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and gender-related issues

485 Reproductive psychiatry, sexual health, and gender-related issues Introduction 486 Menstrual-related disorders 488 Premenstrual disorders 490 Disorders associated with pregnancy 492 Disorders related to childbirth 494 Sexual dysfunction 1: general principles 496 Sexual dysfunction 2: problems common to men and women 498 Sexual dysfunction 3: problems specific to women 500 Sexual dysfunction 4: problems specific to men 502 Disorders of sexual preference 1: general aspects 504 Disorders of sexual preference 2: assessment and management 506 Gender identity and gender dysphoria 1: overview 508 Gender identity and gender dysphoria 2: diagnosis 510 Gender identity and gender dysphoria 3: assessment 512 Gender identity and gender dysphoria 4: management 514 Chapter 11

486 Chapter 11 Reproductive psychiatry and sexuality Introduction Of necessity, this chapter is an amalgam of a number of areas in psych iatry that overlap but which are important subspecialties in themselves. They intersect with other medical specialties, including gynaecology, obstet rics, urology, and general practice. Most services will be integrated with their medical counterparts, as the assessment process necessitates a more holistic approach, even to the point where psychiatrists are employed in obstetric departments and offer a perinatal service for pregnant and post- partum women. It is true to say that research has formerly focused more on ♀ reproductive psychiatry. This does not mean that men do not have their share of problems in this area, rather that the research base is relatively lacking at this point in time. Mental health problems can arise at various milestones in an individual’s physiological, psychological, and social development. It is important to in clude issues relating to normal physiological changes, hormonal factors, sexual orientation and its expression, and sexual function when considering associated predisposing, precipitating, and perpetuating factors. Other important considerations relate to side effects and risks of the medications we prescribe for the treatment of mental disorders. These are covered in the therapeutic section of this handbook, e.g. prescribing during pregnancy (E Prescribing in pregnancy, p. 1028) and prescribing during lac tation (E Prescribing in lactation, p. 1030). It is also

vital that psychiatrists are involved in assessing the presence or absence of psychiatric disorder when it comes to major life decisions such as those generated by disorders of gender identity (E Gender identity and gender dysphoria 1: overview, p. 508). The taboo associated with many of the topics covered in this section, even in the twenty-first century (and despite—or perhaps because of—the popular media), means that psychiat rists will often have an educative role. There are still many myths that need to be dispelled. Equally, many psychiatrists have neither the theoretical framework nor the experience to deal competently with reproductive or sexual issues. While this text can serve as an introduction to the topic and offers some signposts to management, there is no substitute for seeking expert advice when confronted with complex problems.

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488 Chapter 11 Reproductive psychiatry and sexuality Menstrual-related disorders Premenstrual symptoms Characteristic physical signs and symptoms affect up to 75% of women with regular menstrual cycles. The most common presentations are abdominal bloating (in 90% of women with any symptoms), breast tenderness, and headaches. These mild symptoms do not usually interfere with a woman's ability to function. Management—premenstrual symptoms that do not meet premenstrual syndrome (PMS) or premenstrual dysphoric disorder (PMDD) criteria are initially managed conservatively, unless there is signifi cant psychiatric comorbidity. Management involves a diet low in salt, fat, caffeine, and sugar; restriction of alcohol and tobacco; exercise; and stress reduction. If there is no adequate response to conservative management in 2–3mths, a trial of an SSRI may be considered. Premenstrual syndrome or tension (For further details, see E Premenstrual disorders, p. 490.) Clinically significant PMS occurs in 20–30% of women, with severe impairment in about 5%, including associated PMDD. PMS is characterized by the pres ence of both physical and behavioural symptoms that recur in the second half of the menstrual cycle, and often in the first few days of menses. The most common behavioural symptoms are fatigue, labile mood, ir ritability, tension, depressed mood, i appetite, forgetfulness, and diffi culty concentrating (see Table 11.1). These symptoms must be severe enough to impair the patient's social and occupational functioning. The most common diagnostic criteria used are: University of California San Diego (UCSD) criteria for PMS.1 Women with PMS have a higher inci dence of affective and anxiety disorders and are at greater risk of having them in the future. The reason for this correlation is not yet known. Premenstrual tension (PMT) syndrome is in ICD-11's 'Diseases of the genitourinary system'. Premenstrual dysphoric disorder (See also E Premenstrual disorders, p. 490.) After appearing as a research diagnosis in DSM-IV, PMDD appears in the main index of DSM-5 as one of the depressive disorders, characterized by the regular presence of dys phoric and labile mood, irritability, and anxiety in the premenstrual period, relieved around the onset of menses. There must be associated distress and functional impairment. Incidence: 2–8% of women with regular men strual cycles. There is no evidence for cultural, ethnic, or socio-economic differences in prevalence. Note: criteria require behavioural symptoms only; the presence of physical symptoms is not required. PMDD may be diagnosed in addition to other mental disorders if symptoms can be clearly differentiated. In ICD-11, it appears in 'Diseases of the genitourinary system'. 1 Mishell DR (2005) Epidemiology, and etiology of premenstrual disorders. In: Mishell DR. Managing the Spectrum of Premenstrual Symptoms: A Clinician's Guide, pp. 4–9. San Antonio, TX: Dannemiller Foundation/Med Pro Communications.

Menstrual-related disorders Menopausal disorders There is an i incidence of anxiety and depression in peri- or post-menopausal women. This is not related directly to hormonal changes. Rather, patients presenting with mood-related problems around the menopause experience coincident psychosocial stressors,2 and the changes in gonadal hormones may exacerbate pre-existing mood disorders.3 Assessment—exclude other causes of mood disturbance. Particular attention paid to past psychiatric history and current social history. Management—evidence for HRT is incon clusive, although if mood symptoms are secondary to physical symptoms, this may have a role (HRT may also augment the effects of antidepres sants).4 Treatment is with standard approaches for depression/anxiety. Table □□ .□ Most frequent premenstrual symptoms* Symptom Frequency (% of cycles) Fatigue Irritability Bloating Anxiety and/or tension Breast tenderness Mood lability Depression Food cravings Acne i appetite Over-sensitivity Swelling Expressed anger Crying easily Feeling of isolation Headache Forgetfulness GI symptoms Poor concentration

- Reprinted from Mortola JF, Girton L, Beck L, et al. (1990) Diagnosis of premenstrual syndrome by a simple prospective reliable instrument. Obstet Gynecol 76(2):302–307 with permission from Wolters Kluwer. 2 Cooke DJ (1985) Psychosocial vulnerability to life events during the climacteric. Br J Psychiatry 147:71–5. 3 Sagsoz N, Oguzturk O, Bayram M, et al. (2001) Anxiety and depression before and after the meno pause. Arch Gynecol Obstet 264:199–202. 4 Birkhauser M (2002) Depression, menopause and estrogens: is there a correlation? Maturitas 41(Suppl 1):S3–8.

490 Chapter 11 Reproductive psychiatry and sexuality Premenstrual disorders Aetiology Evidence supports a genetic vulnerability conferring i sensitivity to normal changes in hormone levels throughout the menstrual cycle. This causes al terations in the normal cyclic ovarian steroid interactions with central neuro transmitters and neurohormones. Cyclic changes in ovarian steroids alone do not lead to PMS/PMDD. Most evidence supports involvement of the serotonergic system, endorphins, and GABA and the renin–angiotensin– aldosterone system. The autonomic and peripheral nervous systems may be involved in certain symptoms. Minimal or no evidence for: trace vitamin and element deficiencies, personality factors, and stress. Stress also has little effect on PMS severity, and PMS is more likely to cause stress than vice versa. Morbidity These disorders can extend over a woman’s entire reproductive cycle, from age of 714 to 50. Symptoms are relatively constant between cycles and can cause an aggregate total of years of disability over a lifetime. This nega tively affects quality of life and can have both direct and indirect economic consequences. Psychiatric consultation For already diagnosed premenstrual symptoms, this is rare unless emotional symptoms are marked and/or there are vegetative symptoms, suicidal idea tion, or a frequent inability to function. Differential diagnosis Up to 40% of women presenting to a physician with presumed PMS have another mood disorder; many meet the criteria for a depressive or anx iety disorder.5 PMDD can be a premenstrual exacerbation of an underlying psychiatric disorder or of a medical condition. Medical disorders such as migraine, CFS, and IBS can have exacerbations prior to, or during, menses. Exclude perimenopause, gynaecological disorders (dysmenorrhoea, post- partum status, polycystic ovary disease, and endometriosis), hypothy roidism, and nutrient deficiencies (e.g. manganese, magnesium, B vitamins, vitamin E, and linoleic acid). Investigations • There are no specific tests diagnostic of premenstrual disorders. Prospective charting of daily symptoms for at least two menstrual cycles is essential to confirm the cyclical pattern. • If menses are not regular and/or if they have a length of <25 days or >36 days, referral should be made for a reproductive endocrine evaluation. • For concomitant medical

conditions, consultation with a GP or gynaecologist for a physical examination and exclusion of medical disorders, as well as appropriate routine blood tests, including TFTs, may be warranted. 5 Keenan PA, Stern RA, Janowsky DS, et al. (1992) Psychological aspects of premenstrual syndrome. I: Cognition and memory. Psychoneuroendocrinol 17:179–87.

Premenstrual disorders Assessment tools The Prospective Record of the Impact and Severity of Menstruation (PRISM), the Calendar of Premenstrual Experiences (COPE), and the Daily Record of Severity of Problems (DRSP). The DRSP is available online at: M www.aafp.org/afp/2011/1015/afp20111015p918-fig1.pdf [accessed 8 July 2018]. Treatment of PMS and PMDD First-line therapy • Antidepressants are effective for PMDD, with fluoxetine the most studied. At a dose of 20mg/day, the overall response is 60–75%. Other SSRIs and venlafaxine have also shown efficacy in placebo-controlled trials. • Luteal phase therapy: therapy in the luteal phase alone, starting 14 days prior to the expected next menses, and terminating with the onset of menses. Second-line therapy • Alprazolam (250–500µg tds) for luteal phase depression. • For severe PMDD refractory to other treatment, refer to a specialist. Potential treatments include medical oophorectomy with a GnRH agonist (e.g. leuprorelin, danazol). There are significant side effects related to hypo-oestrogenism (e.g. hot flashes, long-term effects of oestrogen deficiency, osteoporosis, etc.). For patients who respond well, treatment can continue over the long term (>6mths), with continuous add-back of oestrogen (+ progesterone when indicated) to decrease and/or prevent these side effects. For rare, refractory cases with severe disabling symptoms, surgical bilateral oophorectomy may be considered. Other promising possible treatments or adjuncts • RCTs initially failed to demonstrate the effectiveness of OCP in treating PMS or PMDD. Newer placebo-controlled trials are showing that a 24- day (rather than 21-day) hormonal formulation is efficacious for PMDD.6 • Diuretics for severe oedema, e.g. furosemide, spironolactone; danazol for mastalgia. • There is some evidence for the efficacy of pyridoxine (vitamin B6) (no more than 100mg/day), vitamin E, calcium, vitamin D, and magnesium. • No evidence for multiple other treatment options, including progesterone treatment, ginkgo biloba, evening primrose oil, and essential free fatty acids. 6 Yonkers KA, Brown C, Pearlstein TB, et al. (2005) Efficacy of a new low-dose oral contraceptive with drospirenone in premenstrual dysphoric disorder. Obstet Gynecol 106:492–501.

492 Chapter 11 Reproductive psychiatry and sexuality Disorders associated with pregnancy Anxiety/mood symptoms in normal pregnancy Although there is usually an increase in symptoms of anxiety and depression during pregnancy, these are quite normal and usually related to ‘adjustment’ in the first trimester and ‘fears’ in the third trimester. Unless there is a past history of psychiatric illness, there is no reported increase in the incidence of psychiatric disorders.7 Risk factors—family or personal history of depres sion; ambivalence about the pregnancy; high levels of neuroticism; lack of marital, family, or social supports. Treatment—usually will focus on psycho social interventions; specific psychiatric disorders should be identified and treated appropriately (E Prescribing in pregnancy, p. 1028). Miscarriage and abortion There is an increase in psychiatric morbidity, with over 50% of women ex periencing an adjustment disorder (grief reaction) with significant depres sive symptoms.8 Chronic symptoms are rare, but risk is i when there is a history of previous miscarriage or abortion, or where conflict is experi enced related to religious or cultural beliefs. Hyperemesis gravidarum9 Vomiting in pregnancy that is sufficiently pernicious to produce weight loss, dehydration, acidosis from starvation, alkalosis from loss of hydrochloric acid (HCl) in vomitus, and hypokalaemia. Occurs in 1–20/1000 preg nant women. Although psychological factors

may be important in benign forms, these are now regarded as secondary, rather than primary (i.e. not a somatoform disorder). Complications—muscle weakness, ECG abnormal ities, tetany, psychological disturbance, and more seriously (but rarely): oe sophageal rupture, Wernicke's encephalopathy, central pontine myelinosis, retinal haemorrhage, renal damage, spontaneous pneumomediastinum, intrauterine growth retardation, and fetal death. Associations—transient hypothyroidism (60%), Helicobacter pylori infection. Management— admission to hospital (724%), parenteral fluid, electrolyte replacement, vitamin supplementation, anti-emetics or short-term steroids, diazepam (for nausea and associated distress). Pseudocyesis A condition in which a woman firmly believes herself to be pregnant and develops objective pregnancy signs (abdominal enlargement, menstrual dis turbance, apparent fetal movements, nausea, breast changes, labour pains, uterine enlargement, cervical softening, urinary frequency, positive preg nancy test) in the absence of pregnancy.10 Differential diagnosis—possible 7 Klein MH, Essex MJ (1995) Pregnant or depressed? The effect of overlap between symptoms of depression and somatic complaints of pregnancy on rates of depression in the second trimester. Depression 2:308–14. 8 Clare AW, Tyrrell J (1994) Psychiatric aspects of abortion. Ir J Psychol Med 11:92–8. 9 Kuscu NK, Koyuncu F (2002) Hyperemesis gravidarum: current concepts and management. Postgrad Med J 78:76–9. 10 Small GW (1986) Pseudocyesis: an overview. Can J Psychiatry 31:452–7.

Disorders associated with pregnancy medical disorders should be excluded (ectopic pregnancy, corpus luteal cyst, placenta praevia, pituitary tumour, pelvic tumour). Aetiology—regarded as a somatoform disorder or a variant of depression, it may present as a complication of post-partum depression or psychosis with amenorrhoea. It may be related to Couvade's syndrome in expectant fathers (E Dictionary of psychiatric symptoms, p. 105). Treatment—tends to include supportive or insight-orientated psychotherapy and a trial of an antidepressant. Childbearing in patients with pre-existing mental disorders Schizophrenia Patients who remain on treatment are less likely to relapse post-partum, compared to affective disorders or other psychosis diagnoses. Around 20% of those admitted to inpatient setting prior to pregnancy will relapse. Lifestyle factors related to illness are linked to poorer outcomes for the parent/child, e.g. multiple partners, no current partner, unplanned preg nancy, risky behaviours, victims of violence, unemployment, young, socially disadvantaged, substance misuse, poor antenatal care attendance. Bipolar disorder Two-thirds of women will experience a relapse of illness post-partum. i risk: family history of post-partum psychosis, 4+ illness epi sodes pre-pregnancy, (rapid) discontinuation of medication during preg nancy. Recurrence of relapse in later pregnancies: 50–90%. Anxiety and panic disorders Anxiety symptoms and potential harm to baby unclear across multiple studies. Evidence of panic disorder relapse is conflicting—some studies show symptom reduction during pregnancy. PTSD No clear data regarding relapse; however, possible i risks for com plications of pregnancy. OCD Small studies indicate 730% worsening in symptoms during pregnancy. Eating disorders Several studies report symptoms improve during preg nancy; however, i risk of postnatal depression and poorer health outcomes for baby. ID Borderline and mild ID patients are more likely to become pregnant than moderate or severe ID patients. Parent's IQ is not main issue, un less <60; rather, child's age, gender, temperament, family size, other mental health issues in the family result in social difficulties similar to schizophrenia. Personality disorders Many can parent adequately; others cannot, and diagnosis cannot discriminate between them. Assessment of their ability to meet a child's needs and awareness of exposure to social factors similar to ID and schizophrenia is important. Multidisciplinary input is required when associated with chaotic lifestyles, substance misuse, and comorbidity.

494 Chapter 11 Reproductive psychiatry and sexuality Disorders related to childbirth 0 Always ask about thoughts of self-harm or harming the baby. Despite the significant life event that pregnancy is, psychiatric admission and completed suicide are surprisingly less common in pregnancy. There may be subclinical mild anxiety or mood disturbance, worse in the third and first trimesters. A 10% risk of significant depression is seen in the first trimester, associated with a history of depression, abortion, intrauterine loss, or unwanted pregnancy. Third trimester depression may persist as post-partum depression. DSM-5 includes 'with peripartum onset' as a spe cifier for depression or mania occurring during pregnancy or in the 4wks following delivery, and 'with post-partum onset' for brief psychotic epi sodes. ICD-10 coded these disorders as 'Mental and behavioural disorders associated with the puerperium', whereas ICD-11 has a separate broader category 'Mental or behavioural disorders associated with pregnancy, child birth or the puerperium, with/without psychotic symptoms'. Baby blues Up to three-quarters of new mothers will experience a short-lived period of tearfulness and emotional lability, starting 2–3 days after birth and lasting 1–2 days. This is easily recognizable by midwifery staff and requires only reassurance and observation towards resolution. There is weak evidence that it may relate to post-partum reductions in the levels of oestrogen, pro gesterone, and prolactin (which do occur around 72hrs after the birth). Postnatal depression A significant depressive episode, temporally related to childbirth, occurring in 10–15% of women within 6mths post-partum (peak 3–4wks). The clinical features are similar to other depressive episodes, although thought content may include worries about the baby's health or being able to cope with the baby. There may be a significant anxiety component. Ninety per cent of cases last <1mth; 4% >1yr. Risk factors Personal/family history of de pression, older age, single mother, poor relationship with own mother, am bivalence towards or unwanted pregnancy, poor social support, additional psychosocial stressors, severe 'baby blues', previous post-partum psychosis (no evidence for association with obstetric complications). Management Early identification; close monitoring of those 'at risk' [Edinburgh Postnatal Depression Scale (EPDS) in primary care setting'; see Box 11.1]; education, support, and appropriate pharmacological intervention; depressive episode treated in usual way with antidepressants and/or brief CBT; if severe or associated with thoughts of self-harm or harm to baby, may require hos pital admission. Post-partum psychosis An acute psychotic episode, occurring following 1.5/1000 live births, peak occurrence at 2wks post-partum. Aetiology Unknown, but may relate to a reduction in oestrogen levels (leading to DA super-sensitivity), cor tisol levels, or post-partum thyroiditis. Symptoms Three common clinical presentations: prominent affective symptoms (80%): mania or depression with psychotic symptoms; schizophreniform disorder (15%); acute organic

Disorders related to childbirth psychosis (5%). Common features Lability of symptoms; insomnia; per plexity, bewilderment, and disorientation; thoughts of suicide or infanti cide. Risk factors Personal or family history of major psychiatric disorder; lack of social support; single parenthood; previous post-partum psychosis (30% risk of psychosis; 38% risk of postnatal depression). Management Prevention—identification, education, support, and treatment of 'at-risk' individuals; Treatment—admission to hospital (specialist mother–baby unit, if possible); for major affective disorder, there is good evidence for ECT, mood stabilizers (especially carbamazepine), and early use of antidepres sants; psychotic symptoms should be treated with usual protocol (E Initial treatment of acute psychosis, p. 200). Box 11.1 Edinburgh Postnatal Depression Scale (EPDS)* As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today. I have been able to laugh and see the funny side of things. As much as I always could/Not quite so

much now/Definitely not so much now/Not at all I have looked forward with enjoyment to things. As much as I ever did/Rather less than I used to/Definitely less than I used to/Hardly at all

- I have blamed myself unnecessarily when things went wrong. Yes, most of the time/Yes, some of the time/Not very often/ No, never I have been anxious or worried for no good reason. No, not at all/Hardly ever/Yes, sometimes/Yes, very often
- I have felt scared or panicky for not very good reason. Yes, quite a lot/Yes, sometimes/No, not much/No, not at all
- Things have been getting on top of me. Yes, most of the time I haven't been able to cope at all/ Yes, sometimes I haven't been coping as well as usual/ No, most of the time I have coped quite well/ No, I have been coping as well as ever
- I have been so unhappy that I have had difficulty sleeping. Yes, most of the time/Yes, sometimes/Not very often/No, not at all
- I have felt sad or miserable. Yes, most of the time/Yes, quite often/Not very often/No, not at all
- I have been so unhappy that I have been crying. Yes, most of the time/Yes, quite often/Only occasionally/No, never
- The thought of harming myself has occurred to me. Yes, quite often/Sometimes/Hardly ever/Never Responses are scored 0, 1, 2, and 3, according to i severity of symptoms. Items marked with an asterisk are reverse scored (i.e. 3, 2, 1, and 0). Total score of 12+ is significant.
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496 Chapter 11 Reproductive psychiatry and sexuality Sexual dysfunction 1: general principles A brief note on 'talking about sex' Discussing sexual issues, particularly sexual dysfunction, may be embarrassing for the individual, and this is compounded if the clinician is also uncomfortable. Aside from experience of asking about these issues, a few general principles should be borne in mind. • An empathic, non-judgmental, understanding approach is essential. • Acknowledge the difficulty in talking about sexual problems. • Reassure that such problems are common and are treatable. • Avoid 'medical' terminology (or explain adequately any terms used). • Start with general enquiries before moving on to more specific issues. • Do not make any assumptions (especially orientation, practices, experience, number of partners). • Be aware of common sexual myths (see Box 11.2). Defining sexual dysfunction Despite disagreement about what constitutes 'normal', there is general consensus that sexual dysfunction is present when there are persistent impairments of normal patterns of sexual interest or response. Usually these manifest as lack or loss of interest/enjoyment of sexual activities, the inability to experience or control orgasm, or a physiological barrier to successful sexual intercourse. Criteria for a diagnosis of sexual dysfunction include: • Inability to participate in a preferred sexual relationship. • Presence of sexual dysfunction on (almost) all occasions. • Duration of at least 6mths. • Significant stress or interpersonal difficulties. • Not accounted for by a physical disorder, drug treatment (or use), or other mental or behavioural disorder. Subclinical problems Certain individuals will not meet strict criteria for a specific diagnosis but nevertheless experience significant distress. Usually these problems are ad justment difficulties related to timing, frequency, and method of initiating sexual activity. Any treatment tends to be

supportive (for the patient and their partner) and educative (sex education; see Box 11.3). Classification of sexual dysfunctions ICD-10 separates dysfunction due to physical causes from those due to psychological problems, classifying the latter in the category ‘Sexual dys function, not caused by organic disorder or disease’, within ‘Behavioural syndromes associated with physiological disturbances and physical factors’. DSM-5 has a separate section ‘Sexual dysfunctions’, and ICD-11 places ‘Sexual dysfunctions’ and ‘Sexual pain disorders’ within a new section ‘Conditions related to sexual health’, separate from ‘Mental, behavioural or neurodevelopmental disorders’.

Sexual dysfunction 1: general principles Box 11.2 Common sexual myths • Men should not express their emotions. • All physical contact must lead to sex. • Good sex leads to a wild orgasm. • Sex = intercourse. • The man should be the sexual leader. • Women should not initiate sex. • Men feel like sex all the time. • Women should always have sex when her partner makes sexual approaches. • Sex is something we instinctively know about. • ‘Respectable’ people should not enjoy sex too much and certainly never masturbate. • All other couples have ‘great’ sex, several times a week, have an orgasm every time, and always orgasm simultaneously. • If sex is not good, there is something wrong with the relationship. Source: data from Andrews G and Jenkins R (eds) (1999) Management of mental disorders, UK edn, vol. 2, Sexual Dysfunction, pp. 612–13. Sydney: World Health Organization Collaborating Centre for Mental Health and Substance Abuse. Box 11.3 Common triggers for sexual problems • Psychological Relationship problems; life stressors; anxiety/depression; low self-esteem; sexual performance anxiety; excessive self-monitoring of arousal; feelings of guilt about sex; fear of pregnancy or STDs; lack of knowledge about sexuality/’normal’ sexual responses; previous significant negative sexual experience (especially rape or childhood sexual abuse issues). • Environmental (Fear of) interruptions (e.g. from children, parents); physical discomfort. • Physical Use of drugs or alcohol; medication side effects; pain or discomfort due to illness; feeling tired or ‘run down’; recent childbirth. • Factors related to the partner Sexual attractiveness (gender, physical characteristics); evidence of disinterest, constant criticism, inconsideration, and inability to cope with difficulties (especially sexual); sexual inexperience/poor technique; preference for sexual activities that are unappealing to the partner.

498 Chapter 11 Reproductive psychiatry and sexuality Sexual dysfunction 2: problems common to men and women Sexual dysfunction is common in the general population, with a lifetime prevalence in young adults as estimated in Table 11.2.11 Lack or loss of sexual desire Lack of pleasure in anticipating, or reduced urge to engage in, sexual ac tivity. May be primary (always has been absent) or secondary (has declined recently), situational (specific settings or partners), or total. For a diagnosis, the loss of desire ought not to be secondary to other sexual problems (e.g. dyspareunia or erectile failure). Differential diagnosis Sexual aversion, lack of sexual enjoyment, depression, physical causes (chronic pain, endocrine disturbance, effects of drugs or alcohol). Management • Treat any primary cause found (physical, psychological, psychiatric). • Establish the reasons for seeking help, provide information (e.g. common triggers; see Box 11.3). • Address general relationship issues. • Consider specialist referral (behavioural work and graded individual and couple exercises require an experienced therapist (e.g. ‘sensate focus’ techniques; see Box 11.4). Sexual aversion and lack of sexual enjoyment Sexual aversion Strong negative feelings, fear, or anxiety due to prospect of sexual interaction; of sufficient intensity to lead to active avoidance of sexual activity. Lack of sexual enjoyment Lack of appropriate pleasure, despite

normal sexual responses and achievement of orgasm. Management Both conditions tend to be related to difficult and com plex psychosocial factors, often stemming from a previous traumatic sexual experience (e.g. rape or molestation). For this reason, only a skilled, ex perienced therapist should attempt treatment. Where possible, refer to a specialist service. Establishing the reasons for seeking help may clarify sens ible outcome goals. 11 Haas K, Haas A (1993) Understanding Human Sexuality. St Louis, MO: Mosby. Table 11.2 Prevalence of sexual dysfunction in young adults Problem ♂ ♀ Reduced libido 30% 40% Arousal difficulties 50% 60% Reaching orgasm too soon 15% 10% Failure to have orgasm 2% 35% Dyspareunia 5% 15%

499 SEXUAL DYSFUNCTION 2: PROBLEMS COMMON TO MEN & WOMEN Excessive sexual desire Occasionally, i sexual drive may occur, presenting as a problem for indi viduals, partners (on whom 'unreasonable' demands are made), or carers (when sexual disinhibition occurs). Referred to as nymphomania (women) or satyriasis (men). Usually occurs in late teenage/early adulthood, secondary to a mood disorder (e.g. mania), in the early stages of dementia, associ ated with ID, secondary to brain injury, or as a side effect of some drugs. Management Treatment should address any problem and general relation ship issues. When the problem is persistent, specialist referral may be ap propriate (for cognitive, behavioural, or, rarely, pharmacological therapy). Box 11.4 'Sensate focus' (Masters and Johnson, 1966)* A series of specific exercises for heterosexual couples (essentially a form of in vivo 'desensitization' to reduce sexual anxiety), initially encouraging each partner to take turns in paying i attention to their own senses. There are a number of stages to a course of therapy: Stage one The couple take turns to touch each other's body (with the breasts and genitals off limits), to establish an awareness of sensations (touching and being touched) and usually in silence (to avoid distractions). If sexual arousal does occur, they are not to proceed to intercourse. If any touch is uncomfortable, the partner being touched must let his or her partner know, either verbally or non-verbally. Stage two Touching is expanded to include the breasts and genitals, still with an emphasis on awareness of sensations, and not the expectation of a sexual response (intercourse and orgasm are still prohibited). A 'hand- riding' technique is used (placing one hand on top of the partner's hand while being touched) to indicate more or less pressure, faster or slower pace, or change to a different spot. Stage three The couple tries mutual touching (not taking turns), to practise a more natural physical interaction. Intercourse still off limits. Stage four Mutual touching continues, moving to the ♀-on-top position, without attempting penetration. The woman can rub the penis against her clitoral region, vulva, and vaginal opening, regardless of whether or not there is an erection, still focusing on the physical sensations, and stopping or returning to non-genital touching if either partner becomes orgasm-orientated or anxious. In later sessions, she may progress to putting the tip of the penis into the vagina if there is an erection, and after completing a few sessions in this way, couples are usually comfortable enough to pro ceed to full intercourse.

- Source: data from Masters WH and Johnson VE (1966) Human sexual response. New York: Bantam Books.

500 Chapter 11 Reproductive psychiatry and sexuality Sexual dysfunction 3: problems specific to women Failure of genital response This is usually due to vaginal dryness or lack of lubrication; due to psychological factors (e.g. anxiety), physical problems (e.g. infection), oestrogen deficiency (especially post-menopausal); or secondary to lack or loss of sexual desire. Management • General aims: increasing arousal levels during periods of sexual activity (E Orgasmic dysfunction, see

below), alleviating vaginal dryness (with use of lubricating gel, oestrogen replacement), and reducing factors that may inhibit arousal (see Box 11.3). • If problems persist, referral to a specialist should be considered. Orgasmic dysfunction The most common sexual complaint in women. Experience of orgasm is delayed or does not occur at all, despite normal sexual arousal and excite ment. Individuals may consider this to be normal and not complain of dys function. Problems may be primary (never had an orgasm in any situation), secondary (previously able, but not currently), situational (problems only occur in certain situations), or total (in all situations). Complicating factors may include secondary lack or loss of sexual desire, other sexual dysfunc tions, and relationship problems. Management • Complex cases should be referred to a specialist sex therapist. • Less complex cases may respond to a directed self-help programme.12 This usually includes directed masturbation, 'sensate focus' for couples, Kegel's pelvic floor exercises, and use of sexual fantasy. Non-organic vaginismus Penetration is impossible or painful due to blockage of the vaginal opening caused by spasms of the pelvic floor muscles. Usually related to anxieties or fearful thoughts, e.g. fear of pain on penetration, previous sexual assault, belief in premarital sex being wrong or sinful, childhood punishment for masturbation, general fear of sex (especially the first experience of inter course is likely to be painful or bloody), fear of pregnancy, and painful labour. Vaginismus leads to pain during intercourse, thus reinforcing these beliefs. Management • Physical examination (to exclude vaginal obstruction due to a growth, a tumour, or the hymen). • Vaginismus is best treated by an expert, and management will include: education (to dispel myths and tackle misunderstandings or negative attitudes), relaxation techniques, and strategies to achieve penetration (e.g. self-exploration, Kegel's exercises, use of graded trainers, sensate focus exercises, involvement of partner, graded attempts at intercourse, reassurance for the partner; see Box 11.5). 12 Heiman JR, LoPiccolo J (1988) Becoming Orgasmic. London: Piatkus Books.

Sexual dysfunction 3: problems specific to women Non-organic dyspareunia Pain during intercourse that may be felt superficially (at the entrance of) or deep within the vagina. Management • Exclude physical causes of pain (e.g. infection, tender episiotomy scar, endometriosis, ovarian cyst). • Provide information about ensuring adequate arousal, variation of intercourse positions to avoid 'deep' penetration. • Relaxation techniques (including Kegel's exercises) and 'positive self-talk' may help reduce anxiety and ensure the woman feels 'in control'. • Where deep pain is experienced after intercourse, this may be due to pelvic congestion syndrome (with symptoms similar to PMS), caused by accumulation of blood during arousal without occurrence of orgasm. Achieving orgasm (by intercourse, masturbation, or use of a vibrator) may help to alleviate this congestion. • For complex cases, with vague or intermittent problems or associated secondary sexual or psychiatric problems, or when initial treatment is unsuccessful, referral to a specialist is indicated. Box 11.5 Kegel's exercises These are pelvic floor muscle exercises. The muscle can be identified by attempting to stop urine flow, and contraction of this muscle may need to be practised before voluntary control is mastered. The exercises should be practised for a few minutes every day. Repeat (a) and (b) ten times initially (building up to 30 times over 4–6wks) and (c) and (d) five times (building up to 20 times over 4–6wks). (a) Breathing normally, quickly contract and relax the muscle. (b) Breathing normally, contract the muscle for a count of 3, and then relax. (c) Inhale slowly, contracting the muscle for a count of 3, hold for a count of 3, then, exhaling slowly, relax to a count of 3. (d) With the muscle relaxed, bear down (as if trying to push something out of the vagina) for a count of 3.

502 Chapter 11 Reproductive psychiatry and sexuality Sexual dysfunction 4: problems specific to men Erectile failure (failure of genital response) Inability to develop or maintain an erection, leading to failure of coitus or sexual intercourse. Subtypes Primary—never been able to sustain an erec tion; secondary—able to do so in the past; situational—only successful under certain circumstances; total—not under any circumstances. Contributing fac tors Moral/religious views on sex and masturbation; previous negative sexual experiences (may undermine sexual confidence and increase 'performance anxiety'); secondary to other sexual dysfunction (e.g. premature ejaculation); use of alcohol and drugs; stress and fatigue. Management Physical assessment to exclude organic causes (disease or surgery affecting the blood supply of the penis, side effects of drugs or medication) especially in older men; refer to an expert on sexual problems if primary, total, long-standing (years), or not associated with obvious triggers. General—education (about physical and psy chological factors that may contribute to erectile failure) and self-help exer cises13,14 (better if partner involved). Physical—phosphodiesterase 5 (PDE5) inhibitor drug [e.g. sildenafil (Viagra®, Granpidam®, Revatio®, Vizarsin®), tadalafil (Adcirca®, Talmanco®)]; training in self-administration of papaverine or prostaglandin E1 into the penis prior to intercourse; use of a vacuum constriction device; surgical implantation of semi-rigid or inflatable penile prostheses. Note: relapse common (775%), usually related to clear triggers and improves naturally or through use of previously successful techniques. (Seeing this as a 'normal' situation helps relieve anxiety and reduce the sense of failure, which might otherwise prolong problems.) Orgasmic dysfunction (or 'inhibited ejaculation') Relatively rare in men. Orgasm delayed/does not occur at all, despite normal sexual excitement and arousal. Situational dysfunction Usually has a psychological cause (see Box 11.3); total dysfunction may have a var iety of causes. Management Main aims—reducing 'performance anxiety', increasing arousal and physical stimulation, i.e. addressing common triggers, relationship problems, associated feelings of anxiety or guilt, or memories of past traumatic/unpleasant sexual experiences. Education—dispelling myths, understanding 'normal' physiology and the effects of alcohol; use of sensate focus techniques. Persistent problems—should be referred to an expert. Premature ejaculation The inability to control ejaculation adequately for both partners to enjoy the sexual interaction. Ejaculation may occur immediately after penetration, or in the absence of an erection. Differential diagnosis Delayed erection (prolonged stimulation needed to achieve adequate erection; short time to ejaculation); organic impairment (especially pain); 'normal' rapid ejaculation in young or sexually inexperienced men (control is learnt with practice); 13 Williams W (1985) It's Up To You. Sydney: Maclennan and Petty. 14 Zilbergeld B (1980) Men and Sex. London: Fontana.

Sexual dysfunction 4: problems specific to men secondary to psychological stressors; transient problem following a period of reduced sexual activity. Management Expert advice should be sought for complex cases or where there is associated orgasmic dysfunction/lack or loss of sexual desire. Sympathetic partner is crucial to successful manage ment. General education—specific issues of 'normal' time before ejaculation occurs; reduction of 'performance anxiety' (as for orgasmic dysfunction). Use of self-help guides.14 Specific exercises—may include: the 'stop–start' technique, the 'squeeze technique' (see Box 11.6), and sensate focus (see Box 11.4). Non-organic dyspareunia Pain during intercourse in men; usually has a physical cause [e.g. urethral infection, scarring secondary to sexually transmitted disease (STD), tight foreskin] that can be directly treated. If psychological factors are the root cause, reassurance, education, and use of relaxation and cognitive tech niques may be helpful. Complex cases require expert management. Box 11.6 Stop–start (Semans') technique Developed by Masters and Johnson;1,2 effective in up to 90%

of cases. Aims: To increase the frequency of sexual contact and increase the sen sory threshold of the penis. Setting: Best performed in the context of sensate focus exercises—to ensure non-genital areas are focused on first (less threatening for anxious individuals, allowing recognition of sensations leading up to ejaculation, and may make the 'quality' of the sexual experience better), to limit the number of 'accidental' ejaculations (may discourage couples early on), and to increase good communication and cooperation. Technique: • Stimulation of the penis until high arousal (but not the ejaculation threshold) is achieved. • Cessation of stimulation for a few minutes to allow arousal to subside. • Repetition 4–5 times until ejaculation is permitted. Squeeze technique If control does not develop using the 'stop–start' technique, this method may be used to inhibit the ejaculatory reflex: • Stimulation of the penis until high arousal (but not the ejaculation threshold) is achieved. • The man (or his partner) applies a firm squeeze to the head of the penis for 15–20s. (The forefinger and middle finger placed over the base of the glans and shaft of the penis, and the thumb applies pressure on the opposite side at the base of the undersurface of the glans.) Note: this technique should be practised before high arousal occurs, to establish how firmly the penis may be squeezed without causing pain. 1 Masters WH, Johnson VE (1966) Human Sexual Response. New York, NY: Bantam Books. 2 Masters WH, Johnson VE (1980) Human Sexual Inadequacy. New York, NY: Bantam Books.

504 Chapter 11 Reproductive psychiatry and sexuality Disorders of sexual preference 1: general aspects Essence Disorders of sexual preference (ICD-10) or paraphilic disorders (DSM-5/ ICD-11) are disorders in which an individual is sexually aroused by inappro priate stimuli. There is overlap between these disorders, sex offending, and inappropriate sexual behaviour, but the three are separate concepts. In some cases, more than one disorder may be present.15 Definition In DSM-5, each individual paraphilic disorder is defined as at least 6mths of recurrent, intense sexual arousal involving a particular inappropriate act or object, with associated clinically significant distress or functional impair ment. ICD-10 has less strict or detailed criteria, requiring the particular ob ject or act to be the most important source of sexual arousal or essential for satisfactory sexual response. ICD-11 specifies the presence of a 'sus tained, focused, and intense pattern of sexual arousal'. Classification There are many different objects and acts that may be the focus of dis orders of sexual preference. Most of the defined categories are extreme forms of behaviours that are common parts of 'normal' sexual activity. The classification systems in DSM-5 and ICD-10 are very similar (see Table 11.3). In ICD-11, the ICD-10 categories of 'Fetishism', 'Fetishistic trans vestism', and 'Sadomasochism' have been replaced by new categories of 'Coercive sexual sadism disorder', 'Frotteuristic disorder', 'Other paraphilic disorder involving non-consenting individuals', and 'Other paraphilic dis order involving solitary behaviour or consenting individuals'. Aetiology Physiological factors These may include genetic factors, prenatal influence of hormones in utero, hormonal abnormalities in adults, and perhaps brain abnormalities. Psychological theories Include absence of an effective father with over- protective/close-binding/intimate mother; failure of successful resolution of Oedipal conflict; modelling and conditioning; and masculine insecurity. The various factors may lead to sexual deviation by: (1) preventing normal sexual development and relationships; and/or (2) promoting de viant sexual interest. Epidemiology It is difficult to estimate the prevalence of these disorders, as many in dividuals do not present for help and are unlikely to admit to sexually deviant arousal in surveys. Rates of sexual offending do not give a good approximation of rates of disorders of sexual preference, as these dis orders represent one of many factors that may lead to such offending 15 Federoff JP (2009) The paraphilias. In: Gelder MG, Andreasen NC, Lopez-Ibor JJ, Geddes JR (eds). New Oxford Textbook of Psychiatry, Volume 1,

pp. 832–42. Oxford: Oxford University Press.

Disorders of sexual preference 1: general aspects (E Table 16.2 Crime statistics for the British Isles, p. 729). There is probably a wide range of sexual practices in the ‘normal’ population. Disorders of sexual preference are more common in ♂ than ♀ (perhaps 30 times more common). From clinical samples, age of onset is usually between 16 and 20yrs, and many individuals have multiple paraphilias, in series and/or in parallel. Table 11.3 Classification of disorders of sexual preference ICD-10 DSM-5 Sexually arousing object or act Fetishism Fetishistic disorder Non-living object (e.g. clothing, shoes, rubber) Fetishistic transvestism Transvestic disorder Cross-dressing (not few articles—complete outfit, wig and make-up). Association with sexual arousal distinguishes from transsexual tranvestism, but may be an early phase in some transsexuals Exhibitionism Exhibitionistic disorder Exposure of genitals to strangers Voyeurism Voyeuristic disorder Watching others who are naked, disrobing, or engaging in sexual acts Paedophilia Paedophilic disorder Children (usually pre-pubertal or early pubertal). May be specified as attracted to ♂, ♀, or both, or as limited to incest Sadomasochism Sexual masochism disorder Being humiliated, beaten, bound, or made to suffer Sexual sadism disorder Psychological or physical suffering of others – Frotteuristic disorder Touching and rubbing against non-consenting person Other disorders of sexual preference Other specified paraphilic disorder Includes telephone scatalogia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (faeces), urophilia (urine), klismaphilia (enemas), autoerotic asphyxia (self-asphyxiation) Multiple disorders of sexual preference – Many individuals manifest multiple disorders. The term ‘polymorphous perversity’ has been used. The most common combination is fetishism, transvestism, and sadomasochism

506 Chapter 11 Reproductive psychiatry and sexuality Disorders of sexual preference 2: assessment and management Assessment Why is the person presenting now? • May present directly or at the request of spouse when behaviour is discovered or starts to cause problems in relationships. Occasionally present as sexual dysfunction, with disorder of preference coming to light on further assessment.16 • May present at own request, or more likely at request of the court, prosecutor, or solicitor, after committing offence. Is there another mental disorder? Various psychiatric disorders may lead to the release of sexually deviant behaviour, perhaps in individuals who have experienced fantasies but not acted on them previously. Particularly important to exclude in someone presenting for the first time in middle age or later. So full psychiatric history, MSE, and perhaps neurological examination/investigation important. Psychosexual assessment Full psychosexual assessment essential in anyone presenting with sexual problems. The interviewer should put the person at ease and be able to facilitate by being open, sensitive, and able to discuss sexual matters. Involvement of the sexual partner in assessment (either at the same time or through another interview) is usually helpful. The following areas should be covered: • Sexual knowledge and sources of information. • Sexual attitudes to self and others. • Age of onset and development of sexual interest, masturbation, dating, sexual intercourse. • Relationship history, including: age of self and partner, gender of partners, duration, quality, problems, and abuse. • Fantasy (content/use/development). • Orientation. • Drive (frequency of masturbation/intercourse) and dysfunction (specific inquiry about arousal, impotence, premature ejaculation). • Experience (range of sexual behaviours, with specific enquiry about paraphilias). • Current sexual practices: mood, thoughts, visual images, material used, and conditions for arousal during both intercourse and masturbation (many men with paraphilias report ‘normal’ intercourse, although, at the time,

they are imagining deviant scenarios); where various forms of arousal are reported, estimate the proportion of sexual practice devoted to each. What does the person want from treatment? • Do they want help at all, or have they just come as they have been forced to (by spouse, courts, etc.)?
16 Brockman B, Bluglass R (1996) A general psychiatric approach to sexual deviation. In: Rosen I (ed). Sexual Deviation, 3rd edn, pp. 1–42. Oxford: Oxford University Press.

 • Do they want to change the focus of their sexual arousal and/or desist from the overt behaviour? • Do they want to adapt better to the behaviour without changing it? • Are they motivated to engage in treatment? Further investigations Physical examination and investigations may be indicated, particularly if sexual dysfunction coexists. Penile plethysmography, polygraphy, and visual reaction times may be useful in assessing paraphilias. Management General issues Treatment should not be imposed on people who do not want it. Patients should realize that treatment will take considerable effort on their part. The aims of treatment should be clear from the beginning, e.g.: • Better adjustment without changing the behaviour. • Desisting from overtly problematic behaviour, but retaining 'deviant' arousal. • Changing the focus of the arousal. Where treatment is aimed at change, the following may need to be addressed: • Encouraging development of 'normal' relationships. • Addressing sexual inadequacy (perhaps using approaches similar to those for sexual dysfunction). • Develop interests, activities, and relationships that will fill the time previously taken up by fantasizing about, preparing for, and taking part in the deviant activity. • Decreasing masturbation to deviant fantasies and encouraging masturbation to more appropriate fantasies. Specific treatment approaches Physical treatments Neurosurgery and bilateral orchidectomy ('castration') are of historical interest only. Various medications have been used: anti psychotics, oestrogens, progestogens, LH-releasing hormone (LHRH) analogue, anti-androgens, and SSRIs. There is evidence for the efficacy of cyproterone acetate (an anti-androgen) and medroxyprogesterone acetate (a progestogen) in the treatment of hypersexuality and paraphilias. Recently, SSRIs have been used increasingly, and some use them first line due to their relative lack of side effects. Psychodynamic psychotherapy Individual and group approaches have been used, ranging from sophisticated psychoanalysis to primarily sup portive therapy. CBT Specific techniques may be used to decrease deviant (covert sen sitization, aversive therapy, masturbatory satiation, biofeedback) and in crease 'normal' arousal (orgasmic reconditioning, shaping, fading, exposure to explicit stimuli, biofeedback, systematic desensitization). Controversially used to treat homosexuality until the 1970s. Social skills training, assertive ness training, sexual education, and relapse prevention can also be helpful. Addressing cognitive distortions regarding sex, women, or children may also be important.

 Gender identity and gender dysphoria 1: overview Introduction People who identify as transgender were previously regarded as having a disorder of gender identity, characterized by the desire to live and be ac cepted as a member of the opposite sex, usually accompanied by a sense of discomfort with one's anatomical sex. In recent years, there has been a sig nificant shift in how this group of people are conceptualized within the med ical profession and in wider society. They are now accepted as displaying a normal variant of gender identity, rather than a disorder. Transgender people usually come to psychiatric attention, not with a wish to change these feelings, but rather seeking onward referral to specialist services for assessment and management of gender reassignment. Gender specialists are often psychiatrists but may be chartered psycholo gists or medical practitioners

from other specialties with specific experience in the assessment and management of people with gender dysphoria. Most treatment is provided by gender identity clinics, with input from a range of specialists, including surgeons, endocrinologists, sexual health physicians, speech and language therapists, psychologists, and counsellors. The aim is to make an accurate diagnosis, to assess and treat comorbidity, and to pro vide support through the period of assessment and transition. Ongoing care is increasingly provided in primary care, with specialist advice as needed.
Cultural context The terms gender non-conformity, gender variance, gender incongruence, or transgender are attempts to describe individuals for whom gender iden tity does not match the identity usually identified with the sexual anatomy at birth. The language used is shifting, as medical models of illness are in creasingly abandoned for this group of people (see Box 11.7). There is ten sion regarding the role of psychiatry and medicine in the lives of people who are transgender. Like the historical inclusion of homosexuality in the Diagnostic and Statistical Manual of Mental Disorders, the application of a medical diagnosis (such as 'Gender identity disorder' or 'Transsexualism') to transgender individuals is felt by some to ascribe pathology to a normal variant of human experience. Evidence for the separation between gender identity and natal sex is found across cultures. Anthropological and historical studies describing gender identities that do not conform with rigid biological boundaries are numerous. It is important to note that cultural recognition of communities, categories, and roles for people who have minority gender identity does not prevent marginalization, discrimination, violence, or social control. These cross-cultural definitions may not map in an uncomplicated way to a diag nosis of transsexualism or gender dysphoria. Epidemiology Data regarding the prevalence of transgender individuals in the population is difficult to gather. Research has largely depended on people presenting for treatment. A primary care survey in Scotland estimated a population

Gender identity and gender dysphoria 1: overview prevalence of transgender individuals, either receiving treatment or re questing assessment, of 78 per 100,000.17 More recent attempts to estimate the actual population, rather than the treatment population, of transgender individuals in the UK suggest a prevalence of about 600 per 100,000.18 This is extrapolated from treatment data and assumes that 80% of transgender individuals are natal ♂. Emerging data suggest the sex ratio is likely to be closer to equal, which would make the above figures an underestimate, po tentially putting the actual prevalence closer to 1%. 17 Wilson P, Sharp C, Carr S (1999) The prevalence of gender dysphoria in Scotland: a primary care study. Br J Gen Pract 49:991–2. 18 Gender Identity Research and Education Society (GIRES) (2011) The number of gender variant people in the UK – Update 2011. M http://www.gires.org.uk/wp-content/uploads/2014/10/ Prevalence2011.pdf [accessed 8 July 2018]. Box 11.7 Language • Gender: an individual's internalized sense of masculinity or femininity. This may be apparent through the outward signs of gender expression, including gendered behaviours or roles. • Sex: ♂ or ♀ biological phenotype. This is often referred to as natal sex or birth-assigned sex. • Sexuality: the range of people to whom a person is sexually attracted (including, but not limited to, heterosexuality, homosexuality, bisexuality, etc.) and unrelated to a person's gender identity. • Transgender: a description for an individual or group of people with a gender identity that challenges the cultural expectations of their natal sex. Other terms with subtle variations of meaning include gender non- conformity, gender incongruence, and gender variance. • Transsexual: a medical description of a transgender individual who has modified, or is seeking to modify, their gender expression. Although this terminology is used in ICD-10, its usage has become regarded as stigmatizing and inappropriately pathological. • Transgender woman: a person of ♂ natal sex who identifies as a woman (also: transwoman; ♂-to-♀; MtF). •

Transgender man: a person of ♀ natal sex who identifies as a man (also: transman; ♀-to-♂; FtM). • Non-binary: a person of either ♂ or ♀ natal sex who identifies as neither ♂ nor ♀. • Cisgender: a person with gender identity matching their natal sex. • Gender-affirming treatment: medical, surgical, and psychosocial interventions aimed at achieving lasting comfort with an individual's gender identity.

510 Chapter 11 Reproductive psychiatry and sexuality Gender identity and gender dysphoria 2: diagnosis Current practice is to diagnose the distress associated with a gender identity that is divergent from biological sex. This distress is referred to as gender dysphoria. Gender non-conformity is not synonymous with gender dys phoria. Medical and/or psychiatric treatment is offered to relieve gender dysphoria. This approach is integrated into DSM-5 and extends to ICD-11, with the new diagnosis of 'Gender incongruence' moved from the chapter 'Mental, behavioural, and neurodevelopmental disorders' to 'Conditions re lated to sexual health'. Using DSM-5 criteria, gender dysphoria is identified by incongruence be tween an individual's gender identity or expression and their natal sex of at least 6mths' duration. It requires clinically significant distress or impairment in function. An ICD-10 diagnosis of transsexualism requires the features of incongruence to exist for 2yrs. In ICD-11, 'Gender incongruence of child hood' requires at least 2yrs' duration, but 'Gender incongruence of adoles cence or adulthood' should be present for only 'several months'. Differential diagnosis • Non-conformity to gender roles: the diagnosis of gender dysphoria should be restricted to individuals with distress or functional impairment and is differentiated from uncomplicated non-conformity by the strong and pervasive desire to be of another gender. • Transvestic disorders/fetishistic transvestism: engaging in cross-dressing for sexual excitement is not a feature of gender dysphoria. The diagnoses may rarely coexist, and transvestic behaviours may be part of gender role exploration. • Dual-role transvestism: adopting the outward expression of the opposite sex to gain temporary membership of that gender category. This does not carry with it the desire for permanent adoption of a new gender identity. • Body dysmorphic disorder/dysmorphobia: an expressed dissatisfaction with specific body parts, possibly including primary or secondary sexual characteristics, but without a desire to change gender. Careful assessment to exclude these disorders is required, as misdiagnosis reduces the success of surgical interventions. • Intersex conditions: disorders of sexual development or intersex conditions are usually identified in childhood (e.g. congenital adrenal hyperplasia, androgen insensitivity syndrome, Klinefelter's syndrome, Turner's syndrome, Rokitansky syndrome19). They previously precluded the diagnosis of transsexualism or gender identity disorder. The possibility of gender dysphoria existing within this population is now acknowledged in DSM-5. • Schizophrenia and other psychoses: delusions of being the wrong sex or needing to change sex arising in the context of a functional psychosis do not constitute gender dysphoria. 19 Rokitansky syndrome (also known as Mayer–Rokitansky–Küster–Hauser syndrome, Müllerian agenesis, Müllerian aplasia, vaginal agenesis) has an incidence of 1 in 4500–5000 ♀ and is caused by embryologic underdevelopment of the Müllerian duct, with resultant agenesis or atresia of the vagina, uterus, or both.

Gender identity and gender dysphoria 2: diagnosis Comorbidity Transgender populations have poorer health outcomes than the gen eral population, with an i prevalence of affective, anxiety, and substance misuse disorders. There are conflicting data regarding any difference in the prevalence of personality disorders. A Swedish long-term cohort study has shown that high rates of premature mortality, suicidal behaviour, and psychiatric comorbidity exist, even after treatment

for gender dysphoria.20 It remains impractical to design long-term prospective, controlled studies comparing psychiatric outcomes in transgender individuals who do and do not receive treatment.21 Transgender women are regarded as being a high-risk group for HIV and other sexually transmitted infections (STIs). Other sexual and reproductive health issues affecting transgender women and men are not well studied. Legal aspects In the UK, the Equalities Act (2010) defines protected characteristics that afford an individual specific legal protection. In particular, ‘gender reassign ment’ is a protected characteristic under the Act afforded to any individual who identifies as transgender. This protection does not depend on a med ical or psychiatric diagnosis or the undertaking of any medical or surgical treatment. The Equalities Act does not make provisions for the legal recog nition of a change in gender. The Gender Recognition Act (2004) allows transgender individuals to change their legal gender. The change is by application to the Gender Recognition Panel and the granting of a Gender Recognition Certificate, which can be used to have a new birth certificate issued. A person is re quired to show evidence that they have lived in their acquired gender for the last 2yrs and that they intend to live permanently in their acquired gender. Differing from protection under the Equalities Act, the application for a Gender Recognition Certificate requires a diagnosis of gender dysphoria. It needs to be supported by two medical reports, one completed by a registered medical practitioner or a psychologist who has been recognized as a gender specialist by the Gender Recognition Panel and the other a registered medical practitioner who may or may not be a specialist. In prac tice, this means that a person has been assessed over a sufficient period in a gender identity clinic and has had their diagnosis confirmed by a second opinion. A legal change of name is often sought as part of a transition to the ac quired gender. This is accomplished by the same mechanisms as any other person wishing to change their name and depends on jurisdiction. 20 Dhejne C, Lichtenstein P, Boman M, et al. (2011) Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. PLoS One 6:e16885. 21 White Hughto JM, Reisner SL (2016) A systematic review of the effects of hormone therapy on psychological functioning and quality of life in transgender individuals. Transgend Health 1:21–31.

512 Chapter 11 Reproductive psychiatry and sexuality Gender identity and gender dysphoria 3: assessment Many patients will arrive with a clear idea of their diagnosis and preferred treatment options. The task of assessment is to establish a clear diagnosis and identify any important psychiatric or medical comorbidities. Learning disability, affective illness, personality disorder, and stable psychotic illnesses, for example, are not contraindications to treatment for gender dysphoria, but rather demand care with diagnostic accuracy, coordinated treatment of comorbidity, and careful consideration of capacity to consent. Most patients presenting to general psychiatric services with a confirmed diagnosis of gender dysphoria will require onward referral to specialist gender identity clinics. In many cases, this referral will be made directly from primary care. During assessment, subsequent contact, and communication with col leagues, it is important to respect the personal pronoun and termin ology choices of an individual being assessed. In general, simply asking how an individual prefers to be addressed at an early stage avoids later issues. Psychiatric history • Obtain a comprehensive psychiatric history, focusing on the development of gender identity and gender dysphoria, the impact of gender dysphoria over the lifespan, and the availability of support, whether family or not. • Some patients have social circumstances that prevent a social transition prior to medical intervention. • A collateral history is likely to be useful in establishing an accurate diagnosis, but care needs to be taken to establish appropriate consent. • In young people, corroboration of the history is essential. • Note: a ‘real life

test’ is no longer required before treatment. Medical history • Obtain a thorough medical history, including family history, to establish the cardiovascular state, vulnerability to thromboembolic disease, and risk factors for malignancies potentially exacerbated by cross-sex hormone treatment. • Ask about current and past substance use. Physical assessment • Weight, height, BP, fasting lipids, and fasting glucose are checked as part of a cardiovascular risk assessment and form a useful baseline prior to treatment. • High BMI is a potential contraindication to endocrine and surgical interventions and will need to be discussed with the patient early on.

Gender identity and gender dysphoria 3: assessment • FBC, electrolytes, and liver enzymes can be affected by hormone regimes and, along with prolactin in natal ♂, form part of an initial assessment for treatment. • If there are signs of endocrine abnormalities (e.g. irregular menstruation in natal ♀), a sex hormone profile is obtained. • Natal ♂ should have any signs of prostate disease appropriately evaluated, and natal ♀ should be up-to-date with routine smear testing. • HIV, hepatitis C, and general sexual health screening should be offered, if indicated, by a patient’s risk profile.

514 Chapter 11 Reproductive psychiatry and sexuality Gender identity and gender dysphoria 4: management22 Treatment Care for patients with gender dysphoria encompasses a spectrum of treat ments and should be individualized for each patient. Careful selection of treatments, review of goals, and regular assessment of clinical response are particularly important for non-binary patients. • Non-medical treatments—such as facial hair removal, voice training, and supportive counselling are low-risk interventions with significant benefit. • Endocrine treatments—aim to supress endogenous sex hormone levels and replace with cross-sex hormones at a normal physiological level (see Box 11.8). All patients should be offered fertility preservation where endocrine treatment is being considered. Suppression of puberty may be appropriate in adolescents who have been assessed by specialist services. • Surgical treatments—generally have a higher threshold for assessment and consent. In the UK, a second opinion and 12mths of social transition are required for genital reassignment surgeries. This is not the case for less invasive procedures such as chest reconstruction. Prognosis Most studies show a positive impact of treatment for gender dysphoria. Almost all patients are satisfied with sex reassignment at follow-up. A ma jority have both subjective and objective improvements in psychological well-being (including intensity of gender dysphoria) and quality of life. Less than 2% of patients express regret regarding their treatment. Published studies do not readily distinguish the relative benefits of each specific inter vention. A sustained positive response to treatment depends on appro priate ongoing support. Regulatory bodies are increasingly clear about the responsibility non-specialist clinicians have in delivering high-quality and prejudice-free care to transgendered patients. 22 For further information, see: General Medical Council M https://www.gmc-uk.org/ethical- guidance/ethical-hub/trans-healthcare---advice-based-on-gmc-guidance [accessed 9 January 2019]; Royal College of Psychiatrists (2013). Good practice guidelines for the assessment and treatment of adults with gender dysphoria. No. CR181. M http://www.rcpsych.ac.uk/usefulresources/publica tions/collegereports/cr/cr181.aspx [accessed 8 July 2018].

515 GENDER IDENTITY AND GENDER DYSPHORIA 4: MANAGEMENT Box 11.8 Endocrine treatments Feminizing hormones • Synthetic oestrogen and androgen suppression—produces breast development, body fat redistribution, thinning of body hair, reduced erectile function and libido, reduced muscle mass, and emotional changes. Regimes include oral or transdermal oestrogen and a GnRH analogue or cyproterone. Finasteride or spironolactone may be used. Oestrogen alone may

provide sufficient androgen suppression. • Side effects—include i risk of venous thromboembolism, liver dysfunction, migraine, cardiovascular and cerebrovascular disease. Data regarding breast cancer risk is inconclusive. Masculinizing hormones • Testosterone—produces i muscle mass, i growth of facial and body hair, cessation of menses, clitoral enlargement, and deepening of the voice. Administration is parentaral or transdermal. Rarely, androgen supression is required for incomplete cessation of menses. • Side effects—include polycythaemia, liver dysfunction, ♂ pattern baldness, and metabolic changes, including weight gain (impacting cardiovascular and cerebrovascular risk). i aggression has been reported. Exogenous testosterone is teratogenic. Monitoring • Cardiovascular risk at baseline and during treatment. Assessment should encompass physical and metabolic parameters, including lipids, glucose, BP, and BMI. • Blood monitoring should additionally include liver enzymes, U&Es (if prescribed spironolactone), FBC (if prescribed testosterone), and hormone profile for dose adjustment. • Surveillance for specific malignancies (e.g. breast and cervical).

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