychotherapeutic support.
- Endocrine treatment - see below for specific details.
- Surgery. 12-18 months of endocrine therapy is usually required prior to surgical intervention. Surgical treatments include:
    - Chest surgery - breast augmentation or mastectomy.
    - Genital surgery - for those becoming male: vaginectomy, hysterectomy, salpingo-oophorectomy, phalloplasty, metoidioplasty, testicular prosthesis, scrotoplasty.
    - Genital surgery - for those becoming female: penectomy, orchidectomy, vaginoplasty, cliteroplasty, labioplasty.
    - Facial surgery - particularly feminisation surgery.
    - Vocal surgery - to change pitch of voice.
- Speech and language therapy - help with developing gender-appropriate voice and communication skills.
- Hair treatments - including hair transplantation, hair removal, hairpieces.
- Exploration of fertility implications of treatment, and gamete storage.

Endocrine treatment

As with any hormonal treatment, risk factors must be assessed, and risks and benefits explained before treatment. Baseline and ongoing monitoring is required. Treatment, once initiated, is often lifelong. Some hormonal treatments are discontinued four weeks prior to gender surgery, and restarted four weeks afterwards. Endocrine treatment should be initiated and overseen by a specialist in this field. However, GPs may at times be involved in ongoing prescribing and monitoring when prescribed by NHS services, and therefore should be familiar with risks, contra-indications, etc, of individual preparations.[12]

For trans women, or for women following genital change surgery, the goal is to suppress androgens and provide oestrogen therapy. Traditionally cyproterone acetate or spironolactone have been used, but as these have been associated with risks and side-effects, increasingly depot injections of gonadotrophin-releasing hormone (GnRH) analogues are used. These include goserelin and leuprorelin. Typical doses would be goserelin 3.6 mg every four weeks, or 10.8 mg every three months. This would be stopped if gonads were removed surgically. Oestrogen supplementation can be delivered orally (1-6 mg per day) or subcutaneously (50-150 microgram patches every three days or in gel) with an optimum dose achieved by monitoring of plasma levels. Lipids, liver function and blood pressure should also be monitored. Contra-indications and cautions for oestrogen use should be considered (thromboembolic disease, migraine, cerebrovascular disease, coronary heart disease, etc).

For trans men, or men following genital change surgery, the goal is to suppress oestrogens and provide testosterone therapy. Long-acting GnRH analogues as above are used to suppress ovarian function, and stopped if ovaries are removed. Testosterone replacement may be given in the form of depo injections (eg, Nebido® 1 g every three months, or Sustenon® 250 mg every 2-3 weeks) or by transdermal gel (5 g per day). Contra-indications and cautions should be considered (eg, breast cancer, uterine cancer, severe liver disease). Haemoglobin and haematocrit levels should be monitored as polycythaemia may occur.

Hormone treatments in transsexual individuals are considered to be relatively safe, and although mortality is higher than in the general population, this is not thought to be related to hormone treatment.[14]

Routine screening in the transgender population[7]

Routine screening may be missed or appointments for inappropriate screening tests received in the transgender population due to current logistics. The NHS cervical screening programme, for example, cannot recall males. A trans man who still has a cervix should be offered routine cervical screening, and the GP practice will need to inform the cytology services that the sample does need to be checked.

Trans women do not need breast screening as their risk of breast cancer is very low. They would however be missed in the routine screening for aortic aneurysm but should be offered screening.

A GP practice should be involved in setting up individualised reminders for appropriate screening and alerting the relevant services.

Children and adolescents

Multidisciplinary care is crucial. . Psychotherapy, counselling, and family therapy are integral aspects. The option of deferring puberty with the use of GnRH analogues had been being increasingly used to allow more time for the individual to be comfortable with their gender identity before undertaking any irreversible treatment but is now more controversial. Gender incongruence in children does not necessarily persist into adulthood; indeed, studies suggest it only does so in 6-23%. If gender incongruence [15] persists then hormone treatment may be considered from the age of 16 years. Seamless transition to adult care services at the age of 18 years should be the norm if this is the case.

Prognosis [1]

Outcome of the various treatments used has been difficult to establish but is generally considered to be good and continuing to improve. Generally assessments of outcome from genital surgery show benefit to well-being, cosmetic result and sexual function. [16] [17] Outcome of hormonal treatment has also been shown to improve well-being and quality of life. [18] Few report regret following treatment; recent studies suggest this is between 1 and 2% although some studies do show much higher rates. [15]

Studies have reported higher mortality rates in transsexual individuals, as well as higher rates of suicide and psychiatric morbidity.[19] [20] These rates are higher irrespective of whether gender-related surgery has taken place. Mostly mortality was not related to hormone treatment, although those treated with oestrogen may have a slightly higher mortality related to cardiovascular causes.

Surgical complications may include necrosis, fistulae, stenosis, urinary problems, anorgasmia and poor cosmetic result.

Side-effects of hormonal treatment may be a problem; minimisation of risks by lifelong monitoring is required.

HIV disproportionately affects trans women, with an estimated prevalence of 19% in this population worldwide.[21]

Peer support and family support are conducive to good outcomes.

Further reading

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Authored by:	Peer Reviewed by: Dr Colin Tidy, MRCGP	
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