Too much sexual desire, a reason to stop hormone therapy in a trans men: a case study.

[redacted]

Introduction

It's commonly known that males have a higher libido than females (1). When undergoing hormonal therapy with testosterone as part of a female-to-male transition, there will be an initial raise in sexual desire, which eventually drops again to pre-treatment level (2). In our case study however, the raise in sexual desire caused hypersexuality and together with unfulfilled sexual desires it eventually led to thoughts about transgressive sexual behavior making it impossible to function in daily life.

Case report

The patient presented himself at my Endocrinology department in [redacted] at the age of 18 with the question to start with hormone therapy. He has been followed-up for three months by a psychiatrist who confirmed the diagnosis of gender dysphoria, regarding the DSM V criteria. The patient is also known with an autism spectrum disorder (ASD) with important social and communicative disabilities and the need to be home schooled by his mother in the past three years. Furthermore, he has a history of a subdural bleeding and corrective surgery for a pyloric stenosis as newborn, with unexplained bowel complaints the last five years.

Because of the diagnosis of ASD and the absence of current professional care for this co-morbidity the patient was referred to a psychologist specialized in both autism and gender dysphoria to further explore gender identity and offer counseling regarding the autism.

The patient was referred back [redacted] where gender dysphoria was confirmed, as well the assumption that the patient was a vulnerable youngster with difficulties in communication and somatization. Hormone therapy, namely intramuscular testosterone esters 125mg every three weeks, was started. In addition, his oral contraceptive pill (OAC) was changed to medroxyprogesterone. His menarche was at [redacted] years and he had been taking an OAC for three months because of severe complaints of abdominal cramps and emotional difficulties during his periods.

During follow-up the patient flourished and gained more communicative skills. He allowed other care givers to give him counselling and he gained a larger social network. The bowel complaints disappeared and he started to explore his sexuality and began to masturbate.

The dose of testosterone was initially raised to 200 mg every 18 days with a reduction again after 9 months of treatment to 150 mg because of complaints of palpitations and muscle strain. Cardiac exam was performed and was completely normal. Progesterone was discontinued [redacted] In [redacted] he had a mammectomy.

The first emotional problems started in [redacted] months after starting hormone therapy. He was pleased with his physical appearance but developed hypersexuality and a strong desire to have a sexual relationship with a partner. He became depressed and masturbation became more a need instead of a choice. In consultation with his psychologist the dose of testosterone was further reduced, and his psychiatrist started with venlafaxine.

Unfortunately, the depressive thoughts were not countered, and he developed suicidal thoughts leading to admission on a psychiatric ward. A compulsive sexual behavior with dangerous to others was diagnosed by the psychiatrist. Psychotherapy was started and because of slow improvement we agreed to stop the testosterone therapy. In addition, a progesterone-only-pil was started to prevent recurrence of menstrual bleeding. A telephone follow-up one month after discontinuation learned that the unpleasant sexual desires and suicidal thoughts were reduced.

Discussion

Sexual desire is determined by biological, psychological, relational, contextual and sociological factors and next to sexual activity and sexual satisfaction important aspects of human life (3). In transgender persons sexual dysfunction is common and the hormone regimens and surgeries may impact sexual function. In transmen sexual desire is raised, especially in the first 12 months of testosterone therapy (2,4,5). The only long-term study by Defreyne et al showed a normalization after three years. Little is known about problematic sexual desire. In a small study of Wierickx et al 3,6% of transmen experienced personal or relational distress due to their experienced sexual desire (6). Even less is known about sexual function in transgender people with an ASD.

Studies in individuals with an ASD show that they have more hypersexual behaviors than the general population (7). Possible explanations may be linked to the core symptoms of individuals with ASD, namely the deficits in social skills, sensory hypo- and hypersensitivities, difficulties in adhering to privacy norms, greater concerns about themselves and receiving less informal and formal sexual health education (8).

In our case report we assumed that the cause of the compulsive sexual behavior is multifactorial. Firstly, it was until transition that he started exploring his sexuality and having sexual arousal. In addition, he had never had a meaningful relationship, nor sexual intercourse and due to his limited social skills, it was also difficult to initiate and seek sexual contacts. The latter being one the most frequent sexual dysfunctions in transgender persons in general and it can therefore be expected that it is even more difficult for our patient (5).

Further research is needed to explore sexual experiences in transgender people with an autism spectrum disorder. Especially because it's stated that transgender and gender diverse adults are 3-6 times more likely to be autistic than cisgender people (9). Moreover, studies are showing that being both transgender and autistic is associated with higher rates of mental health problems, making them probably even more prone to sexual dysfunction (10).

In conclusion, besides further research it is also important to develop coping strategies and guidelines for counselling this fragile population.

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