Editorial

Gender variant patients with psychiatric illnesses: Health care barriers, treatment challenges and ethical dilemmas

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Gender variance is an umbrella term describing behaviours, interests, appearance, expression, or an identity of persons who do not conform to culturally defined norms expected of their natal gender [1]. There are additional experiences of discomfort with their biological sex, primary and secondary sex characteristics and social gender roles. Resultantly, they experience various levels of distress, from depressive moods, anxiety, low self-esteem, lack of confidence, intra-psychical conflicts to suicidal ideation and psychotic breakdowns. The last decade has witnessed a significant rise in gender variant persons looking for care at gender clinics across the world. The LGBTQ+ population is also referred to as gender variant persons. Increasing psycho-social awareness, socio-political initiatives in support, social media empowerment, globalisation through the information world, greater receptivity by the family members and peers with regard to one's gender identity crisis and media appearances of LGBTQ+ individuals have encouraged a lot of individuals to come out about their sexuality.

In accordance, some individuals may choose to undergo 'transition' in order to comply with the gender they (psycho-socially) identify with. Transitioning is a process of changing one's gender presentation in order to align it with their internal sense of gender identity. Transitioning may happen *socially,* which may involve using a different name, pronouns, transformation of physical appearance, use of suitable bathrooms, and taking social roles of the affirmed gender. However, transitioning may also be *medical* where the individual may choose to undergo hormonal and medical surgeries. More transitions happen from male to female (MTF) than from female to male (FTM)- transgenders are MTF transsexuals [2].

The challenge of accessing mental health care for the LGBTQ+ community has remained as a doubled edged sword given their non-conforming gender identities and stigma towards mental health. The incidence of mental health problems among the LGBTQ+ is noted to be 2-3 folds higher than their heterosexual counterparts. Within the gender variance, there are some sub-populations that face greater challenges than the other. Lesbians and transgender communities are said to face 2-fold greater risk for mental health problems within the community [3]. Some of the common mental health problems seen among the LGBTQ+ persons are: depression, anxiety, suicidality, post-traumatic stress disorder, bipolar disorder, schizophrenia, obsessive compulsive disorder, panic disorder, eating disorder.

Additional socio-cultural barriers present as low self-esteem, low confidence, body image issues, social ostracization, homelessness, forced prostitution, poverty and interpersonal relationship violence [4]. Formulation of public health policies directed to the group, implications of gender issues, the structuring of health services, and performance of professionals, directly interfere with access of and guarantee the right to health of the LGBTQ+ population [5]. Though the governments have taken some active steps for the wellbeing for the community, the similar fails to reflect in implementation and the discriminatory divide persists. There are various challenges that

exist and the present article shall discern the health-related barriers, treatment challenges and ethical dilemmas.

Health-care barriers

One of the greatest barriers that LGBTQ+ people experience in accessing mental health care is the anticipation of and experience of discrimination. Some disquieting barriers [6] in mental health care, faced by gender variants person are as enlisted:

1. Several mental health professionals lack knowledge about the sexual orientation of the person. Either, sexual orientation is disregarded because of which the approach to healthcare becomes unsatisfactory from the perspective of patient-needs; or, patients are asked to 'explain (educate)' the professionals about their non-conforming orientation. In such cases, it is not uncommon for patients to feel uncomfortable and they report to feel 'not understood'. It is not the best practice to have patients educate professionals about some fundamental parameters which are indicated as a must-know for professionals.
2. Often transgender patients become a specimen sample for doctors, creating grounds of ridicule and disregard for the patient. It has been documented in newspaper reports how doctors use trans patients to show their residents about 'what and how do trans people look like'; appalling to learn that trans patients are often asked to undress for this purpose of teaching the students. This not only dwindles the health care access for trans patients but is also an outright violation of patient and human rights.
3. For trans patients, there is ridicule right from the gate of the hospital to the clinic of the doctor. Given their appearance is stark, they are often subject to derision by peons and sometimes asked to return from the gate of the hospital.
4. Policy provisions fail to issue anti-discriminatory health policies for the inclusive benefits of gender variant persons. Paradoxically, though they have fundamental constitutional rights, they fail to receive the benefit of the health care services.
5. Till today, a majority of the mental health care professionals do not have an understanding of the problems of the gender-variant population as a consequence to their homophobic and transphobic attitudes. Most mental health professionals either belittle the problems, may have belligerent attitudes towards patients or may categorically deny treatment. Additionally, it is saddening to encounter that several health professionals continue to believe homosexuality as an illness.
6. Lack of trained and specialised mental health professionals in the LGBTQ+ health concerns is a further challenge for addressing their issues. Several patients feel they are not welcomingly understood by professionals and this gap in rapport building impedes further treatment outcomes.
7. Family non-acceptance, bullying by peers and ostracization by the heteronormative society adds to the struggle for healthcare access and seeking such services for gender variant individuals. As a society that supposedly is increasingly progressive and inclusive, we still lag to see the cultural competence that can disable the existing stigma towards gender non-binaries.
8. Lastly, there is still lack of data when it comes to accounting for records and health trends among the LGBTQ+ population. Especially so, the dearth of literature is lesser in developing countries like India.

Treatment Challenges and Ethical Dilemmas

Among the several disabling mental health conditions, one of the challenges faced by the LGBTQ+ population is gender dysphoria. Gender dysphoria (GD) has replaced the diagnosis of Gender Identity Disorder. GD represents a condition where a person's gender assigned at birth and the gender with which they identify themselves are incongruent. It is a condition where the individual experiences dysphoria (persistent low mood) because of this incongruence. Prevalence rate cannot be correctly estimated considering that people are still hesitant to come forward to health centres. According to DSM-5, the prevalence of gender dysphoria is 0.005-0.014% for adult

natal males and 0.002-0.003% for adult natal females [7] There is paucity of scientific data from India on gender dysphoria.

Ethical principles in bio-medical practice are autonomy, beneficence, nonmaleficence, and informed consent. The individual must have autonomy of thought and intention when making decisions about medical treatment. This is an especially sensitive field in treatment of gender dysphoria, because sometimes the individual's desires, hopes, and expectations might not correlate with reality.

Experts must be very straightforward and transparent regarding specific possibilities, risks, and benefits of medical treatment, especially considering that the last step in medical transition, GAS, is irreversible. Beneficence implies doing only good, only what is in the patient's best interest. Nonmaleficence must ensure that the treatment does not harm the individual in an emotional, social, or physical sense. It seems that, even with the reassurance and recommendation from a mental health professional, ethical unease cannot be entirely erased.

One of the fundamental challenges with treating GD is that despite the diagnostic revision and several efforts taken to create awareness around the phenomenon, gender dysphoria continues to remain misunderstood, underdiagnosed and misdiagnosed. Further, lack of specialised professionals in queer mental health and prevalent homophobia among mental health professionals has deterred and delayed treatment for many.

With recognised rights and access to health care services, there has been a surge in adolescents seeking for gender affirmation surgeries and hormone replacement treatments to do away with the distress. Such a medical treatment is a sensitive one involving a liaison among experienced mental health professionals, endocrinologists, and surgeons.

The seventh edition of the Standards of Care of the World Professional Association of Transgender Health (WPATH) offers flexible guidelines for the treatment of people experiencing gender dysphoria and describes the criteria for surgical treatment [8]. However, many countries including India do not have such care-bound guidelines. Psychiatric assessment is the first and very complex step before undergoing any medical surgery. Psychiatric assessment involves an in-depth history taking along with adequate psychological testing administered, to rule out psychiatric conditions that might mimic gender dysphoria. Often, psychotic presentations (schizophrenia, psychotic depression, brief psychotic disorder) are found to mimic GD.

The next in process is hormonal treatment which is governed under the care of an endocrinologist, which is then followed by "a real-life trial." Some individuals decide to stop here, while others continue to gender-affirming surgery (GAS). Gender affirmation surgery refers to all surgical procedures that a patient wishes to undergo in an attempt to become as similar as possible to the desired gender.

Children with Gender Dysphoria

Typically, 10-20% children continue to live with gender dysphoria and most children return to their natal genders (process referred to as 'desisting'). The challenges is typically with those children whose gender dysphoria translates into their adolescence; such individuals are more likely to experience gender dysphoria as adults as well. As part of procedural protocol, no GAS can be undertaken without confirming through psychiatric assessment that elements of psychosis and / or other interfering psychiatric comorbidities has been ruled out. Further, counselling sessions prior to the surgery must help in establishing a psycho-social readiness for the patient before they permanently transform to another gender orientation and identity. More often than not, often this readiness may not be long-lasting and may find incongruence in post-surgery counselling.

Paediatric patients are unable to make decisions with autonomous, independent informed consent for medical treatments. This protects children who often do not possess fully developed cognitive decision-making capacity by preventing rash, permanent, and potentially regrettable medical decisions. Until adolescents reach age of majority, the decision making remains with parents. However, increasingly, there has been a surge in the younger population demanding for GAS owing to liberal awareness. One of the preferred treatments for underage population is to treat them with gonadotropin-releasing-hormone that delays puberty, prevents development of secondary sexual characteristics and thus helps to buy time to consider next stages of therapy.

Another treatment option is to allow cross-sex hormone therapy (androgens for natal females and oestrogens for natal males) and GAS at reaching age majority. Puberty suppression using gonadotropin-releasing-hormone analogues has become increasingly accepted as an intervention during the early stages of puberty in individuals with clear signs of childhood-onset gender dysphoria. However, lowering the age threshold for using medical intervention for children with gender dysphoria is still a matter of contention, and is more controversial than treating the condition in adolescents and adults, as children with gender dysphoria are more likely to express an unstable pattern of gender variance. Furthermore, concerns have been expressed regarding the risks of puberty suppression, which are poorly understood, and the child's ability to make decisions and provide informed consent [9].

Parental hesitance is common when the child demands to get a sex-reassignment surgery done. For a parent who has always been used to see their child, address them and identify them as their natal gender, it can be an arduous deal to see them as another (opposite) gender [10]. Many parents find it more accepting to have their children come out as homosexual in orientation however, it is far more distressing for them to come to terms with their children pursuing to undergo GAS. The similar is aggravated with societally prevalent transphobic attitudes. Considering the patient rights and non-binary gender approaches forming a crucial element in treatment processes, it is imperative that parents choose the well-being of children.

Literature has reported individuals who are allowed to conform to their psychological gender are found to have correlates with positive mental health (emotional well-being, emotional stability and overall health) than their counterparts [11]. A lot of them come to terms with their inability to procreate however some of them do grieve their infertility [12]. A lot of families fail to integrate transsexual / transgender individuals which leads to homelessness among these individuals.

Many parents bring children presenting with gender variance to mental health professionals with a request to counsel the child or medicate them in order to maintain heteronormativity. There is a percentage of mental health professionals who do engage in talk therapy and electroconvulsive therapy with a guarantee to 'change' their homosexual / trans orientation and identity. Such procedures only aggravate mental health conditions among the individuals. On the other hand, queer friendly mental health practitioners find it a strenuous task to make parents understand the normalcy of their children not wanting to identify with heteronormative cultural identities.

Conclusions

Regardless of independent conclusions from research studies and individuals, there is a need for additional research into gender identity development into the long-term safety of cross-sex hormone therapy is imperative. It is imperative that all ethical analysis must acutely consider the age and cognitive development of the person with gender dysphoria. While long-term safety and reversibility of puberty-suppressing hormones make the first-stage treatment justifiable for many assenting children, the second-stage treatment of cross-sex hormones—with the long-term fertility implications—are generally justifiable only with adolescents that can provide fully informed assent. No treatment comes with complete satisfaction and without risk, thus, the pros and cons must be weighed in the context of individual concerns and needs.

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