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CASE REPORT

Gender Dysphoria and A De-Transition to the Biological Gender: A Case Report from a Primary Care Perspective

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ABSTRAK

Disforia jantina menggambarkan tekanan dan ketidakselesaan yang dialami oleh seseorang apabila jantina ketika dilahirkan tidak sesuai dengan identiti seseorang. Ini boleh menimbulkan kegelisahan, kemurungan dan bahkan membawa kepada cubaan membunuh diri. Namun, ini tidak berakhir begitu sahaja kerana selama tempoh transformasi, beberapa 'transgender' menghadapi tekanan yang ketara disebabkan oleh tekanan dari budaya, agama, pekerjaan, kewangan dan sosial, sehingga akan beralih kembali ke identiti jantina mereka dilahirkan. Peralihan jantina ke arah jantina kelahiran, adalah proses di mana seseorang tidak lagi mengikut atau mengamalkan beberapa atau semua aspek yang melibatkan perubahan jantina. Semasa proses peralihan ke arah jantina mereka dilahirkan, masalah kebingungan, kekeliruan, keraguan mengenai kemampuan mereka untuk melaksanakan peranan dan tanggungjawab mengikut jantina kelahiran adalah perkara biasa. Peralihan ke arah jantina kelahiran dari disforia jantina yang dialami memerlukan bantuan profesional; tetapi stigma dan diskriminasi menghalang mereka untuk meminta pertolongan daripada penyedia penjagaan kesihatan (HCP). Doktor penjagaan primer sering memainkan peranan penting dalam aspek ini walaupun masalah identiti yang berkaitan dengan jantina ini lebih baik didiagnosis oleh pakar psikologi atau psikiatri. Kes ini menggambarkan perilaku kesihatan dan cara mendapatkan bantuan oleh seorang transgender yang pernah mengalami disforia jantina dari awal usia remaja. Lama selepas itu, dia menghadapi kehidupan yang sukar dan ini membuatnya beralih ke jantina asalnya. Dia cuba mendapatkan perawatan

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kesihatan primer dengan harapan dapat menyelesaikan krisis yang dialami.

Kata kunci: anggota kesihatan, disforia jantina, peralihan, tabiat meminta bantuan, transjantina

ABSTRACT

Gender dysphoria describes the feeling of distress and discomfort experienced when the assigned gender does not match the person's gender identity. In its severe form, it leads to anxiety, depression and even suicidal ideation or attempts. Unfortunately, this does not end as some transgenders faced significant pressure by cultural, religious, employment, financial and social during the transformation period, hence would de-transition back to their natal gender identity. Gender de-transition is a process through which a person discontinues some or all aspects of gender affirmation. During the de-transition, ambivalence, confusion, doubts about their ability to carry out the gender role and responsibilities are common. Gender dysphoria and gender de-transition requires professional help, but the stigma and discrimination hinders them from seeking help from health care providers (HCP). Although these gender-related identity problems are preferentially diagnosed by a specialised psychologist or psychiatrist, primary care physicians often play an important role in this aspect. This case illustrates the health and help-seeking behaviour of a transwoman who had experienced gender dysphoria in the early adolescence year. Long after that, he faced a difficult life, making him de-transition to his original gender. He eventually presented with trivial symptoms in primary care hoping to solve the crisis.

Keywords: de-transition, gender dysphoria, health care providers, help-seeking behaviour, transgender

INTRODUCTION

Gender dysphoria, previously known as gender identity disorder, is the feeling of discomfort or distress that might occur in people whose gender identity differs from their sex assigned at birth or sex-related physical characteristics (American Psychiatric Association 2013). However, it does not imply that it is a mental disorder per se. Transgender and gender-nonconforming people might experience gender dysphoria at some point in their lives. According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorder (American Psychiatric Association 2013), individuals need to experience at least six months duration of significant distress or functional impairment as a result of incongruence between their expressed gender and the biological gender. The distress is so substantial thus causing confusion, poor sense of self, existent crisis, depression, anxiety, and suicidal

ideation or attempts (Cooper et al. 2020). To resolve gender dysphoria, some often transform to the desired gender identity (Cooper et al. 2020). Gender transition is complicated as the process may involve social transition through changing names and clothing, biological transition through hormonal treatment or surgical gender-affirming surgeries (Turban & Keuroghlian 2018; Coleman et al. 2012). However, some are content to remain as he or she is without having these profound "makeover" (Levine 2018).

Gender de-transition on the other hand is a process through which a person discontinues some or all aspects of gender affirmation. Of note, as with the term "transition," the term "de-transition" has become less acceptable to transgender and gender-diverse (TGD) communities, due to its incorrect implication that gender identity is contingent upon gender affirmation processes. During the de-transition, ambivalence and confusion about their gender identity are usual. Doubts about their ability to carry out the gender role and responsibilities expected by society do arise. Worries of the future and health-related concerns may add to compound their concurrent existing gender-related distress. There is documented reason for the de-transition which had been discussed at length (Turban et al. 2021).

The case illustrates a man who experience gender dysphoria early in his teenage life, who eventually transforms himself into a woman. Unfortunately, the "new" life eventually had exposed him to a high risk of sexually transmitted disease, job dissatisfaction, and mental disharmony making him de-transition to his original gender.

CASE REPORT

A 29-year-old male gender presented to a primary care clinic with a 3-day history of dry cough. He was a non-smoker with no past medical problems. Nonetheless, the history and physical examination were incongruent to what he had complained about when in the last six months, he had five clinic visits with the same presentation. These multiple visits with similar complaints had alerted the attending doctor to explore more into the patient's pattern of health seeking behaviour. Eventually, upon further questioning, he expressed his fear of contracting human immunodeficiency virus (HIV) as he had a long history of men who have sex with men (MSM) relationships and his previous male partner was recently diagnosed as having HIV. He contemplated performing the HIV test for himself, but he was too ashamed to declare to previous attending doctors. In addition to that he revealed that he was about to get married, and the HIV test was required prior to this.

From there, other sensitive issues related to his gender identity and sexual orientation were explored. He disclosed his fond childhood memories of being the girl in his family, doing house chores, playing with girl toys and dressing up as a girl. He admitted that he felt distressed to "pretend" as a boy and the feeling continues to make him depressed. He thought he was born and trapped in a

different gender as he felt great relief when he started to behave as a female. His action was not objected to by his family who never reprimanded his gender non-conformity behaviour. He then disclosed about having a sexual and intimate relationship with his neighbour at the mere age of 12. He admitted that those experiences had led him to feel more comfortable and this kept him motivated to continue living in a transgender environment. He even joined a transgender society and started to take injectable oestrogen at the age of 24 years old as these could make him feel even more relieved. Fortunately, he did not proceed to perform gender-affirming surgeries due to high cost and possible complications. He acknowledged that during those years, he still felt distressed, and any action inclined to female behaviour could make him feel better. Along the way, his risk of promiscuity had tripled until at one time he felt that he had to de-transition back to his natal gender to avoid the stigma that had negatively affected his earnings, adhere to the religious teaching and protect himself from HIV and sexually transmitted disease. He felt helpless and didn't know what to do next. He felt grateful when eventually the doctor was able to sense his difficulties and handle the conflicting thought he had suffered. Nonetheless, he denied any symptoms of anxiety, depression nor having a thought or attempted suicide. He just felt uneasy and distressed with what he currently faced.

In his effort to de-transition, he believes he could, but he knew that he had to struggle very hard to achieve the momentum back like a real man. He became receptive to his mother's request for him to get married, to which he agreed. Nevertheless, deep inside he still doubted his ability to form an intimate relationship with a woman let alone to perform the role of a husband. He said that he would get married in a few months and he must perform the HIV test as a condition before marriage.

On physical examination, he was neat and well-groomed with male attire, a soft-smelling perfume and a corset. He wore his hair short with no facial and body hair. His mini mental examination was intact and there was no signs of anxiety nor depression. There were no enlarged breasts and he had grossly normal male genitalia. Blood investigations for HIV, Hepatitis B, Hepatitis C and syphilis were taken respectively in view of his promiscuity behaviour as well as his wish to know about his HIV status. He was scheduled to return to review the results and to evaluate his progress. On the subsequent follow-up, he was told that all the results were normal including his cardiovascular screening. He was overjoyed and had promised to remain at this de-transition phase and behave and living with his gender of origin.

DISCUSSION

Gender identity is one's sense of belonging to a particular gender (Byne et al. 2018). Whereas binary gender identity, either female or male, is the common societal gender norm that individuals are expected to conform

to (Cooper et al. 2020). Their gender-related behaviour, gender expression and gender role are culturally defined, and transgressing the norms may lead to significant distress and struggles (Barmania & Aljunid 2017). Gender-related distress is common when the gender identity that they experienced or expressed is not aligned with their biological gender (American Psychiatric Association 2013).

The presentation of gender dysphoria includes low self-esteem, becoming withdrawn or socially isolated, depression or anxiety, taking unnecessary risks and neglecting themselves (Anderssen et al. 2020). Likewise, as reported in the above case, the patient had significant distress and depression in early childhood but not to the extent of having suicidal ideation and attempt prior to behave like a woman.

People with gender dysphoria could have changed their appearance, behaviour or their interests by modifying the way they look and behave. This could be done through medical means such as using hormones and sometimes to the extreme of performing reaffirming surgery to express their gender identity. A review of 38 cross-sectional and longitudinal studies had reported that people with gender dysphoria do improve their distress and psychological morbidity following gender-confirming medical intervention (Dhejne et al. 2016). In Malaysia and some other countries, the change of gender is prohibited (Barmania & Aljunid 2017). In addition, the healthcare system in the country does not support designated clinics according to gender-specific and the gender-affirming interventions are not practised, unless for those who are born with gender ambiguity.

Importantly, gender dysphoria is not a mental illness per se, but they are at risk of inflicting mental health problems. It was reported that main psychiatric disorders among gender dysphoria include depression and anxiety disorder. Other major psychiatric disorders are schizophrenia and bipolar disorder. However, these were rare and were no more prevalent than in the general population (Dhejne et al. 2016).

Transgender often experience stigma, discrimination, bullying and violence (Barmania & Aljunid 2017). Therefore, they would choose to de-transition to their original gender. In extreme cases some reported that they even requested reversal surgeries to help them adjust back during the de-transition. (Turban & Keuroghlian; Levine 2018). Few cases had been reported around the world about this de-transition in which the reasons are multiple (Turban et al. 2021). In the above case the patient was struggling until he decided to de-transition back to his natal gender identity.

There are limited works of literature related to the topic of de-transition, especially in Malaysia. The studies that have been done suggest the rate of de-transition was very low. One study reported the proportion of de-transition was at less than 0.5% (Davies et al. 2019). If this phase is managed carefully, it can bring success to patients who want to conform to their natal gender (Turban & Keuroghlian

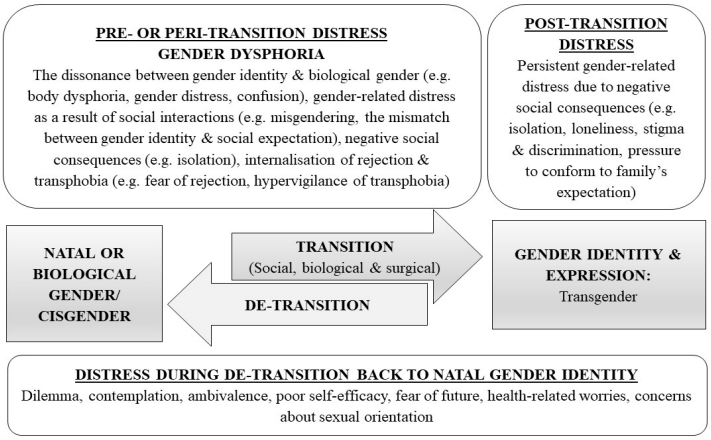

Figure 1: Conceptualisation of distress experienced during de-transition based on the patient's narrative and previous literature (Cooper et al. 2020)

2018; Barmania and Aljunid 2017; Hsiao 2018; Cooper et al. 2020). However, to date, the management of de-transition is not included in the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People-Version (Coleman et al. 2012).

After a detailed assessment to confirm the diagnosis of gender dysphoria and emotional turbulence during pre-and post of the de-transition phase, an agreed treatment plan should be discussed openly with the patient with the aim to provide lasting relief from these issues. In Malaysia, the management of gender dysphoria and de-transition is challenging due to limited resources and expertise. At the primary care level, as in the above case, success can be achieved through the application of family medicine principles that ensure personalised, comprehensive, holistic and continuity of care. These principles can be largely embraced by primary care doctors and the respective health care providers working throughout the country. The case then can be referred to psychologist and psychiatrist if needed. A non-judgemental and neutral attitude provides a safe space for the patient to share the deepest secret of their life, dilemmas, worries and fears, allowing exploration of the inner self, needs and life priorities (Chipidza et al. 2015). It is important to assess the patient's competency to make an informed decision and identify support from others (Coleman et al. 2012; Byne et al. 2018).

Based on the patient's narrative and a review of the previous literature, the distress experienced when living as a transgender and during de-transition can be conceptualised in Figure 1 (Cooper et al. 2020).

Since transgender is a sensitive and culturally unacceptable issue in some countries, gender-related problems are often patients' hidden agenda when they visit health care providers as illustrated by this case. Undifferentiated symptoms and recurrent visits for trivial problems are cues for a hidden agenda. Although our knowledge of this special

group is limited (De Vries et al. 2020) our intention to help and good doctor-patient communication could unmask the hidden agenda by exploring their ideas, concerns, and expectation with a non-judgmental, empathetic, and neutral attitude. These are the key remedies to develop a good rapport and trusting doctor-patient relationship (De Vries et al. 2020).

CONCLUSION

Although traditionally gender dysphoria and de-transition are often being managed by psychiatrist and phycologist, the awareness about this condition should be alerted to primary care doctors to understand more about its existence. This is because primary care doctors are the closest to the society hence, they have a great opportunity to identify the problem when dealing with transgender people. The cornerstone of management is to clarify the person 's decision making, address any concerns and assist the de-transitioning phase. Consequently, a safe space and supportive environment, needs to be created by any treating doctor in which stance of neutrality is emphasised, providing a therapeutic doctor-patient relationship.

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