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GENDER DYSPHORIA GENERAL THEORETICAL CONSIDERATIONS AND BIOETHICAL ASPECTS OF MEDICAL TREATMENT

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Abstract

The concept of being transgender or gender variant goes back to Asia and India where there was a third recognized gender, Hijra. More recently, there has been a significant increase in the awareness of people who are not comfortable with the sex assigned to them at birth and who choose to assume gender roles of the opposite sex, and even resort to medical treatments or surgery to change their sex. assigned in the opposite sex. In recent centuries, this topic has been treated differently, for example, in 1972 an educational book for children, William's Doll, was published by an influential American writer, Charlotte Zolotow, about a boy, William, who desperately wants a doll. to love despite his father's persistent desire to play with traditional male toys. In addition, over the next four decades, children's books have been developed on this topic, such as how to approach boys who wanted to wear dresses. To understand this disorder in the broader context of sexual disorders, we first ask ourselves: What is gender dysphoria? As a general definition, gender dysphoria can be presented as a condition that causes a person discomfort or suffering because there is a mismatch between their biological sex and their gender identity. Or, as otherwise defined, a condition in which the gender of a person assigned at birth and the gender with which he identifies are incongruent. (Davy, 2018). Until the adoption of the ICD-11 (International Classification of Diseases Review 11) by the WHO, it was called a sexual identity disorder and later the condition was renamed and moved from the Mental and Behavioral Disorders section to get rid of the stigma associated with the term disorder. Along the same lines, in the 5th edition of the Handbook of Diagnosis and Statistics of Mental Disorders, the American Psychiatric Association changed the diagnosis of gender identity disorder into Gender Dysphoria (DG). In the literature, this initiative has been praised, precisely for excluding the term "disorder" (Davy, The DSM-5 and the Politics of Diagnosing Transpeople, 2015).

Keywords: gender, gender dysphoria, treatment.

INTRODUCTION

The treatment of gender dysphoria has always raised many ethical issues and, recently, with the evolution of society, new complex problems have arisen in medical management. With unknown etiology and questionable definition (mental / medical illness, social construct and gender variation) who can decide, with 100% certainty, what treatment is in the interest of a particular patient? The most important ethical challenges and questions relate to the treatment of minors, fertility after GAS

(gender-affirming surgery) and the possibility of regret after it. The main ethical principles are autonomy, benevolence, non-malice and informed consent. (Giordano Selvaggi, 2014)

The individual must have autonomy of thought and intention when making decisions about medical treatment. This is a particularly sensitive area in the treatment of gender dysphoria, as sometimes the individual's desires, hopes and expectations may not be correlated with reality. It was emphasized that experts need to be very careful about the risks and benefits of medical treatment, especially given that the latest step in the medical transition, GAS, is irreversible. The question is how to approach this delicate behavior because some specialists are against the surgical alteration of healthy organs, in the case of GAS.

Non-harm must ensure that the treatment does not harm the individual emotionally, socially or physically. With these principles in mind, WPATH (World Professional Association for Transgender Health) care standards and diagnostic criteria may not be sufficient to take the best measures. paper, sometimes one can notice personal disadvantages, youth, deficiency or despair. Even with the reassurance and recommendation of a mental health professional, ethical uneasiness cannot be completely eradicated because treatment guidelines preceded the answers to vital questions. (Levine, 2017).

Because of these, in recent years there have been ongoing discussions on the bioethical aspects in the treatment of people with gender dysphoria. Gender change is a difficult process, which includes not only hormonal treatment with possible surgery, but also social discrimination and stigmatization.

Depending on their wishes, people with this condition can choose the direction in which their transition will take place. To take advantage of their condition, one can choose to go through a social transition. Social transition includes the use of a first name, the transformation of physical appearance, and the assumption of social roles of the stated gender.

A more radical approach is the medical transition that includes hormonal and surgical treatment. Medical treatment requires a team of experienced experts and usually includes mental health professionals, psychologists, psychiatrists, endocrinologists and surgeons. Recommended, psychiatric evaluation is the first step and is very complex because it is necessary to exclude other conditions that could mimic gender dysphoria.

The next step is hormone treatment, under the care of an endocrinologist. Later, some individuals decide to stop here, while others continue to perform gender assertion surgery (GAS).

Transgender youth

Children represent a small number of individuals with gender dysphoria and in only 10-20% of children, gender dysphoria will continue to manifest in adolescence (Hembree, 2011). However, psychological therapy and support are highly recommended, and although such services are now more widely available, they are still insufficient to ensure the full well-being of these patients. Improper management of children with persistent gender dysphoria can lead to isolation, self-hatred, and suicidal thoughts and attempts. At the same time, "going through the wrong puberty" can have serious consequences for them. Viable treatment options range from completely reversible treatment, such as puberty-suppressing gonadotropin-releasing hormone (GnRH) analogues to partially reversible treatment, gonadal steroid treatment, and irreversible treatment, such as surgical removal of the genitals. and the reconstruction of new ones according to the desired genre. (Jaime Stevens, 2015)

Pubertal suppression is implemented using GnRH analogues in Tanner phase 2 or 3 of puberty. The hypothalamus produces low levels of GnRH in prepubertal children. Levels become cyclical during puberty, leading to the production of luteinizing hormone (LH) and follicle-stimulating hormone (FSH) by the anterior pituitary gland. LH and FSH stimulate the ovaries and testicles to produce sex hormones, estrogen and testosterone, which are responsible for stimulating the growth of the genitals. They also lead to breast development,

deepening of the voice, menstrual cycle, and so on, which young transgender people may find particularly difficult to manage (K. P. Corley, 1981).

There are only a few reports of the use of GnRH analogues in transgender youth. De Vries et al. they were the first to introduce the concept and research on the use of puberty blockers for the treatment of transgender young people. The main idea behind the suppression of endogenous puberty was to reduce suffering by preventing the development of "incongruent" secondary sexual characteristics. This would give young people more time to get used to their situation and to better explore their sex. The authors concluded that the treatment was completely reversible, which was one of its main advantages (Annelou L.C. de Vries, 2011).

Despite the positive results, many experts are not fully convinced of the benefits of this method and oppose the implementation of this treatment in their usual practice. Thus, they claim that the method can be physically harmful for teenagers and can lead to unfavorable psychological consequences. Another argument against this treatment was that going through puberty can help the individual become congruent with his or her biological sex, which means that GD would not persist into adolescence.

Finally, the decision to implement GnRH treatment is very difficult and cannot be made without ethical dilemmas. Both opponents and proponents of suppression of puberty are guided by the same ethical principles, benevolence, non-maleficence, and autonomy, but they have different views on where these principles lie. A unique and clear overview is needed and has not yet been developed. Given that GnRH treatment is relatively new and controversial, further qualitative research and empirical studies are needed for appropriate bioethical definitions. (T. D. Steensma, 2013)

One of the questions is the possibility of cross-hormone therapy in people under 16 years of age. The authors of the latest Endocrine Society guidelines have acknowledged this possibility, but only on a case-by-case basis, which means that age does not always accurately reflect one's preparation for medical interventions. Some experts have also noted that a clear majority of children on GnRH therapy will decide to take cross-hormone therapy. Only a few side effects of GnRH use have been observed, such as decreased bone density (M. Rosenthal, 2016).

Based on bioethical principles, children usually do not have the power to make legal decisions and actions when initiating such proceedings. However, their judgment and opinions should not be overlooked. Cross-sex therapy primarily helps individuals with DG to harmonize their appearance with experienced sex. In this case, proper patient education and highlighting the advantages and disadvantages of such treatment are of crucial importance. Following the principle of charity, clinicians are always obliged to help the person and follow the prescribed hormonal treatment, as there are no better options at this time. Patients who are denied treatment can develop serious psychological consequences. In general, the transgender population has a higher risk of self-harm and suicide (Richard T. Liu, 2012). A more individualized approach, as in the "case" system, will ensure that the right decision is made according to the patient's maturity, age and reasoning.

Gender surgery is the last step in the medical transition. It is considered to be irreversible and is technically demanding, even for experienced surgeons. One of the main concerns in this area is the possibility of regret after surgery. As already mentioned, gender dysphoria does not persist until adolescence or later in the vast majority of children. GAS outcomes in transgender minors and their possible regret are a major concern and a major responsibility for health care professionals. Are children or teenagers mature enough to make such decisions? Certainly, many in-depth research studies are still needed to elucidate these dilemmas.

Fertility

DG treatment allows individuals to continue their life in their own way. For some transgender people, this implies the same as for

cisgen, marriage and / or children. Members of the transgender population have the same desire for offspring, for the same reasons as the cisgender population, and fertility is one of the most delicate issues.

In the literature, several authors reported the desire of transgender people to have children and found that about half of trans men and trans women wanted offspring after the transition. (P. De Sutter, 2002)

Cryopreservation of embryos, oocytes or ovarian tissue is a viable option for trans men. Cryopreservation of sperm, surgical extraction of sperm and cryopreservation of testicular tissue could be offered as opportunities to maintain fertility in trans women. In some countries, however, cryopreservation is not technically available to the transgender population and therefore cannot be provided during the transition. Despite the fact that cryopreservation is a routine procedure in the case of malignancies, it still remains a controversial topic in less economically developed countries.

Fertility, including all related issues and dilemmas, should be discussed very thoroughly and meticulously. The transgender population should be informed of all the possibilities, advantages and disadvantages before any treatment and each option should ultimately be the patient's decision.

Regret and revision surgery

There are different levels of regret after gender reassignment surgery. Definitive regret occurs when the patient wants to return to the sex assigned at birth after performing GAS. They come to surgeons with the request to restore the congenital anatomical features. Regret is manifested by a more or less pronounced expression of dissatisfaction and secondary thoughts about GAS. After suicide, regret could be considered one of the greatest dangers in treatment. Reasons for regret vary widely. Inadequate social adjustment, comorbidity with certain mental disorders, poor psychological and psychiatric evaluation and dissatisfaction with the aesthetic or functional result. The researchers concluded that the presence of the following factors may be associated with a risk of regret: age over 30 at first surgery, personality disorders, social instability, dissatisfaction with surgical results and poor support from partner or family. (Moller, 2006)

In 2016, a study was published in seven patients who underwent reverse surgery after regretting GAS from male to female elsewhere. The main reasons for regret in these cases were related to inadequate psychiatric evaluation. The early stages of the transition, such as "real-life experience," were largely omitted, cross-hormone therapy was not performed properly, and letters of recommendation were written by inexperienced psychiatrists. Also, the main diagnostic criteria for gender dysphoria were neglected. Therefore, it is important to avoid situations where inadequate or inexperienced psychologists or psychiatrists work with transgender patients without supervision or collaboration with more experienced colleagues. Satisfactory postoperative results were obtained in all patients. Reverse surgery has significantly improved their overall well-being. (Marta R. Bizic, 2018)

CONCLUSION

All physicians included in the treatment of gender dysphoria face major bioethical challenges and dilemmas. A multidisciplinary approach is needed and a successful outcome cannot always be guaranteed. The most sensitive issues are the treatment of transgender young people, fertility and parenting in transgender people and the risk of regret after the irreversible part of the treatment, the gender assertion operation. To avoid the complex problem of regret, an appropriate preoperative assessment is needed by experienced professionals, psychologists and psychiatrists. More research and studies are needed to shed light on these issues.

Today, although awareness and acceptance of the transgender community has greatly increased, many health care professionals, nurses, and family members report that they are not prepared to adequately address the gender and sexual health needs of these individuals.

As a personal note, I would like to point out that in our country there are not enough specialized studies in this field, and too few competent institutions and specialized medical staff are involved to provide support to people (especially children and adolescents, and their families) facing this condition.

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