Difficult Issues In Sexuality Development: A Mental Health Perspective

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Abstract

Sexual development is a dynamic process that continues across the lifespan with multiple facets. There is a need to understand evolving perspectives of childhood and adolescent phase that shapes sexual attitudes, sexual identity and directly impacts sexual behavior. Gender dysphoria is one of the difficult issues encountered across developmental phase. Early identification of gender dysphoria and comprehensive assessment of physical as well as mental health by a multidisciplinary team is essential. Its diagnosis has complex social, medical, ethical and political ramifications. So, management should require a fine balancing between concerns of the family as well as myriad of emotions of patient. This article discusses possible biopsychosocial etiology behind this problem, prognosis of gender dysphoria across lifespan, different treatment strategies and associated ethical, legal and medical dilemmas. Barriers to treatment and

legal difficulties encountered in health seeking with regard to Indian health care system are elaborated. Reflections from the past concerning management guidelines across various countries, current scenario and implications for future management are also discussed.

Introduction

Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values and behaviors of individuals. It deals with the anatomy, physiology and the biochemistry of the sexual response system. It focuses on roles, identity and personality. It also reflects individual thoughts, feelings, behaviors and relationships [1].

Healthy sexuality is a positive, dynamic and enriching part of being human. It is the sexual dimension of an individual's personality which underpins much of what a person is. It is the key to sexual health and sexual expression and also to an individual's overall health and wellbeing [1]. While sexuality is often seen merely in terms of sexual orientation, it is a much broader concept. It contributes to our self esteem, the way we relate to others, our feelings and our behaviors. It includes knowledge about reproductive and sexual health, and of oneself, opportunities for healthy sexual development and sexual experience, the capacity for intimacy, the ability to share relationships and to be comfortable with different expressions of sexuality including love, joy, caring, sensuality, passion, pleasure or celibacy [2].

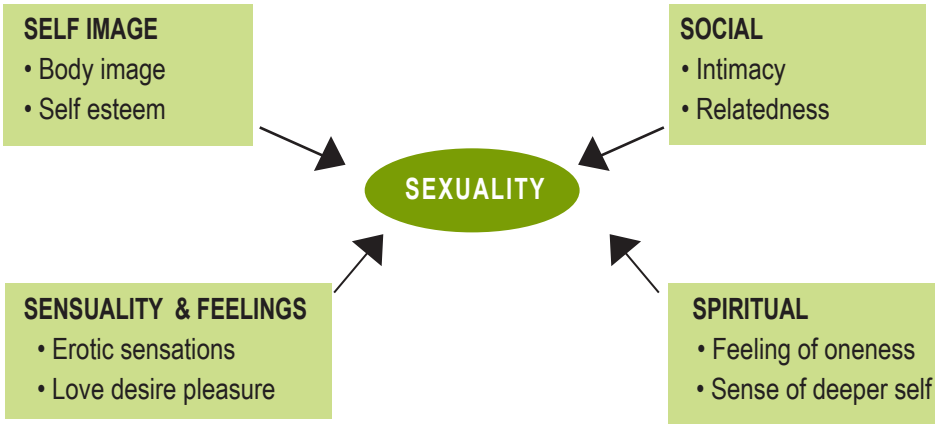

Fig. 1: Multiple dimensions of sexuality [3]

Sexual development across lifespan

Sexual development continues across the lifespan as a dynamic process with multiple facets. Studies in childhood sexuality are difficult because of inherent ethical and technical limitations. But available studies clearly demonstrate that children of all ages display behaviors or feelings that could be identified as sexual in nature. De Lamater & Friedrich indicated that human sexual development begins in infancy and certainly extends across the lifespan of humans [4]. Conclusively, human sexuality integrates both behavioral and biological

factors manifested across all phases of aging; childhood, adolescence, adulthood and old age. These developmental stages shape sexual attitudes, sexual identity and directly impact sexual behavior. While humans certainly share similarities in their sexual progression, it is further indicated that differences are also present.

Sex, gender and gender role: Concepts

Sex refers to a person's biological endowment for being categorized as male, female, or intersex. It includes sex chromosomes, gonads, internal reproductive organs and external genitalia as indicators of biological sex [5].

Gender describes psychological recognition of self as well as wish to be regarded by others as the social categories of male or female. It refers to the attitudes, feelings and behaviors that a person associates self with. It includes ones identity, sexual orientation and preferences [5].

Stoller first time defined 'Gender Identity' as a complex system of beliefs about oneself and a sense of one's masculinity or feminity. It refers to "one's sense of oneself as male, female or trans-gender" [6].

John Money gave the concept of 'Gender Role' for the first time and defined it as a set of feelings, assertions and behaviors that identified a person as being a boy or a girl from the contrasting conclusions one could have reached merely by considering their anatomical sex only. It refers to social and cultural role sanctioned to or expected from a particular gender [7].

'Gender Expression' refers to the "…way in which a person acts to communicate gender within a given culture; for example, in terms of clothing, communication patterns and interests". A person's gender expression may or may not be consistent with socially prescribed gender roles, and may or may not reflect his or her gender identity [5].

'Gender-Normative Behavior' refers to gender specific behavior that is compatible with cultural expectations [5].

Gender dysphoria and gender non-conformity: Different concepts (5)

'Gender Non-conformity' refers to gender behaviors viewed as incompatible with cultural expectations. It includes variations from the norm, different influences, associations & trajectories but may not be associated with dysphoria in all cases.

'Gender Dysphoria' refers to experience of distress felt due to discordance between internal sense of gender (gender identity) and physical sex (which generally matches the sex, assigned at birth).

Most people with gender non-conformity do not have gender dysphoria, although many people with gender dysphoria have gender non-conformity. Both frequently, but not always are associated with homosexual & bisexual orientation. But both are to a large extent associated with degree of mental health problems.

'Coming Out' refers to the process in which one acknowledges and accepts one's own sexual orientation. It also encompasses the process in which one discloses one's sexual orientation to others. The term 'Closeted' refers to a state of secrecy or cautious privacy regarding one's sexual orientation.

What is gender dysphoria?

Most people experience little doubt about their

gender, seeing themselves as either male or female. However, others experience an inconsistency with their physical sex and/or gender role. For children, this generally means that they think of themselves as or desire to be of the opposite sex. However, it is important to note that many people question the idea that male and female are fixed opposites. Theorists have suggested that it may be more appropriate to think of gender as lying on a continuum or having multiple categories. Others have proposed a position of gender transcendence, arguing that traits, behaviors, and roles should be divorced from gender [8]. Regardless, a desire to be of the opposite of their physical/assigned sex is a common experience for both girls and boys [9, 10]. Moreover, studies suggest that in western population, this is a frequent reason children are referred to school counselors [11], however, often goes undetected in India.

Gender dysphoria is much more common in children than in adults. However, the majority of children seem to outgrow it [9]. In children, the salient disjunction of assigned gender is with gender expression in play, clothing, and peer preference and in some also with primary sex characteristics. In adolescents, the secondary sex characteristics acquire increasing salience. Gender dysphoria remaining through adolescence usually persists long-term. However, most childhood gender dysphoria has not persisted (persistence rates of 1.5% to 37% by adolescence) in various clinical samples [8]. Instead, many gender dysphoric children become homosexual or bisexual but not transgender by adolescence/adulthood.

Since cross-gender behavior in childhood is very common, it may represent a normal part of development. Nonetheless, gender may cause problems or distress for affected children and their families. In such cases, a professional help may be needed to help children with any difficulties resulting from expressing their gender differently from their peers. Children with gender dysphoria may be more likely to have problems of anxiety and depressed mood than other children [12, 13]. It is not clear if these problems are the cause, or the result, or are unrelated to the gender dysphoria. Regardless, children and the families of children with gender dysphoria may benefit from psychological treatments aimed at helping them with any mood and anxiety related problems.

There are more boys than girls among the affected children, although this apparent asymmetry may well be due, in part, to the greater social acceptance of gender-atypical behavior in girls [9]. Gender dysphoria manifests a highly variable and plastic course because these patients' psychosexual development is not yet complete.

What is gender identity disorder?

Diagnostic and Statistical Manual of Mental Disorders, DSM-IV TR [14] outlines the criteria for childhood gender identity disorder (GID) as follows: (a) a continuing and strong identification with the opposite gender; (b) a continuing discomfort with one's current gender or gender role; (c) the gender dysphoria is not due to an intersex condition; and (d) the gender dysphoria causes a high degree of distress or impairment in the child's life. The final criterion is very important. A diagnosis of gender identity disorder requires evidence that the gender dysphoria leads to significant distress and/or life problems. There is nothing wrong or harmful about having traits and behaving in ways that have commonly been associated with the

other gender. Indeed, individuals who possess high levels of both 'Male' and 'Female' traits have been shown to be especially well-adjusted [15].

Although gender dysphoria has been viewed as a mental health issue in recent past, it was not always this way. Recorded history includes many descriptions of people, from a range of cultures, who did not fit into the simple categories of male or female. In some cases these people were highly regarded and viewed as holy by virtue of their insight into both female and male worlds such as the description of the character 'Shikhandi' in religious epic Mahabharata [16].

Gender identity disorders of childhood are only rarely (in 2.5% to 20% of cases) the initial manifestation of a trans-sexual development [14, 17]. Nonetheless, because of the severe social isolation that they cause, they are often associated with a considerable degree of emotional stress for the affected children (and their parents), as well as with a high psychiatric comorbidity, especially disturbances of affective and social behavior that require treatment. The presence of intersexual anomalies must be ruled out on clinical, genetic, and endocrinological grounds.

Gender dysphoric disorder of childhood [18]

Diagnosis requires marked incongruence ≥ 6 months between experienced/expressed & assigned gender including strong desire/ preference for 6 of following:

1. Strong desire to be or insistence one is the other gender (or some alternative) different from assigned one (mandatory characteristic)
2. Strong preference for cross-dressing in or simulating female attire (assigned boys); or only masculine clothing/resistance for wearing feminine clothing (assigned girls)
3. Strong preference for cross-gender roles in make-believe/fantasy play
4. Strong preference for toys, games, or activities stereotypically used/played by other gender
5. Strong preference for playmates of the other gender
6. Strong rejection of typically masculine toys/ games/activities & strong avoidance of rough-and-tumble play (assigned boys); or strong rejection of typically feminine toys, games, and activities (assigned girls)
7. Strong dislike of one's sexual anatomy
8. Strong desire for the primary and/or secondary sex characteristics that match one's experienced gender

Also: distress or impairment in social, school, or other important areas

Gender dysphoric disorder of adolescence [18]

For making the diagnosis, there must be marked incongruence ≥ 6 month between experienced/ expressed & assigned gender including 2 of following:

1. Marked incongruence between experienced/ expressed gender and primary and/or secondary sex characteristics (or anticipated ones in young adolescents)
2. Strong desire to get rid of primary and/or secondary sex characteristics because of marked incongruence with experienced/ expressed gender (or desire to prevent development anticipated secondary sex characteristics in young adolescents)
3. Strong desire for primary and/or secondary sex characteristics of other gender
4. Strong desire to be of the other gender (or an alternative one from assigned one)

5. Strong desire to be treated as the other gender (or an alternative one from assigned one)
6. Strong conviction that one has typical feelings & reactions of the other gender (or an alternative one from assigned one)

Also: distress or impairment in social, school, or other important areas

Most gender dysphoria in children is found to fade around the age of 10-13; on the other hand it may emerge around puberty or later and may require contra sex hormonal treatment[19, 20, 21].

Following are the predictors of persistence of childhood gender dysphoria into adolescence [20, 22, 23].

- Intensity of dysphoria & meeting criteria for formal diagnosis
- Cognitive cross-gender identification ("I am the other sex")
- Younger age of presentation
- Natal male sex
- Early social role transition (especially natal boys)

Etiology and pathogenesis

The development and continuation of gender identity disorders is held to be a multifactorial pathological process, in which individual psychological factors exert their effects in concert with biological, familial and sociocultural ones.

Different theoretical conceptions imply different complementary, not necessarily contradictory notions of the possible causes of GID. Thus, a generalization should be made with caution.

Neurobiological genetic research has not yet convincingly shown any predominant role for genetic or hormonal factors in the etiology of GID [13]. Some study findings originally suggested a possible effect of sex steroids in utero and an inadequate masculinization or defeminization of hypothalamic nuclei (Gender Role Centers) because of pathologically altered maternal hormone levels; these findings are now viewed more critically [24]. On the other hand, studies of gender identity in patients with various types of intersex syndrome (e.g. complete versus partial androgen receptor defects) have led to the formulation of a biological hypothesis for the etiology of gender identity disorders, in which these are caused by hormone resistance restricted to the brain [25,26]. Contrary to earlier assumptions, gender identity cannot be changed by external influences alone, i.e. attempts at so-called 'Re-education', even when these attempts are begun as early as the first year of life; this implies an early, somatic determination of gender identity. Moreover, because bodily and genital sensations exert a major effect on psychosexual and gender-identity development, one must assume that the overall process involves an interaction of biological and psychosocial factors [27].

In psychological theories, profound disturbance of the mother-child relationship is often postulated to be a causative factor [28]. The desire to belong to the opposite sex is held to be a compensatory pattern of response to trauma. In boys, it is said to represent an attempt to repair the defective relationship with the physically or emotionally absent primary attachment figure through fantasy; the boy tries to imitate his missing mother as the result of confusion between the two concepts of having a mother and being one [29]. In girls, the postulated motivation for gender switching is the child's need to protect herself

and her mother from a violent father by acquiring masculine strength for her. The maladaptive reactions can be seen as failed attempts to fulfill particular developmental tasks: separation from parents, establishment of an individual identity, and attainment of sexual maturity [30].

Identifying GID: Tools & strategies

Following guidelines and questionnaire can be utilized by clinicians for detection and intervention while dealing the patients with gender dysphoria.

Standardized questionnaires

1. Gender Identity Interview for Children (GIIC) [23]
2. Gender Identity Questionnaire for Children (GIQC) [31]
3. Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults (GIGDQAA) [32]

Guidelines

1. Fenway LGBT Guide [33]
2. WPATH SOC-7 [34]
3. AACAP LGBT Practice Parameter [35]

Differential diagnosis

Gender identity disorders are often the forerunner of a homosexual orientation. In adolescence, the main differential diagnoses are:

- Intersex condition or disorders of sexual development {46,XX (masculinisation of a female), 46,XY (undermasculinisation of a male), ovotesticular,46,XX testicular (XX sex reversal), and 46,XY complete gonadal dysgenesis (XY sex reversal) and most common (60-70%) congenital adrenal hyperplasia (CAH)} [36],
- Sexual maturation disorder (ICD-10 F66.0),
- Rejected (repressed or denied) ego-dystonic homosexual orientation (ICD-10 F66.1),
- Fetishistic transvestism (ICD-10 F65.1),
- Severe personality disorders,
- Less commonly psychotic disorders.

Before diagnosing the patient with gender dysphoric disorder, physical signs of intersex or endocrine status should also be carefully looked. Laboratory tests apart from complete physical examination might be necessary as a part of the physical work up to rule out above said disorders. Comorbid psychiatric conditions should be looked by mental health professionals as there is high rate of comorbid depressive and anxiety disorders, and they may not only increase the distress but also complicate the issue related to management.

The initial diagnosis must be made by a multidisciplinary team, where present, composed of a paediatric endocrinologist, geneticist, paediatric surgeon or urologist, and a psychiatrist. The timing of the disclosure of information to the patient is mostly adapted to the child's maturity and the social characteristics of the family.

Intervention: General principles

Anticipatory guidance, screening & treating for medical or mental illness is the mainstay of treatment. Long-term approach includes setting realistic expectations, help to manage stigma & monitor for psychosocial problems like abuse, homelessness & provide specific transgender health needs with appropriate consent [36].

Sometimes unintentionally health professionals and teams end up hurting patient's feelings by repeated examinations and using the patient as a unique case for teaching and training purposes and forgetting the holistic care. Here are some general principles of care [37, 38].

1. Provide medical and surgical care when dealing with a complication.
2. Recognize that what is normal for one individual may not be normal for others; care providers should not seek to force the patient into a social norm that may harm the patient.
3. Minimize the potential for the patient and family to feel ashamed, stigmatized, or overly obsessed with genital appearance; avoid the use of stigmatizing terminology and excessive medical photography; promote openness and positive connection with others, avoid 'parade of white coats' and repetitive genital examinations, especially measurements of genitalia.
4. Delay elective surgical and hormonal treatments until the patient can actively participate in decision-making about how his or her own body will look, feel, and function; when surgery and hormonal treatments are considered, health care professionals must ask themselves whether they are truly needed for the benefit of the child or are being offered to allay parental distress; mental health professionals can help assess this.
5. Respect parents by addressing their concerns and distress empathetically, honestly, and directly; if parents need mental health care, help them obtain it.
6. Directly address the child's psychosocial distress (if any) with the efforts of psychosocial professionals and peer support.
7. Always tell the truth to the family and the child; answer questions promptly and honestly, which includes being open about the patient's medical history and about clinical uncertainty where it exists.

Apart from psychiatric and medical management, this diagnosis is almost uncomparable in the complexity of its social, ethical and political ramifications. Management sometimes requires fine balancing between the concerns of the family who wants to cure their patient, while on the other hand is the person battling through myriad of emotions. Psychiatrists have wide role ranging from diagnosis, helping client realize his/her gender identity, informing about gender role expression and modes available, assessment of eligibility for hormonal or surgical therapies, making formal recommendations, documenting details, arranging for follow ups and at all stages to screen for mental health co-morbidity [39].

Current scientific controversies: Different treatment strategies

Two treatment strategies are available, first phase involving reversible hormonal therapy followed by irreversible hormonal therapy and surgery (sex reassignment surgery). Two approaches exist across the globe, one instituting early intervention with hormonal therapy and other supporting delaying treatment, till client attains maturity or legal age to participate in decision making process.

A review of the scientific literature reveals two different scientific positions leading to different approaches to treatment. Multiple longitudinal studies provide evidence that gender-atypical behavior in childhood often leads to a homosexual orientation in adulthood, but only in 2.5% to 20% of cases to a persistent gender identity disorder [13, 40]. Even among children who manifest a major degree of discomfort with their own sex, including an aversion to their own genitalia, only a minority go on to an irreversible

development of transsexualism. Irreversibility of the manifestations, however, is considered to be an indispensable requirement before the diagnosis of trans-sexualism can be made, or any body-altering treatments to be initiated. In England and Canada, in accordance with this view, hormonal treatment or surgery is not recommended until the patient's somatic and psychosexual development is complete [41].

In other countries, however, the opinion prevails that it is appropriate to use LHRH (luteinizing hormone-releasing hormone) analogues, which block gonadotropin secretion and secondarily inhibit the sex steroids, for diagnosis and treatment [42]. Using LHRH analogues is held to give the patient time to assess whether GID will persist, and to prevent the irreversible somatic changes corresponding to the sex of birth. This is supposed to bring relief and prevent psychiatric co-morbidity [43]. The guidelines of the British Royal College of Psychiatrists [44] and, those of the German Society for Child and Adolescent Psychiatry and Psychotherapy [45] generally recommend against treatment with hormones of the opposite sex before the patient's 16th birthday, yet they support the administration of sex-steroid inhibitors at much earlier ages in rare, individual cases. Physical and psychosexual development are already complete in some individuals by age 16, but most adolescents at this age are still in the process of establishing their sexual identity and the diagnostic and therapeutic approach should accompany this process rather than overwhelm it.

The pros and cons of early hormonal therapy [46, 47]

It is said that suppression of further somatosexual development rapidly alleviates the patient's sufferings. If puberty-blocking treatments and opposite-sex hormones are given early, then a sex-change operation performed later on in life will have a better cosmetic result. The patient's psychosocial and sexual functioning will improve, and psychiatric co-morbidity will be prevented.

Advocates of early hormonal intervention assert that the effects of puberty blocking treatment are totally reversible. But, this is true, however, only with respect to its physical effects, not with respect to the irreversible damage it does to the process of psychosexual development.

On the other hand, a treatment of this kind changes the individual's sexual experience both in fantasy and in behavior. It restricts sexual appetite and functionality and thereby prevents the individual from having age appropriate socio-sexual experiences that he or she can then evaluate in the framework of the diagnostic-therapeutic process. As a result, it becomes nearly impossible to discover the sexual preference structure and ultimate gender identity developing under the influence of the native sex hormones.

Experiences have shown that, in not a few cases, a strongly and resolutely asserted desire to change to the opposite sex becomes markedly neutralized over the course of time, and the individual later undergoes a homosexual 'Coming Out'. In view of this fact, it must be understood that early hormone therapy may interfere with the patient's development as a homosexual. This may not be in the interest of patients who, as a result of hormone therapy, can no longer have the decisive experiences that enable them to establish a homosexual identity. It is not known with any certainty at present how hormone therapy before the end of puberty might

affect the further development of gender identity, or to what extent it might even iatrogenically induce persistence of GID.

Children and adolescents generally lack the emotional and cognitive maturity needed to consent to a treatment that will have lifelong consequences. The fact must be taken into account that children with GID have an above average prevalence of deficient social skills, behavioral abnormalities & psychiatric co-morbidities and are therefore particularly susceptible to the temptation of a supposedly rapid solution to all of their problems.

Health care delivery in India: Limitations

If we discuss the ground realities of treatment in India, then except in a few government hospitals, sex reassignment surgery and other gender transition-related services are not available for free in tertiary level government hospitals. A study conducted in 2013 to assess the situation of gender transition-related health services for male to female (MtF) transgender people reported that [48, 49]:

- Lack of free sex reassignment surgery (SRS) in public hospitals and the prohibitive cost of SRS in private hospitals seem to be the key reasons behind why some hijras and other MtF trans people go to unqualified medical practitioners for surgery, resulting in post-operative complications.
- Unwillingness among qualified medical practitioners to prescribe hormone therapy and self-administration of female hormonal tablets among hijras and other MtF transgender people.
- Lack of national guidelines on gender transition services and ambiguous legal status of SRS makes even qualified medical practitioners hesitant to perform SRS.
- Limited expertise in India on SRS (especially penile construction or metaidioplasty for female to male (FtM) people. This means many FtM transgender persons wait for years before they undergo penile construction (phalloplasty).
- Limited knowledge among health care providers on the range of surgical and non-surgical options available for FtM transgender people.
- Lack of awareness about devices used by FtM transgender people such as binders, packers, urinating devices, and penile prosthesis.
- Limited knowledge about male hormone therapy among health care professionals. This means many FtM transgender people self-administer male hormones.

Ethical and legal difficulties in India for transsexuals

In India, transsexual individuals are often an outcast, as there are no specific guidelines for management and there is lot of ambiguity in law about their status. Recently in 2013, the Supreme Court of India quashing the earlier Delhi High Court judgement on Article 377 has again raised new ethical and legal debates. In India, still no state except Tamil Nadu has legal statutory provisions in place for changing transgender people's birth name and sex in the official gazette and official identity documents either after realizing their gender identity or sex reassignment [50]. However, a recent landmark judgment by Supreme Court in April 2014 has identified transgender as the third gender and has ordered government to make suitable changes in law. However, still there is a

long way to go for achieving a stigma free society [51].

Need for change in Indian health care delivery system

Following steps can be initiated for bringing requisite change in Indian health care delivery system:

- Improving access to and use of gender transition-related health services
- Reducing stigma
- To prepare policy guidelines for providing gender transition services in public hospitals
- To train and sensitize relevant health care providers on offering gender transition services
- Enabling better understanding and enhancing competency among health care providers in dealing with some transgender-specific health issues
- To make non-discriminatory policy/guidelines
- To prepare national clinical guidance document in line with the international WPATH (World Professional Association for Transgender Health) guidelines [34].

Following are the suggestions for what can be addressed in the national guidelines/standards of care for gender transition of transgender people in India:

1. Sensitization programmes for health professionals
2. Summary of current diagnostic guidelines ICD-10/DSM-5 to be made available to all clinicians
3. Defining role and competency of mental health professionals working with transsexual, transgender and gender non-conforming people
4. Psychological assessment and psychosocial support needed for transgender people and their family/friends/partners
5. Relationship of mental health professionals with hormone-prescribing physicians, surgeons, and other health professionals to be defined
6. Hormone therapy (informed consent, regimens, follow-up care) to be regulated
7. Surgery and pre requisites and follow up criteria to be laid down
8. Linkages (psychosocial support services, social welfare schemes and support in terms of legal name/sex change) and referral services
9. Age criteria for decision making for treatment to be specified

Conclusion

There is a need to understand developmental perspective of evolving gender roles across childhood and adolescence. Early identification of gender dysphoria, holistic assessment of special physical and mental health needs of patient and psychosocial needs of family. The guiding principle for the treatment of children with gender identity disorder is to strengthen patient's feeling of belonging to their gender identity without placing a negative value on his or her atypical gender role behavior. The child's parents, and usually the school teachers should also be involved in the treatment and any co morbid psychiatric disorder should be effectively treated. Adolescents should be treated in a diagnostic and therapeutic process that is open to multiple outcomes, utilizing the concepts of adolescent psychiatry and sexual medicine. This will enable the affected adolescent to resolve one's own identity conflicts. The treating physician should assess the degree of

persistence of the patient's desire for a gender transformation while paying special attention to other unresolved developmental tasks and/or conflicts aside from the specific problem of GID. The diagnosis of a transsexual, i.e., irreversible GID should be made only when the individual's psychosexual development is complete and after his or her sexual preference structure has been elucidated clearly. A further prerequisite of it, being free from any influence from extraneous hormones should be ensured. There is a need for bringing appropriate changes in health care system to make services accessible and suitable for needs of transgender people. Need to bring legal and social reforms for acceptance of these individuals in society and helping them attain their full potential is also important.

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