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Dissociative symptoms in individuals with gender dysphoria: Is the elevated prevalence real?

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ABSTRACT

This study evaluated dissociative symptomatology, childhood trauma and body uneasiness in 118 individuals with gender dysphoria, also evaluating dissociative symptoms in follow-up assessments after sex reassignment procedures were performed. We used both clinical interviews (Dissociative Disorders Interview Schedule) and self-reported scales (Dissociative Experiences Scale). A dissociative disorder of any kind seemed to be greatly prevalent (29.6%). Moreover, individuals with gender dysphoria had a high prevalence of lifetime major depressive episode (45.8%), suicide attempts (21.2%) and childhood trauma (45.8%), and all these conditions were more frequent in patients who fulfilled diagnostic criteria for any kind of dissociative disorder. Finally, when treated, patients reported lower dissociative symptoms. Results confirmed previous research about distress in gender dysphoria and improved mental health due to sex reassignment procedures. However, it resulted to be difficult to ascertain dissociation in the context of gender dysphoria, because of the similarities between the two conditions and the possible limited application of clinical instruments which do not provide an adequate differential diagnosis. Therefore, because the body uneasiness is common to dissociative experiences and gender dysphoria, the question is whether dissociation is to be seen not as an expression of pathological dissociative experiences but as a genuine feature of gender dysphoria.

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1. Introduction

In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), people whose gender at birth is contrary to the one they identify with are diagnosed with gender dysphoria (GD). This diagnosis is a revision of DSM-IV criteria for Gender Identity Disorder (APA, 2000) and is intended to better characterize the experiences and discomfort of GD patients (www.dsm5.org). Most of the countries involved in the care of persons with GD have accepted the standards of care (SOC) developed by the World Professional Association for Transgender Health (WPATH) which are based on a somatic and psychiatric assessment before the initiation of a hormone-surgical treatment (Coleman et al., 2012). The psychiatric evaluation consists of verifying the following main criteria: to accurately diagnose the gender dysphoria (DSM criteria fulfilled); to verify the persistence of the request; to diagnose/treat any comorbid psychiatric conditions. It is important to note that gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the

condition (Gómez-Gil et al., 2009; Colizzi et al., 2013). In accordance with the WPATH SOC (Coleman et al., 2012), the two major goals of cross-sex hormonal therapy are as follows: (1) to reduce endogenous hormone levels and, thereby, the secondary sex characteristics of the individual's biological (genetic) sex and assigned gender; and (2) to replace endogenous sex hormone levels with those of the reassigned sex by using the principles of hormone replacement treatment of hypogonadal patients (Hembree et al., 2009). Sex reassignment surgery is often the last and the most considered step in the treatment process for GD. For many patients, relief from GD cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity (Coleman et al., 2012).

The origins of gender dysphoria are still largely unclear (Cohen-Kettenis and Gooren, 1999). Various studies investigated concurrent psychopathology in GD, with contradictory findings. Some research reported a high prevalence of psychiatric comorbidity, including affective disorders, anxiety disorders, substance-related disorders and personality disorders (à Campo et al., 2003; Hepp et al., 2005; Heylens et al., 2014). Moreover, in some cases also a high prevalence of psychotic disorders (à Campo et al., 2003; Hepp et al., 2005), dissociative disorders (à Campo et al., 2003) and somatoform disorders (Hepp et al., 2005) was reported. Instead, other studies indicated that the majority of GD patients had no

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psychiatric comorbidity (Hoshiai et al., 2010; Gómez-Gil et al., 2012; Fisher et al., 2013; Colizzi et al., 2014). Among these studies showing a low level of psychopathology, affective disorders, anxiety disorders and adjustment disorders were the most common comorbidities (Hoshiai et al., 2010; Gómez-Gil et al., 2012; Fisher et al., 2013; Colizzi et al., 2014).

Attention has been repeatedly drawn in the scientific literature to clinical similarities between GD experiences and dissociative disorders (Coons, 1984; Putnam, 1989; Modestin and Ebner, 1995; Steinberg, 1995). Patients with dissociative identity disorder (DID) frequently experience disturbances in their sexual identity, and many patients with DID have sexually oriented changes in alter-personalities, so that special significance is to be attributed to this disorder with respect to the differential diagnosis of GD. In the last decades a number of case reports of GD patients with features of a DID draw attention to this problem (Lief et al., 1962; Money and Primrose, 1968; Weitzmann et al., 1970; Money, 1974). However, only two studies have recently investigated the occurrence of dissociative symptoms in GD patients by disorder-specific assessment instruments, reporting higher dissociative symptoms than control subjects (Kersting et al., 2003; Shiah et al., 2004). Moreover, in the first study of 41 GD patients who performed a self-reported scale about dissociative symptoms only six patients were also evaluated by a clinical interview (Kersting et al., 2003). Instead the second research studied only a small group of 18 Male to Female (MtF) subjects by self-reported evaluations (Shiah et al., 2004).

In the past few decades follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on GD patients' subjective well-being. In contrast, the role of the cross-sex hormonal treatment in the well-being of GD patients has been the subject of very little investigation (Murad et al., 2011; Coleman et al., 2012). A meta-analysis identified only five studies that specifically examined the impact of hormonal therapy on GD patients' well-being, focusing on transformation satisfaction, psychological profile, cognitive function and emotional repercussions (Murad et al., 2011). More recently other studies revealed that hormonal therapy is positively associated with quality of life (Gorin-Lazard et al., 2012; Motmans et al., 2012) and mental health (Gómez-Gil et al., 2012; Colizzi et al., 2014). Instead, no research has previously investigated the possible effects of hormone therapy as well as sex reassignment surgery on dissociative symptoms in gender dysphoria.

To our knowledge, GD patients' dissociative disorders comorbidity (qualitative data) and self-reported dissociative symptoms (quantitative data) in the same large sample have not been previously evaluated. Similarly, differences in dissociative symptoms related to hormonal treatment and sex reassignment surgery in a longitudinal study have not been previously reported.

As part of a larger research on psychobiological and mental distress in GD patients attending a Gender Identity Unit (Colizzi et al., 2013, 2014), using diagnostic clinical interviews and self-reported scales, the aims of this study were to assess the following: (1) dissociative disorders/symptoms; (2) other dissociative disorder related conditions, including childhood trauma history (abuse and neglect) and body image related distress; (3) dissociative symptoms in follow-up assessments after the beginning of the cross-sex hormone treatment and after sex reassignment surgery. On the basis of our clinical experience and of previous studies, we hypothesized a high rate of dissociative symptomatology, dissociative disorder related conditions and childhood trauma in GD individuals. Moreover, we suggested a higher prevalence of dissociative disorder related conditions, trauma and body image related distress in GD patients who fulfill diagnostic criteria for a dissociative disorder. Finally, we suggested a significant reduction of

dissociative symptoms in GD patients after the beginning of hormonal treatment as well as after sex reassignment surgery.

2. Methods

2.1. Study design and sample

This study incorporated a longitudinal design and was conducted at the Gender Identity Unit of the Bari University Psychiatric Department. A consecutive series of 118 patients was evaluated for gender dysphoria from 2008 to 2012. The inclusion/exclusion criteria have been described previously (Colizzi et al., 2014); they were verified during a period of about 24 weeks (enrolment period). The study was proposed to each consecutive eligible subject by the care team during a routine visit. All the 118 individuals (82 MtF; 36 Female to Male, FtM) agreed to voluntarily participate in the study and provided written informed consent.

All the patients in this study received hormonal therapy after the enrollment period. Hormonal treatment for MtF patients consisted of transdermal estradiol gel (1.84 ± 0.49 mg/day), in association with oral cyproterone acetate (100 mg/day). The androgen administration schedule in FtM patients consisted of testosterone administered as intramuscular injections of a testosterone esters depot (250 mg every 26.31 ± 2.68 days).

While the entire sample of this study received hormone therapy, only 22 subjects (19%) received also sex reassignment surgery [16 MtF (20%), six FtM (17%)]. The relatively small numbers of patients who underwent sex reassignment surgery was prevalently due to (1) limited number of surgical units providing these surgical services at the Bari University. Other less common reasons for not receiving sex reassignment surgery included (2) specialist medical/psychological report not yet completed ($N=23$, 19%); (3) patient's refusal of surgical treatment ($N=16$, 14%); (4) waiting for legal authorization ($N=11$, 9%); (5) contraindication to surgery ($N=1$, 1%). Of the 16 MtF patients, all individuals received additive mastoplasty while 69% ($N=11$) received also vaginoplasty surgery. Of the six FtM patients, all individuals received reductive mastoplasty while only 33% ($N=2$) received also phalloplasty surgery.

Only nine GD patients (8%) [seven MtF (9%) and two FtM (6%)] passed in their desired gender role without hormonal treatment; all the other GD patients required hormonal treatment before undertaking gender role reassignment. During the study period all the individuals underwent a "real-life experience", living full time and continually in the desired gender role, including dressing and interacting socially as the desired gender. The unit has adopted the standards of care guidelines of the WPATH (Coleman et al., 2012).

The following data were collected: age, gender identity (MtF, FtM), education level (years of study), partnership status (not single/single), living arrangement (partner or parents/alone), employment status (no/yes) and sexual orientation (same biological sex: MtF patients androphilic, FtM patients gynephilic; opposite biological sex: MtF patients gynephilic, FtM patients androphilic).

2.2. Clinical assessment instruments

2.2.1. Dissociative Disorders Interview Schedule (DDIS)

In order to investigate dissociative disorders in the sample, we used the DDIS schedule. The DDIS is a structured interview consisting of 132 items which investigate dissociative disorders/symptoms, other related conditions, previous/current psychopharmacological treatments, suicide attempts and childhood trauma history (Ross et al., 1989). The DDIS has an overall inter-rater reliability of 0.68 (κ), a sensitivity of 90% and a specificity of 100% for the diagnosis of dissociative identity disorder (Ross et al., 1989; Saxe et al., 1993). The DDIS was performed during the enrollment period.

2.2.2. Body Uneasiness Test (BUT)

In order to investigate body image related distress, we used the Body Uneasiness Test (BUT). The BUT is a self-administered questionnaire specifically designed to explore several areas in clinical and non-clinical populations: body shape and/or weight dissatisfaction, avoidance, compulsive control behaviors, feelings of detachment and estrangement toward one's own body, and specific worries about particular body parts, shapes or functions (Cuzzolaro et al., 2006). The BUT consists of two parts. BUT-A consists of 34 items scored on a six-point Likert-type scale (from 0 to 5); the scores are combined in a Global Severity Index and in five subscales: weight phobia, body image concerns, avoidance, compulsive self-monitoring, and depersonalization. BUT-B has 37 items that look at specific worries about particular body parts or functions; the number of items from BUT-B with scores of 1 or higher is summed in a global measure, the Positive Symptoms Total, to indicate overall dislike of body parts. Higher scores indicated greater body uneasiness. The levels of Cronbach's alpha coefficients range between 0.64 and 0.89 (Cuzzolaro et al., 2006), therefore, internal consistency of BUT appears to be good (Thompson et al., 1990). The BUT was performed during the enrollment period.

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