# Treating Gender Dysphoria with Hormone Treatments Carries Risks

Several important new studies on the serious risks to young women for depression and suicide from the use of hormonal contraceptives should be presented to male youth and adults who are considering or who are using hormones in preparation for sexual reassignment surgery.

While this risk of depression and suicide has not been proven yet in males from the use of hormones, the demonstrated risks to younger females should raise serious concerns about possible similar risk to males.

In a nationwide prospective cohort study published in JAMA Psychiatry in 2016 of more than 1 million women living in Denmark, an increased risk for first use of an antidepressant and first diagnosis of depression was found among users of different types of hormonal contraception, with the highest rates among adolescents and with a two fold risk compared to adults.

This study found a 70 percent higher risk of depression among users of hormonal contraception compared with never-users. The mean of the women was age 24.4. This study found a 70 percent higher risk of depression among users of hormonal contraception compared with never-users.

A November 2017 study in the American Journal of Psychiatry has shown even more serious psychiatric consequences stemming from the use of hormonal contraceptives. Nearly half a million women who used hormonal contraceptives compared with women who never used them were at two times greater risk for suicide attempts and at three times greater risk for completed suicides.

A 2017 retrospective review of 201 transgender patients aged between 18 and 64 revealed that overall, 95 percent of them were prescribed hormones by their primary care provider, with the mean age of initiation of masculinizing or feminizing hormone prescriptions 31.8 years.

Primary care providers, surgeons, mental health professionals, endocrinologists, should be aware of the potential risks to males who request hormone therapy and sexual reassignment surgery. They should provide them informed consent about possible risks. This is, after all, required by law.

These new research findings may also explain, in part, the elevated risk of depression and markedly increased risk of suicide after sexual reassignment surgery (SRS).

**SRS and increase of depression and suicide**

A 2015 study reported from Boston of sexual reassignment surgery on adolescents demonstrated these risks. The 180 transsexual youth (106 female-to-male; 74 male-to-female) in the study had a twofold to threefold increased risk of psychiatric disorders, including depression, anxiety disorder, suicidal ideation, suicide attempt, self-harm without lethal intent, and both inpatient and outpatient mental health treatment compared to a control group of youth. Also, the mean age at which they presented for consideration for sexual reassignment surgery was 9 years old.

When a male with gender dysphoria who is on hormone therapy develops depressive illness, the role of hormones needs to be considered as a possible major factor. If the depressive illness does not respond to appropriate treatment, cessation of the hormonal therapy needs to be considered.

Two large studies have demonstrated similar risks of suicide after sexual reassignment surgery.

The largest study of SRS, an analysis of over 300 people in

Sweden over the past 30 years, demonstrated that afterwards there were considerably higher risks for mortality, suicidal behavior, and psychiatric morbidity than in the general population.

In 2014 Dr Paul McHugh commented in the Wall Street Journal on this research:

> *"Most shockingly, their suicide mortality rose almost 20-fold above the comparable non-transgender population. This disturbing result has as yet no explanation but probably reflects the growing sense of isolation reported by the aging transgendered after surgery. The high suicide rate certainly challenges the surgery prescription."*

McHugh has also described his study of people with gender confusion over the past 40 years, 26 of which he spent as chief psychiatrist at Johns Hopkins Hospital. He wrote in 2015:

> *"In fact, gender dysphoria – the official psychiatric term for feeling oneself to be of the opposite sex – belongs in the family of similarly disordered assumptions about the body, such as anorexia nervosa and body dysmorphic disorder. Its treatment should not be directed at the body as with surgery and hormones any more than one treats obesity-fearing anorexic patients with liposuction."*

He went on to say:

> *"The treatment should strive to correct the false, problematic nature of the assumption and to resolve the psychological conflicts provoking it. With youngsters, this is best done in family therapy."*

The second study with similar results was a review of 11 years of Veterans Health Administration electronic medical records

of veterans from 2000 through 2011. This showed that Gender Identity Disorder prevalence was far higher (22.9/100 000 persons) than previous estimates of GID in the general US population (4.3/100 000 persons).

Most troubling was the rate of suicide-related events – it was similar to the Swedish study. Among GID-diagnosed veterans the rate was more than 20 times higher than for the general VHA population. And the prevalence of GID diagnosis nearly doubled over 10 years among VHA veterans.

Paul Hruz, a pediatric endocrinologist and an associate professor of cell biology and physiology at Washington University School of Medicine, St. Louis, led a 2017 research study, "Growing Pains: Problems With Puberty Suppression in Treating Gender Dysphoria" that raises serious questions about the current treatment of youth with gender dysphoria. He wrote:

> *"Of particular concern is the management of gender dysphoria children. Young people with gender dysphoria constitute a singularly vulnerable group and experience high rates of depression, self-harm, and even suicide. Moreover, children are not fully capable of understanding what it means to be a man or a woman. Most children with gender identity problems eventually come to accept the gender associated with their sex and stop identifying as the opposite sex."*

The report went on, "In light of the many uncertainties and unknowns, it would be appropriate to describe the use of puberty-blocking treatments in children for gender dysphoria as experimental." This new treatment has been offered to youth without the usual safeguards that govern the provision of experimental therapies, such as carefully controlled clinical trials, as well as long-term follow-up studies.

The use of hormone therapy in male youth can also be described as experimental since it also lacks controlled clinical

trials, as well as long-term follow up therapy.

Young males, in particular, with gender dysphoria deserve to know the truth about the serious risks of depression and suicide associated with the use of hormonal treatment and with suicide which are associated with SRS. Their lack of knowledge and the failure to provide informed consent from primary care providers, mental health professionals, pediatricians, endocrinologists, and mental health professionals must end.

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