Journal for Re Attach Therapy and Developmental Diversities
eISSN: 2589-7799
2024 August; 7(6): 98-103

Gender Dysphoria - Diagnosis And Treatment - Dysphoria.Org

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Received: 02/2024 **Published: 08/2024**

Abstract:

Gender identity is a sensitive issue in our current era and is considered a complex process involving biological, social, subjective and cultural factors, among others. It is constructed and formed through the individual's identification process throughout the stages of psychological and sexual development. Psychologists can define it through the resolution of the Oedipus complex in the boy and the Electra complex in the girl, of course with a number of conditions, including the differentiation of the sexes, the abandonment of the gender binary and the overcoming of the primary love stage (mother-father), in which the individual feels his or her sex and determines his or her identity as male or female. Any disruption in the above factors can lead to the emergence of gender identity dysphoria, which manifests itself in various symptoms, including the desire to be of the opposite sex.
In this article, we have addressed the issue of gender identity disorder, which is considered to be one of the most sensitive issues of our time. It is a theoretical study in which we discussed the issue of gender identity in the individual, the conditions for its acquisition and the factors influencing it. We also discussed sexual function in children and adolescents, and then we discussed gender identity disorders and some of their types and ways of treatment.
We have concluded that an individual's gender identity is formed from the early stages of development, involving various aspects such as the social, psychological and biological. Any disturbance in any of these aspects may lead to a disturbance in the acquisition of this identity, which may result in a gender identity disorder. This disorder, according to analytical psychologists, indicates a failure in the adolescent process to establish a gender identity that matches the individual's biological sex. This disorder is a combination of hormonal, psychological and genetic imbalances, particularly the adolescent's psychological mismatch with their body.
Among our conclusions is the role of psychologists in treating these disorders, especially through counselling and therapeutic programmes, and focusing on parents and the environment, as they play a significant role in mitigating these disorders. In addition, pharmacological treatment through hormones, suppression and activation, depending on the psychological identity of the adolescent.

Keywords: Gender dysphoria, Diagnosis, Treatment

Introduction:

The sex of a child can be determined from birth, whether male or female, which further reinforces the way the individual expresses themselves through their relationships with their social environment. An individual's gender identity is not limited to biological aspects alone, but involves an interaction of innate, cultural, social and psychological factors.
The sexual aspect of individuals is determined by three integrated aspects: gender identity, attraction and desire for the opposite or same sex, and finally sexual practices.
When discussing the normalcy or abnormality of this gender identity, it is clear that the adolescent stage is a critical period, as this stage plays a significant role in shaping the individual's personality. If the process is normal, there is a harmony between the subjective and objective aspects of gender identity. However, a disruption in this process results in a contradiction between the individual's biological sex and their expressed desire to belong to the opposite sex, which we refer to as gender identity disorder, and has a significant impact on the individual's psychological well-being
In himself and in his relations with others.
The American biologist Alfred Kinsey (1894-1956), who conducted a comprehensive study of the sexual preferences and practices of men and women in American society, is credited with being the first to break through the social blockade surrounding the study and research of sexual behaviour. His study was one of the first to provide reliable and consistent information about human sexual behaviour and paved the way for objective studies of sexual activity.

The scientific study of sexual disorders in modern Europe can be traced back to Richard von Krafft-Ebing, a professor of psychiatry at the University of Vienna. He is credited with being the first to develop a theory that focused on the sexual instinct and linked it to psychopathology. This was done in his famous essay “Psychopathia Sexualis”, published in 1886. In addition to the innovative terminology he introduced (such as sadism and masochism), Krafft-Ebing provided some scientific analyses of sexual disorders.
The first third of the last century saw the emergence of Freud, who presented the sexual instinct as the basis of all behaviour and the inability to satisfy it as the primary basis of all mental disorders and illnesses. He tried to make the sexual instinct the exclusive origin of mental life and the core of mental disorders.
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Since the advent of Freud and the revolution he brought about in the field of psychology, research and studies on sexual life have proliferated and flourished. Many concepts of theoretical depth and practical utility have been developed to understand the sexual life of individuals, as well as their sexual dysfunctions and disorders. Among the most prominent concepts that have come to occupy a central position in the sexual discourse is the concept of “sexual identity” or what is known as gender identity disorder, which has a significant impact on the individual’s psychological adjustment, both to self and to the environment (Freud, 1983, p.69).
In this study we will try to examine the issue of sexual identity, especially during the stages of childhood and adolescence, the factors that influence it, the conditions for its acquisition, and some of the disorders of sexual identity through their diagnosis and some ways of dealing with them. What is sexual identity, the conditions for its acquisition and the factors that influence it? What is gender identity disorder, what are its types and what are some ways of dealing with some of them?

1. Sexual Identity

1.1 Concept:
Sex is an organic concept defined by biology, while gender is a psychological concept and is known as the sexual category or class of the individual. However, we find that the two terms are used with the same meaning. If sex is defined by sexual organs, gender is defined by two components: gender identity and gender role.

Gender identity: This is the individual’s sense of belonging to one of the sexes.

Gender role: The individual’s social role.
Normally, gender identity and gender role coincide, but in some disorders they diverge. Identity and role can be observed from the age of three (3).

1.2 Factors influencing sexual identity
There are three main factors:
The physiology of the sexual organs: The individual’s possession of the sexual organs of a particular sex, and their perception and meaning.
The “parent-child” relationship: When parents become aware of the child’s sex, they give him or her a sex-appropriate name, choose appropriate clothing for him or her, and treat him or her in ways appropriate to his or her sex. The order of siblings also plays a role in this (the younger child, the sister for boys, the brother for girls, etc.). Also, assigning and teaching the child the roles appropriate to his or her gender (bathing, cleaning, shopping, etc.). Toys also play a role.
All these factors play a role on a conscious level, while on an unconscious level the relationship between the parents influences the growth and nature of the child’s gender identity by providing identification models.
Biological force: This is particularly noticeable between the sexes, for example, the child’s reaction to the mother, who is seen as a small child, and the desire to identify with the male.

1.3 Conditions for the acquisition of sexual identity:
Differentiation between the sexes: The child recognises the difference between father and mother. In the early stages, the child realises that the father is one of the parents who separates the merged relationship between the mother and the child. Despite this, the child still maintains the perception of the existence of a single sex, which is clearly manifested in its identification with the parents. The child is in an Oedipal triangle, attracted not only to the parent of the opposite sex, but also to the same sex in a homosexual relationship. This later turns into a jealous relationship with the parent of the opposite sex as the object of love. This allows the son or daughter to recognise and accept their anatomical male or female sex.
Abandonment of sexual duality: The individual chooses the object on the basis of the difference between the sexes, orienting towards the opposite sex. However, there is also a same-sex orientation. The role of social aspects in directing sexual desires towards an object of the opposite sex is also evident here, as the adolescent defines his or her identity through sexual affiliation.
The abandonment of the sexual nature of the first objects of love: This occurs from childhood, when the child works to build a healthy and consistent sexual identity with the biological body, and is manifested in the mourning of the Oedipal object during adolescence and the investment in a new external love object. In this way, the child or adolescent recognises their sexual affiliation and separates each of their parents from it, and the relationship between the child and their parents becomes a family relationship with a social-emotional character.

3. Sexual function in children and adolescents:

3.1 In children:
It appears that the child recognises his or her affiliation to one of the sexes within the limits of the second to third year (2-3) of life. Children (between the ages of 2 and 6) show a natural sexual curiosity that leads them to engage in exploratory or exhibitionist behaviour without modesty. In the pre-pubertal stage, the child may engage in idealised or heterosexual sexual play with other children in the family (siblings, cousins, etc.). This does not in any way imply the possibility of a later sexual disorder (Canoui, 1994, p.182).

3.2 In adolescents:
Puberty brings physical and psychological changes to adolescents, who are confronted with a new body image and arousing desires and attractions towards the opposite sex and sometimes the same sex. These sexual desires can interfere with their work or sleep. Idealised sexual experiences, whether for the boy or the girl, remain mostly isolated and have no predictive value for the future. As for masturbation, it is practised by the majority of adolescents (90% of males - 40% of females admit to practising masturbation) and is accompanied by rich fantasy activities.
At the same time, a natural sense of modesty is developed, which deserves respect from those around them. The desacralisation of sexual relations and obscenity sometimes raise questions of normality for adolescents who prefer to take their time. The first sexual relationships are rarely satisfactory: lack of pleasure, pain, premature ejaculation, impotence, etc. (Canoui, 1994, p.182).

4. Gender Identity Disorders

As mentioned earlier, gender identity refers to an individual's sense of belonging to a particular gender, i.e. the sense of "I am a man" or "I am a woman". Normally, an individual's biological sex, gender identity and social role are the same. In other cases, however, gender identity disorders occur, which are usually of psychological origin (CANOUI, p.184). The most prominent of these disorders is gender dysphoria.
These disorders usually first appear in early childhood and are characterised by intense and persistent distress related to one's biological sex, accompanied by a desire to belong to the other sex or a strong conviction of belonging to the other sex. The child abandons his or her biological sex and his or her interests persistently focus on the clothing and activities associated with the other sex. Gender dysphoria is less common in females than in males. A small number of children with gender dysphoria go on to become transgender in adolescence and adulthood. In contrast, the majority of adults with gender dysphoria had gender dysphoria in childhood.

5. Diagnosis of gender dysphoria according to international diagnostic guidelines and classifications

5.1 The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV):
Gender dysphoria is characterised by the following symptoms:
- Intense and persistent identification with the opposite sex, not for the purpose of gaining benefits associated with the other sex.

- Persistent discomfort with one's assigned biological sex, manifested in children by toy orientation (wearing clothes and playing roles of the opposite sex) and in adolescents by an explicit desire to be the other sex or to live and be treated as the other sex, or by a belief that one has the characteristics and behaviors of the other sex.

5.2 The World Classification of Mental Disorders (ICD-10):
Gender identity disorder is a general desire in the child to change to the opposite sex from the actual sex or to insist on belonging to the opposite sex, in addition to a strong rejection of the behavior or characteristics or clothing of the actual sex or all of them.

5.3 The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition:
The symptoms of this disorder were named "dysphoria" or distress, according to the following diagnostic indicators:
- A clear contradiction between the expressed gender and the actual gender for a period of six (6) months, accompanied by a decrease and frustration in the areas of social, professional, and academic performance, which is evident from one of the following manifestations:
- Contradiction in the expressed gender and the primary and secondary sexual characteristics.
- Desire to get rid of sexual characteristics.
- Desire for the sexual characteristics of the other sex.
- Desire to be of the other sex.
- Desire to be treated as the other sex.
A strong belief that he has feelings and reactions like the other sex. (Samir, Yamana, 2016, pp. 33, 34)

5.4 The Third Chinese Classification of Mental Disorders (CCMD-3):
It was classified under the seventh axis, which includes personality disorders, habit and impulse disorders, and sexual psychological disorders, under the name "Sexual Psychological Disorders (Sexual Deviation)", which includes [F64 Gender Identity Disorder; F65 Sexual Preference Disorder; F66 Psychosexual Development and Sexual Orientation Disorders].
It was defined as "a sexual psychological disorder characterised by abnormal sexual behaviour, characterised by a strong desire to change sex (gender identity disorder); the use of abnormal sexual behaviours, different from normal people, to satisfy sexual desires (sexual preference disorder); personalities that do not arouse sexual arousal in normal people. People who suffer from strong sexual arousal (sexual orientation disorder). In addition, there is no obvious impairment of unrelated mental activities".
It excluded simple loss of sexual desire, excessive sexual desire and sexual physiological dysfunction.

6. Examples of gender dysphoria:

6.1 Transsexualism:
This is a desire to live as, and be accepted as, an individual of the opposite sex. This desire is usually accompanied by a feeling of discomfort or incongruity with one's anatomical sex and a desire to undergo surgery or take hormones to change one's body to the desired sex (CANOUI-PP184-185). This preoccupation develops continuously and lasts for at least two years, is not a symptom of a mental disorder, and is not associated with organic or chromosomal abnormalities or intersex conditions.
Most studies of transsexuals have confirmed the presence of gender dysphoria throughout childhood, characterised by early cross-dressing (for males) and a lived experience dating back to the first haircut. These individuals want to see themselves and be seen by others as a (beautiful) woman (1/30,000 men - 1/100,000 women).
These individuals feel uncomfortable wearing clothes of their own sex and desire the clothes of the opposite sex, find their own genitals repulsive and constantly try to change them as they feel misunderstood, mistreated and unhappy (bitter). Throughout their childhood and adolescence, their adjustment has been inadequate, but some have managed to find an acceptable way of life until they discover similar cases that arouse their desire to transition (CANOUI-P185).

6.2 Gender change in children
This topic has been studied by "R. Stoller", "R. Greenson" and "L.A. Newman". Transformative boys begin to express their acute femininity in the second or third year of life, while the first signs may appear as early as the first year. From the time they begin to express their gender, these boys feel a desire to live as girls and wish to change their bodies to female, wearing feminine clothing as much as possible and with great comfort. They show a passionate interest in their mothers' clothes, jewellery and hairstyles. They display feminine mannerisms that seem natural, and in their play and fantasies they assume exclusively female roles.
These boys are almost always the youngest children in the family, and their mothers confirm that they were enamoured of their sons' good looks from a very early age. These boys often have handsome features, soft hair, delicate movements

and especially large, penetrating eyes. These boys are particularly creative and artistic, loving colours, drawings, patterns, music and sounds. They have a poetic sensitivity to words, an empathy rarely seen in other boys.
The pattern of the mother-son relationship is highly distinctive, involving a close and continuous physical and emotional symbiosis that begins at the child's birth and continues for many years. This relationship is also characterised by constant physical contact and ongoing communication, with the eyes often being the primary means of interaction. In addition, the mother promptly responds to all the child's needs (De AJURIAGUERRA, 1980, pp. 442-443).

In adolescence:
For the transforming individual, adolescence is a period of crisis (Newman). The masculine role is impossible to fulfil because it contradicts the individual's inner sense of self. To truly live as a woman, she must first overcome the obstacle of family opposition or flight. Another pressing issue during puberty is the emergence of masculine physical characteristics that reduce their chances of feminisation and create a conflict with their feminine self-image.

For those transsexuals who try to live according to their "natural gender role", their inner disappointment is reflected in the form of depression and other psychological disturbances may appear, although these tend to diminish or disappear when the transsexual begins to live in the desired "gender role".

Stoller affirmed that children become transformative individuals only when several factors converge, including: a bisexual mother, an absent father (psychologically and physically) who allows the acute symbiotic relationship to develop and persist for many years. He also mentions a particular attractiveness that reactivates a latent reaction within the family up to the birth of the individual (De AJURIAGUERRA, 1980, p. 443).

7. Treatment of gender transformation:

Grelmin, Newman and Stoller stated that after childhood, psychotherapy, psychoanalysis and various other methods (such as desensitisation, hypnosis and chemical treatment) are ineffective. These scientists emphasised that the treatment of children between the ages of 5 and 12 is based on the following general principles
1. Developing a relationship of trust and affection between a male therapist and the boy.
2. Raising the awareness of the parents so that they begin to disapprove of the boy's feminine interests, while refraining from covert encouragement.
3. To involve the father or a male surrogate in the child's life.
4. Making the parents aware of the relationship difficulties arising from the mother's excessive closeness to her son and the father's emotional detachment from family activities.
The ultimate outcome of treating severely effeminate boys is unknown. While treatment may halt the development of gender reassignment, the strong female identification may persist, making a normal sexual life in adulthood impossible (De Ajuriaguerra, 1980, pp. 443-444).

8. Homosexuality:

In the Chinese Classification of Mental Disorders (CCMD-3), homosexuality is classified under the category of "sexual orientation disorder" [F66.x1] with the following diagnostic criteria:
The individual lives in normal circumstances, but since adolescence has had a sexual orientation towards individuals of the same sex, including thoughts, feelings and sexual behaviour.
Although the individual may be able to engage in normal sexual behaviour with the opposite sex, it is clear that their sexual orientation towards the opposite sex is weak or absent, making it difficult to establish and maintain a relationship with the opposite sex.
The formation of family relationships is also limited to individuals of the same sex.
The meaning of homosexuality differs between children and adolescents. Bender and Paster distinguished two idealised sexual types in children:
- The first group includes children who engage in transient sexual play without any future homosexual orientation.
- The second group includes children with sexual expressions that may stem from latent homosexuality and reach the point of adopting the behaviour patterns of the opposite sex. According to Bender, disturbances in psychosexual development are associated with significant difficulties in the "parent-child" relationship, which may be expressed through latent or overt homosexuality (De AJURIAGUERRA, 1980, pp. 445-446).
In a study of homosexuals, Bender distinguished three subgroups based on their identifications:
The first subgroup: includes children who have internalised a dominant parental image and homosexuality because the other image is itself inappropriate (this usually results in a neurotic structure).
The second subgroup: includes cases of identification with the opposite-sex parent when the same-sex parent is hated, feared, failed or absent.

The third subgroup: includes children deprived of their parents during early childhood, who later internalise a parental substitute of the opposite sex (the future of these children is that of a psychologically disturbed personality).
According to Bender, the profound identification disorders in some cases do not seem to result solely from the relationship with the identification model and environmental anomalies, but rather from the interaction of a confused internal process - which seems to have a genetic source - with the particular conditions of their environment (De Ajuriaguerra, 1980, p. 446).
As for the adolescent, homosexuality manifests itself in specific and disturbed conditions, where Lebovici and Kreisler mention eight situations, including
- Those who become homosexual adults and feel attracted to men, wondering about their lack of interest in women; they may be confused by this or accept it, but we know that transient homosexuality is very common at this stage.
- Adolescents whose parents took them to a psychiatrist because of their confusion and rejection of the idea that their child could be or become homosexual; these two experts found that many adolescents became firmly immersed in homosexuality because of their conflicts with their parents.
- Homosexuality can be an aspect of a personality or behavioural disorder.
- When homosexuality is revealed to the adolescent it can be very confusing, and the desires expressed may be part of their impulses; so the obsessional neurosis may take as its object compulsive homosexual desires.
- Adolescent psychosis, especially schizophrenia, is a major problem in which homosexuality is usually present.
- Adolescent victims of trauma, in whom the orientation seems to be less pronounced than in adolescents traumatised before puberty (De AJURIAGUERRA, 1980, pp. 446-447).

Conclusion:

Sexual identity is a complex process that begins during pregnancy and continues through the manifestations of psychosexual development. It is formed through the interaction of subjective and objective aspects that give the individual a sense of belonging to a particular gender. This identity is constructed through the process of identification, in which the child internalises the role of the father and the daughter internalises the role of the mother. How the Oedipus complex is resolved later determines the quality of the psychic life, whether it is normal or disturbed, because the Oedipus complex builds and structures the adult. Through the process of identification, the child or daughter is able to define his or her sexual identity.
There are conditions which, when fulfilled, lead to the attainment of an appropriate sexual identity. First, the differentiation between the sexes, then the abandonment of sexual duality and the abandonment of the sexual nature of the first objects of love. This is manifested in adolescence by the investment in a new external object of love, whether for the young man or the young woman. However, the abnormal resolution of the Oedipus complex leads to a problem in the individual's sense of sexual identity.
Adolescence is considered to be one of the most sensitive periods in the life of an individual, due to the changes it witnesses in various aspects of physiological or psychological growth, etc. This undoubtedly plays an important role in the construction of the definitive system of sexual identity through the reconstruction and restructuring of identifications. We find that there is a mourning for the primary objects through the overcoming of the primary identifications with the parents and the investment and discovery of new external objects. This leads the individual to a final image of their body, including mature genitals and desires.

The sexual identity disorder is due to the failure to properly resolve the Oedipus complex in childhood and the continuation of the problem into adolescence, which causes a contradiction in the young person between what they feel and their anatomical or physiological character, which manifests itself in a strong desire to be of the opposite sex, whether male or female.
Since the adolescent period is the stage of final diagnosis of the disorder, despite its onset in childhood, the therapeutic process for the individual must begin with the discovery of the disorder, focusing in particular on the role of the parents in it.

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