Models of care for gender dysphoria in young persons: How Psychiatry lost and is finding its voice

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ARTICLE INFO

Keywords:
Gender incongruence
Diagnostic frameworks
History of psychiatry

ABSTRACT

Globally, models of care for young persons with gender dysphoria differ across jurisdictions. Historically, developed countries have utilised the medical approach. More recently, broader models that place a greater emphasis on psychological interventions are emerging. This piece utilizes the Australian experience to compare models of care for gender dysphoria. Reflecting on the relative passivity of Psychiatry to date, historical reasons for this silence are explored. As relative experts in relationship dynamics and key bearers of the history of sexual health diagnoses, it is proposed that Psychiatrists have both the requisite skills and responsibility to share reflective lessons with other medical specialties in this space. Only by doing so may they provide appropriate care and treatment for young persons suffering mental distress due to gender incongruence.

1. Introduction

An estimated 2–3% of young persons worldwide identify as transgender and/or gender diverse (trans) (Strauss et al., 2021), with a gender identity that is not congruent to the sex documented at birth. Trans children and adolescents suffer discrimination, bullying and social exclusion (Telfer et al., 2018a), with high rates of psychiatric comorbidities, self-harm and suicide attempts relative to the general population (Strauss et al., 2020). The provision of care to this vulnerable population operates in contentious waters where socio-cultural movements fuel identity politics and invariably influence legal and clinical frameworks. It is a complex, dynamic space that attracts media coverage that can be unsympathetic to the challenges faced by healthcare pioneers. Perhaps the most controversial and topical area is that of appropriate models of care for trans young persons.

This piece reviews models of care for gender dysphoria in young persons in Australia, contrasting the dominant medical model of care with the broader approach recently proposed by the Royal Australian and New Zealand College of Psychiatrists (RANZCP). While access to medical treatment requires a mental health diagnosis of gender dysphoria, it is noted that to date, psychiatrists have played a relatively passive role in providing care for trans young persons. Historical reasons for this are explored and lessons from history utilised to propose Psychiatry’s role in the future. Importantly, psychiatrists have both the requisite skills and responsibility to speak up and collaborate with physician colleagues in pioneering care and treatment for this vulnerable population.

2. Models of care

2.1. The medical model

In 2018, the first Australian guidelines was published by The Royal Children’s Hospital Gender Service (Telfer et al., 2018b). Drawing from existing international standards of care developed by the World Professional Association for Transgender Health (WPATH), it was the first in the world to focus exclusively on the trans children (Jowett et al., 2021). The Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents (‘the Guidelines’) was based primarily on expert consensus and created in consultation with “all the known child and adolescent psychiatrists, paediatricians, paediatric endocrinologists and allied health specialists who work clinically in the area of transgender health across Australia” (Telfer et al., 2018a: 132). This was endorsed by the Australia and New Zealand Professional Association for Transgender Health (AusPATH), the peak body for professionals involved in the health, rights and well-being of trans people (Telfer et al., 2018a).

Authored by two paediatricians, a research officer and a clinical psychologist, the Guidelines endorse the gender-affirming model of care, a multidisciplinary, individualised approach which facilitates the young person to make decisions according to their felt sense of gender. A core belief of this approach is that children should have the freedom to live and express their gender with “freedom from restriction, aspersion, or rejection” (Hidalgo et al., 2013: 286). Thus, acceptance of the child’s stated gender is key; conversely, psychotherapeutic approaches that explore, and may be seen to question, a young person’s sense of gender
are not included. In practice, this gender-affirmative approach is often equated with a medical intervention pathway (Kozlowska et al., 2021).

Medical treatment for gender dysphoria generally occurs in three stages beginning in early puberty: stage 1 puberty blockers, stage 2 gender-affirming hormones, and stage 3 surgical interventions. In the gender-affirmative approach, the decision to have medical treatment is driven by the young person. Psychological support for trans young persons and their families is an essential component of medical care (Telfer et al., 2020).

To access treatment, a diagnosis of gender dysphoria in adolescence must be made by a mental health clinician with suitable expertise. The young person must also have a medical assessment including fertility preservation counselling by a GP, paediatrician, adolescent physician, or endocrinologist and, if required, further fertility preservation counselling by a gynaecologist and/or andrologist (Telfer et al., 2020).

Over the past decade, there has been an unexplained proliferation in the number of trans young persons seeking medical treatment (Kenny, 2020) with an increased proportion of presentations amongst sex-assigned females (Kaltiala et al., 2020) and those with a co-occurrence of autism spectrum disorder (Warrier et al., 2020). Many suffer from gender dysphoria, defined by the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5) as significant distress or functional impairment associated with incongruence between their internal sense of gender and the sex assigned to them at birth (American Psychiatric Association, 2013).

In keeping with the gender-affirmative approach, services have been established across Australia with paediatricians leading multidisciplinary specialized gender identity clinics in major cities (Telfer et al., 2018a). Psychiatrists typically provide specialist consultation for issues pertaining to the diagnosis of gender dysphoria and tend to be unpopular with young persons (Ho and Mussap, 2017) due to their perceived gate-keeping role, with no scope for engagement in a therapeutic process or explorations of alternative models of care (Ho and Mussap, 2017; Kozlowska et al., 2021). In Re Imogen (2020: 224–226), a landmark case regarding access to stage 2 hormonal treatment, the Family Court of Australia recognised the Guidelines as that “currently accepted by the majority of the medical profession.” The alternative approach of psychological exploration with an agenda free therapist to address issues such as past trauma, anxiety, school refusal and social difficulties in addition to gender identity as a pre-requisite to medical treatment was termed the “conservative approach” and deemed a “risky and unproven strategy.” At the time of hearing, the RANZCP did not have an official position statement.

2.2. The RANZCP model

RANZCP endorsed the Guidelines up until August 2019 when position statement 83 “Recognising and addressing the mental health needs of the LGBTQI+ population” was revised and removed reference to the Guidelines pending further review of evidence for the standards (RANZCP, 2021a). No explanation was given for this and no alternate position statement was available for the next years (D’Abrera et al., 2020). In the meantime, the lack of an official position statement was interpreted by the media as “abandonment” (The Australian, 2019), by the Family Court of Australia as a compromise with the Guidelines (Re Imogen, 2020), and by some psychiatrists as a deft sidestep to “core controversies by remaining vague and non-committal” (D’Abrera et al., 2020).

In August 2021, RANZCP released position statement 103 “Recognising and addressing the mental health needs of people experiencing Gender Dysphoria/ Gender Incongruence” (“the statement”), developed from the perspective of psychiatry (RANZCP, 2021b). While acknowledging the gender affirmative approach, the statement notes that there is a paucity of quality evidence and professional opinion is divided. In particular, “better evidence in relation to outcomes, especially for children and adolescents is required.”

The statement explicitly states that there is no preferred guideline, instead encouraging psychiatrists “to be aware there are multiple perspectives and views.” It appears to broaden the definition of “affirmative approaches” to include approaches that “focus on utilising psychotherapy to aid individuals with gender dysphoria in exploring their gender identity and aid alleviation of any co-existing mental health concerns identified in screening and assessment.” Contrary to the Guidelines, psychotherapy is viewed as an integral part of, rather than adversarial, to the gender-affirmative approach; acceptance is re-emphasised in favour of “full exploration of the person’s gender identity” while acknowledging the “dynamic changes in a child or adolescent’s identity and brain development” and inherent complexities of clinical care and assessment. While access to medical interventions is not the key focus, where “appropriate, psychiatrists can additionally facilitate the assessment of eligibility, preparation and referral to treatment.”

In the RANZCP model of care, psychiatrists “play a crucial role … [of] thorough assessment and evidence-based treatment ideally as part of a multidisciplinary team, especially highlighting co-existing issues which may need addressing and treating.” The psychiatrist has a consultation liaison role, providing both consultation from a biopsychosocial perspective and liaison services. In the latter, the psychiatrist self-defines their role, attending to any issues within the team that may impact on the provision of care and often includes education, primary prevention and systems orientated intervention. This is not antithetical to that of medical model but does require psychiatrists to broaden their self-defined scope and play a more active liaison role.

Finally, while the statement acknowledges gender dysphoria as a DSM-5 diagnosis, it recognises that psychiatric diagnoses may not be warranted for gender incongruence. Referring to the International Classification of Diseases 11th revision (ICD-11), it notes that Gender Incongruence is no longer classified as a mental disorder, but a condition related to sexual health (World Health Organisation, 2020). The title of the position statement being dedicated to “Gender Dysphoria/Gender Incongruence” takes a subtle, but significant step towards demedicalisation of gender incongruence.

Why has it taken this long for Psychiatry to voice its perspectives on appropriate models of care for a mental health condition defined by its own bible, the DSM? How is it that treatment for an ailment with a mental health diagnosis is being led by paediatricians, with a physical intervention as the key solution? Aside from a paucity of evidence to guide treatment, the reluctance of Psychiatry to speak out may be elucidated by considering the burden of historical guilt and stigma attached to psychiatric interventions for the treatment of homosexuality, a notably distinct construct.

3. Diagnostic frameworks

The evolution of diagnostic frameworks for a condition mirrors society’s conceptualisation of its symptoms. Historically, sexual orientation and gender identity were conflated, as was homosexuality (desire for partners of the same sex) with transgenders (desire to live as the other sex) (Beek et al., 2016).

Homosexuality was first listed as a sociopathic personality disturbance in DSM-I (American Psychiatric Association, 1952) and a sexual deviation in DSM-II (American Psychiatric Association, 1968). These first iterations of the DSM were driven by the dominant psychoanalytic thinking of the 1940s to 1970s (Lieberman and Little, 2015). Homosexuality was understood as a form of neurosis that originated from traumatic conflicts in childhood due to domineering mothers and abdicating fathers (Socarides, 1968). This illness model of homosexuality was preferred by some gay activists to the alternative social model of “immorality” (Drescher, 2015). When unearth and resolving these unconscious conflicts failed, psychiatrists offered other modalities including hypnosis and even physical aversion therapies (Lieberman and Little, 2015). There was no evidence of any conversion therapy working (Moor, 2002).

By the late 1960s, disdain for psychiatrists grew. The profession
faced a credibility crisis with the key criticism that psychiatric diagnoses were highly unscientific and unreliable. Fuelled by a growing body of sex research disproving the pathologisation of homosexuality in an era of activism, gay rights groups joined a burgeoning anti-psychiatry movement in protests at the 1970 American Psychiatric Association (APA) annual meeting (Lieberman and Little, 2015; Drescher, 2015). Unbeknownst to the gay rights movement, this implied merger with anti-psychiatrists confounded their cause. Anti-psychiatrists disavowed the concept of mental illness generally, believing it to be an artificial social construct that victimised those who did not fit cultural stereotypes. Instead, mental disturbances were thought to arise from a person’s social environment. While the anti-psychiatry formulation may have had merits for homosexuality, the APA faced an intellectual bind – to acknowledge that homosexuality was not an illness would risk opening the flood gates for anti-psychiatrists to argue that the same should be conceded for depression or schizophrenia (Lieberman, 2015).

A compromise was engineered with the concept of ‘subjective distress.’ On review of characteristics of mental disorders, the APA noted that ‘they all regularly caused subjective distress which were associated with generalized impairment in social effectiveness of functioning’ (Spitzer and Williams, 1982: 16). This distinguished homosexuality from disorders such as schizophrenia in which an afflicted person may not suffer distress but would be functionally impaired. In 1974, DSM-II was revised such that homosexuality, on its own, was no longer a mental disorder; however, an individual who experienced subjective distress due to their sexual orientation may be diagnosed with ‘sexual orientation disturbance’ (American Psychiatric Association, 1974) and access insurance for psychiatric treatment if they wished (Lev, 2013).

The concept of subjective distress became a core criteria for diagnosis in DSM-III. In pursuit of reliability, DSM-III abandoned psychoanalytic conceptualisations of illness for a neo-Kraepelinian framework. Rather than pursuing aetiological causes of illness such as unconscious conflicts, it drew on clinical descriptions of psychiatric symptoms to construct diagnostic categories (Lieberman and Little, 2015). It was in this milieu that transsexualism was introduced as a unique psychological phenomenon in DSM-III (American Psychiatric Association, 1980). Two decades after gender-identity clinics were established for adults seeking hormonal and sex-reassignment surgeries, there was sufficient clinical data to substantiate diagnostic criteria (Zucker and Spitzer, 2005). Since then, the diagnostic category has undergone revisions with each edition of the DSM (see table 1).

The most recent revision from DSM-IV (American Psychiatric Association, 1994) to DSM-5 (American Psychiatric Association, 2013) focused on finding a balance between reducing stigma and ensuring access to care (Drescher, 2010a). By shifting the spotlight onto the subjective distress that may arise from gender incongruence, the evolution of the diagnosis from ‘Gender Identity Disorder’ to ‘Gender Dysphoria’ is thought to be less stigmatising (Zucker et al., 2013). This is reminiscent of the shift in conceptualisation of homosexuality from a sexual deviation in DSM-II to a sexual orientation disturbance in DSM-III where an individual’s distress, rather than the condition, became the focus of diagnosis.

4. Lessons from history

The evolution of the conceptualisation of gender dysphoria as a mental illness echoes that of homosexuality. Across the world, activists have called for the depathologisation of transgender issues, with a majority believing that transgender diagnosis should be removed from the DSM. The key reasons cited for ongoing inclusion are access to treatment and insurance reimbursement (Drescher et al., 2012) – these were the same justifications given for retaining ‘sexual orientation disturbance’ in DSM-III. Today however, treatment for homosexuality is condemned by society. Is it possible that one day, treatment of gender dysphoria may be similarly condemned?

The statement may be commended for its recognition that “there is a paucity of quality evidence on the outcomes of those presenting with Gender Dysphoria... [and] a need for better evidence in relation to outcomes for children and young people.” In this climate, it is crucial to scientific enquiry to keep an open mind and consider all possibilities (RANZCP, 2021b).

We could consider that the dysphoria arising from gender incongruence may be, at least in part, attributable to societal responses when an individual’s felt sense of gender does not align with sociocultural expectations of its expression, as determined by reference to assigned sex. If so, rather than altering an individual’s physique to accord with societal-fuelled notions of gender, addressing societal expectations by decoupling gender identity from assigned sex, may, just as equally, contribute to destigmatisation and lessen dysphoria.

The notion that incongruence with societal expectations may contribute to the dysphoria one experiences is particularly striking in considering the historical emphasis on postoperative assimilation with conventional gender roles as key to transition success (Drescher, 2020).

| Table 1 |
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| **Evolution of diagnostic categories for sexual and gender related mental disorders.** |
| **DSM** | **Diagnostic category** | **Notes** |
| DSM-I (1952) | Sociopathic personality disturbance | This category consisted of antisocial and dissocial reactions and sexual deviations. Homosexuality listed as a first example in this category. Diagnosis of transvestitism included for the first time under this category but no description was offered. “This category is for individuals whose sexual interests are primarily towards objects other than people of the opposite sex, towards sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances. Even though many find their practices distasteful, they remain unable to substitute normal sexual behaviour for them.” |
| DSM-II (1968) | Sexual deviations | This category, homosexuality, on its own, was no longer a mental disorder; however, an individual who experienced subjective distress due to their sexual orientation may be diagnosed with ‘sexual orientation disturbance’ (American Psychiatric Association, 1974) and access insurance for psychiatric treatment if they wished (Lev, 2013). |
| DSM-III, 7th print (1974) | Sexual orientation disturbance | First introduction of gender identity disorders, listed amongst psychological disorders. |
| DSM-III (1980) | Ego-dystonic homosexuality | Homosexuality eliminated as a disorder, subsumed under “sex disorder not otherwise specified” which could include “persistent and marked distress about one’s sexual orientation.” Listed amongst disorders usually first evident in infancy, childhood or adolescence. |
| DSM-III-R (1987) | Transsexualism (adolescents and adults) Gender identity disorder of childhood (GIDC) Gender identity disorder of adolescence and adulthood, nontranssexual type (GIDAANT) | Listed amongst disorders usually first evident in infancy, childhood or adolescence. |
| DSM-IV (1994) | Gender identity disorder (GID) GID in childhood GID in adolescents and adults | Transsexualism eliminated as a disorder. Listed amongst sexual and gender identity disorders. |
| DSM-5 (2013) | Gender dysphoria in children Gender dysphoria in adolescents & adults | Listed in its own category gender dysphoria, separate from the paraphilias and sexual dysfunctions. Distinct criteria for children and adolescents and adults. |
In the 1980s, most university-affiliated gender clinics in the United States closed following the publication of a controversial study demonstrating that sex reassignment surgery conferred no objective advantage in social rehabilitation (Drescher, 2020, 2010b). Free from the assimilative policies of postoperative living promulgated by medical models, trans communities formed and proposed an alternative model in which:

Transexuals were not mentally ill men and women whose misery could be alleviated only by sex reassignment, but rather emotionally healthy individuals whose expression of gender was not constrained by societal expectations. Instead, the pathology was shifted from the gender non-conformist to a society which cannot tolerate difference (Denny, 2002: 43–44).

This model echoes the sentiments of anti-psychiatrists. In contrast to the milieu of crisis that led to a rejection of anti-psychiatry notions in the 1970s however, Psychiatry is arguably secure enough itself to acknowledge the formulation of anti-psychiatrists without threat to its credibility. In fact, the biopsychosocial approach that is now central to psychiatric formulations of illnesses embraces considerations of social determinants of illness. The defences that protected Psychiatry from collapse in its budding days may now be barricading its progression.

The depathologisation of homosexuality was followed by a change in cultural attitudes across the world, leading to a movement towards equal rights for gay people (Drescher et al., 2012). Still, stigma endures - same-sex marriage has only been legal in Australia since December 2017 and the expansion of LGBTQ+ rights varies globally (Council on Foreign, 2021). Nonetheless, the removal of homosexuality as a DSM diagnosis has led to an important shift “from asking questions about ‘what causes homosexuality?’ and ‘how can we treat it?’ to focusing instead on the needs of LGBT patient populations” (Drescher, 2015: 572).

Stigma endures. The dramatic failure of conversion therapy continues to cast a shadow over Psychiatry. In considering the scant evidence-base regarding diagnosis and treatment of gender incongruence (RANZCP, 2021b) and the public scrutiny that has plagued paediatricians brave enough to pioneer services in this field (Australian Press Council, 2021), it is no wonder that psychiatrists have played a relatively passive role to date.

The above comparisons between gay and transgender movements are not made to equate the two; or to suggest that gender dysphoria should necessarily be depathologized. Rather, it is hoped that by acknowledging its tumultuous past, Psychiatry may grow in awareness of its present, and in so doing, more adeptly navigate its future.

5. The role for psychiatry

Gender politics have become a topic of popular discourse. For young persons seeking care for distress related to issues of gender incongruence, the leading gender-affirmative model is often equated with that of medical treatment. As current clinical frameworks rely on a mental health diagnosis of gender dysphoria to access care, it is no wonder that medical colleagues, courts and the media look towards Psychiatry for input. Until 2019, Psychiatry piggy-backed off the medical model; it has since been cornered into either developing a voice, or having words put in its mouth.

The statement takes a brave first step in voicing psychiatric perspectives and specifying a consultation-liaison role for psychiatrists, beyond that of gatekeeping. Trans issues are inherently complex, and adolescents present at a particularly vulnerable time – when they are developing their sense of self, with gender identity being a fluid component of this. Amongst physicians, psychiatrists are arguably unique in their expertise of navigating multi-disciplinary team dynamics and advocating for patients with complex needs. They are trained to recognise abnormal behaviours in patients (Pilowsky, 1978), colleagues (Singh et al., 1981), and their own selves, and to take a liaison role in navigating complex system dynamics to advocate for consumer needs (Lipowski, 1971). Hence they are perhaps best placed to mediate between a diverse range of perspectives in facilitating the development of best-practice care.

The statement provides backing for psychiatrists to define their own expertise and broaden their role so that they may provide holistic bio-psychosocial care to trans persons. The liaison component is particularly important – as relative experts in both relationship dynamics and key bearers of the history of sexual health diagnoses, it is up to psychiatrists to share reflective lessons with medical colleagues in this space. It has perhaps taken this long for Psychiatry to speak up because it has traversed similar waters and is familiar with the treacheries of pioneering treatment in a field with scant evidence. The stigma of conversion therapy continues to haunt Psychiatry today, and the earlier defences it erected against anti-psychiatrists may yet be obscuring its vision for the future. It is important to acknowledge these historical sources of bias so that we may move beyond them.

Finally, while legal frameworks of care are beyond the scope of this piece, it is worth noting that mental health practitioners may be dissuaded by perceived legal barriers to care (Parkinson and Morris, 2021) particularly if they have strong personal moral and/or religious beliefs guiding their practice (Ryan and Callaghan, 2022). The statement broadly details what clinically appropriate practice entails and undoubtedly broadens the role of the psychiatrist beyond that of a gatekeeper. Importantly, legal frameworks in the treatment of gender dysphoria do evolve in tandem with advances in clinical understanding and practice (Ouliaris, 2021). Psychiatrists who choose to practice in this area have the opportunity not only to shape clinical practice, but also legal frameworks of care.

6. Conclusion

In this historically polarised space, it is far too easy for the Psychiatric model (as per the statement) to be deemed adversarial to the Medical model (as per the Guidelines), and it is imperative that we do not fall trap to this narrative. Instead, a collaborative approach that focuses on the common goal of caring for a vulnerable population with complex care needs is key (Lipowski, 1971; Rhodes and Strain, 2000). As specialists in team dynamics and biopsychosocial approaches to care, it is essential that psychiatrists continue to develop their voice and share the burden of pioneering care in this space with medical colleagues.

CRediT author statement

The author confirms sole responsibility for this work.

Declarations of Competing Interests

None.

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