Outside the Binary: Diagnostic Grey Areas in Gender Dysphoria

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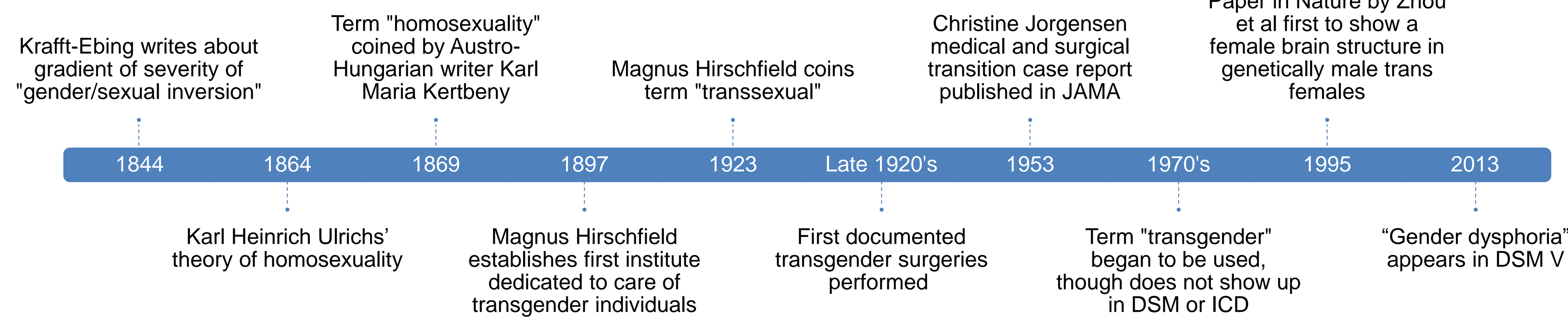
Background - History

Medical conceptualizations of what we would now consider gender dysphoria or transgender identity first appeared in the 19th century with the proliferation of the natural sciences.



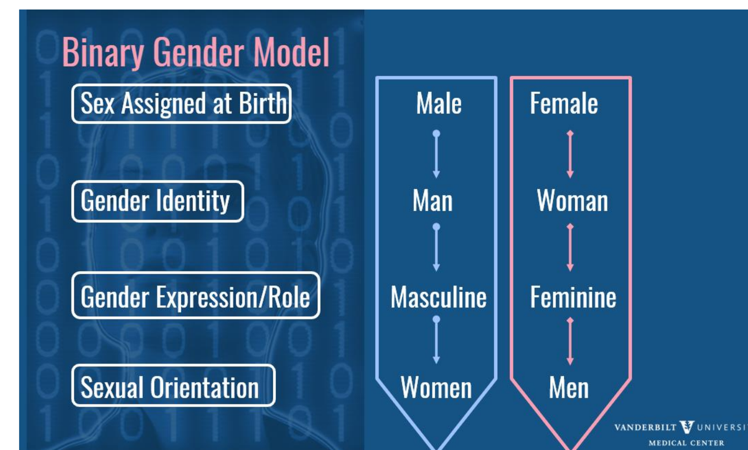
Psychiatric diagnostic references to transgender experiences first appeared in the DSM II and definitions have evolved with each edition.

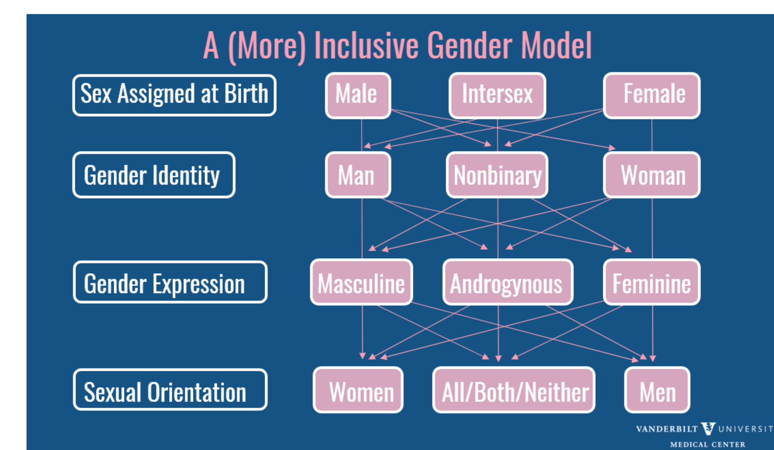
DSM-III – classified in section on Psychosexual Disorders
- Transsexualism
- Gender Identity Disorder of Childhood (GIDC)

DSM-IV (TR) – classified in section on Sexual and Gender Identity Disorders
- Gender Identity Disorder (sexual orientation specifiers)

DSM-V – Gender Dysphoria in distinct section
- Gender Dysphoria (sexual orientation specifier removed)

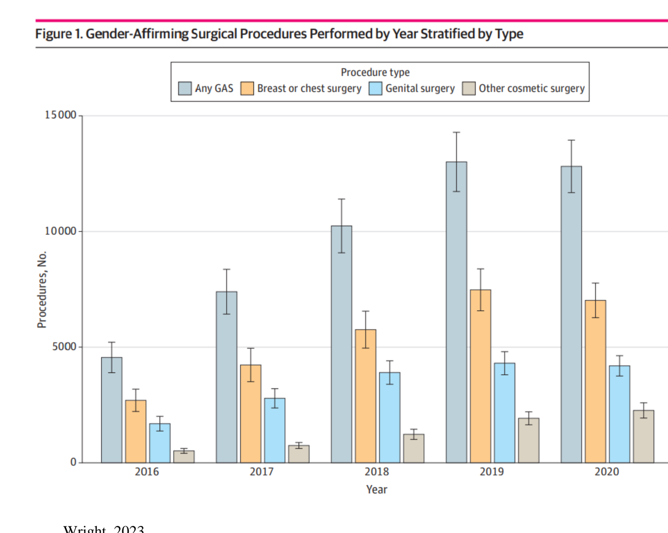
Costume party at the Institute for Sexual Research in Berlin. Magnus Hirschfeld (*in glasses*) holds hands with his partner, Karl Giese (*center*). Credit: Magnus-Hirschfeld-Gesellschaft e.V., Berlin



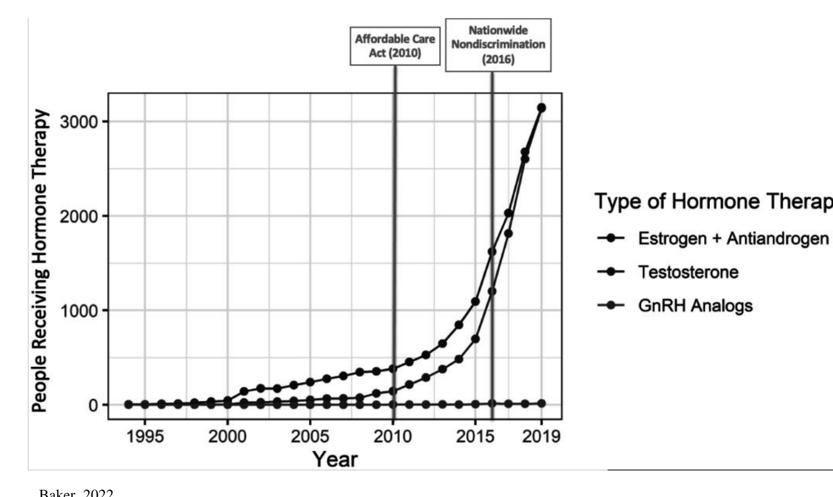


Background – Current Practice

The World Professional Association for Transgender Health (WPATH) Standards of Care recommends patient considering medical or surgical interventions for gender affirming care be evaluated for mental health concerns, and current standard practice typically includes 1-2 mental health professionals to attest to a diagnosis of gender dysphoria prior to intervention



Rising utilization of gender affirming care (medical and surgical) means rising rates of referrals for psychiatric evaluations



Case Series

History	Components of identity	Exploration of dysphoria:	Social transition goals:	Diagnostic assessment:	Outcome
35 yo h/o MDD, HIV presenting for pre-surgical evaluation, seeking phallus-sparing vaginoplasty + testosterone therapy	• Gender assigned at birth: Male • Gender identity: non-binary • Pronouns: "he/him" • Sexual orientation: gay	• Felt like being in the wrong body since childhood • Dislike of his penis, disdain of being the insertive partner • Preference as receptive partner, interest in how it feels to have a vagina • Desire for more "toned" body	• No desire for social transition as female because "it wouldn't be much different" • Living in a small town hindered ability to "live freely"	Felt not to clearly meet criteria for gender dysphoria at this time given ill-defined goals, which may have been complicated by social factors	• Continued follow up with PCP with GAC expertise • Continued to explore gender in therapy • Clarified gender identity and goals – started GAC with estrogen therapy and testosterone blockers
64 yo h/o HTN, HLD, DMII, chronic pain, presenting for gender dysphoria vs body dysmorphia evaluation, seeking vaginoplasty	• Gender assigned at birth: Male • Gender identity: male • Pronouns: "he/him" • Sexual orientation: unclear – denies interest in sexual relationships with others	• Strong desire to "get rid" of his penis due to belief that it was "useless" • Experienced gender euphoria wearing female underwear • Not interested in female secondary sex characteristics • No dysphoria around male secondary sex characteristics • Distress intense enough that patient had considered self-castration	• No desire for social transition as female • Would like to still identity and be perceived as male	Felt not to clearly meet criteria for gender dysphoria at this time as desire to be rid of penis driven by functional limitations from ED rather than dysphoria, lack of desire for other female characteristics or be perceived as female	Lost to follow up

Conclusions

While operating in current landscape, we can continue to:

Considerations from cases:
- Gender conceptualization can evolve over time and can be influenced by social context
- Patients can experience clinically significant distress around sex characteristics without meeting criteria for gender dysphoria, or *any* psychiatric diagnoses from DSM-V-TR

Differential diagnosis to consider:
- Body dysmorphia
- Paraphilias:
- Transvestic fetishism
- Other Specified Paraphilic Disorder

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