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Short Communication

Intersexuality, Transsexuality and Mental Health

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Abstract

Introduction: Currently, matters related to a person's gender are of the utmost media and scientific validity. In this paper, we will aim to help clarify the relevant issues that affect mental health.

Materials and methods: In accordance with the best, high-quality international literature, we will present a rough critical, global and local analysis of the state of the matter.

Results and Discussion: In Spain, in order to rectify the register entries relating to intersexuality and transsexuality, a gender dysphoria diagnosis is required; that is, a sexual identity disorder diagnosis. The DSM-5 (American Psychiatric Association) classification of mental disorders, and equivalently, the ICD-10 (World Health Organization), both recognize the existence of the gender dysphoria diagnosis, and the upcoming ICD-11 will include, for gender disagreement, the so-called gender incongruence diagnosis. Issues associated with intersexuality and transsexuality are sufficiently and extensively addressed in scientific journals, and in many other journals that are exclusively informative. However, there is a risk of indiscriminately extending and even inadequately promoting everything related to the "transgender" concept, popularly abbreviated with the "trans" prefix. The psychiatric morbidity frequently associated or related to it is also commonly ignored or justified.

Conclusion: Should there be, in certain cases, a comorbid mental pathology, its correct and early identification, dismissal or adequate health consultation would be crucial for the client. Often times, it would be appropriate to implement a specific psychotherapy, to be conducted only by psychiatrists or clinical psychologists.

INTRODUCTION

Currently, matters related to a person's gender are of the utmost media and scientific validity. In this paper, we will aim to help clarify this question from the concurrent mental health perspective.

MATERIALS AND METHODS

Revision of the normative regulations in this regard in Spain (ES, Europe), and of the international diagnostic classifications associated or related to the ICD-10 (1992), and ICD-11 (World Health Organization, WHO) and DSM-5 (American Psychiatric Association).

RESULTS AND DISCUSSION

Regarding intersexuality and transsexuality, in Spain, it is imperative to refer to Law 3/2007, which regulates the rectification of register entries relating to a person's gender, last amended in 2019. There are also regional laws, such as Law 8/2017 in the Valencian Community, which recognize the right to gender identity and expression. The above-mentioned Law 3/2007 amended the laws pertaining to the civil registry (1957) and to the expedition of a National Identity Document (1978). Since 2007, in Spain, a gender dysphoria diagnosis (codes 302.6 and 302.85 of the DSM-5) is required to rectify the register entries relating to gender or sex. In other words, a gender identity disorder diagnosis (as per the current ICD of the WHO, online version 2019), is required and must only be conducted by the appropriate health professionals. These gender identity disorders are: transsexualism (code 64.0); dual-role transvestism, and gender identity disorder of childhood (F64.1 and 2); other gender identity disorders (F64.8); and gender identity disorder, unspecified (F64.9).

It is clear that the appropriate physician will need to dismiss certain main coexisting mental pathologies, which are, according to the ICD-10: 1- unspecified sexual dysfunction not due to a substance or known physiological condition (F52.9); 2- disorders of sexual preference or paraphilias (F65); 3- psychological and behavioural disorders associated with sexual development and orientation (F66); and 4- occasionally, hypochondriacal disorders (F45.2) or dysmorphophobia (nondelusional), among

others. In general, it can be assumed that there are three degrees of biological sex differentiation: genetic, gonadal and genital. That being said, it should be emphasized that, for 30 years now, according to the WHO, sexual orientation alone should never be considered a mental disorder. Indeed, as is the case now with the ICD-10, variations in gender preferences and behavior will not constitute enough basis for a mental pathology diagnosis in the upcoming ICD-11: Mental, Behavioural or Neurodevelopmental Disorders. It is well known that this new classification was approved in Geneva, Switzerland (CH, Europe) in 2019 and will enter into force globally in 2022.

Most individuals experiment psychological congruence between their biologic sex, gender identity and sexual role. However, despite the inevitable stigmatization inherent to certain gender incongruence diagnosis, the WHO has not found sufficient reason to remove them from the ICD-11 [1-3]. As an exception, dual-role transvestism will be removed, and according to the DSM-5, it is a paraphilic disorder with abnormal object desire. Precisely, the DSM-5 includes the following disorders among pathologic paraphilias, redefined as persistent, intense and atypical sexual arousal patterns: voyeurism, exhibitionism, frotteurism, sexual masochism and sexual sadism, pedophilia, fetishism, transvestism, and others. To counter the aforementioned stigma and maintain access to the healthcare system, the ICD-11 will include gender incongruence in chapter 17 of conditions relating to sexual health, together with other concepts like sexual dysfunctions or sexual pain disorders. Sexual dysfunctions, in particular, will also need to be persistent or recurrent, although they may be absent on occasion, and cause significant discomfort from a clinical perspective. Alterations with an organic base will be excluded. Such alterations will be discussed later on, in the intersexuality section of this paper.

Even though the ICD-11 has not introduced paradigm shifts in the disease classification, it has added a dimensional focus to it. The gender incongruence diagnosis shall be exclusive of all those alternative diagnoses mentioned in the previous paragraph, when they are predominant. In fact, this diagnosis will move away from dichotomous or binary thinking. Clinically significant distress will not be considered as an inherent symptom of gender incongruence either [4]. Nevertheless, it should be noted that there is a real possibility that pre-pubertal children with gender-variant behaviors might be prematurely or mistakenly typified and treated as transgender individuals, with the consequent suspension of puberty [5]. Undoubtedly, the most important matter in mental health is treating sexually discordant persons of every age in an adequate and non-stigmatizing manner.

It is well known that intersexuality may appear, among other ways, as the presence of genital organs that are not exclusively masculine or feminine, or internal sexual organs that do not match the external sex characteristics. This is the case when an individual presents ovarian and testicular tissues at the same time, which is a disorder of sex development, specifically named true hermaphroditism. Alternatively, an individual may present a peculiar chromosome dotation, as is the case of Turner syndrome and its variations; or may present rare hormonal plasma concentrations for their sex as shown and recognized at birth. All dysgenesis or embryonic developmental disorders, as well as other genetic alterations, deserve the same consideration. Matters related to intersexuality and transsexuality are sufficiently described in the professional literature. It is accepted that one may suffer from gender dysphoria or from the well-known anatomic dysphoria without a disorder of sex development. However, we have been witnessing for a few years now, a wide movement that often aims, in an indiscriminate way, to separate everything related to the popularly called “trans” gender from pathologic disorders.

This movement is, in fact, a “transversal” trend that seems to be accelerated and that tends to criticize the role of medical professionals as mere controllers. See the international campaign Stop Trans Pathologization. Likewise, invoking human rights, many people have celebrated the imposition of activism and what some consider to be trans erudition against international scientific agreements (like the ICD-11). Those who share that opinion, claim to base their thoughts on the principles about the application of international legislation on human rights with regard to sexual orientation and gender identity, or Yogyakarta Principles (Java, Indonesia, ID), published in 2007 and expanded in 2017 [6]. The scientific reality, however, is not at all about pathologizing or discriminating sex and gender diversity, as some physicians have reported to be the case sometimes [7]. Clinical matters shall be carefully observed from the specific psychopathologic point of view since, for example, the risk of suicide is higher among transgender individuals than for the general population, and this, throughout all the stages of their transition [8].

The term “transgender” is understood as a reference to individuals who do not conform to the gender norms associated to their manifested sex and, as a consequence, the sex they were assigned at birth. Some transgender people have pointed out feeling that the internalized discrimination has contributed to their mental health problems *[9]*. In effect, quality research on this regard constantly documents high prevalence of those problems and the use or abuse of substances among this population [10]. In general, they present adverse health results, including HIV and other sexually transmitted infections, when there are coexistent unsafe practices. Whatever the reason, teenagers with pronounced gender dysphoria with or without an organic disorder of sex development, who seek treatment in the gender identity services, show a considerable added psychiatric comorbidity [11]. It is worth mentioning that in Spain, the first public sector unit to include gender identity services was located at the Malaga Regional University Hospital, then called Carlos Haya Hospital (1999).

It is becoming increasingly common for transgender and non-binary gender people to block their transition to puberty or use hormone therapy to obtain the phenotype of their desired gender. However, little is known about the impact of these manipulations on the brain [12]. According to the German Network of Disorders of Sex Development, these disorders are a heterogeneous group of pathologies related to the sex determination or sex differentiation. All these pathologies are considered rare conditions [13]. That is, they are atypical congenital states of lack of coincidence of the chromosomic, gonadal and phenotypic sex, which is likely due to multiple factors *[14]*. Since 1959, significant

progress has been made in the knowledge that early exposure to androgens permanently influences the subsequent behavior of the subjects who received that treatment [12,15,16].

CONCLUSIONS

In summary, aside from a priori positions, trends, currents or modern political doctrines, the responsible physician will need to differentiate in each particular case whether or not there are related or associated mental pathologies that may be comorbid to intersexuality or transsexuality. Should those pathologies be present, their correct and early identification, dismissal or adequate consultation could be critical for the client. The implementation of adequate psychotherapy treatment will often be appropriate. Nevertheless, it should be noted the inevitable risk associated to engaging in interventions or alleged "psychotherapies" promoted by people, private entities and various associations that are not carried out by psychiatrists or clinical psychologists, which are quite common [17].

In short, if a client is finally diagnosed with gender dysphoria with the DSM-5 (302.x), or with gender incongruence in the upcoming ICD-11, it must be remembered that this diagnosis is a revision of DSM-IV's criteria identity disorder. In all cases, the following scenarios will need to be determined: 1. whether the individual suffers from a disorder of sexual development or simply presents mere gender-variant behaviors; 2. whether they present gender incongruence (ICD-11) or gender identity disorder diagnosis (ICD-10) as a current identified issue, and sufficiently enough to hold that clinical entity; 3. Whether the interested party has an explicitly expressed wish to free themselves from their original primary and secondary sexual characters; and 4. To conclude, the responsible physician will need to rule out that the individual does not currently suffer from a main disorder of sexual preference or paraphilic disorder.

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