Gender identity and Mental health

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This article is aimed to review gender identity implications in psychic construct and mental health. It is not intended to be a comprehensive review, given the complexity of the subject. It depicts a picture about the conceptual definitions of gender identity, describing some explanatory models of itself, as a way to grasp this experience. Additionally, transgender reality will be addressed as a factor of psychosocial stress. From a clinical perspective, its psychic impact will be reviewed, thus emphasizing differentiation of trans identities with diagnostic entity named as gender dysphoria. Finally, gender dysphoria will be characterized, emphasizing on subjective discomfort secondary to gender discordance, its relationships with other psychiatric diagnosis, its psychosocial implications and medical attention issues this group has to experience.

Keywords: *gender identity, transgender, gender dysphoria.*

INTRODUCTION

The WHO has defined gender as "social concepts of the functions, behavior, activities and attributes each society deems as appropriate for men and women"[1]. Learned behavior determines the roles of each gender within the society and makes up the gender identity[2]. Gender identity is the intimate/internal/individual experience of the gender in each person, which may or may not match the assigned sex at birth[3]. These attributes are manifested by means of clothing, gestures, way of speaking, body expressions and behavior patterns when dealing with other people, and may include modification of looks or body functions by means of medical/surgical procedures or others alike, although this not necessarily[4]; represents the concept of gender expression.

Transgender people (trans) are those whose identity and gender expression differ -in some degrees- from their sex assigned at birth[5, 4]. Even though, a significant group of these people will find a comfortable role and gender expression for them, even if that differs from the rules or predominant gender expectations in society[6, 7], that is not the rule of thumb. In this context, the concept of gender dysphoria deals with the extreme discomfort or distress caused by the discrepancy between gender identity and the assigned sex at birth, frequently with a social origin[8,4]. It is quite relevant to state that not all people with gender nonconformity experience gender dysphoria, i.e. is not inherent

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to trans identities, which by themselves are not pathological[4].

COMPREHENSIVE THEORIES ON GENDER IDENTITY DEVELOPMENT

Cognitive Theories

Prematurely, boys and girls in early childhood, show the first keys about beliefs and distinctive behavior of each gender. Gender tagging use appears at 18 months, while gender understanding appears at 30 months, even though there are some studies stating it could appear even at 24 months. Nearly at 3 years old, the stereotyped conception of gender is concretely related with some roles, games, objects and physical appearance, thus becoming more abstract and complex as boys and girls grow up, especially after 5 - 6 years old[9].

According to Kohlberg, based on the Piaget´s cognitive development theory, boys and girls cross various stages regarding their sexual identity: tagging of oneself and others in one of the two categories within the historical binary i.e. man or woman; stability, where he/she understands that he/she still belongs to that category, despite shallow/external changes, such as clothes and accessories; and gender constancy, where he/she assimilates an identity consistency, despite the situational variability. These stages become an evolution achievement of the development. The first stage happens at 2 years; the second one between 2 to 5 years old; the third one from 5 years old, considering a significant variability among individuals[10]. The information-processing theories, describe the importance of schemes in gender identity formation. These are understood as those cognitive structures leading the way how such information is processed. Boys or girls who automatically identify themselves as man or woman interpret a series of roles, stereotypes, behavior, models of being and expression which lead the way how he/she perceives the world and himself/herself[11].

Psychodynamic Theories

According to Freud, the evolution of psychosexual development in gender identity and in choosing the object of desire is fundamental: so the phallic stage and the stage of Oedipus complex play a fundamental role, thus allowing divergence among boys and girls. However, genital stage during puberty would be the critical/final period for consolidation of masculine and feminine. The main criticism to this conception is based on a biologicist-based orientation, where the premise starts from the masculine sexuality, the existence or not of a phallus.

According to Lacan, the existence of the phallus holds a significant differentiating power of gender. Even though this phallus may be illusory and imaginary, it symbolically represents the imposition of the name of the father. Therefore, just as Freud did, it perpetuates the importance of the male member as identity signifier; therefore, the resulting dialectics matches the dichotomy of the phallic/castrated subject.

On his part, Chodorow states that, due to the contextual/physical similarities between mothers and daughters, a closer identification among them would be created. Boys will identify themselves with a male role, based on a relationship at a distance with the father, according to a traditional family model. Differential identification experiences with parents, in preoedipal stages[13] are deemed as significant. Stoller introduced the concept “core gender identity”, which deals with the first infantile identification of masculine or feminine features (father or mother). This is prior to the evolution period where sex differentiation is integrated[14].

Social Theories

The socializing role of the family is a basic component for developing a sexual identity in each person. This niche supports the essential conception of what is feminine/masculine in culture. These features may be transmitted by means of the differential treatment given to the infant, according to his/her gender. In this way, the family introduces this subject into society with his/her relevant expected behavior, according to the traditional functions of each sexual nature. The importance of Bandura´s social learning as a gender modulator has been considered as well, while boys and girls learn to be “masculine” or “feminine” by virtue of imitating, observing and interacting with others (15). According to the Gender Role Theory, identity is a set of shared meanings which allows to keep a certain social equilibrium and provide limits

for interaction modes, thus perpetuating stereotyped/ categorical roles, which are further comprehended by the individuals (16). According to Foucault, sexuality is operationalized within an intrincated mesh of domain provisions in a certain cultural and contextual framework. Speech generation derived from "sexual" are subject to social power forces (17).

Neurobiological Theories

The most studied aspects are genetic/hormonal factors (especially in utero) and structural/functional brain changes. However, these studies are just a few and are inconsistent. Mutations in Ryanodine receptor type 3 (RYR3) gen in a small group of transgender people belonging to the Han ethnicity, in China (18) has been found. Polymorphism of the gen CYP17 (CYP17-34C) and disturbances in the gene expression of sexual hormones (19) has been described, as well. Anyway, studies made on sexual differentiation and altered intrauterine hormone environment, just like in cases of congenital adrenal hyperplasia or of 5-Alpha reductase have proved that gender identity is neither related to gonadal in utero condition nor with the differential exposure to sexual hormones (20).

In neuroimaging studies, a thicker temporal/parietal cortex in masculine trans people against cis men has been reported. No differences were found between female trans and female control cis. Female trans patients would also have a thicker cortex in occipital/orbital and medial occipital regions (21). In the white substance, Kranz et al. found a gradient of diffusivity, which is higher in female control cis, followed by masculine trans patients, female trans patients and finally male control cis. This diffusivity pattern is directly related with plasma levels of testosterone (22). Also, a lower hemispheric connectivity in the subcortical/ limbic areas of trans people (23) is considered. However, these data are not generalizable findings and do not account for the complexity of the topic.

PSYCHOSOCIAL ASPECTS

Various studies report discrimination against trans people in different daily life scenarios, such as access to health, employment, and housing. Besides, in countries whose governments have discriminatory policies, the risks of psychiatric pathology are higher (24). Social exclusion and oppression turn out to generate higher prevalence of mental health disorders, higher risk of sexually transmitted infections STIS contagion, limited access to education and employment, apart from poor access to social services (25), thus causing further limitations for social/economic progress; and a low or null representativity. Hatred and aggressiveness coming from discrimination against sexual minorities, expose them to severe situations of violence which may be extreme violence (26), such as physical/sexual vulneration, abuses and even murderer (27). A national survey reported that in various scenarios (school, relatives, and health services), the main forms of discrimination are related with questionings, due to his/ her gender identity, to be ignored, invisibilized, rejected and suffer verbal aggressions (28).

GENDER DYSPHORIA AS NOSOLOGIC ENTITY

Epidemiology

Exact prevalence of young trans is unknown and the estimations are variable (29, 30). A recent study suggests that prevalence of a self-reported transgender identity in boys, teenagers and adults vary from 0.5 to 1.3%. There are no formal epidemiological studies on prevalence of gender dysphoria in boys or girls, same scenario in teenagers (29).

There are some workshops for youngsters/ teenagers trans in Europa, North America and some places in Asia, where a constant increasing demand of consultations within the last few years (31) has been reported. Enrollment in these programs usually happens at an older age, just as Spack et al. work reports who found average start of special treatment is given at 14.8±3.4 years old (with no sex difference), when average puberty onset already was in Tanner 4,1±1.4 for female genotype patients and 3.6±1,5 for male genotype patients. At this stage, these patients already had significant psychiatric comorbilities (32).

In adults, DSM-5 reports that prevalence of gender dysphoria is between 5 to 14 by 1,000 people born with male sex (0.005-0.014%) and

2 to 3 by 1,000 people born with female sex (0.002-0.003%) (33). A Dutch retrospective study analyzed the data of patients attended in gender identity clinics between 1972 and 2015. During this period 6,793 patients were assisted, 65.2% were female trans and 34.8% masculine trans patients. A prevalence of gender dysphoria in 2,015 out of 1 : 3.800 for female transgender and 1 : 5.200 for male transgender (34) was reported. A Spanish Research, using CIE-10 criteria for transsexuality or DSM-IV-TR for gender identity disorder, found a prevalence regarding general population older than 15 years out of 22.1/100,000 inhabitants: 31.2 for female transgender and 12.9/100,000 for male transgender, while the incidence rate was 2.5/100,000 inhabitants. It is important to highlight that it was a clinical reference sample, it was not extracted from the community (25).

In general, literature reports a higher prevalence of gender dysphoria in female trans patients. When performing a cohort study, in two periods between 1999–2005 and 2006–2013, a female trans/male trans correlation of 2,11:1 (67.9% vs 32.1%) was reported for the first period and 1:1.76 (36.1% vs 63.9%) for the second period, thus proving an inversion in the prevalence pattern of this clinical sample in teenagers (36). There is no information in Chile (37).

Symptomatic Characteristics & Evolutivity

Although identification with certain gender identity is given during early childhood, there is a critical period in psychosexual development which has to do with puberty and body changes related with sexual maturation process, in such a way as to increase stress between assigned sex and affirmed gender (38). Initial studies report that most trans boys and trans girls do not evolve with gender dysphoria. However, new research state that psychosexual differentiation of these boys and girls is more variable than previously assumed and around 15% of the boys will remain with dysphoria during adolescence (39). There are data reporting persistence during adolescence of up to 27% (20% for boys and 50% for girls) (40).

A person suffering gender dysphoria shows his/her symptomatology, depending on their life stage cycle. Boys and girls may express their discomfort when they feel displeasure with their own genitals, they may feel they are rejected by their own mates and feel isolated, they openly express they want to belong to the opposite sex (41). Teenagers may see their own age conflicts aggravated, as their sexual development does not match their gender identity; they may have conflicts at home, as they do not feel they are understood or accepted; they may be victims of mistreatment and harassment at schools; they may have a higher risk of substances consumption (42). On the one hand, adults can dress as if they belong to the opposite sex; they feel isolated; they want to live as a person of the opposite sex; They want to get rid of their own genitals. Both boys, girls, teenagers and adults may want to show typical habits of the opposite sex; they may suffer depression or anxiety; they may get away from social interaction (41). However, it is important to reassert these experiences may be provisional during identity process; or else they become pathological to the extent that these cause and intense and steady suffering on them, thus causing significant functional compromise.

Diagnose Criteria

Transsexuality becomes part of DSM-III influenced by sexual diversity activist groups and by a group of health personnel who work directly with trans people, in order to facilitate access to social/health services. However, some people stated that inclusion of transsexuality as a diagnostic unit would only cause stigmata and discrimination (42). In DSM-IV the name was modified into Gender Identity Disorder. In this way pathologyzation of mismatching gender identity remained. In DSM-V a significant epistemological modification was made, as the name Gender Identity Disorder was changed by Gender Dysphoria, after the concept stated by Fisk in 1974, who aimed to highlight discomfort arising from the conflict between gender identity and biological sex, beyond this gender discordance condition (43) (Table # 1). When CIE-11 was published (44), the term transsexualism was deleted. In this way, de-pathologyzation of trans identity started and a new concept “gender contradiction” appears as a new diagnostic entity within disorders related with sexual health, so the focus was set not on

mismatch between experienced sex and assigned sex, but on discomfort and dysfunction this situation causes on people (Table # 2).

Relationship of Gender Dysphoria with other Psychiatric Pathologies

High rates of comorbid psychiatric pathologies have been reported as depressive/anxiety disorders, suicidal conduct, substances dependence, personality disorders, suicidality. The latter is the most frequent in trans women (45). Judge et al. (46), state that depression is the main mental health problem, followed by suicidal conduct in a group of patients included to start hormone treatment. An observational study made in a group of 298 female trans, aged 16 to 29 years old, found that 41.5% had –at least- a psychiatric diagnosis, while 20% had two or more comorbid pictures, especially depression, suicidal conduct, generalized anxiety disorder, disorder caused by post-traumatic stress, dependence on alcohol and other psychoactive substances (47).

Higher prevalence of depression has been explained by using the Minority Stress Model (48), which has mental/physical health implications. Major depressive symptoms in trans population have been reported, especially when disconfirmation or social non-validation of the gender is experienced and when they have internalized transphobia. This prevalence of mood symptoms is higher in those who do not identify themselves within male transgender/female transgender binarism (49).

In a group of college trans, twice as much risk in psychiatric pathologies was found, especially depression and anxiety (50). In trans women, abuse, and gender violence, apart from depressive symptoms is associated to higher rates of substances consumption (51). Patients who start early hormone treatment have been reported to significantly decrease their anxiety/depressive symptoms, with a significant improvement of their functionality (52).

Suicide rate and suicidal tendencies are quite high compared with the general population and range between 32% to 50%. Vulnerability/discrimination/violence scenarios, rejection for the family, friends and the community, harassment caused by their couple or family members or the police, discrimination and maltreatment suffered in health system, are the main risk factors (53). From the perspective of the Interpersonal Psychological Theory of Suicide, the higher perceived burden and the sense of frustrated belonging are associated to higher frequency in suicidal attempts. Likewise, continued experience of painful and traumatic events, was also correlated with a higher risk of suicidal conduct (54). Suicidal attempt rates vary according to the gender subgroups: male trans reported rates of 32.1%, while female trans reported rates of 25.5% (55).

Research focused on the correlation between personality disorders and gender dysphoria using standardized methods are just a few and contradictory. However, literature available reports there is a higher prevalence of personality disorders (56). A study comparing a group of 30 adults who suffered gender dysphoria and 30 cisgender heterosexual people from the general population by using self-managed scales found a higher prevalence of personality disorders, mainly paranoid, borderline, evitative and obsessive-compulsive disorders, existing in nearly half of the patients plus a diagnosis of the Axis II (57). The Millon Clinical Multiaxial Inventory II (MCMI- II), was applied to a group of patients who requested Genital Reassignment Surgery finding a prevalence of 81.4%. The main diagnosis was Narcissistic Personality Disorder in 57.1% of all cases. Additionally, according to the foregoing study, comorbility among these disorders was high, and the average of associated diagnoses was 3 (58). No significant differences have been found between male trans and female trans (59).

Among teenagers, some studies refer a higher prevalence of Autism Spectrum Disorders (ASD) when compared with general population (60). However, many works state that symptoms of this disorder are overrepresented, due to poor scales specificity, and because similarity of symptoms have to do with social deficits, secondary to psychosocial stress conditions (61).

Psychopathological similarities with eating disorders have been found, mainly regarding non-conformity with their body image and weight (62, 63). A higher likelihood of comorbility among these disorders has also been reported. This situation arises mostly with restrictive pictures, thus increasing the risk to 19 times in male trans teenagers, and 10 times in female

trans, regarding the general adolescent population (64).

HEALTH ATTENTION HINDRANCES

Trans population has to fight every day against discrimination and social stigmata. This scenario complicates sanitary situation due to the lack of culturally competent/trained professionals (65, 66), plus the current cisnormative model, thus making even harder for them to seek some type of attention, and increasing health attention problems (65, 66, 67). These hindrances affect health of transgender community, including an increase in rates of depression, suicide and VIH (68). The biggest hindrance for proper general medical attention and for safe hormone therapy for trans patients is lack of access[66, 69].

White et.al. (70) identifies individual/interpersonal/structural factors correlated with low access to attention related with the transition: younger age, low income, low educational level, limited insurance coverage and sanitary discrimination (66). Low income trans people, who do not have insurance coverage, who are foreign and do not have a stable housing have a lower access to regular medical assistance (65). Many trans patients report to feel verbally/physically insulted during medical consultation and discriminated in health centers; therefore, many times they prefer not to go to consultation or to postpone it in time (65, 66, 71). This happens due to the poor training these health professionals have in their conventional study curriculum, plus poor knowledge and skills to grant gender focused quality attention (66, 69, 72).

CONCLUSIONS

Gender identity is a part of human existence which is hard to appraise with just one single outlook. Various complicated/intricate aspects interact, whether they are social, biological, cultural and political aspects. Even more, the tendency is oriented more and more to deconstruction of stereotyped/binary gender conception. Trans identities scape from the traditional biological logical determinism, so they were pathologized and stigmatized for a long time. However, this is not a clinical diagnosis by itself; this is not a disease that requires a treatment. We must be capable to detect gender dysphoria when it comes to us, with its particular/specific clinical situation, caused by social/cultural discrimination due to individual identity, as it involves a higher possibility of psychiatric morbility, specially mood disorders and suicidality increase. Some cultural/structural changes must be generated at various levels, as trans people experience does not remain as a reason for discrimination, stigmata, daily life hindrances; specially, in health attention, according to their specific needs.

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