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Review Article

Environments and Gender Dysphoria: A Case-Based Appraisal

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Abstract

While gender dysphoria, as a general descriptive term, refers to an individual's affective or cognitive discontent with the assigned gender, its dysphoric compartment denotes the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. On the other hand, people with gender dysphoria may have coexisting mental health problems, most commonly anxiety and depressive disorders. Anyway, disregarding current debates about associated taxonomy, distinctiveness, social complications, or therapeutic concerns, many gender dysphoric patients who are living in traditional societies may believe that their settings have an ominous prognostic impression on their personal and social lives, which supposedly could be corrected by moving to a more developed society. So, they may perceive their problem as, essentially, an environmental condition rather than a psychopathological disorder. Hence, in the present article, based on the history of some reported cases, the said conception, or misconception, regarding the existence of a substantial relationship between environments and the prognosis of patients with gender dysphoria has been probed again to check the validity or helpfulness of such a claim.

Keywords: gender dysphoria; gender identity disorder; transgender; transgenderism; transsexual

Introduction

No doubt, gender dysphoria (GD), according to DSM-5 [1], or gender identity disorder, consistent with early terminology, is an important condition that may demand more attention and study with respect to related nomenclature, classification, core psychopathology, and potential managements, particularly when there are some inclinations that wish to detach it from psychiatry [2] and introduce it as a new identity that is based on innovative concepts. Perhaps therapeutic disappointments, social frustrations, and taxonomical anarchy, too, have expedited such a struggle. On the other hand, it is not deniable that uncertainty of identity may constantly hinder the actualization of personality or the development of a subject's social participation [3]. Also, many patients with GD who are living in traditional societies may believe that their settings have an ominous influence on their ultimate personal and social lives, which supposedly could be corrected by moving to an industrialized society. So, they perceive their problem more as an interactional or environmental complication than a psychopathological condition. So, in the present article, the said conception or misconception has been probed again to check its validity or helpfulness.

Background:

A) Definition:

While gender dysphoria, as a general descriptive term, refers to an individual's affective or cognitive discontent with the assigned gender, transgender refers to the broad spectrum of people who persistently or transiently identify with a gender different from their natal gender. Likewise, transsexual denotes an individual who seeks, or has undergone, a social transition from female to male or male to female, which in many, but not all, cases also involves a somatic transition by cross-sex hormone treatment and genital surgery [sex reassignment surgery (SRS)]. Hence, the said dysphoria is due to a marked incongruence between the gender they have been assigned to (usually at birth, referred to as the natal gender) and their experienced or expressed gender. Therefore, in adults with GD, the incongruity between experienced gender and physical sex characteristics is frequently, but not at all times, accompanied by a craving to be rid of primary and/or secondary sex characteristics and/or a strong aspiration to acquire some primary and/or secondary sex characteristics of the other gender. As a result, adults with GD may adopt the manners and gestures of the experienced gender because they feel uncomfortable being regarded by others as members of their assigned gender [1].

B) Gender and Terminology:

Although gender is used to denote the public role of a person as boy or girl, man or woman, biological factors are seen as contributing, in interaction with social and psychological factors, to gender development. So, while gender assignment refers to the initial assignment as male or female, gender-atypical or gender-nonconforming refers to somatic features or behaviors that are not typical of individuals with the same assigned gender in a given society and historical era. In general, gender identity is a category of social identity and refers to an individual's identification as male, female, or, occasionally, some category other than male or female [1]. Lexically, while in DSM-IV-TR this condition was classified as gender identity disorder, defined as 'accentuated

incongruence between the gender assigned at birth of the individual and the gender with which he/she/they identify, the DSM-5 modified this nomenclature to 'gender dysphoria', emphasizing that the diagnosis is characterized by the suffering related to this incongruence [1]. Similarly, while the ICD-10 defined 'transsexualism' as 'the desire to live and be accepted as a person of the opposite sex, in the ICD-11, the term was reclassified into conditions related to sexual health, such as 'gender incongruence,' which is 'characterized by a marked and persistent incongruence between an individual's experienced gender and the assigned sex.' [4]

c) Transgenderism:

Out of psychiatry and behavioral sciences and in line with social activists in the sphere of gender and sexuality, transgender ideology, or transgenderism, declares that everybody has a 'gender identity' that may or may not line up with their biological sex and that this identity is as imperative as natal sex. Such an ideology is based on the impression that feelings determine reality, and it demands that society play in conjunction with such subjective reality because they exist and shouldn't be discriminated against. As said by gender activists, the term gender is commonly used to refer to the psychological, cultural, and social characteristics that distinguish the sexes. From the idea of gender, such notions as gender bias and stereotyping have developed. Thus, stereotypes have led society to believe that only a male or a female should appear, act, or exist. But sex and gender aren't the same. Gender identity is more of an inner sense of being male, female, or somewhere in between, regardless of physical anatomy. It may be influenced by genetics and other factors, but it's more about the brain than the sexual organs. As a result, according to gender activists, transgender is not a mental disorder but simply "a normal developmental variation." As said by the activists, people have five different characteristics, each of which falls along a spectrum. First, there's "gender identity," which is "how you, in your head, define your gender, based on how much you align (or don't align) with what you understand to be the options for gender," and which may include "woman-ness," "man-ness," "two-spirit," or "genderqueer." The second characteristic is "gender expression," which is "the way you present gender through your actions, dress, and demeanor," which may include "feminine, "masculine," "butch," "femme," "androgynous," or "gender neutral." Third is "biological sex," defined as "the physical sex characteristics you're born with and develop, including genitalia, body shape, voice pitch, body hair, hormones, chromosomes, etc." The final two characteristics concern sexual orientation: "sexually attracted to" and "romantically attracted to," which may include "women/females/femininity" and "men/males/masculinity," and which seems rather binary. Also, they try to localize these five characteristics on the body: gender identity in the brain, sexual and romantic attraction in the heart, biological sex in the pelvis, and gender expression everywhere [5, 6, and 7].

D) GD and the Risk of Psychiatric Comorbidities:

While in children with GD, elevated levels of anxiety, depression, disruption, and impulse control are evident, in older children, gender-variant behavior often leads to peer ostracism, which may lead to more behavioral complications. Also, autism spectrum disorder (ASD) is more prevalent in this group of children in comparison with the general population [1]. Adolescents with GD, as well, appear to have comorbid mental disorders, especially anxiety and depressive disorders. ASD, too, is more prevalent in adolescents with GD than in the general population. Similarly, adults with GD may have coexisting mental health problems, most commonly anxiety and depressive disorders. On the other hand, preoccupation with cross-gender wishes may interfere with daily activities. In older children, failure to develop age-typical same-sex peer relationships and skills may lead to isolation from peer groups and distress. Some children may refuse to attend school because of harassment, teasing, or pressure to dress in attire associated with their assigned sex. In adults and adolescents, too, preoccupation with cross-gender desires often interferes with regular deeds. Relationship difficulties, including sexual relationship problems, are common, and functioning at school or at work may be impaired [1]. Gender dysphoria, along with atypical gender expression, is usually associated with high levels of stigmatization, discrimination, or victimization, as well as negative self-concept, school dropout, and economic marginalization, including unemployment, especially in individuals from resource-poor family backgrounds [1]. In general, while some studies showed that in patients with GD, the rate of psychiatric comorbidity is low [8, 9, and 10], other comparable studies have demonstrated that, in patients with GD, in addition to anxiety and depression, other psychiatric disorders, like bipolar disorder, trauma- and stressor-related disorders, personality disorders, substance-related disorders, psychotic disorders, dissociative disorders, somatoform disorders, suicidal ideation, child abuse, and neglect, are more prevalent than the general public [11]. In the same way, additional studies have revealed that maladjusted behaviors such as self-mutilation, suicidal attempts, or school refusal are evident in around 30% of this group of patients [12]. Moreover, it has been reported that, while the said patients may experience subtle behavioral symptoms or emotional problems, they may not have any definite psychiatric ailment [13]. In Table 1, the prevalence [(current, 12-month, or lifetime), according to available data, which is prepared in line with extreme values] of psychiatric comorbidities among patients with GD and homosexual individuals has been compared, roughly, with that of the general public.

Psychiatric Comorbidities	Gender Dysphoria [8 - 25]	Homosexuality [26 - 27]	General Population [1, 28-30]
Depression	17.4% - 77%	10.5 % – 34.5%	7% - 9.6%
Dysthymic disorder	4.7% - 7.2%	1.9% - 5.7%	0.5%
Bipolar mood disorder	2.3% - 2.4%		0.6%
Anxiety disorders	18.6% - 36.1%	15% - 40%	12.9%
Obsessive-compulsive disorder	6% - 14%		1.2%
Panic disorder	12.5%	1% – 5.9%	2% -3%
Specific phobia	20.5%	8.3% - 25%	7% - 9%
Social phobia		2.4% - 8.8%	7%
Generalized anxiety disorder	6%	0.9% - 13.5%	2.9%
Agoraphobia		0.4% – 7%	1.7%
Post-traumatic stress disorder		1.3% – 20.9%	0.5% - 8.7%
Adjustment disorder	15.7%		5% - 20%
Substance abuse	8.4% - 45.2%;	19.5% - 20%	10.7%
Eating disorders		1.1% - 10.3%	0.4% - 1.5%
Attention Deficit Hyperactivity Disorder		16.6% - 18.9%	2.5% - 5%
Personality disorders	15% - 80%		7.8%
Suicide	suicidal thoughts: 40%	suicidal thoughts: 1.9% - 13.9	suicidal thoughts: 4.9%

	suicidal attempts: 32% - 50%	suicidal attempts: 0.6% - 1.5%	suicidal attempts: 0.7%
Total	52.6% - 71%		29.2%

Table 1: Prevalence of Psychiatric Complications among Persons with Gender Dysphoria or Homosexuality in Comparison with the General Population.

Discussion:

While some researchers may consider GD a subgroup of borderline personality disorder due to higher levels of aggression, self-injury, suicidal ideation or attempts, and boundary confusion among them [31], symptoms like anxiety, depression, low self-confidence, social isolation, unstable self-image, relational problems, identity confusion, and suicidal ideation, too, may overlap with traits of personality disorders [4]. On the other hand, though minority stress and social exclusion may predispose them to experience more negative emotions such as anxiety and depression, attitudes toward such patients differ from society to society [17]. Likewise, while some investigators consider GD in the psychotic spectrum, it does not seem that psychotic disorders are more frequent in patients with GD [32]. Anyhow, while many patients with GD, transgender people, or transsexual individuals, especially in developing countries, may believe that society and its values have an influential role in their problems and prognosis, by interfering with their favorite activities, orientations, or objectives, there are tangible events or proofs, too, which contradict such an influence as a determining dynamic. For example, a girl with GD, from her early childhood epoch, was fond of dressing like boys before announcing a few years later that she liked to be a boy and hated to behave like a girl, and had stated, during her teenage years, that she preferred to take a girlfriend and female spouse instead of a boyfriend or male mate; a series of proclaims that never waned or vanished in spite of huge familial stresses and social difficulties, on the one hand, and psychiatric or psychological management or consultations, on the other hand. Since she was living in a traditional society and her hopes for finding an ideal life were not attainable there, she immigrated, during her young adulthood, to a developed society, which, based on its sociocultural ideals, could be acknowledged by some as a paradise for transgender or homosexual people with respect to the availability of favorable social acceptance, de-stigmatization, marriage of homosexual individuals, and possible adoption of kids through same-sex parenting. Hence, after migration and primary stabilization, she received the necessary hormone therapy and sex reassignment surgery (SRS), and after that, she (or he) married another transsexual person, who was initially a man, and a decade ago, by means of SRS, had turned into a woman. Nonetheless, the marriage was not stable enough and, after a while, ended in separation. Eventually, in spite of her fairly established financial and social situation, and during her middle adulthood, she committed suicide and terminated her life by hanging. In another example, a young man in a traditional community who had declared during his early teenage years that he wished to be a woman and, by wearing erotic and womanly clothes and having promiscuous homosexual relationships, had experienced a lot of familial, social, and legal conflicts in his own old-style community, decided to leave his out-of-date hometown and relocate to another developed country for the achievement of his idealistic dignity, equality, and freedom. He believed that this is the society that should change its attitude regarding transgender and homosexual persons, not him or individuals like him, because they are a group of people who have been created, unintentionally, in this form, and they have the right to live freely and enjoy their lives. Anyhow, after migrating to a developed society as a refugee and finding his desiring social network, in spite of receiving some management, due to a number of reasons, he could not undertake SRS, and while he remained, biologically, a man, he was introducing himself as a lady and was behaving womanly, along with his beloved boyfriends and homosexual relationships. Eventually, a few years after his moving to his ideal utopia, though he was one of the prominent protagonists of transgenderism and homosexuality, at least in his own community, he committed suicide, aggressively, by self-mutilation and cutting off his penis, resulting in hemorrhage, because he did not want to die as a man, on the word of his explanatory letter, which was found a few days later along with his corpse in his apartment. Similarly, there was a young woman who wished to be a guy from her childhood and had never worn female outfits or behaved femininely. In this regard, she always carried different kinds of blades for bullying others or, according to her, as a defending strategy for defending against her foes. So people were usually trying to avoid confronting, criticizing, or mocking her, though her community was relatively rural and traditional and could not tolerate such a demeanor easily. In addition, she was involved in a series of homosexual relationships with a number of her classmates and had chosen one of them as her topmost belle. Similar to previous cases, due to social concerns, problems, stigma, and limitations, she decided to move to a developed country, turn into a real man, and start a new life. Though she could eventually migrate, she could not successfully attain the supposed objectives, and after a while, she returned to her native country. After her arrival, she wanted to meet her aforementioned sweetheart again. But, during rendezvous, the said sweetie informed her that she is going to marry one of her wooers in the near future, and, therefore, they cannot continue their earlier romantic relationship more than this; an alertness that infuriated the present case so harshly that she killed her former honey mercilessly by stabbing, which caused her, too, a serious sentence. Anyway, though the said case histories are too scarce for a comprehensive formulation and generalization of consequences due to a lack of data regarding confounding variables, like comorbid psychiatric problems or social complications, all of them, except the last one, have occurred after their settlement in new areas, which, hypothetically, were not as rejecting as traditional societies with respect to transgenderism or homosexuality. Accordingly, it seemed that relocation and a new milieu could not substantially change or mitigate the inner tensions of people who were suffering from gender dysphoria. This may show that either the said developed regions are not supportive enough with respect to said sexual aberrancies or gender dysphoria is not essentially dependent on surroundings. Indeed, it may expose that, though developed societies may not be as unconcerned as what is liked to be acknowledged, supposedly, by transgender people in developing countries, gender dysphoria is mainly influenced by psychopathologic modules rather than environmental interactions, though the impact of surroundings is not deniable. Also, while transgenderism and homosexuality may sometimes try, forensically or socially, to overlay each other, they are basically unalike. For example, though homosexuality is an aberration in the sphere of sexual orientation and sex objects, gender dysphoria is a problem in the sphere of identity and self. So, in spite of some overlaps, gender dysphoria seems to involve a deeper amount of psychopathology than homosexuality, which looks to be a circumscribed aberrancy. On the other hand, in psychopathological classifications, gender identity disorder (GID), or gender dysphoria (GD), has been generally acknowledged as an over-valued idea [an unreasonable and sustained belief that is maintained with less than delusional intensity (i.e., the person is able to acknowledge the possibility that the belief may or may not be true)], and the belief is not one that is ordinarily accepted by other members of the person's culture or sub-culture [33]. Also, its diverse presentations may represent some similarity with obsessive-compulsive disorder or body dysmorphic disorder regarding insight, particularly with respect to individuals who may recognize undoubtedly themselves as a gender who has borne wrongly in an incorrect physique. Therefore, patients with GD, too, may be specified as 'with good or fair insight' (the individual recognizes that his or her idiosyncratic beliefs are just about wishes or ideals), 'with poor insight' (the individual thinks his or her idiosyncratic beliefs are probably factual), or 'with absent insight or delusional beliefs' (the individual is completely convinced that his or her idiosyncratic beliefs are true). As a

result, the said specification may not be devoid of therapeutic amendments during the psychological or pharmacological management of such patients after a thorough psychiatric examination and interview. Then again, perhaps earlier classification of GD or GID as an over-valued idea (33), due to its specific physiognomies, has prevented its accurate biological and psychopharmacologic evaluation so far, while its compulsive or developmental aspects may demand more comprehensive and methodical exploration, whether psycho-pathologically or therapeutically. Likewise, since gender identity may be accounted for as one of the most important foundations of identity or self (3), any deliberate doubt or harm to it may be accounted for, symbolically, as psychological self-harm or sub-intentional suicide, which may be comparable a bit with physical self-mutilation or masochistic inclinations. The said profile is slightly similar to that of borderline personality disorder, too, which is not rare in people with GD. Even from a psychopathologic standpoint, it may be accounted for, figuratively or approximately, as an extended or generalized variant of body dysmorphic disorder, an idea that certainly demands more methodical evaluation or contemplation.

Conclusion:

Based on available data, observations, and comorbidities, it seems that surroundings may not have any influential impression on the prognosis of GD, and the related psychopathology looks to be, in essence, an innate, continual, and bothersome mental conflict rather than a peripheral, passing, or characterological phenomenon.

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