

GENDER IDENTITY DISORDERS

...when nature misses the gender...

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EPIDEMIOLOGY

Prevalence of transsexualism in adult :	1 in 37000 males
	1 in 107000 females
Prevalence in Netherlands	1 in 11900 males
	1 in 30400 females

Four observations, not yet firmly supported by systematic study, increase the likelihood of an even higher prevalence:

- 1) unrecognized gender problems are occasionally diagnosed when patients are seen with anxiety, depression, bipolar disorder, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, other sexual disorders and intersexed conditions;
- 2) some nonpatient male transvestites, female impersonators, transgender people, and male and female homosexuals may have a form of gender identity disorder;
- 3) the intensity of some persons' gender identity disorders fluctuates below and above a clinical threshold;
- 4) gender variance among female-bodied individuals tends to be relatively invisible to the culture, particularly to mental health professionals and scientists.

DEFINITIONS

Before 1960, the concept of atypical development of gender identity was rather fuzzy

- **Harry Benjamin in 1953** had already defined **the difference between sex and gender**: the sex is what one sees, the gender is what one feels.
- Harmony between the two is essential for human beings to be happy.
- **Sexual identity role or Gender role**: set of feelings and behaviour patterns that identify a subject as being a boy or a girl, independently from the result indicated by gonads alone. (**John Money, 1955**)
- **Gender identity**: Feeling of belonging to a class of individuals who are the same as oneself and recognised as being of the same sex. (**Research group, University of California, 1960s**)
- **Gender Dysphoria**: discrepancy between biological gender and psychological gender (**Fisk, 1973**)
- A different formulation for **Gender identity** was given by **Stoller in 1972** : Complex system of beliefs about oneself, subjective feeling of masculinity or femininity.

EVOLUTION OF IDEAS

In DSM fourth version, the term of **transsexualism** was broadened into **gender identity disorder**, less specific, that includes the so-called **transgender** (individual or transcend culturally defined categories of gender) :

- Transsexual
- Cross gender (transvestist)
- Non operative transgender
- Drag Queen/King
- “Trans People”
- ...

TYPOLOGY

Male to Female Transsexual (MtF)

Female to Male Transsexual (FtM)

- **According to evolution :**

- Early diagnosis (previously primary transsexualism)
- Late diagnosis (previously secondary transsexualism)

- **According to the sexual preferences of sexual partner :**

- A subject can do a homosexual choice according to his biological sex and a heterosexual choice according to his psychological sex or vice-versa.

MtF androphilic /early onset = positive pronostic factor

MtF gynephilic /late onset = negative prognostic factor

The best prognostic concern the heterosexual choices in relation to the psychological sex

and also those having not adopted another orientation before the onset of GID.

Some transsexuals don't make a sexual choice (asexuals, bisexuals) = negative pronostic factor

NEW ASSUMPTION

- **Many adults with gender identity discomfort find comfortable, effective ways of identifying themselves that do not involve all the components of the triadic treatment sequence.**
- **Options for the management of cross gender feelings are no longer limited to adjustment in either the male or female gender role, but include the possibility of affirming a unique transgender identity.**
- **For patients who identify a core transgender identity, a transgender “coming out” process can be facilitated, which may or may not include changes in gender role, hormone therapy or sex reassignment surgery.**

(Bockting, 1997)

THE 5 ELEMENTS OF CLINICAL WORK

Professional involvement with patients with gender identity disorders involves any of the following:

- diagnostic assessment,
- psychotherapy,
- real life experience,
- hormonal therapy,
- and surgical therapy.

THE 5 ELEMENTS OF CLINICAL WORK

1/ DIAGNOSTIC ASSESSMENT

TRANSSEXUALISM AND DSM

- The diagnosis of **Transsexualism** was introduced in the DSM-III in 1980 for gender dysphoric individuals who demonstrated at least two years of continuous interest in removing their sexual anatomy and transforming their bodies and social roles
- DSM IV /1994 : Gender Identity Disorder (GID)
- « Depending on their age, those with a strong and persistent cross-gender identification and a persistent discomfort with his or her sex or a sense of inappropriateness in the gender role of that sex were to be diagnosed as **Gender Identity Disorder of Childhood, Adolescence, or Adulthood** (302.6), **Adolescence, or Adulthood** (302.85)
- For persons who did not meet the criteria, **Gender Identity Disorder Not Otherwise Specified** (GIDNOS) (302.6) was to be used. This category included a variety of individuals--those who desire only castration or penectomy without a concomitant desire to develop breasts; those with a congenital intersex condition; those with transient stress-related cross-dressing; those with considerable ambivalence about giving up their gender roles.

THE 5 ELEMENTS OF CLINICAL WORK

1 DIAGNOSTIC ASSESSMENT

.../... TRANSSEXUALISM AND DSM

Patients with GID and GIDNOS were to be subclassified according to the sex of attraction:

- attracted to males;
- attracted to females;
- attracted to both;
- attracted to neither.

This subclassification on the basis of orientation was intended to assist in determining over time whether individuals of one orientation or another fared better in particular approaches; it was **not** intended to guide treatment decisions.

Between the publication of DSM-III and DSM-IV, the term "**transgendered**" began to be used in various ways. Some employ it to refer to those with unusual gender identities in a value free manner—that is, without a connotation of psychopathology.

Some professionals informally use the term to refer to any person with any type of gender problem. Transgendered is not a diagnosis, but professionals find it easier to informally use than GIDNOS, which is.

THE 5 ELEMENTS OF CLINICAL WORK

.../... 1/ DIAGNOSTIC ASSESSMENT

TRANSSEXUALISM AND ICD-10

- **Transsexualism** (F64.0) has three criteria:
 1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment
 2. The transsexual identity has been present persistently for at least two years
 3. The disorder is not a symptom of another mental disorder or a chromosomal abnormality
- **Dual-role Transvestism** (F64.1) has three criteria:
 1. The individual wears clothes of the opposite sex in order to experience temporary membership in the opposite sex
 2. There is no sexual motivation for the cross-dressing
 3. The individual has no desire for a permanent change to the opposite sex
- **Other Gender Identity Disorders** (F64.8) has no specific criteria
- **Gender Identity Disorder, Unspecified** has no specific criteria. Either of the previous two diagnoses could be used for those with an intersexed condition.

THE 5 ELEMENTS OF CLINICAL WORK

2/ PSYCHOTHERAPY

. Sexual transformation success depends closely on several concrete factors and benefit in particular from a psychological and psychiatric follow-up

The aims of Mental Health Professional are mainly :

- 1-To diagnose the individual's gender disorder according DSM IV and/or ICD-10
- 2-To evaluate any co-morbid 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 relevant history in a letter of recommendation
- 8-To be a colleague on a team of professionals with an interest in the 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 gender patients.

THE 5 ELEMENTS OF CLINICAL WORK

3/ REAL LIFE EXPERIENCE

When clinicians assess the quality of a person's real life experience in the **desired gender**, the following abilities are reviewed:

1. To maintain full or part-time employment;
2. To function as a student;
3. To function in community-based volunteer activity;
4. To undertake some combination of items 1-3;
5. To acquire a (legal) gender-identity-appropriate first name;
6. To provide documentation that persons other than the therapist know that the patient functions in the desired gender role.

THE 5 ELEMENTS OF CLINICAL WORK

4/ HORMONES

Eligibility Criteria.

The administration of hormones is not to be lightly undertaken because of their medical and social risks.

Three criteria exist :

1. Age 18 years;
2. Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks;
3. Either:
 - a- A documented real-life experience of at least three months prior to the administration of hormones; or
 - b- A period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

THE 5 ELEMENTS OF CLINICAL WORK

5/ SURGERY

Eligibility Criteria :

1. Legal age of majority in the patient's nation;
2. Usually 12 months of continuous hormonal therapy for those without a medical contraindication
3. 12 months of successful continuous full time real-life experience.
4. If required by the mental health professional, regular participation in psychotherapy throughout the real-life experience
5. Demonstrable knowledge of the cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches
6. Awareness of different competent surgeons.



RETROSPECTIVE STUDY OF 128 CASES OF GID

(Mireille BONIERBALE, Noëlle MAGAUD-VOULAND, 2004)

Population

• Initial Gender Dysphoria Population: N=128

82 Biological males (64%),

46 Biological females (36%),

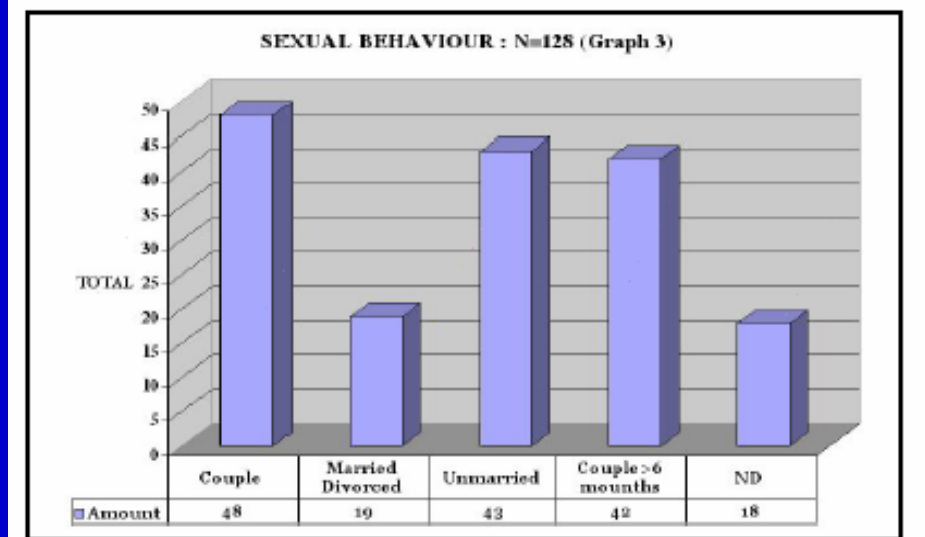
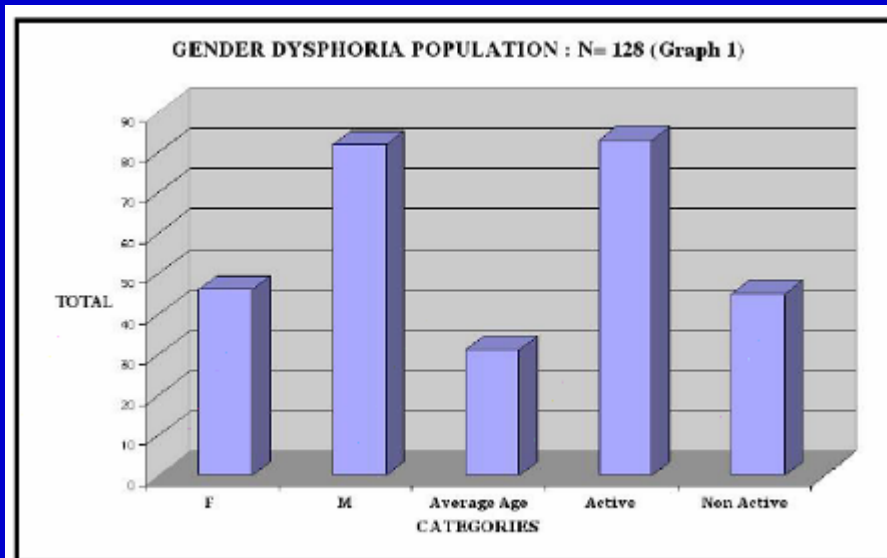
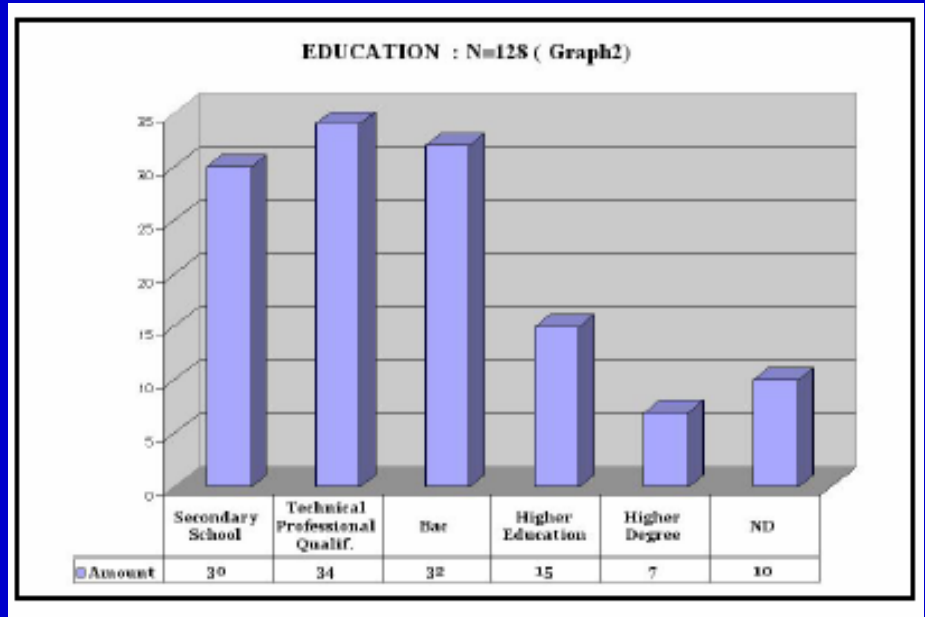
Average age : **31.16** years, (17 to 69 years).

Professional activity : active (**64.8%**), non active (35.1%).

Education tended to stop after secondary school, or was orientated towards technical professional qualifications (such CAP, BEP: “professional aptitude qualifications) rather than towards traditional higher education

Sexually active behaviour : **63.3%**, stable relationship as a « heterosexual » couple **37.5%** vis-à-vis their psychological gender for more than 6 months in 37.5% of cases.

- Single individuals, or unstable couples : 33.6%
- Individuals suffering from gender identity dysphoria living in heterosexual relationships in terms of the genetic gender, or
- divorced, represent the whole number of so-called secondary late onset or repressed disorders (14.8%).



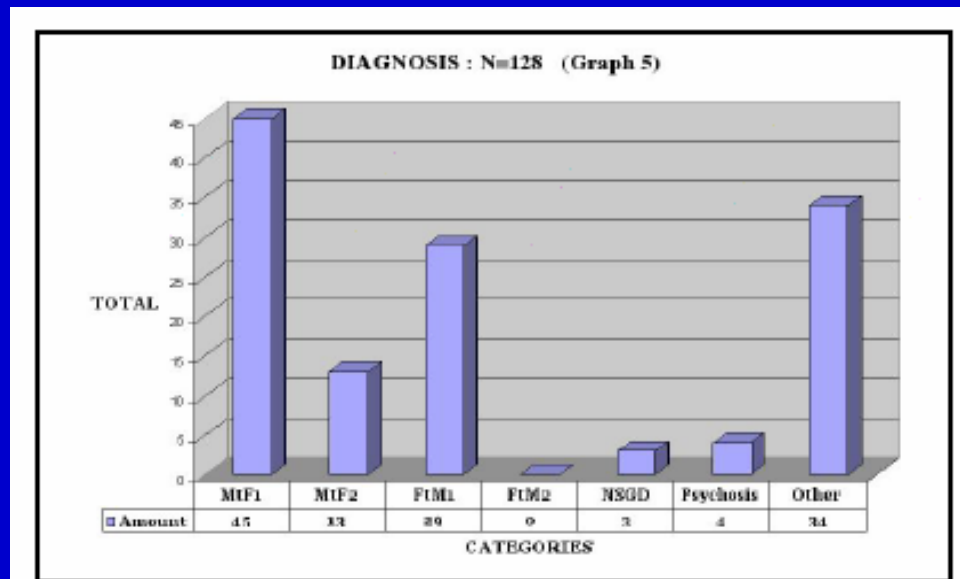
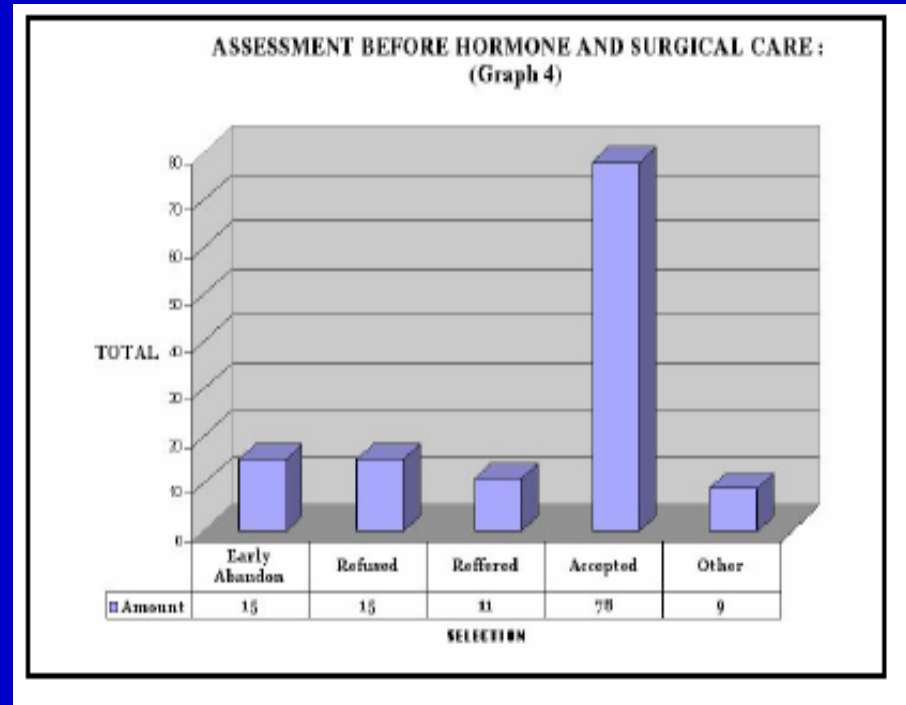
RETROSPECTIVE STUDY OF 128 CASES OF GID

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Results

Assessment before any hormone or surgical treatment:

- 11.7% early abandon
- 11.7% are refused (psychopathological symptoms++)
- 8.6% are referred to centres closer to their place of residence
- **61% are accepted** in the hormonal-surgical management protocol.



From a diagnosis point of view (according to the DSM III and ICD 10):

- **35.15%** cases of **primary MtF** transsexuals,
- **10.15%** cases of **secondary MtF** transsexuals
- **22.65%** cases of **primary FtM** transsexuals
- **0%** cases of **secondary FtM** transsexuals,

RETROSPECTIVE STUDY OF 128 CASES OF GID

(Mireille BONIERBALE, Noëlle MAGAUD-VOULAND, 2004)

Results

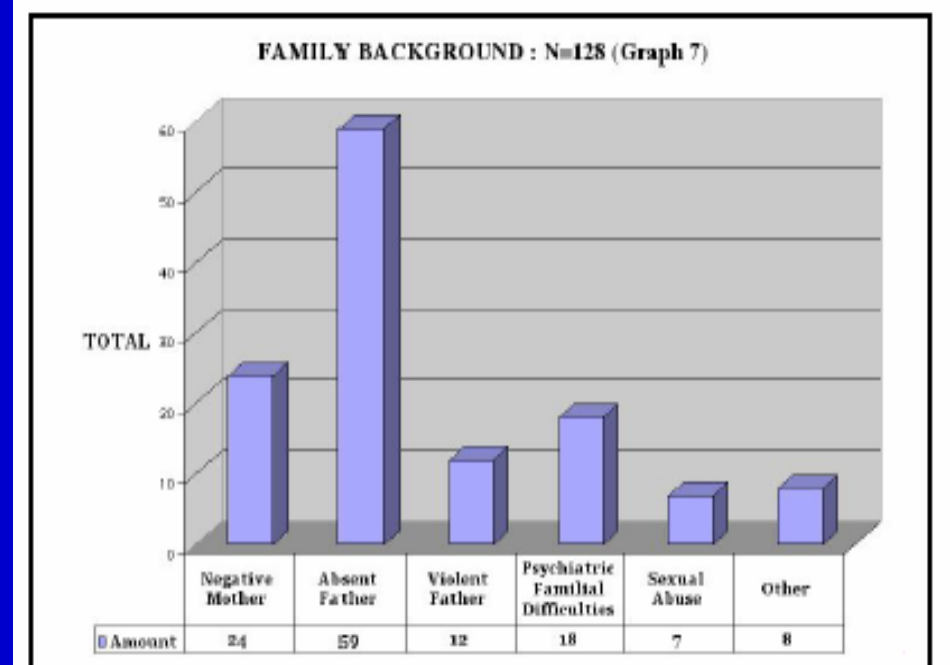
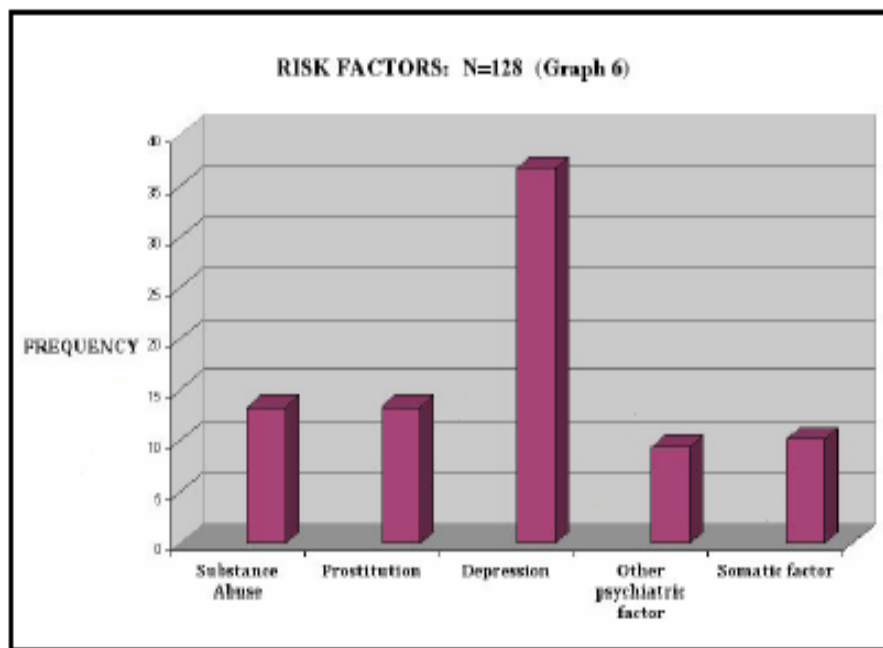
Negative risk factors ; a previous history of depression (35%), substance abuse (12%) and prostitution (12%).

Somatic factors found: HIV(2), thrombo-embolism (1), thyroid cancer (1), serious kidney failure (1), hyperandrogenism of the ovaries (2), XXXY mosaic (1), ulcerative colitis (1), obesity (2), hepatitis C (1), suspicion of pituitary tumour (1)

In the family backgrounds : high percentage (46%) of “absent fathers”

The mothers are often over-protective or emotionally distant (18.75%).

The biological girls suffered the largest amount of sexual and other types of abuse.



REGRETS

WOULD YOU START THE SRS PROCESS AGAIN ?
DO YOU HAVE ANY REGRETS ABOUT THE DECISION ?

Subjects	Again	Regret
1 (MF)	No	Yes
2 (MF)	No	Yes
3 (MF)	No	Yes
4 (MF)	No	Yes
5 (MF)	Yes	No
6 (MF)	No	Doubts
7 (MF)	No	No
8 (MF)	No	No
9 (MF)	No	Yes
10 (FM)	No	Yes

*Kuiper A. J. and Cohen-Kettenis P.T. (1998)
Gender Role Reversal among Postoperative Transsexuals. IJT 2,3*

REGRETS

SELF REPORT REASONS

Subjects	Regret	Reasons
1(MF)	Yes	« I am not a transexual ; the real problem has not been treated ; my body is mutilated »
2(MF)	Yes	« I am not a transexual ; SRS was unnecessary ; I had to accept my body »
3(MF)	Yes	« Never wished a sex-change ; felt forced by my partner ; I am a homosexual »
4(MF)	Yes	« Lost my partner and children ; very lonely ; feel more accepted now as man than as woman »
5(MF)	No	« No doubts ; double-role on request of my wife and children »
6(MF)	Doubts	« Disappointing surgical results + unstable psychic functioning »
7(MF)	No	« I am not a transsexual : gender dysphoric feelings have probably another background »
8(MF)	No	« After SRS my urge to live as a woman suddenly disappeared »
9(MF)	Yes	« Passing as woman socially unrealizable, an illusion ; cold-shouldered by society ; lost my life and children »
10(FM)	Yes	« I am not a transexual : I am a woman who had to accept her femininity »

STANDARDS OF CARE

Mental health professionals (MHPs) who work with individuals with gender identity disorders may be regularly called upon to carry out many of these responsibilities:

- 1. To accurately diagnose the individual's gender disorder;
- 2. To accurately diagnose any co-morbid 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 relevant history in a letter of recommendation;
- 8. To be a colleague on a team of professionals with an interest in the 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 gender patients. (*HBIGDA*)

NEGATIVE PRONOSTIC CRITERIA

- Older age at the moment of the request
- Morphological characteristic of biological sex too pronounced
- Choice of heterosexual object before transformation (MtF gynephilic)
- Unsatisfactory social support
- Mental instability
- Emotional vulnerability
- Criminal record
- Military service accomplished
- Professional inadequacy in relation to desired sex
- Misunderstanding of limits and consequences of surgery
- Self-mutilation *Walinder et al 1998 Doorn 1997*
- Alcohol or other substances abuse *Lindelmalm 1986 Kockott et Fahrner 1987*
- Ambivalence toward surgery *Ross et Need 1989 Johnson et Hunt 1990*
- Severe psychopathology... *Blanchard 1984*

IDENTITY DISORDERS IN CHILDREN

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GENERAL COMMENTS

- A subject is said to suffer from **Gender Identity Disorder (G.I.D)**: where there is inconsistency between the assigned biological sex and their psychological and behavioural manifestations.
- The encounter with a child or adolescent presenting with G.I.D often causes feelings of discomfort and embarrassment, not only for the parents, but also for the professionals being consulted.
- The diagnosis can have serious psychological consequences on family circle.

EPIDEMIOLOGY

- **Zuger and Taylor (1969)**: interviews with mothers of 7-year old boys: 27% of these children presented cross-gender behaviour: the desire to be a girl: 7%; to dress in women's clothes: 13% ; use lipstick: 7%; play with dolls : 7% ; prefer female friends: 15% ; aversion to virile boys' games: 2%.
- **Feinblatt and Gold (1976)**: out of 193 children referred to a paediatric guidance centre: 3.6% for inappropriate gender behaviour.

The prevalence of gender dysphoria is higher in children than at an adult age

Children: 2 to 4% of mothers report that their child wants to change sex*

Adults (transsexuals): 1 man in 30,000 / 1 woman in 100,000

* Achenbach & Edelbrock, 1981, quoted by Zucker, 1995 (Gender Identity disorder and psychosexual problems in children and adolescents. NY, Plenum, Press)

OUTCOME OF G.I.D.

What is the outcome for children who wanted (or stated that they wanted) to become a member of the opposite sex ?

- **Zucker (1985)** Meta-analysis of outcome for children referred to mental health professionals as cross-gender:
5.3% are transsexuals; 45.7% are homosexual or bisexual; 1% became transvestites, 22.3% are heterosexual, and the rest (25.5%) have an uncertain outcome
- **Green (1987)** re-examined at adolescent age or as young adults, 44 boys who had been referred to him as children in a children's psychiatric ward for G.I.D.:
75% had become homosexual or bisexual, only one (2%) had a transsexual outcome, all the others had "conformed" (23 %)!
- It would therefore appear that **most children** with gender identity disorders **do not become** gender dysphoric adults.
- There is a **high correlation** between early onset of gender identity disorder and **homosexuality**

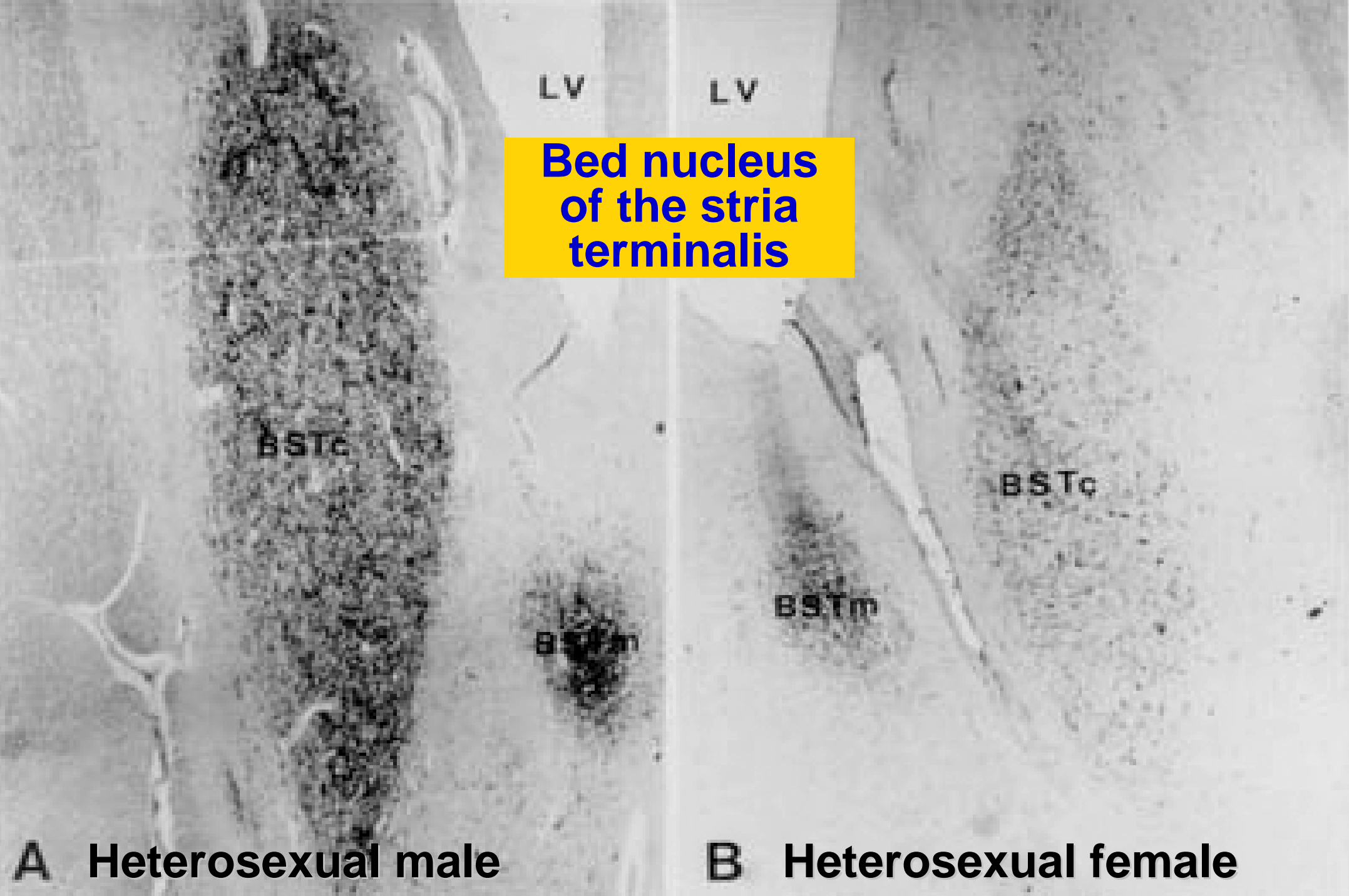
SOCIAL PERCEPTIONS

G.I.D. = 5 BOYS FOR 1 GIRL

- **Cross-gender behaviour is perceived differently by society according to the child's biological sex.**
- **Cross-gender behaviour is more noticeable in boys.**
- ***Feminine* behaviour in boys is perceived more negatively than *masculine* behaviour by girls, both by other children and by adults.**

BIOLOGICAL HYPOTHESES

- Hereditary factors (*Bailey and Pillard, 1991*)
- Hormonal factors: masculinisation of the brain during a critical phase of foetal development
- BSTc : The Bed Nucleus of the Stria Terminalis is generally larger in men(44%) than in women; in 9 transsexuals (MtF) it was of the same size.
In a case of transsexualism FtM, this nucleus had male dimensions.



LV

LV

Bed nucleus
of the stria
terminalis

BSTc

BSTm

BSTc

BSTm

A Heterosexual male

B Heterosexual female

LV LV

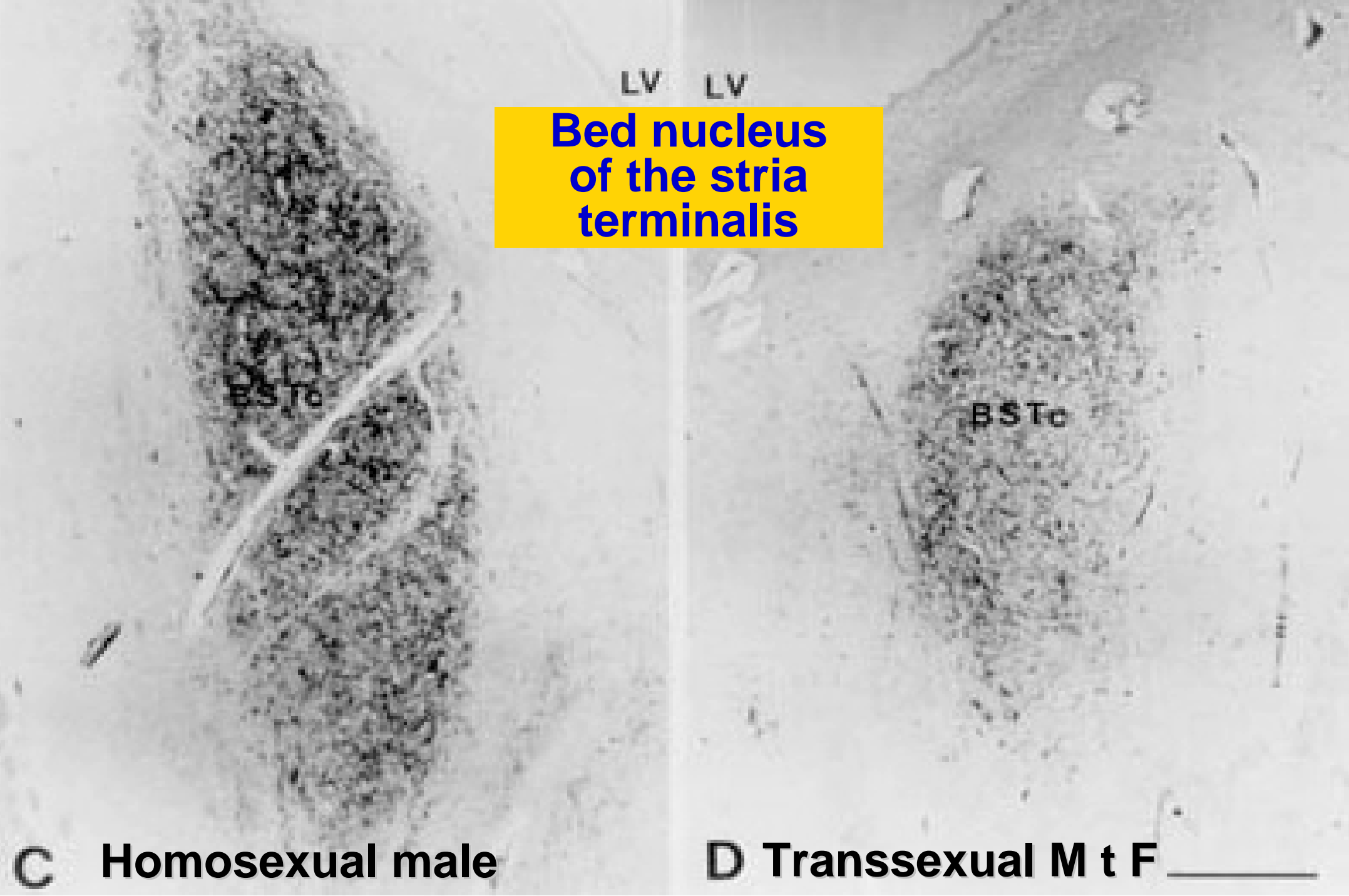
**Bed nucleus
of the stria
terminalis**

BSTc

BSTc

C Homosexual male

D Transsexual M t F _____

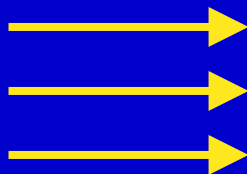




PSYCHOLOGICAL HYPOTHESES

- **Early influence of the mother** (*Marrantz et Coates, 1991*)
 - Desire on the mother's part to have a child of the opposite sex.
 - Presence in the siblings of a deceased child of the opposite sex, replaced by the subject.
- **Specific family constellations**: (*Stoller, 1968*)
 - *For boys*: extended symbiotic relationship with the mother, with whom the child identifies (excessive emotional and physical closeness); father distant.
 - *For girls*: mother suffering from depression during the first months of life, father absent, but giving the child the responsibility of supporting the mother.
 - Family complacency.
- **Inability to cope with bereavement**: loss of a parent or an important family figure during infancy. (*Bleiberg, 1986*)

Alone, none of these factors would be sufficient to cause the G.I.D.

SOCIAL COGNITIVE THEORY OF GENDER DEVELOPMENT AND DIFFERENTIATION

- **Psychosocial**
Sociocultural | **determinants**
- **Network of social influences**  **societal sub-systems**
- **Bodily structures**
Biological potentialities  **several possibilities of
gender differentiation**
- **People contribute to their**  **social changes
& gender relationships**

CONCEPT OF ESSENTIAL GENDER IDENTITY (STOLLER, 1964)

Produced by:

- The relationship Child-Parent
- The child's perception of his external genitals
- A biological force involving:
 - chromosomes, gonads, hormones,
 - internal genitals,
 - external genitals

DIAGNOSTIC CRITERIA

- **Stoller (1968)**: Firm belief by the child that he belongs to the opposite sex and that he will do everything necessary to obtain the corresponding characteristics.
- **Rosen et al (1977)**: His distinction between *transgender identification* and *gender behavioural disorder* proved to lack precision: 71% of children have both (*Bentler et al. 1979*).
- **D.S.M.IV (1994)**: 4 groups of criteria are required: A, B, C, D.
- **I.C.D. 10 (1992)**: Does not make a distinction between criteria A and B. « *tomboy* » behaviour in girls, « *effeminate* » behaviour in boys, is not sufficient in itself. There has to be a **deep-rooted** gender identity disorder.

DISGNOSTIC CRITERIA

D.S.M. IV (1994)

Criteria A: identification with the opposite sex (desire to belong to the opposite sex and statement that they **are** the opposite sex)

Criteria B:

- persistent discomfort with the assigned sex
- feeling of inappropriateness with the gender role of that sex

Criteria C: absence of concurrent inter-sex phenotype

Criteria D: clinical distress
impairment of social and occupational functioning

DIAGNOSTIC CRITERIA FOR G.I.D.

D.S.M.IV (American Psychiatric Association, 1994)

A – STRONG PERSISTANT CROSS-GENDER IDENTIFICATION

Children (*code 302.6*): 4 or + of the following criteria

- Repeatedly stated desire to be, or insistence that he or she is, the other sex
 - Boys: preference for feminine clothing and accessories.
 - Girls: insistence on wearing only stereotypical masculine clothing
- Strong and persistent preferences for cross-sex roles in “*make believe*” play or persistent fantasies of being the other sex.
- Intense desire to participate in the stereotypical games and pastimes of the other sex .
- Strong preference for playmates of the other sex.

Adolescents and Adults

- Repeated stated desire to be the other sex
- Frequent passing as the other sex
- Desire to live and be treated as the other sex
- Conviction that he or she has the typical feelings and reactions of the other sex

.../...

B – PERSISTANT DISCOMFORT WITH HIS OR HER SEX AND SENSE OF INAPPROPRIATENESS IN THE GENDER ROLE OF THAT SEX

Children:

- **Boys:**
 - assertion that his penis or testes are disgusting or will disappear,
 - *or* that it would be better not to have a penis,
 - *or* aversion for rough-and-tumble play and rejection of male stereotypical toys, games and activities,
- **Girls:**
 - refusal to urinate in a sitting position,
 - assertion that she has, or will grow a penis,
 - *or* that she does not want to grow breasts or menstruate,
 - *or* marked aversion for conventionally feminine clothing.

Adolescents and adults:

- Preoccupation with removing primary and secondary sexual characteristics (request for hormone treatment, surgery or other processes to physically alter sexual characteristics in order to simulate the other sex)
- or conviction that he or she was born with the wrong sex.

.../...

DIAGNOSTIC CRITERIA FOR G.I.D.

D.S.M.IV (American Psychiatric Association, 1994)

C - The disorder is not concurrent with physical intersex condition.

Homme
46,XX, SRY+

Translocation du gène
SRY sur le bras court
d'un des chromosome X

SRY+
Différenciation
testiculaire

Phénotype masculin
(Trouble de la
spermatogénèse)

**Comportement sexuel
masculin**



Andrology. Nieschlag & Behre eds, Springer, 2nd Edition, 2000.

**Insensibilité complète
aux androgènes** (46,XY)

Mutation Inactivatrice du récepteur aux
androgènes

Phénotype féminin
Pilosité réduite ou absente
Hypoplasie vaginale (35%)
Clitoris de petite taille (55%)

Comportement sexuel féminin

Difficultés sexuelles dans 90 % des cas :
Rapports peu fréquents
Pénétration vaginale difficile

Minto et al. Fertil Steril 2003;80:157



D - The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

DISTRESS

- YOUNG CHILD** • UPSET BY HIS OR HER SEX:
DISTURBED IN HIS OR HER PLAY AND SCHOOL ACTIVITIES
- OLDER CHILD** • FAILURE IN HIS OR HER RELATIONS WITH PEERS
ISOLATION, CONFUSION, REFUSAL TO GO TO SCHOOL
- ADO AND ADULT** • THE DESIRE TO BELONG TO THE OPPOSITE SEX IMPAIRS HIS
OR HER DAILY ACTIVITIES, STUDIES AND WORK
- OBSESSION WITH PERFECT DESIRED APPEARANCE
- HORMONE SELF-MEDICATION
- PROSTITUTION

CO-MORBIDITY

CHILDREN

- SEPARATION ANXIETY
- GENERAL ANXIETY
- DEPRESSIVE SYMPTOMS

ADOLESCENTS

- DEPRESSION
- SUICICIDAL INCLINATIONS
- ATTEMPTED SUICIDE

ADULTS

- IMPAIRED RELATIONS WITH PARENTS
- PERSONALITY DISORDERS (MALE > FEMALE)
- DRUG ADDICTION (INCREASED RISK OF HIV & HEPATITIS C)
- ANXIETY, DEPRESSION, ATTEMPTED SUICIDE

CO-MORBIDITY

- **CIRCUMSTANCES ASSOCIATED WITH G.I.D.**
(for the 124 first cases referred to the G.I.D.S., *Portman Clinic, London*)
 - Difficult relations with parents 57%
 - Difficult relations with peers 52%
 - Depression, psychological distress 42%
 - Family history of mental health problems 38%
 - Family history of physical health problems 38%
 - Bullying, persecution 33%
 - Social sensitivity 31%
- Difficult relations increase isolation and loneliness and contribute to depression.
- Boys are more often bullied than girls
(*there is less tolerance of lack of gender conformity in boys*)

G.I.D. AND SCHIZOPHRENIA

- Gender Identity Disorder in Schizophrenia 15 to 25%
- Schizophrenia in candidates for sex change
 - Hoemg & Kemma 1974 2.8 %
 - Wolinder 1967 4.9 %
 - De Cuypere 1993 6.9 %
 - Lothstein & Robach 1984 16 %
- Schizophrenia in general population : 1 %

SPECIFIC COGNITIVE ABILITIES

- Cognitive abilities of the biological sex
- On 17 FtoM transsexuals: they all had a female cognitive profile

(Gaillarda & Cordier, 2001)

CONCEPT OF ATYPICAL ORGANISATION OF G.I.

(Di Ceglie, 1998)

- Rigidity > Flexibility
- Chronology of training
- Traumatic events in correlation
- Continuum schizoid paranoid position > depressive position.

ATTITUDE TOWARDS THE PARENTS

In the current state of affairs, it is impossible to provide answers to the questions that the parents of these children have a right to ask:

- Will our child eventually accept his biological sex, or will he become homosexual or transsexual?
- Should we allow him to play with dolls or wear make-up at home, but prohibit him from doing it outside (*at school, for example*)?
- Should we approve or disapprove of his preferences ?
- To what extent can we have an influence on his sexual orientation in adult life?

Ellen C. Perrin, Brown University Child and Adolescent Behavior Letter 19(1):1, 3-5, 2003.

ACCEPTED PRINCIPLES

- Make the child feel secure in his identity as a girl or a boy.
- Support the child by stimulating his strong points.
- Reduce social isolation and being ostracised by his pairs as far as possible.
- Detect and treat emotional distress (the parents are naturally more inclined to satisfy material needs than to look for emotional distress).
- Devote more efforts to the child's need for intimacy with each of his parents.
- Parents showing that they are satisfied with their respective genders.

RECOMMENDED ATTITUDES

- Ensure that there is a favorable environment for harmonious development.
- Teach children techniques for recognising and preventing the detrimental effects of stigmatising their peers.
- Prepare the child to answer questions (anticipated in advance) that could embarrass him or her.
- Open discussions in the family:
 - to reduce guilt and shame.
 - to enable the parents to imagine their reaction in the event of homophile or transsexual course for the child.

TREATMENT PRINCIPLES

Model for Gender Identity Development Service

- The etiology of the disorder is not clear, and is probably multifactor.
- None of the various “therapies” used has proved to be effective.
- **The main objective of therapy is not to modify the G.I.D. itself, but to have an effect on the developmental process that seems to have been negatively affected in this child.**
- Hypothesis: it is possible that by improving the development process supporting the forming of gender, the atypical organisation of this identity can be secondarily modified.
- *List of actions: (next slide)*
- *Means available:*
 - Various types of psychotherapy
 - Social and educational intervention
 - Integration into a global management project
 - Working groups for parents

MAIN THERAPEUTIC OBJECTIVES

- To foster recognition and acceptance of G.I.Ds
- Improve associated behavioural and relationship difficulties
(Coates et Spector Person, 1985)
- Break out from the secrecy cycle
- Give rise to interest and curiosity by exploring inhibitions
- Encourage psychosomatic assessment (multi-specialty collaboration)
- Enable the bereavement process to run its course *(Bleiberg, 1986)*
- Facilitate symbolisation *(Segal, 1957)*
- Promote separation and differentiation
- Help the child and his family to accept the uncertainty present in the course of his or her gender identity

*(Di Ceglie, 1998
According to HBIGDA)*

TREATMENT OF A G.I.D.

(According to H.B.I.G.D.A: CARE STANDARDS, v 6, 1998)

- 1. Therapeutic investigation (main objectives)**
Remain prudent in the face of pressure for treatment, on changes in puberty.
- 2. Entirely reversible measures**
Medically delaying puberty to give the young adolescent time to mature his decision before the physical changes become too accentuated.
- 3. Partially reversible treatments**
Hormonal treatments to make the body more masculine or more feminine. Treatment in stages according to the assimilation of the progressive effects.
- 4. Irreversible interventions**
No surgery before coming of age! But rather psychological therapy to understand and facilitate adaptation for the child and his/her family.

G.I.D.s are a difficult and painful experience.

*It is essential to provide a forum for space, **EXPRESSION** and **COMMUNICATION**
for the adolescent and his/her family*

RECOMMENDATIONS FROM THE ROYAL COLLEGE OF PSYCHIATRISTS, 1998)

GENDER IDENTITY DISORDERS in CHILDREN AND ADOLESCENTS

- Rare
- Predominantly in boys
- Developmental
- Involve psychological, biological, social and family aspects
- Their course is difficult to predict
- Require early and careful assessment and particular attention to the emotional and developmental needs of the child

The possibility of physical intervention should be carefully examined, and involves:

- *full psychological, family and social investigation*
- *taking account of undesired effects on growth*
- *and should only be undertaken by highly specialised teams*

CONCLUSIONS

- To overcome the incompatibility between the intimate feeling of gender identity and their external appearance, dysphoric patients must therefore either change identity to bring it in line with his/her body, or change their body to bring it into line with his/her identity.
- But the host of solutions that these patients can adopt during the various phases of their development cannot be summarized in these two options alone. According to their choice of lifestyle and their sexual preferences, they may desire a sex life as a woman or as a man, with a woman or with a man, or both, or neither.
- So, there could be:
 - Non resolved course,
 - Acceptance of their biological gender,
 - Intermittent cross-gender behaviour,
 - Continuous cross-gender behaviour, with or without reassignment surgery.



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