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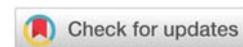
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Research Article

Etiological factors and comorbidities associated with the “Gender Dysphoria”: Definition, clinical contexts, differential diagnosis and clinical treatments

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Abstract

Purpose: Starting from the concept of “gender dysphoria”, this research aims to find out if there is a correlation between GD and personality disorders.

Methods: Having selected the population sample of 255 subjects, having the requirements of age between 18 and 72 years and a declaration of perceived transsexuality, in transition or final, and domiciled in Italy for at least 5 years regardless of citizenship and nationality, it was decided to proceed with the clinical interview and administration of the PICI-1 (TA). It was considered unnecessary to administer the MMPI-II, as a previous study by the same author has demonstrated the effectiveness and efficiency of the test.

Results: Using the PICI-1, the following data emerged during the clinical interview: 1) The female population sample (F→M) is smaller and more difficult to find; moreover, the perception of one’s transsexuality, as well as the desire to change one’s gender occurs in 100% (40/40) of cases before the age of 36. 2) The sample of the male population (M→F) is more consistent and reports 84.13% (179/211) perceived or acted on the change before the age of 36. 3) The total population sample of 255 subjects had 97.5% (250/255) at least 5 dysfunctional personality traits among the disorders of PICI-1 cluster B (TA), i.e. borderline, histrionic, narcissistic, antisocial, sadistic and masochistic, while 56.55% (145/255) had at least 3 dysfunctional traits among the disorders of PICI-1 cluster A (TA), i.e. anxious, obsessive, depressed, phobic and somatic.

Conclusions: The research carried out gave further evidence that 97.5% (250/255) at least 5 dysfunctional personality traits among the disorders of PICI-1 cluster B (TA), i.e. borderline, histrionic, narcissistic, antisocial, sadistic and masochistic, while 56.55% (145/255) had at least 3 dysfunctional traits among the disorders of PICI-1 cluster A (TA), i.e. anxious, obsessive, depressed, phobic and somatic. However, in the future, studies are expected that subject children between the ages of 2 and 6 who already have the first dysphoric symptomatology to MRI and electroencephalogram every six months, following them up to adulthood, to understand if the anomalies represented are already present or not, and from that point begin to reason about the subject’s sexual evolution. Furthermore, a series of researches focused on a relevant and significant statistical sample is hoped, to be able to reconstruct the genesis of dysphoria and understand the exact incidence of serious psychopathological forms (including indirectly related disorders, such as paraphilias and different orientations sexual) and whether these are etiological factors, contributing factors or consequences of the primary condition, also and above all concerning the neurobiological and endocrinological clinical profiles.

Contents of the manuscript

Definition and clinical contexts

“Gender dysphoria” is the new definition of “gender identity disorder” contained in previous versions of DSM-V, the diagnostic and statistical manual of mental disorders, intended as a strong and persistent identification with the opposite sex, associated with anxiety, depression, irritability, malaise, a sense of non-belonging and an intense desire to live as a gender other than the sex assigned to birth. People with gender dysphoria feel victims of a biological accident and therefore live their condition as if they were cruelly imprisoned in a body incompatible with their subjective gender identity. “Sex” therefore refers to a person’s biological and physiological properties, while “gender” refers to the personal psychological identification of the binary gender for men and women, to the social roles assigned and to social and cultural learning processes. On this assumption, gender dysphoria is independent of sexual orientation and should not be confused with it: transsexual women and men can have any sexual and sentimental orientation, for example they can be heterosexual, homosexual, or bisexual. The result of an inconsistency between the psychological gender and biological sex determines in the transsexual individual a continuous search for similarity to the preferred sex and the strong identification with the opposite gender in combination with the prevalence, in most cultures, of a system of binary gender, as well as poor social acceptance, causes serious psychological stress in transsexuals. Psychiatric disorders appear high in this patient population when compared with the general population, with a spike in anxiety and mood disorders. However, transsexualism, according to the modern DSM-V, is not directly associated with psychiatric disorders, but it is assumed that these problems are the result of strong stressful social experiences and therefore transsexuals who suffer from their condition can also receive the diagnosis of “Gender dysphoria”. Being transsexual is not an automatic condition for assigning a dysphoric diagnosis [1].

Differential diagnosis and clinical treatments

In the past, drawing on psychoanalytic theories, it was believed that gender dysphoria was associated with personality disorders, and that it was often the consequence of such serious disorders, due to a dysfunctional attachment [2], psychophysical violence in childhood [1,3] and a genetic-neurobiological predisposition. Therefore, personality disorders were considered an etiological factor and not a consequence of the disorder itself [1,4].

In particular, Sperber [5] stated that colors such as showing a Dysphoria of Gender presented a Borderline type personality, while - more recently - Chiland [6] considered transsexualism as a Narcissistic Disorder with a profound disturbance of self-constitution. Hoening, et al. [7], however claimed that 70% of transsexuals showed a psychiatric diagnosis, although only 13% were frankly psychotic and Meyer [8] and Steiner [9] found Narcissistic, Borderline and Antisocial Personalities, with some schizoid traits, or structured disorders such as depression, anxiety, suicidal tendencies, and homicidal impulses. Gosselin and Wilson [10] also found evidence of introversion and high

neuroticism compared to males without dysphoria. Dèttore [11] notes, however, that the tendency to show serious psychopathological forms is greater in transsexual males than women, despite contrary literature, signed by Lothstein [12,13]. Bockting and Coleman [14]-which detected important phobic, obsessive, anxious, depressive and dysmorphic traits [15]- and Hartmann [16]-which revealed important psychopathological aspects and a considerable narcissistic dysregulation.

Lev [17], distancing himself from this type of literature, argues that research on gender variance and transsexuals was conducted on people who go to specialized clinical centers, and therefore they were more suffering subjects and therefore more likely to have serious psychopathologies, connected or secondary to their primary condition. The author also maintains that easy diagnostic labeling speeds up the pathologization process of dysphoria which instead must simply be considered a normal healthy variant of the expression of human identity, without any pathological component.

This position, although extreme and disavowed by neurobiological results [1], is supported in part by a more indulgent literature on the transsexual phenomenon, which therefore adheres to a milder interpretation of clinical morbidity. Starting from the second half of the last century, Holtzman, et al. [18] argued that subjects with dysphoria were generally well organized and with intellectually adequate thought processes. Bentler and Prince did not observe important differences on the neurotic or psychotic scales between transsexuals and control subjects, while Cole et al., more recently, had shown that less than 10% of their statistical sample (approximately 400 people) showed previous mental disorders. Carroll [19], Menichini [20], Haraldsen [21], Miach [22], Cohen-Kettins and van Goozen [23,24] stated that transgender people did not necessarily show higher mental disorder levels than the non-clinical population [25]; however, the statistical data in many of these searches were not significant, effectively invalidating the result obtained. Another figure that appears truly relevant is offered by the research by Courvant and Cooke-Daniels [26], which connect the psychiatric symptomatology of subjects with dysphoria with the high psycho-social stress to which they are subjected (with strong prejudice and public condemnation) and with the results of one or more post-traumatic stress events in childhood, the consequence of physical and / or psychological sexual violence. [27-30] For Mathy and Marshall, suicidal risk [31] is extremely frequent [32], as well as eating disorders, for Hepp [33] and drug abuse and spirits, for Day [34].

On the basis of these results, the writer used the PICI-1 (TA) [35-37], during the clinical interview, in a population sample of 255 subjects, having the requirements of age between 18 and 72 and a declaration of perceived transsexuality, in transition or definitive, and domiciled in Italy for at least 5 years regardless of citizenship and nationality, obtaining the following results:

AGE	Perceived Transsexualism (cluster A)			Transsexualism in transition (cluster B)			Definitive Transsexualism (cluster C)		
	18-36	37-54	55-72	18-36	37-54	55-72	18-36	37-54	55-72
M->F	21	6	0	86	16	0	72	10	0
F->M	12	0	0	16	4	0	12	0	0



The selected setting, taking into account the protracted pandemic period (already in progress since the beginning of the present research), is the online platform via Skype and Videocall Whatsapp, both for the clinical interview and for the administration.

All participants were guaranteed anonymity.

The present research work was carried out from March 2020 to December 2020.

Using the PICI-1, unlike the MMPI-II, the following data emerged during the clinical interview:

- 1) The female population sample (F→M) is smaller and more difficult to find; moreover, the perception of one's transsexuality, as well as the desire to change one's gender occurs in 100% (40/40) of cases before the age of 36.
- 2) The sample of the male population (M→F) is more consistent and reports 84.13% (179/211) perceived or acted on the change before the age of 36.
- 3) The total population sample of 255 subjects had 97.5% (250/255) at least 5 dysfunctional personality traits among the disorders of PICI-1 cluster B (TA), i.e. borderline, histrionic, narcissistic, antisocial, sadistic and masochistic, while 56.55% (145/255) had at least 3 dysfunctional traits among the disorders of PICI-1 cluster A (TA), i.e. anxious, obsessive, depressed, phobic and somatic.

The main limitations of the research are two:

- a) The use of a population sample that is not sufficiently representative; however, the data obtained are very interesting and deserve to be further investigated with a larger population sample.
- b) The PICI-1 is not yet standardised psychometric instruments but are proposed, despite the excellent results obtained and already published in international scientific journals [35-37].

This research has no financial backer and does not present any conflicts of interest.

Conclusions

Although the discomfort regarding one's gender identity can take various forms and different intensities, the etiology of Gender Dysphoria is still uncertain and the many theories on the subject highlight its multifactorial: genetics and neurobiology [1,38,39], hormonal [1,40,41], psychological [2,3,42].

It is therefore clear that, from the studies conducted so far, there are substantial elements to be able to assume that the neuroanatomophysiology of a dysphoric is different from a non-dysphoric subject, but the studies have not yet clarified if it is these differences that cause the dysphoric condition or if the dysphoric condition shapes the anatomy and physiology of the

brain by inducing the changes. It is logical and consequential to think, however, that the first solution is the most acceptable, and therefore certain anatomical-physiological alterations cause the subject to perceive his identity status in a dysphoric way [1,43].

In the future, studies are expected that subject children between the ages of 2 and 6 who already have the first dysphoric symptomatology to MRI and electroencephalogram every six months, following them up to adulthood, to understand if the anomalies represented are already present or not, and from that point begin to reason about the subject's sexual evolution. Furthermore, a series of researches focused on a relevant and significant statistical sample is hoped, to be able to reconstruct the genesis of dysphoria and understand the exact incidence of serious psychopathological forms (including indirectly related disorders, such as paraphilias and different orientations sexual) [44-48] and whether these are etiological factors, contributing factors or consequences of the primary condition, also and above all concerning the neurobiological and endocrinological clinical profiles.

Despite the full desire to derubricate transsexualism, by the scientific community, the author of this work is strongly skeptical, taking into account the neurobiological results published so far, like homosexuality and bisexuality, and clinical results regarding comorbidity profiles with depressive [49], anxious [50], phobic, obsessive [51], post-traumatic [52], food [53], psychotic [54,55] and personality disorders (with a higher incidence on borderline disorder [56], narcissistic and histrionic) [38,57]. A very controversial and not statistically relevant and significant case was recorded in 2014, in which the patient appears to have undergone a trend conversion, from dysphoric to heterosexual male, following an epileptic state [39]. This circumstance seems to reinforce the neurobiological and endocrinological hypothesis of dysphoria, as one of the primary causes [58-60].

The research carried out, albeit with an unrepresentative sample, gave further evidence that 97.5% (250/255) at least 5 dysfunctional personality traits among the disorders of PICI-1 cluster B (TA), i.e. borderline, histrionic, narcissistic, antisocial, sadistic and masochistic, while 56.55% (145/255) had at least 3 dysfunctional traits among the disorders of PICI-1 cluster A (TA), i.e. anxious, obsessive, depressed, phobic and somatic.

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