

Diagnostic and Therapeutic Complexity of Gender Dysphoria: About A Clinical Case

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Abstract

Case Report

Gender dysphoria is a medical term used in the American Psychiatric Association (APA) textbook to describe the distress of the transgender person in the face of a sense of inadequacy between their assigned sex and their gender identity. The work we present is based on a clinical case in which we have retained the diagnosis of gender dysphoria comorbid with other psychiatric disorders after several close consultation appointments, and through which we will address the socio-cultural aspect of this disorder within our society. Adults with gender dysphoria can benefit from psychological, medical and surgical treatment in France. However, this dysphoria rarely appears in adulthood, often being present since childhood and adolescence and generating difficulties in family, social and school life, particularly at the time of puberty. It is necessary to take adequate care of patients with gender dysphoria, often generating psychological suffering responsible for numerous comorbidities.

Keywords: Gender dysphoria, adolescence, comorbidities, collaboration, accompaniment, morality.

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INTRODUCTION

Gender dysphoria is a medical term used in the American Psychiatric Association (APA) manual to describe the transgender person's distress over a sense of mismatch between their assigned sex and their gender identity [1].

In fact, the prevalence of the number of transgender people varies internationally, due to societal and cultural norms, and differences in definition.

Although precise figures are lacking, it is estimated that between 0.005 and 0.014% of men by birth sex and 0.002 and 0.003% of women by birth sex meet the diagnostic criteria for gender dysphoria based on the estimated prevalence by the DSM-5 working group [2].

Studies suggest that gender dysphoria may have biological causes related to the development of gender identity before birth. More research is needed before the causes of gender dysphoria can be fully understood.

We report a case of gender dysphoria diagnosed according to the diagnostic criteria of the DSM-5 and discuss its diagnostic and therapeutic characteristics, and through which we approach the sociocultural aspect of this disorder within our society.

Comment

The patient is a 14-year-old teenager, a student in the common core, who came for consultation accompanied by his mother because the latter reports that "For more than six months, my son has been showing the desire to belong to the feminine gender, he feels lost, he is not like before, he is very isolated, spends most of his time on social networks. Thus, for some time now, he has been showing unexplained fears, academic decline, anxiety attacks and verbalization of death talk".

The child comes from parents in a couple, not consanguineous, of a modest socio-economic level, a civil servant father and a housewife mother. He is the youngest of three siblings, made up of two boys and a girl. Her pregnancy was normal, carried to term, vaginal delivery, medicalized with no notion of neonatal suffering.

With regard to the Acquisition of the spheres of language, psychomotor development and cleanliness seem to be done within the normal time limits. His personal history includes two suicide attempts.

The beginning of the symptomatology seems to go back to the age of 9 years by the progressive installation of a change of behavior without triggering factor contrasting with its previous state manifested by isolation, social withdrawal, sadness of mood, not feeling no pleasure in activities he once enjoyed, with academic disinterest and insomnia and a sense of preoccupation with his biological sex.

In the psychiatric interviews, the adolescent was calm, appropriate body and clothing care, hypomobile mimicry displaying sadness, contact with him was laborious at the beginning which became more fluid over the consultations, his basic psychic activities were preserved and his speech was poor.

At first, he was looking for answers and explanations about what was happening to him, showing fear about his future, about what people, those around him and especially his little family would think.

The thought was the seat of suicidal ideation. He repeatedly reported that he felt more like a girl in a boy's body.

He preferred to be called by a girl's name, dress in girl's clothes saying: "when I stay home alone, I dress in my sister's clothes and I feel better about myself».

The young person showed a distress testifying to the non-congruence between experienced gender and physical sex, accompanied a desire to get rid of primary and secondary sexual characteristics and a strong desire to acquire the sexual characteristics of the opposite sex. On physical examination, self-harm scars were noted on the inner side of both thighs.

As support, she was offered support psychotherapy and family psychoeducation as well as drug treatment based on antidepressants, in particular SSRIs; there was a slight improvement in his mood and an alleviation of suicidal ideation.

DISCUSSION

Stoller conceives the concept of "gender identity" defined as "the conscious and unconscious knowledge and perception that one belongs to one sex and not to the other" [3].

Young people who consult are rare [4], partly because the subject is still very taboo in many countries, including Morocco.

Indeed, in France and in the general population, 2 to 4% of boys and 5 to 10% of girls

between the ages of 4 and 18 behave "from time to time" as if they were of the opposite sex, according to their mother; 5 to 13% of adolescents and 20 to 26% of adolescent girls report sometimes having behaviors of the opposite sex; and 2-5% of teenage boys and 15-16% of teenage girls say they "sometimes" want to be of the opposite sex [5].

Several recent studies have revealed an equivalent number of patients in both sexes, thus contradicting the initially accepted idea of a predominance of male transsexualism (male-to-female) [4].

Carrying out a specific evaluation justifies the intervention of a specialized multidisciplinary team that is both competent in the developmental psychopathology of children and adolescents and in gender dysphoria. The objective of the clinical evaluation is to establish a clinical diagnosis of gender dysphoria by differentiating it in particular from developmental identity disorders and by eliminating differential diagnoses. The child psychiatric interview makes it possible to evaluate the repercussions of dysphoric suffering for the young person, without neglecting the repercussions on family dynamics. It also makes it possible to identify any psychiatric and/or somatic comorbidities, in particular anxiety disorders, mood disorders and neurodevelopmental disorders.

The performance of a pediatric somatic and endocrine assessment is essential for the elimination of differential diagnoses such as intersex pathologies and the establishment of the absence of contraindications to specific treatments such as the suppression of puberty or the hormone therapy [6].

Regarding medical management, several retrospective studies evaluating the physical and emotional impact of hormone therapy have shown beneficial effects on the psychological level, exceeding any negative effect related to puberty blockage [4, 7]. After this period (usually from the age of 16 in the Netherlands), patients receive "cross sex" hormone therapy (androgens or estrogens) similar to the treatments used in pubertal inductions in patients with agonadism or hypogonadism hypogonadotropic. However, no prospective study has assessed the long-term consequences of these hormonal treatments in this population, particularly in terms of impact on growth and bone mineralization. When the adolescent consults at the end of puberty, the medical management after a minimum of 1 year of joint follow-up (medical and psychiatric) is similar to that of transgender adults. Finally, reassignment surgery is not authorized in France before the age of 18 and is only performed after a minimum of two years of life according to the opposite sex. In 2009, the Endocrine Society in the United States published recommendations for the treatment of patients with gender dysphoria, including

recommendations for the management of adolescents [8].

In this area, there is no consensus in Morocco due, among other things, to the absence of a published study on this patient population (epidemiology, incidence, treatment) and the absence of recommendations assessed on the national plan.

The organization of the psychiatric care of patients suffering from this disorder must take into account the specific evolution of gender dysphoria according to the patient's age, its impact and the specific means corresponding to the different stages of the process of gender transition. Its objectives are to promote a reduction in the psychological suffering of the patient and his family, to prevent the progressive complications of gender dysphoria and any associated disorders, to allow the patient and his family to access informed consent to about the care needed for gender transition [6].

The proposal of psychotherapeutic support accompaniment aims to reduce the patient's psychological suffering by allowing him to explore questions around his gender identity and to support the resolution of his possible psychosocial difficulties, particularly those related to transidentity. It makes it possible to identify possible situations of harassment, discrimination or ill-treatment and to organize the measures necessary to protect young people. It also makes it possible to take charge of and/or prevent the risks of adolescent acts (self-mutilation, suicide attempts, dropping out of school, desocialization) [6].

With regard to the care known as the "Dutch Approach", described by De Vries and Cohen-Kettenis [9], of young people who are both prepubescent (under 12 years old) and adolescents (over 12 years old), begins with a rigorous evaluation of the functioning of these young people and by taking charge of the difficulties identified. In children, this team recommends monitoring the evolution of gender dysphoria during the first stages of puberty, in order to consider medical treatment if it persists. For internationally recognized teams, it would seem that postponing physical medical interventions would be harmful [4]. The psychological functioning of these children and adolescents would improve after medical treatment, underlining the importance of early screening and orientation [4, 7]. The period 10–13 years would be particularly important, marking an age when gender dysphoria decreases (sometimes evolving towards a "desistance") or on the contrary is accentuated (persistence) with, in this last case of figure, an experience often very painful from the appearance of secondary sexual characteristics, sometimes the cause of behavioral disturbances. In these young people, the suppression of puberty would seem to lead to a reduction in behavioral and emotional difficulties, as

well as in depressive symptoms [7]. Anxiety symptoms do not seem to evolve on the other hand in such a clear way, nor bodily dissatisfaction. Finally, support for the parents and siblings of these children seems essential and is systematically offered.

The organization of specific care therefore justifies a transversal organization of care between the pediatric psychiatric and somatic teams. It is backed up by an organization in multidisciplinary consultation meeting specific to childhood and adolescence and in connection with the teams in charge of supporting adults with a concern for continuity in supporting the stages of the transition from lifelong gender [6].

In our context, there are no studies or consensus on gender dysphoria in Morocco, which can most likely be translated or explained by the lack of data on this subject which, nowadays, remains overshadowed by the morality of our society, generating diagnostic and management difficulties and leading to serious consequences for patients suffering from this disorder.

CONCLUSION

In conclusion, the therapeutic accompaniment of trans children and adolescents is part of a moving heritage that it is up to us to bring to fruition within the framework of diversified collaborations, with particular attention to the evolution of the concepts of transidentities. Raising complex ethical questions, especially when it comes to children and adolescents, these developments call for ever-renewed vigilance and collegial and collaborative benevolence.

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