GID Patients Need to Be Told of Realities

Get adolescents with Gender Identity Disorder to develop life plans, assess levels of family support.

BY HEIDI SPLETE
Senior Writer

HOUSTON — Most adolescents with gender identity issues initially are treated for comorbid conditions such as depression, Flynn O'Malley, Ph.D., said at the annual meeting of the American Society for Adolescent Psychiatry.

Considerations for managing adolescents with gender issues include treating the comorbid conditions (if any) first, and then educating the patient about the realities of a sex change.

The clinician can assist the adolescent in developing a plan for life as a person of the opposite gender after his/her sex change treatment, and can assess family support and encourage discussion of the family's discomfort with the adolescent's transgendered feelings. A patient who expresses a desire for a sex change must be thoroughly assessed to determine whether he or she meets the DSM-IV criteria for Gender Identity Disorder (GID) and shows commitment to the sex change process.

The problems inherent in gender identity issues among adolescents include the personal struggles of the patient with his or her identity; fears of rejection, attack, or humiliation; desires to keep gender preference a secret; concerns about parental reaction; problems in school and community settings; and the range of differences in professional attitudes and opinions about treatment, said Dr. O'Malley of Baylor College of Medicine, Houston. Dr. O'Malley, also of the Menninger Clinic, an inpatient facility in Houston for adolescents with unremitting psychiatric problems, reported no conflicts of interest related to his talk.

"People come to the Menninger Clinic after multiple hospital admissions and with multiple diagnoses—several of which have changed over time," Dr. O'Malley said. Many patients with gender issues also have mood disorders and substance abuse disorders, and a history of multiple suicide attempts. They often have serious family problems. In addition, many patients have a history of failure to improve or to regress after some improvement.

Suicidality, self-harm, and thought disorders may all occur in the context of gender dysphoria, Dr. O'Malley noted. Some patients reveal the gender dysphoria as part of their psychiatric treatment course; many report a history of sexual abuse. It is tempting to link gender dysphoria to sexual abuse, but the etiology of gender dysphoria is extremely complex.

"If gender dysphoria started early, whatever sexual experiences teenagers have had have been awkward and confusing for them," Dr. O'Malley said at the meeting, cosponsored by the University of Texas Southwestern Medical Center at Dallas.

Adolescents come to the Menninger Clinic in varying stages of intervention. Some have not identified their gender issues; others are already taking hormones. "There is enormous controversy when we admit someone with these difficulties, and discussion of what to do with them," he added.

Some adolescents with gender dysphoria are confused about their gender problems, while others are adamant that they are transsexuals and insist on treatment that would facilitate a sex change. They often suffer enormous humiliation, especially in cases where they have revealed the problems to others.

A controversy persists between those professionals who support psychodynamic therapy and those who back sex reassignment for these patients, Dr. O'Malley said. The psychodynamic supporters ask how one can possibly think about changing the anatomy when the discontent is rooted in psychopathology. Supporters of sex reassignment, on the other hand, recognize that the condition is usually permanent and that people denied a change might become suicidal, he noted.

Careful diagnosis is important. Intersex conditions such as chromosomal abnormalities, pseudohermaphroditism, and enzyme deficiencies should not be confused with gender identity disorders. Intersex conditions, which arise from developmental problems with sexual differentiation, have clear physiologic and biologic aspects. People with those conditions may or may not suffer from psychiatric problems. In contrast, transgender patients do not have ambiguous genitalia or physical inconsistencies related to sex at birth.

Criteria for a GID diagnosis include a persistent, strong identification with the opposite gender, persistent discomfort with one's sex, and feelings of inappropriateness in the gender role for one's sex. To meet the GID diagnosis, these characteristics must not be concurrent with an intersex condition and must cause significant distress and impairment in important areas of everyday life.

Subcriteria for a GID diagnosis in children include repudiation of the genitals among young boys and preference for a penis among young girls. GID is categorized in the DSM-IV under Sexual and Gender Identity Disorders, rather than Psychosexual Disorders, which suggests something about the etiology of the disorders, Dr. O'Malley noted.

Transvestitism differs from gender dysphoria because it involves a feeling of sexual arousal created by putting on the clothes of the opposite sex.

Some relationship appears to exist between childhood gender identity disorder and adolescent transsexuality. However, many children who cross-dress and exhibit gender issues at an early age do not become adolescent gender dysphoric patients or undergo sex change procedures, Dr. O'Malley said. Most children who meet the diagnosis for GID become transsexuals, and early cross-gender behavior often leads to homosexuality. ■

Steps to Take When Decision Is Made

If and when an adolescent makes the choice to change his or her sex, the steps toward sex and gender reassignment should begin with a thorough psychiatric assessment and discussion of plans for the future. Among the steps:

► A clinician determines whether the adolescent meets the DSM-IV criteria for Gender Identity Disorder (GID), and assesses his or her personal and social stability and levels of support from family and friends.

► If he or she meets the assessment criteria, the adolescent starts to live in a cross-gender role and initiates reversible hormone treatments. The fully reversible hormones suppress estrogen and testosterone and delay the physical changes of puberty. Reversible hormone treatments usually do not begin unless the adolescent is aged at least 16 years. Many experts also believe that the adolescent should be in at least Tanner stage 2 of development before initiating hormones.

► If he/she still desires change, the adolescent continues living in a cross-gender role and proceeds to partly reversible hormone treatment, which takes about 1 year for females working to become male and 1.5 years for males working to become female.

The difference in duration reflects the sense that it is more difficult for males who want to be females to pass as women than it is for women to pass as men. In fact, many adolescent girls can start to look like males relatively quickly.

Most physicians recommend that the adolescent wait until age 18 to receive the partly reversible hormone treatment, since these hormones masculinize or feminize the body and could lead to surgery to reverse the results, such as breast development in males.

► The final step is a continuation of hormones and a referral for sex change surgery.

Source: Dr. O'Malley

Adolescent Rebellion Can Interfere With Diabetes Care

BY HEIDI SPLETE
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HOUSTON — Psychiatrists can become part of a child's diabetes treatment team and provide guidance when barriers to compliance arise, Scot G. McAfee, M.D., said at the annual meeting of the American Society for Adolescent Psychiatry.

They can also stay alert to signs of depression—which is three times more likely to strike diabetics as nondiabetics, said Dr. McAfee, who has lived with diabetes since his youth.

Diabetes is considered to be one of the most demanding of all chronic illnesses, mostly because 95% of diabetes management is conducted by the patient. Some children as young as 7 or 8 with diabetes understand how to manage the disease effectively.

But when children with diabetes reach puberty or are diagnosed in adolescence, they might develop compliance issues because of feelings of rebellion and desires to be like their peers, said Dr. McAfee, a psychiatrist at St. Vincent's Hospital, New York.

Children and adolescents with diabetes who learn about their condition immediately and learn to monitor themselves have a better chance of avoiding complications. But some children think it is too difficult to figure out insulin doses and don't want to stand out at the lunch table. "So they eat whatever everyone else is eating," Dr. McAfee noted at the meeting, cosponsored by the University of Texas Southwestern Medical Center at Dallas.

In addition to managing their illness, adolescents with diabetes must face the daily traumas of teenage life. For example, anxiety and stress about a test or about a relationship with a friend can increase blood sugar levels. And diabetic adolescents who exercise during a gym class or an after-school sports practice require additional carbohydrates.

Adolescents require guidance in learning to compromise and achieve a livable balance between the demands of diabetes, the life stresses that all adolescents endure, and a desire for a normal lifestyle, he said.

"If an adolescent with diabetes enters a psychiatric hospital after a suicide attempt with [his or her] diabetes medications, I recommend finding someone with experience in adolescent diabetes to talk with the patient and verify that this was in fact a suicide attempt and not an attempt at overly close diabetes management," Dr. McAfee added.

A diabetic child or adolescent puts stress on the family unit as well. "Adjustments to a diagnosis of diabetes can take 6 months for children and 9 months for parents," Dr. McAfee said. Family issues include social stigma, possible economic burdens, and marital strife, especially when one parent wants to be more coddling of the diabetic child. Health care providers should reassess the families' knowledge of diabetes and coping strategies every 2 years, he said.

Dr. McAfee is a consultant to Janssen and Otsuka, and is a member of the speakers' bureau of AstraZeneca. ■