

ARTICLE

Gender dysphoria: recognition and assessment[†]

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[†]The treatment of gender dysphoria is discussed on pp. 12–16 and 17–24, this issue.

SUMMARY

The role of the mental health professional, and of the psychiatrist in particular, is evolving and changing. As the recognition of transsexualism and gender identity disorder expands across the transgender spectrum, it has been recommended that gender dysphoria should replace existing diagnostic terminology. Patient-focused care is evolving and this article considers the limitations of current healthcare settings and how the mental health professional can support patients undergoing the real-life experience. Differentiation from other mental health conditions that may present as gender dysphoria is outlined, as well as specific clinical situations.

DECLARATION OF INTEREST

None.

Mental health professionals may come into contact with transgender patients under various circumstances. These may range from patients presenting to a psychiatrist for the first time seeking help with cross-gender identification matters, to those with an established diagnosis of gender dysphoria presenting with unrelated mental health problems. Encounters between transgender people and mental health workers occur in a variety of settings, from specialist out-patient clinics to general medical wards, substance-misuse programmes, psychiatric in-patient departments and prisons. Both parties may have anxieties concerning aspects of such encounters, particularly if such experiences are rare.

Classification

The umbrella term ‘transgender’ (often referred to as ‘transsexual’) is used to describe a heterogeneous group of people who do not conform to the conventional ideas of gender as being ‘male’ or ‘female’ according to anatomical sex. Individuals with gender dysphoria are a subset of this population who have been diagnosed as having a gender identity disorder according to the characteristics as defined by the DSM-IV (American Psychiatric Association 1994). That is,

patients ‘with a strong and persistent cross-gender identification and a persistent discomfort with their sex or sense of inappropriateness in the gender role of that sex’ (Meyer 2002).

Gender identity disorders are classified as mental disorders and are therefore included in the DSM-IV and ICD-10 (mental health section; World Health Organization 1992). This classification and its implications are exceedingly controversial and a source of much anxiety, concern and debate within both the transgender population and the medical community.

Prevalence

The DSM-IV reports the prevalence of transsexualism as 1 in 30 000 natal males and 1 in 100 000 natal females, using data derived from the results of a study by Hoenig & Kenna in the 1950s and 1960s (Hoenig 1974). More recent studies estimate the true prevalence to be higher. However, the precise prevalence of transsexualism is unclear (Zucker 2009). The majority of data are collected from patients presenting to medical services seeking treatment for gender identity problems. However, a significant proportion of transgender people (those content with their status or who have found their own coping mechanisms independent of medical input) never present to medical services, resulting in a possible underestimate of the true prevalence of transgenderism.

Prevalence data are also affected by other factors. Prevalence appears to be higher in populations that have increased access to gender services, including gender-reassignment surgery (Tsoi 1988), and in countries such as The Netherlands, where transgender issues are treated with greater tolerance and understanding (Bakker 1993). Despite the difficulties in obtaining true prevalence rates, the general consensus among epidemiological studies is that gender identity disorders are ‘rare’ and are more common in people who are born male than in those born female (Zucker 2009).

Aims

The first aim of this article is to outline the role of the gender specialist in working with patients with

gender disorders and assessing them for gender reassignment, focusing on the current suggested guidelines for diagnosis. The second aim is to highlight some of the issues that transgender patients and patients with gender dysphoria may face when presenting to mental health services and consequently some of the issues faced by mental health workers who have responsibility for their care. Key areas discussed are: concerns about the classification of gender dysphoria as a mental disorder and the implications of this for management; stigma and discrimination in encounters with healthcare practitioners and how these may be reduced; how gender dysphoria is diagnosed; the importance and difficulties of differential diagnosis; and the patient who presents with a psychiatric condition co-existing with gender dysphoria. It is important for the reader to note that gender disorders are a highly emotive and controversial area of medicine, politics and society. Consequently, unfortunately, a fully detailed discussion of all of the possible viewpoints in this debate is beyond the scope of this article. In addition, knowledge and understanding of gender disorders and their treatment is still evolving and the reader should view the content of this article as informative, rather than as offering recommendations that should be applied in clinical practice.

Concerns and controversies: is gender dysphoria a mental illness?

Gender dysphoria is currently classified as a mental disorder along with other disorders of gender identity. This classification is based on the historical theories surrounding its cause and because psychiatrists have traditionally been responsible for managing transgender patients' care (Pfafflin 2007). Whether gender dysphoria should remain classified as such is highly controversial and is a source of great anxiety to patients, the public and practitioners alike. For practitioners, the classification of gender identity disorders influences the approach to patient management. Patients are often concerned about how classification affects their interactions with the medical profession and others in society, as well as the implications for their own understanding of their gender situation.

There are a wide range of stances on this issue and debate is fierce, with some arguing for maintenance of the status quo, some for the removal of gender dysphoria from the classification entirely (similar to the 1974 removal of homosexuality from the DSM) and others arguing instead for reform of the current criteria (Bockting 2009).

Aetiology

One of the main areas for debate as to how gender dysphoria should be classified centres on its aetiology. Some groups argue that gender dysphoria arises from mental illness, whereas others claim it is rooted in biological anomalies. A third group views gender dysphoria as a rare variation on the normal human experience of gender and argues that classifying it as a 'disorder' does not allow for the existence of 'healthy, functional transgender people' (Bockting 2009).

Psychopathology

Those who support the current classification are likely to argue that gender dysphoria arises from psychopathology – put simplistically, the patient has an unconsciously motivated false belief that they are in the 'wrong' physical gender. Psychosocial factors hypothesised to influence the development of this psychopathology include parental factors such as an emotionally distant father (Cohen-Kettenis 1990), parents with an unfulfilled desire for a child of the opposite sex (Buhrich 1978) and parental encouragement of the child participating in the opposite gender role (Schott 1995). Childhood abuse has also been implicated in the development of gender variant behaviour (Gehring 2005).

Biological causes

Opponents of the current classification may support the theory that gender dysphoria arises from biological causes, such as anomalies in brain anatomy, resulting in a gender identity that does not correlate with the anatomical sex, and gender dysphoria should therefore be classified as a medical, as opposed to mental, illness. Some evidence to support a biological cause comes from a discovery made by Zhou *et al* (1995), which found differences between the volume of the central sulci of the stria terminalis (a part of the hypothalamus that is central to sexual behaviour) in the autopsied brains of a sample of transgender and non-transgender adults. More recent studies have suggested a genetic basis for the development of gender dysphoria and several promising studies have reported a link between higher levels of prenatal androgen exposure and the development of gender dysphoria (Veale 2010).

Treatment decisions

Controversies regarding aetiology, coupled with the desire to act in patients' best interests, make it very difficult for practitioners to decide on how to approach and appropriately manage

patients with gender dysphoria. Proponents of the current classification might argue that since gender dysphoria arises from psychopathology, the appropriate treatment should employ interventions that target psychopathologies, rather than surgery or hormone administration, which could at best be seen as colluding with the patient's unconsciously motivated false beliefs and at worst cause immense psychological and physical harm to the patient (Lev 2009). Conversely, opponents of the classification may argue that it is unethical and damaging to attempt to 'cure' a mentally healthy patient of a false belief where no mental illness exists. They may also argue that it is unethical to deny patients with an illness with a biological basis or those who are simply variations on gender 'norms' the opportunity to explore existing means of making their physical being more congruent with their gender identity.

Despite increasing support for a biological cause for gender dysphoria, the fact remains that there is no firm evidence of a biological aetiology. Thus, classifying gender dysphoria as a medical condition rather than a mental illness cannot currently be justified (Bockting, 2009). However gender dysphoria is ultimately classified, having a formal diagnosis of gender dysphoria can be useful to patients, because 'it is often important in offering relief, providing health insurance coverage, and guiding research to provide more effective future treatments' (Meyer 2002).

The current situation leaves practitioners with uncertainty when it comes to dealing with patients who have gender dysphoria. Put simply, are they to accept that such patients' experience stems from a biological cause (or is a variation on 'normality') and ultimately support and facilitate the patients towards gender reassignment if desired, or do they use psychological interventions to challenge the patients' false beliefs and help them cope with or change their gender identity without resorting to potentially damaging surgery?

Guidance for practitioners

Whatever the personal and professional stance of practitioners, in the UK pressure from both the medical profession and various civil rights organisations has resulted in attempts to produce good practice guidelines that clarify the approach to and management of gender dysphoria. They also emphasise patient-centred care, often (and controversially) with the mental health professional taking on more of an advocate and educator role and less of a 'gatekeeper' role (Lev 2009). The Royal College of Psychiatrists is in the process of developing such guidelines.

The World Professional Association for Transgender Health (WPATH) has already produced several versions of their *Standards of Care*, which are generally well respected and frequently referenced when developing clinical protocols. They are suggested clinical guidelines based on the organisation's professional consensus on the management of gender identity disorders and are continually revised as relevant scientific knowledge evolves (Meyer 2002). Clinicians are reminded that much of the efficacy of the *Standards of Care* is as yet unproven (Lev 2009) and are encouraged to tailor the suggested protocols to the specific needs of each patient and according to developing knowledge (Bockting 2007).

The *Standards of Care* remind the practitioner that the general goal of therapy (whether through psychotherapeutic, endocrine or surgical means) is achieve 'lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment' (World Professional Association for Transgender Health 2011: p. 1). For many patients pursuing this goal extrapolates to 'changing' their physical sex through hormones and/or surgery. Therefore, this treatment is frequently more strongly emphasised in current management guidelines (see Wylie 2012, this issue).

Experiences of stigma and discrimination in the healthcare setting

Any individual presenting to mental health services might have concerns about being labelled with having a mental illness and the stigma that this brings. It might be said that the stigma is even greater when that individual has concerns relating to gender identity as 'it is appearing to pathologise an intrinsic part of the patient's identity rather than a less intrinsic part of their being' (Bockting 2009), as might be the case with another psychiatric diagnosis, for example anxiety.

Despite the reminder in the *Standards of Care* that the designation of gender identity disorders as mental disorders 'is not a license for stigmatization or for the deprivation of civil and human rights' (World Professional Association for Transgender Health 2011: p. 5), and despite improvements in tolerance and greater understanding of gender issues, negative reactions and discrimination against transgender people are still common in all areas of society including, unfortunately, the healthcare setting (Whittle 2007).

Previous experiences of negative reactions and discrimination in healthcare settings and a lack of access to practitioners who are competent at treating transgender patients have been

demonstrated to lead to avoidance of medical care (Feldman 2007). In a UK survey 17% of transgender respondents had encountered a doctor or nurse who did not approve of gender reassignment and therefore refused services; 29% felt that being transgender adversely affected the way in which they were treated by healthcare workers (Whittle 2007).

In one study, 80% of substance-misuse counsellors in a US-based cohort were found to have had no training on transgender issues and participants expressed some strongly negative and ill-informed views (Eliason 2000). The origins of such negative reactions from mental health workers are unclear from the literature, but presumably stem from a combination of lack of understanding about gender identity disorders and transference and countertransference issues that occur in interactions between mental health workers and their patients.

Education

Educating healthcare workers in transgender issues appears key to reducing transgender-related discrimination and stigma. Whittle *et al* (2007) propose that to improve patients' confidence in the National Health Service workers should receive regular education on what it is to be a transgender person and transgender peoples' rights. They should also be made aware that transgender people may face the same health problems as non-transgender people and need equal treatment. Furthermore, it should be made clear that there is no basis, such as a conscience clause, on which a doctor may refuse treatment to a person presenting with a transgender issue (Whittle 2007).

Box 1 outlines how mental health professionals can help to promote a therapeutic environment of respect and trust for patients.

The role of the gender specialist

Gender specialists traditionally come from a psychiatric background, probably for two reasons. First, it used to be assumed that transgender people had 'some form of psychosis' (Cole 1997), and second, before the development of gender reassignment treatments, the therapist's only option was to help patients cope with their gender dilemma (Carroll 2007). Currently, the majority of gender specialists are psychiatrists. However, clinical specialist training may be available within other credentialing disciplines, for example psychology, social work counselling or nursing (Meyer 2002). The role of the gender specialist as listed in the sixth version of the Standards of Care and expanded on in the seventh version (World

BOX 1 Promoting a therapeutic environment of respect and trust for patients

- Refer to patients by their preferred name and pronoun
- Emphasise the confidential nature of encounters and respecting the patient's wishes with respect to physical examinations
- Appreciate the heterogeneity of the transgender experience and the way in which patients may present
- It is not necessary to share patients' beliefs about their gender to create a respectful environment and therapeutic relationship, but mental health workers should certainly convey acceptance of the patient's perspective on this matter

(Meyer 2002; Feldman 2007)

Professional Association for Transgender Health 2011) appear in Box 2.

Making a diagnosis of gender dysphoria

There is no current tool or objective method of making a definitive diagnosis of gender dysphoria. As with most of psychiatry, the patient is physically, endocrinologically and genetically normal (Bower 2001), therefore the diagnosis is based on the information given to the clinician by the patient and on the clinician's judgement during assessment and/or psychotherapy. Problems occur when patients alter their life story or their

BOX 2 The ten tasks of the mental health professional

- 1 To accurately diagnose the individual's gender disorder
- 2 To accurately diagnose any comorbid psychiatric conditions and see to their appropriate treatment
- 3 To counsel the individual about the range of treatment options and their implications
- 4 To engage in psychotherapy
- 5 To ascertain eligibility and readiness for hormone and surgical therapy
- 6 To make formal recommendations to medical and surgical colleagues
- 7 To document their patient's medical history in a letter of recommendation
- 8 To be a colleague on a team of professionals with an interest in gender identity disorders
- 9 To educate family members, employers and institutions about gender identity disorders
- 10 To be available for follow-up of previously seen patients

(Meyer 2002)

gender feelings to ‘impress’ the clinician to attain their goal of hormonal or surgical treatment (Cohen-Kettenis 1999; Bower 2001).

The World Health Organization (1992) gives three criteria for diagnosis:

- 1 there must be a desire to live and be accepted as a member of the opposite sex, normally with the additional desire to make their body as congruent as possible with that of the opposite sex;
- 2 the gender identity issues must have been present for at least 2 years; and
- 3 the gender identity issues must not be a symptom of another disorder (including psychiatric illness and genetic abnormalities).

It has been argued that these criteria are somewhat vague and do not emphasise strongly enough the patient’s overwhelming desire to acquire the anatomical characteristics of their preferred gender (Bower 2001).

Interviews and observation

A diagnosis of gender dysphoria is made on the basis of thorough patient interviews and by observing the patient over a suitable period, with some diagnoses seeming to be more clear-cut than others. Take, for example, the case of two patients who present very differently in the initial assessment – one presents with lifelong certainty that they are in ‘the wrong body’, is knowledgeable about the limitations of treatment and has already taken steps to appear as the opposite gender. The other is seeking gender reassignment but has only recently come to feel that they are transgender and has made no progress towards transition. One, both or neither could ultimately transpire to have a diagnosis of gender dysphoria and receive treatment, but without thorough exploration accurate diagnosis is impossible and treatment potentially damaging.

The gender history

Taking a gender history (Box 3) is an essential tool in diagnosis and serves a second purpose by helping the clinician to understand the gender dysphoria in the context of that person’s life and make recommendations towards appropriate treatment (Carroll 2007).

Sexuality

An exploration of the patient’s sexuality is also undertaken. This gives the opportunity to identify those whose cross-dressing behaviour is purely for fetishistic purposes, as well as helping the clinician to understand the importance of sexuality to the individual patient, how treatment might affect

the patient’s sexual relationships and what the patient’s hopes are for their sexual life, so that help may be given.

The relevance of sexual orientation is debatable. However, there is some evidence to show that sexual attraction to the opposite biological sex is a poor prognostic risk factor for reassignment surgery (Smith 2005; Decuypere 2006), with heterosexual patients who undergo surgery demonstrating more post-operative dysfunction and dissatisfaction (Smith 2005).

Other related conditions

It is important that the specialist has an understanding of the other conditions relating to gender identity disorder, which are not gender dysphoria, as clearly defined in the ICD-10 (World Health Organization 1992), such as dual-role transvestism and fetishistic transvestism, as well as more controversial diagnoses, such as autogynaephilia (Lawrence 2008). Autogynaephilia is a term that denotes a natal male with a paraphilic tendency to be sexually aroused by the thought or image of himself as a woman (Blancard 1991).

Further considerations

Patients may also present with non-conformity to stereotypical gender-role behaviour, which does not encompass the desire to live as the opposite

BOX 3 The gender history

Record aspects of the patient’s life that pertain to their gender feelings and experiences:

- type of play as a child (conforming to gender role or non-conforming)
- preferred dress as a child
- gender identity as a child, adolescent and adult
- reactions of others regarding the patient’s gender behaviour
- experience of puberty
- cross-dressing history and whether this was associated with sexual arousal
- cross-gender experiences such as going shopping or socialising in public as a member of the opposite sex
- any progress towards adopting the opposite gender role, such as changing name or hair removal
- contact with other transgender persons
- aspects of self that are perceived to be masculine and those perceived to be feminine
- what the patient’s goals are regarding making the transition to the opposite gender

(Carroll 2007)

gender, but merely having some attributes of the opposite sex. The specialist must also establish that there is no congenital intersex condition present (e.g. Klinefelter syndrome) that will necessitate blood tests, karyotyping and physical examination to confirm the diagnosis.

Differential diagnosis – psychiatric illness presenting as gender dysphoria

As mentioned earlier, in the past, transgender beliefs and behaviours were usually attributed to psychosis and indeed several psychiatric illnesses can present with symptoms of cross-gender identification, including schizophrenia and other delusional disorders, bipolar, dissociative and personality disorders. It is one of the ‘Ten tasks’ in the *Standards of Care* to diagnose an individual’s gender disorder (Box 2; Meyer 2002). Thus, psychiatrists should be able to differentiate between those individuals with gender identity disorders alone, those with gender identity disorders in addition to comorbid mental illness and those demonstrating cross-gender identification secondary to psychiatric illness.

Determining prevalence

Two studies address the issue of determining the proportion of patients who present to medical services with cross-gender identification arising from psychiatric illnesses other than gender dysphoria (or one of the other gender identity disorders). One study (Levine 1980) is an investigation of the diagnoses made in a sample of patients by one clinical team, and the other polls psychiatrists’ past experiences of diagnosing patients with cross-gender identification (Campo 2003). These studies are very different, yet some insight may be gained through comparison.

The study by Levine (1980) found that 84% of patients (from a sample of 51) who presented to a clinic in the USA between 1977 and 1979 requesting gender reassignment had a psychiatric diagnosis other than gender dysphoria that accounted for their desire for transition to the opposite sex. Furthermore, 66% of these were deemed to have personality disorders and 8% schizophrenia. The psychiatric diagnosis was based on data from psychometric tests, several hours of interviews with a ‘primary screener’ (psychiatrist) and one interview with another psychiatrist of the opposite sex to the first, with the results from each stage being discussed in a team conference, leading to a decision about each patient’s final diagnosis.

In a study by Campo *et al* (2003), 186 Dutch psychiatrists were asked about their experiences of patients presenting to their respective clinics with

cross-gender confusion. Respondents reported 584 patients, of whom 46% were deemed to have cross-gender identification accounted for by a psychiatric illness other than gender dysphoria. The most common pathologies identified were personality disorders, major mood disorders, dissociative disorders and psychotic disorders (including schizophrenia).

Although both studies are an attempt to determine the ‘true’ prevalence of gender dysphoria secondary to psychiatric illness, their results differ considerably, with the results from Levine being nearly double those of Campo *et al*. There are innumerable reasons why this is the case, including differences in time (and therefore DSM classification and diagnostic criteria), sample size, geography (USA *v.* Europe), reason for patient presenting (e.g. reassignment-seeking or not) and diagnostic method (team-centered *v.* single clinician). Both studies are valuable in demonstrating the substantial numbers of people with cross-gender identification secondary to psychiatric illness. However, further research is clearly needed to determine the proportion of gender dysphoria that is secondary to other psychiatric illnesses. Further research is also needed to investigate current clinical opinion among psychiatrists and to gauge how opinions affect diagnosis.

Schizophrenia and cross-gender identification

The phenomenon of schizophrenia presenting with cross-gender identification receives particular attention in the literature and, despite the DSM-IV assertion that ‘delusions of belonging to the other sex’ are rarely seen in schizophrenia (Campo 2003), some data on this topic seem to contradict this. In a study of male patients admitted to an acute psychiatric ward, Gittleson & Levine (1966) found that 27% of those with schizophrenia held a delusion of ‘no longer being a man’, compared with 0% of those without schizophrenia. Similar subjective feelings of gender change were seen in 23% of female psychiatric patients with schizophrenia (Gittleson 1967). These values are higher than those of Levine (8%), again demonstrating the difficulty of obtaining the ‘true’ prevalence of the phenomena.

Individual patients with schizophrenia presenting with cross-gender identification are particularly frequently described (Gittleson 1966, 1967; Haberman 1975; Campo 2001) and serve as useful examples of the importance of making a correct diagnosis before initiating treatment for gender dysphoria. On first impression it seems that it would be difficult to misinterpret

a delusion of gender change as a genuine gender identity disorder, given that the diagnostic criteria explicitly state that the cross-gender identification should be ‘strong and persistent’ (Meyer 2002) and is usually long-standing, whereas delusions often occur ‘out of the blue’. However, misdiagnoses have occurred.

Campo *et al* (2001) report one such cautionary case, where a male patient had been started on hormones to treat transsexualism for 6 years before acute schizophrenic decompensation occurred. Subsequent pharmacological treatment with antipsychotic medication for the psychosis also reduced the cross-gender identification to the point where the patient regarded it as having been part of his delusional thinking and regretted the permanent side-effects of the hormonal treatment. This case illustrates that cross-gender delusions can be long-lasting.

Considerations before treatment

Given the difficulties in diagnosis and the health implications of incorrect diagnoses, clinicians are reminded that differential diagnosis should be made tentatively in the first instance and confirmed throughout the course of subsequent long-term interactions with the patient, and re-evaluated over the course of treatment (Bockting 2007). Referral to specialists in gender dysphoria should always be considered, along with adherence to the Standards of Care (World Professional Association for Transgender Health 2011).

Where psychiatric illness apart from gender dysphoria is diagnosed it should be treated in accordance with general mental health practice, and gender reassignment surgery/hormonal treatment is obviously contraindicated. As will be demonstrated later, delusional disorders, and indeed other psychiatric illnesses, can co-exist with gender dysphoria. For such patients, treatment for the gender disorder is not absolutely contraindicated, but the psychiatric disorder (i.e. delusional disorder) should be treated first (through pharmacological or other therapeutic means) with regular monitoring of gender identity, while allowing the patient to experience the opposite gender role. If the gender dysphoria remains after the psychiatric disorder has been stabilised for an extended period of time, then medical treatment of the gender disorder can be commenced (Bockting 2007).

Comorbid mental health illness

As is the case with any non-transgendered person, transgender individuals may experience mental illness at some point in their lives, which may or

may not be gender-related and which may result in them presenting to mental health services. The extent to which gender conflict contributes to the development of mental suffering remains to be elucidated but there has long been speculation that transgendered persons may be at greater risk of developing additional psychiatric problems than the non-transgendered population, owing to the ‘extra stress’ of their gender conflict and the reactions of those around them (Carroll 2007).

Evidence of the extent to which comorbid mental illness exists in the gender dysphoric population is limited. Cole *et al* (1997), in their retrospective study of 435 transgender individuals, found that the lifetime incidence of comorbid mental illness was similar to that of the general population and concluded that gender dysphoria is usually an isolated diagnosis. Where mental illness occurs alongside gender identity disorder, the problems most frequently seen include depression, anxiety, substance misuse, suicidal or self-harming behaviours, personality disorders, mood disorders and thought disorders (Bockting 2007).

Depression

Depression appears to be particularly common among these conditions, with the incidence of clinical depression variously reported between 21 and 44% (Bockting 2008; Lobato 2008). In a study by Cole *et al* (1997), clinical depression was the most frequently reported Axis I psychiatric illness that presented in addition to gender dysphoria. Depression may occur in the transgender population for reasons relating to the gender issue, such as suppression of transgender feelings and behaviours, resulting in social isolation, loneliness and hopelessness, or it may result from non-gender-related causes, for example, genetic predisposition (Bockting 2007).

Substance misuse

Substance misuse and alcohol misuse also appear common. One study of transsexual out-patients (Lobato 2008) found that 47.4% of participants had experienced drug or alcohol problems; another reported that 55% of its sample with gender dysphoria had a history of drug or alcohol misuse – the vast majority attributing it to trying to cope with their gender issues (Cole 1997).

Suicide attempts

The prevalence of suicide attempts is worryingly high in the transgender population. About a third of transgender individuals are reported to have attempted suicide at least once in adulthood (Cole 1997; Clements-Nolle 2006; Whittle 2007),

roughly double the rates for non-transgender adults (Whittle 2007). The experience of gender-based victimisation or discrimination has been shown to be independently associated with suicide (Clements-Nolle 2006). Triggers for suicide attempts include intense frustration stemming from the gender issue and a feeling that things would never improve, feelings of isolation, the inability to discuss problems and emotions with others, rejection from family and other relationships and disgust with the physical body (Cole 1997). Authors have commented that following initiation of treatment for the gender-related condition participants involved in some studies reported a cessation of suicide attempts and self-harm behaviours, although these findings must be interpreted cautiously (Cole 1997; Lobato 2008).

Treating the mental illness

One of the ten tasks of the mental health specialist (Box 2; Meyer 2002) is to identify and treat mental illness where it is seen alongside gender identity disorders. Patients may be reluctant to reveal symptoms of mental illness, for fear that this may jeopardise their treatment of the gender disorder (Bockting 2007) or because of other negative expectations of healthcare. Therefore, it is essential that the clinician develops a non-judgemental approach to dealing with these patients.

Although comorbid mental illness is not an explicit contraindication to commencement of treatment for gender dysphoria, there is some evidence that individuals with additional mental health problems experience more difficulties during the gender reassignment progression (Abramowitz 1986) and that those with greater resilience to adversity fare better throughout life (Bockting 2007). Methods employed to improve patients' mental well-being will include those adopted in general mental health practice (pharmacological therapy, talking therapies etc.) as well as interventions that are more transgender-specific, if the distress is gender-related. Bockting *et al* (2007) highly recommend that clinicians, alongside patients, develop individual healthcare plans to address patients' mental health issues in a stepwise fashion and clearly described how gender-related issues that affect mental health (isolation, body-image concerns, violence, discrimination, substance misuse, relationship issues and spiritual/religious concerns) may be tackled through psychotherapy.

Conclusions

The role of the gender specialist in the management of individuals with gender dysphoria

is concisely summarised by the 'ten tasks of the mental health professional' (Box 2). Making an accurate diagnosis of gender dysphoria, based on the patient's gender history and presentation and on the clinician's own judgement, is the first of these tasks. Extension of the professional groups to whom this responsibility could be tasked are argued in Bockting *et al* (2008).

Cross-gender identification may occur in other psychiatric disorders, for example as part of a delusional psychosis, although the exact prevalence of this is unclear and varies between studies. Where transgender identification occurs secondary to psychiatric illness differential diagnosis may prove difficult, highlighting the need for long-term clinical evaluation. Current data suggest that the majority of those diagnosed with gender identity disorders do not demonstrate consistently elevated levels of comorbid mental illness. Despite this, depression is not uncommon and levels of substance misuse and suicide attempts are worryingly high. These comorbidities are often attributed to the isolation and discrimination faced by transgender individuals, which can be treated through general as well as transgender-specific therapies with the aim of improving mental health and increasing resilience. For patients with gender dysphoria secondary to psychiatric illness and gender dysphoria with comorbidities, treatment will depend on the primary diagnosis.

Once a diagnosis of gender dysphoria is made, the specialist and patient should agree treatment goals. Triadic therapy includes hormonal treatment, the real-life experience and genital surgery, when the desired aim is to transition to the opposite sex (see Wylie 2012, this issue).

One of the primary concerns of clinicians in transgender medicine centres on the current classification of gender dysphoria as a mental illness. Some argue for this classification to be maintained, some for amendment and others for the removal of gender identity disorders from the classification altogether. Despite fierce debate and ongoing research there is still disagreement over the aetiology and treatment of people with gender dysphoria, although standards of care guidelines do exist and are continually evolving. Clinicians are reminded that the aim of treatment is to help the patient to achieve lasting personal comfort with the gendered self.

Potential patients often have concerns about interactions with mental health professionals. Many transgender patients presenting to mental health services fear stigmatisation and discrimination, which, although the situation is improving, appears justified by the literature. Professionals can improve this situation by

promoting an environment of trust and respect through adopting simple procedures, such as ensuring that patients are referred to by their preferred name and by continuing professional education about transgender-specific issues.

Although this is not an exhaustive account of issues facing patients with gender identity disorders and the mental health professionals who care for them, we hope that this article has gone some way towards addressing common concerns encountered in the mental healthcare of transgender individuals.

Our second article (Wylie 2012, this issue) considers in greater detail the treatment and support of patients with gender dysphoria through the period of gender transition.

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MCQ answers

1 d 2 b 3 d 4 b 5 d

MCQs

Select the single best option for each question stem

1 The World Professional Association for Transgender Health *Standards of Care* outline ten tasks of the mental health professional, which include:

- a speaking in a friendly manner to patients
- b avoiding educating family members
- c insisting that all patients have a period of psychotherapy
- d counselling individuals about the range of treatment options and their implications
- e excluding patients with depression from hormone treatment for gender transition.

2 The current ICD-10 diagnostic criteria for gender identity disorders include:

- a the patient must have an overwhelming desire to acquire the anatomical characteristics of their preferred sex
- b the patient must have the desire to make their body as congruent as possible with that of the opposite sex

- c the patient must have experienced the gender identity issues for at least 3 years
- d the patient must have the desire to be accepted as both a member of the phenotypic and opposite sex
- e the patient must have the desire to be respected.

3 Regarding comorbid psychiatric diagnoses:

- a depression is very rare
- b alcohol misuse is uncommon
- c schizophrenia does not present as gender dysphoria
- d the prevalence of suicide attempts is around 33%
- e the lifetime incidence of mental illness is markedly increased.

4 To create a therapeutic environment of respect and trust for transgendered patients, professionals should:

- a not ask to physically examine the patient
- b refer to the patient by their chosen name

- c promote gender reassignment to the patient at the outset
- d share the patient's beliefs about their gender identity
- e insist that the patient be accompanied by an advocate.

5 Considering their gender history, an individual cannot be diagnosed with gender dysphoria if they:

- a have no history of dressing in the clothes of the opposite gender
- b have made no progress towards adopting the opposite gender role
- c have ever been aroused by the thought of themselves as a member of the opposite gender
- d are a natal male with a paraphilia for being aroused by the thought or image of themselves as a woman
- e conformed to gender roles as a child.