

The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets

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ABSTRACT

Background: Over the past decade, the number of people referred to gender identity clinics has rapidly increased. This raises several questions, especially concerning the frequency of performing gender-affirming treatments with irreversible effects and regret from such interventions.

Aim: To study the current prevalence of gender dysphoria, how frequently gender-affirming treatments are performed, and the number of people experiencing regret of this treatment.

Methods: The medical files of all people who attended our gender identity clinic from 1972 to 2015 were reviewed retrospectively.

Outcomes: The number of (and change in) people who applied for transgender health care, the percentage of people starting with gender-affirming hormonal treatment (HT), the estimated prevalence of transgender people receiving gender-affirming treatment, the percentage of people who underwent gonadectomy, and the percentage of people who regretted gonadectomy, specified separately for each year.

Results: 6,793 people (4,432 birth-assigned male, 2,361 birth-assigned female) visited our gender identity clinic from 1972 through 2015. The number of people assessed per year increased 20-fold from 34 in 1980 to 686 in 2015. The estimated prevalence in the Netherlands in 2015 was 1:3,800 for men (transwomen) and 1:5,200 for women (transmen). The percentage of people who started HT within 5 years after the 1st visit decreased over time, with almost 90% in 1980 to 65% in 2010. The percentage of people who underwent gonadectomy within 5 years after starting HT remained stable over time (74.7% of transwomen and 83.8% of transmen). Only 0.6% of transwomen and 0.3% of transmen who underwent gonadectomy were identified as experiencing regret.

Clinical Implications: Because the transgender population is growing, a larger availability of transgender health care is needed. Other health care providers should familiarize themselves with transgender health care, because HT can influence diseases and interact with medication. Because not all people apply for the classic treatment approach, special attention should be given to those who choose less common forms of treatment.

Strengths and Limitations: This study was performed in the largest Dutch gender identity clinic, which treats more than 95% of the transgender population in the Netherlands. Because of the retrospective design, some data could be missing.

Conclusion: The number of people with gender identity issues seeking professional help increased dramatically in recent decades. The percentage of people who regretted gonadectomy remained small and did not show a tendency to increase. **Wierpjes CM, Nota NM, de Blok CJM, et al. The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets. J Sex Med 2018;XX:XXX–XXX.**

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INTRODUCTION

Gender dysphoria (GD) refers to the distress related to a marked incongruence between one's assigned sex at birth and the experienced gender later in life.¹ In this study, we define transwomen as having a male birth assignment and transmen as having a female birth assignment who might receive medical treatment to adapt their physical characteristics to their experienced gender. This treatment can include puberty suppression (PS), gender-affirming hormonal treatment (HT), and gender-affirming surgery.

It has been widely observed that the transgender population is growing and broadening.^{2,3} This increase in the transgender population raises several questions, especially concerning the frequency of performing gender-affirming treatments with irreversible effects and regret from such interventions.

There are no reliable estimations of the current prevalence of transgender people who actually have received gender-affirming treatment (including HT), because most recent studies are based on questionnaires^{4,5} or data about gender-affirming surgery only.^{6,7} In most countries transgender care is performed by multiple health care providers (eg, university clinics or general practitioners), which makes it difficult to provide these numbers. In contrast, in the Netherlands, more than 95% of the transgender population has received treatment in only 1 center, the gender identity clinic at the VU University Medical Center (VUmc; Amsterdam, the Netherlands), currently known as the Center of Expertise on Gender Dysphoria.^{8–10} This center started treating adults in 1972. From 1987 to 2002, children and adolescents were seen by a mental health specialist in the Utrecht University Medical Center (Utrecht, the Netherlands). After they were considered eligible, they could receive medical treatment in the VUmc, which consisted of PS (usually by gonadotropin-releasing hormone analogues), followed by HT (see Kreukels and Cohen-Kettenis¹¹ for the treatment protocol for adolescents diagnosed with GD). After 2002, the Utrecht clinic stopped seeing adolescents and the diagnostics were performed in the VUmc. Adult people are referred to a psychologist or psychiatrist for the diagnostic phase after an initial screening. People diagnosed with GD can start HT if they are considered eligible. HT consists of testosterone for transmen and estrogens, often combined with antiandrogens, for transwomen. In the 1st year of HT, checkups are performed every 3 months. After a minimum of 12 months of HT, gender-affirming surgery can be performed, including mastectomy and hysterectomy with oophorectomy in transmen and breast augmentation and vaginoplasty (including orchiectomy) in transwomen. After gonadectomy (oophorectomy or orchiectomy), people are usually seen every 1 to 2 years for clinical follow-up.

In the present study we included the complete population seen at the gender identity clinic of the VUmc from 1972 through December 2015 to assess the current prevalence of transgender people who received medical treatment, the frequency of specific medical treatments performed, and the numbers of people who

received HT in line with their sex assigned at birth because they regretted undergoing gonadectomy.

METHODS

Study Design and Patient Selection

After approval of the local ethics committee, a retrospective medical record review was performed to identify all people seen in our gender identity clinic from 1972 until December 2015. Data were collected from the hospital registries of the VUmc. The total study population was defined as people who had been diagnosed with 1 of the following *International Classification of Diseases* diagnoses: 302.5 (transsexualism), 302.6 (gender identity disorder not otherwise specified), or 302.85 (gender identity disorder in adolescent or adult) according to the 9th edition or F64 (gender identity disorders) according to the 10th edition.¹² In addition, the administrative employees of our gender identity clinic registered everyone who was referred to our gender identity clinic since the early 1970s. People reported on this list also were included in the study population. Some people of this study population have been described in previous studies.^{9,13–18} People were excluded from the study if they had been registered at our gender identity clinic but had actually never visited the clinic or if they had presented with other complaints than gender identity issues. Because of the retrospective design and the large study population, necessity for informed consent was waived by our local ethics committee.

Hospital Registries

The hospital registries store clinical data obtained during regular patient care performed in our center, including medical diagnoses (since 1985), medication prescriptions (since 2000), surgical interventions (since 2006), laboratory test results (since 2004), radiology results (since 1993), and visit dates (since 2007). The 1st visit was defined as the 1st appointment with the psychologist, psychiatrist, pediatrician, endocrinologist, or gynecologist for health care related to gender identity.

Clinical Data Collection

Not all data were available from the hospital registries, particularly older data or surgeries performed in other centers. To generate the most reliable results, the medical records of all people who composed the study population were checked. All people were classified as transwomen or transmen (based on the sex assigned at birth), and date of birth and death were noted. The following categories were included: the individual was in the diagnostic stage, the individual did not start HT, or the individual was on HT. Start of HT was defined as the 1st date gender-affirming hormones were prescribed by a physician in our gender identity clinic after a confirmed GD diagnosis, irrespective of previous gender-affirming hormone use. Of the people who started HT, baseline and follow-up data, including

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