Case Report
DOI: http://dx.doi.org/10.47746/FMCR.2021.2309
Frontiers in Medical Case Reports, ISSN: 2582-8142

Gender Dysphoria and De-Transition to The Biological Gender: A Case Report from A Primary Care Perspective

Fathima Begum Syed Mohideen[1] | Hizlinda Tohid[2] | Mohd Radzniwan Rashid[1*] | Sharifah Najwa Syed Mohamad[1] | Khadijah Hasanah Abang Abdullah[4] | Hatta Sidi[3]

***Correspondence:** Mohd Radzniwan Rashid

Address: [1]Family Medicine Unit, Faculty of Medicine and Health Sciences, Universiti Sains Islam Malaysia, Bandar Baru Nilai, 71800 Nilai, Negeri Sembilan, Malaysia; [2]Department of Family Medicine, Faculty of Medicine, Universiti Kebangsaan Malaysia, Jalan Yaacob Latif, Bandar Tun Razak, Cheras, 56000 Kuala Lumpur, Malaysia; [3]Department of Psychiatry, Faculty of Medicine, Universiti Kebangsaan Malaysia, Jalan Yaacob Latif, Bandar Tun Razak, Cheras, 56000 Kuala Lumpur, Malaysia; [4]Psychiatry Unit, Faculty of Medicine and Health Science, Universiti Sains Islam Malaysia, Bandar Baru Nilai, 71800 Nilai, Negeri Sembilan, Malaysia

e-mail ✉: mradzniwan@usim.edu.my

Received: 03 May 2021; **Accepted:** 07 May 2021

ABSTRACT

Some transgenders experience de-transition back to their natal gender identity because of being pressured by the cultural, religious, employment, financial and social reasons. During the de-transition, ambivalence and confusion about their gender identity are common. There are also doubts about their ability to carry out the gender role and responsibilities expected by the society. Worries of the future and health-related concerns may add to their concurrent existing gender-related distress. The resultant distress requires professional help, but the stigma and discrimination hinder them from seeking help from the health care providers (HCP). Primary care physicians often play an important role in this aspect although gender dysphoria is preferentially diagnosed by a specialized psychologist or psychiatrist. This case illustrates the health and help-seeking behavior of a transwoman with gender-related issues who presented with trivial symptoms, hoping that the primary care doctor could recognize his hidden agenda. The case emphasizes the importance of unmasking the hidden agenda, a trusting doctor-patient relationship, and provision of a patient-centered and continuity care.

Keywords: Transgender, De-transition, Gender Dysphoria, Health Care Providers, Help-Seeking Behavior

Introduction

Gender dysphoria, previously known as gender identity disorder, is the feeling of discomfort or distress that might occur in people whose gender identity differs from their sex assigned at birth or sex-related physical characteristics (Wenzel, 2013). However, it does not imply that it is a mental disorder per se. Transgender and gender-nonconforming people might experience gender dysphoria at some point in their live. According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorder, individuals need to experience at least six months duration of the significant distress or functional

impairment as a result of incongruence between their expressed gender and the biological gender (Wenzel, 2013) The distress is substantial causing confusion, poor sense of self, existent crisis, depression, anxiety, and suicidal ideation or attempts (Cooper K *et al.*, 2020). To resolve gender dysphoria some often transform to the desired gender identity (Cooper K *et al*., 2020). This gender transition is complicated as the process may involve social transition through changing names and clothing, biological transition through hormonal treatment or surgical gender-affirming surgeries (Turban *et al*., 2018; Coleman Eli *et al.*, 2012). Some however are satisfied to remain as he or she is without having these profound "make over" (Levine SB *et al.*, 2018).

This case illustrates the journey of a male gender who experience gender dysphoria leading him to act as feminine gender. However, he sought repentance and de-transitioned backed to his biological gender. Fortunately, this was feasible because no surgical procedures were done during the transition phase.

Case Report

A 29-year-old male gender presented to a primary care clinic with a 3-day history of dry cough. He was a non-smoker with no past medical problem. Nonetheless the history and physical examination were incongruent to what he had complaint when within the previous six months, he had five clinic visits with the same presentation. This had triggered a doubt hence the attending doctor had explored more to clarify the reason of the multiple clinic visit. Eventually upon further questioning he expressed his fear of contracting HIV as he had long history of men who have sex with men (MSM) relationship and his previous male partner was recently diagnosed having HIV. He contemplated to perform the HIV test for himself, but he was too ashamed to declare to previous attending doctors. In addition to that he revealed that he was about to get married, and the HIV test was required prior to this.

From there, other sensitive issues related to his gender identity and sexual orientation were explored. He disclosed his fond childhood memories of being the girl in his family, doing house chores, playing with girl toys, and dressing up as a girl. His family never reprimanded his gender non-conformity behavior. At 12, he had the first anal intercourse with his 24-year-old neighbour. He enjoyed the experience and they had multiple oral and anal sex then. Subsequently, the 'relationship' ended as he relocated to a different country following his family. Thereafter he sensed some part of him was missing and was distraught with his gender identity. He was able to handle the emotion back then. However, at 24 years old, he could not hold it anymore. He started to explore more in the other side of the world and had an intimate relationship with his housemate. They lived like a 'married' couple for two years. At the same time, he started to take injectable oestrogen and dreamt of having gender-affirming surgeries but

abandoned them due to high cost and possible complications. He even joined a transgender society. Along the way, his risk of promiscuity had tripled until at one time he felt that he had to de-transition back to his natal gender to avoid the stigma that had negatively affected his earnings, adhere to the religious teaching, and protect himself from HIV and sexually transmitted disease. He knew he could, but he knew that he had to struggle very hard to achieve the momentum back as a real man. He became receptive to his mother's request for him to get married, which he agreed. Nevertheless, deep inside he still doubted his ability to form an intimate relationship with a woman let alone to perform the husband role. He told that he would get married in few months' time and it is compulsory for him to perform HIV test as a condition before marriage.

On physical examination, he was well-groomed with a male attire, a soft-smelling perfume, and a corset. He wore his hair short with no facial and body hair. There were no enlarged breasts and he had grossly normal male genitalia. Blood investigations for HIV, Hepatitis B, Hepatitis C, and syphilis then were taken respectively in view of his promiscuity behavior as well as his wish to know about his HIV status. He was scheduled to return to review the results and to evaluate his progress. On the subsequent follow-up, he was told that all the results were normal including his cardiovascular screening. He was overjoyed and had promised to remain at this de-transition phase while behaving and living with his gender of origin.

Discussion

The prevalence of transgender people who seek medical treatment has dramatically increased in the last years, and a recent Dutch study estimated a prevalence of 1:2,800 for transwomen and 1:5,200 for transmen (Wiepjes CM *et al.*, 2018). In addition, a recent review of 38 cross-sectional and longitudinal studies describing prevalence rates of psychiatric disorders and psychiatric outcomes, pre- and post-gender-confirming medical interventions, for people with gender dysphoria are higher but they do improve following gender-confirming medical intervention. The main psychiatric disorders reported are depression and anxiety disorder. Other major psychiatric disorders are schizophrenia and bipolar disorder. However, these were rare and were no more prevalent than in the general population (Dhejne *et al.*, 2016).

Gender identity is one's sense of belonging to a particular gender (Byne *et al.*, 2018). Whereas binary gender identity, either female or male, is the common societal gender norms that individuals are expected to conform to (Cooper K *et al*., 2020). Their gender-related behavior, gender expression and gender role are culturally defined, and transgressing the norms may lead to significant distress and struggles (Barmania and Aljunid 2017). Gender-related distress is common when the gender identity that

DOI: http://dx.doi.org/10.47746/FMCR.2021.2309

they experienced or expressed is not aligned with their biological gender (Wenzel, 2013). Transgender often experience stigma, discrimination, bullying, and violence (Barmania and Aljunid, 2017). Due to the struggle, some transgender de-transition back to their natal gender identity and even requested for reversal surgeries (Turban and Keuroghlian, 2018; Levine SB *et al.*, 2018). Few cases had been reported around the world about this de-transition in which the reasons are multiple (Linda Pressly, 2020; Pieper and Lindsay Parks, 2015). In Malaysia and some other countries, behaving as transgender is an offence against the law and the change of gender is prohibited (Barmania and Aljunid, 2017). At the same time the healthcare system in the country does not support designated clinics according to gender specific and the gender-affirming interventions are not practiced, unless for those who are born with gender ambiguity.

De-transition is a phase that is not well studied and requires further discussion on its psychological and physical implications (Levine SB *et al.*, 2018; Turban and Keuroghlian, 2018). There is limited literatures related to de-transition. The studies that have been done suggest the rate of de-transition is very low – one study reported the proportion of de-transition is at less than 0.5% (Skye Davies *et al*., 2019) If this phase is managed carefully, it can bring success to patients who want to conform to their natal gender (Turban and Keuroghlian, 2018; Barmania and Aljunid, 2017; Wenzel, 2013; Sara Danker, 2018; Cooper K *et al*., 2020). However, to date, the management of de-transition is not included in the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People-Version (Coleman Eli *et al*., 2012).

In Malaysia, the management of de-transition is challenging due to limited resources and expertise. In this case, successful management was achieved through the application of the principles of family medicine that ensure personalized, comprehensive, holistic and continuity of care. A non-judgemental and neutral attitude provides a safe space for the patient to share the deepest secret of his life, dilemmas, worries and fears, allowing exploration of the inner self, needs and life priorities (Chipidza FE *et al*., 2015). It is important to assess the patient's competency to make an informed decision and identify support from others (Coleman Eli *et al*., 2012; Byne *et al*., 2018). A continuous review is needed to ensure positive progress and successful de-transitioning without psychological and physical impairments. The presence of feminine characteristics and persistence of previous sexual orientation should be monitored as well.

Since gender expression is a dynamic process, the desire to be a transwoman may come back that can lead to gender dysphoria (Turban and Keuroghlian, 2018). In this case, the significant distress experienced by the patient was not aligned with the definition of gender dysphoria (Wenzel *et al*., 2013). It was related to the negative social consequences of living as a transgender and not due to body

dysphoria. Thus, during the de-transition, providing adequate support to resolve the gender-related distress, confusion, worries, doubts, and fear of returning to maleness is important. Such supports had helped the patient to clarify his conflicts, needs and life priorities. Based on the patient's narrative and a review of the previous literature by Cooper, *et al*. (2020), the distress experienced when living as a transgender and during de-transition can be conceptualized in Fig. 1 (Cooper K *et al*., 2020).

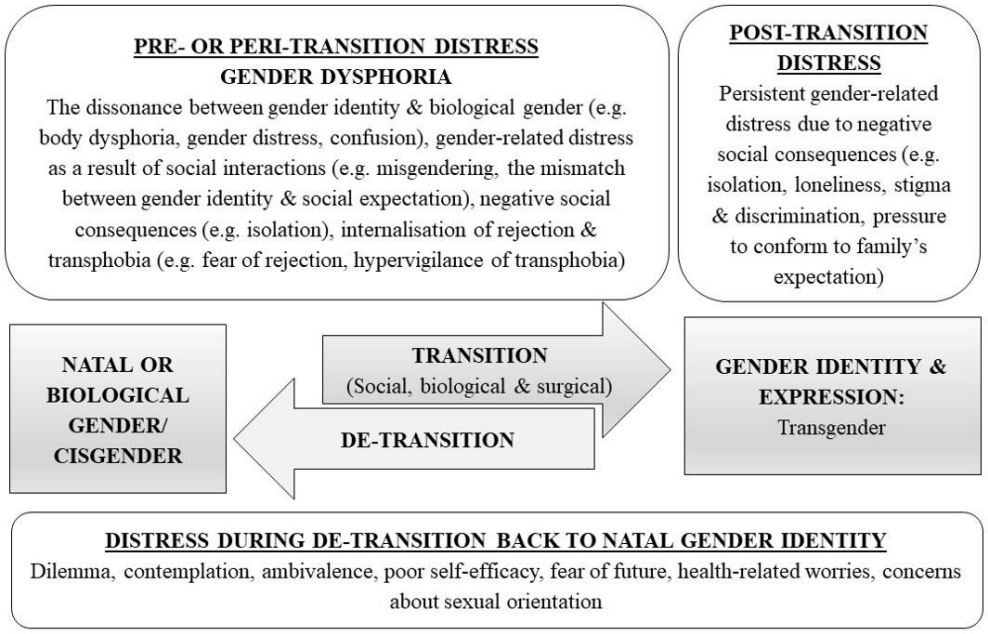

Figure 1: Conceptualisation of distress experienced during de-transition based on the patient's narrative and previous literature reviewed by Cooper *et al*. (2020) (Cooper K *et al*., 2020).

Since transgender is a sensitive and culturally unacceptable issue in some countries, gender-related problems are often patients' hidden agenda when they visit HCPs as illustrated by this case. Undifferentiated symptoms and recurrent visits for trivial problems are cues for a hidden agenda. Although our knowledge of this special group is limited, (de Vries E *et al*.,2020) our intention to help and good doctor-patient communication could unmask the hidden agenda by exploring their ideas, concerns, and expectation with a non-judgmental, empathetic, and neutral attitude. These are the key remedies to develop a good rapport and trusting doctor-patient relationship (de Vries E *et al*., 2020).

Conclusion

Primary care physician often plays an important role in identifying and managing gender dysphoria. The cornerstone of management is to clarify the person's decision making, address any concerns and assist the de-transitioning phase. Consequently, the safe space and supportive environment, need to be created by any treating doctor in which emphasizing the stance of neutrality, providing a therapeutic doctor-patient relationship should be practiced.

References

Barmania Sima and Syed Mohamed Aljunid. "Transgender Women in Malaysia, in the Context of HIV and Islam: A Qualitative Study of Stakeholders' Perceptions." *BMC International Health and Human Rights* 2017; 17: 1–10.

Byne W, Karasic DH, Coleman E, Eyler AE, Kidd JD, Meyer-Bahlburg HF, Pleak RR, Pula J. "Gender Dysphoria in Adults: An Overview and Primer for Psychiatrists." Transgender Health; 2018; 3: 57–70.

Chipidza FE, Wallwork RS, Stern TA. "Impact of the Doctor-Patient Relationship." *Prim Care Companion CNS Disord* 2015; 17: 10.4088.

Coleman E, Bockting W, Botzer M, Cohen-Kettenis P, DeCuypere G, Feldman J, Fraser L, Green J, Knudson G, Meyer WJ, Monstrey S. "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7." *International Journal of Transgenderism* 2012; 13: 165–232.

Cooper K, Russell A, Mandy W, Butler C. "The Phenomenology of Gender Dysphoria in Adults: A Systematic Review and Meta-Synthesis." *Clinical Psychology Review* 2020; 80(101875).

de Vries E, Kathard H, Müller A. "Debate: Why Should Gender-Affirming Health Care Be Included in Health Science Curricula?" BMC Med Educ 2020; 20: 51.

Dhejne C, Van Vlerken R, Heylens G, Arcelus J. "Mental Health and Gender Dysphoria: A Review of the Literature." *International Review of Psychiatry* 2016; 28: 44–57.

Levine SB. "Transitioning Back to Maleness." *Archives of Sexual Behavior* 2018; 47: 1295–1300.

Linda Pressly and Lucy Proctor. "Ellie and Nele: From She to He - and Back to She Again." BBC World Service, Germany. Mac 2020.: https://www.bbc.com/news/stories-51806011

Pieper LP, Lindsay Parks. "'Mike Penner "or" Christine Daniels: The US Media and the Fractured Representation of a Transgender Sportswriter'." *Sport in Society* 2015; 18: 186–201.

Sara Danker. "The Landscape of Transgender Surgery in the United States Presenter: Vivian Hsiao, MD Monday, A Survey Study of Surgeons' Experience with Regret and / or Reversal of Gender- Confirmation Surgeries Presenter: Sara Danker, MD Affiliation: 2018.Oregon Heal.": 188–89.

Skye Davies, Stephen McIntyre, Craig Rypma. "Detransition Rates in a National UK Gender Identity Clinic." 2019. 3rd biennal EPATH Conference Inside. Matters. On Law, Ethics and Religion, 118.

Turban JL and Keuroghlian AS. "Dynamic Gender Presentations: Understanding Transition and 'De-Transition' Among Transgender Youth." *Journal of the American Academy of Child and Adolescent Psychiatry* 2018; 57: 451–453.

Wenzel A. American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition (DSM-5) 2013.

Wiepjes CM, Nota NM, Blok CJM, De, Klaver M, Vries ALC, De, Wensing-kruger SA, Jongh RT, De, Bouman M, Steensma TD, Cohen-kettenis P, Gooren LJG, Kreukels BPC, den Heijer M. "The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets." *J Sex Med* 2018; 15: 582–590.