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Who am I? A Case of Gender Dysphoria

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Abstract

The field of sex and gender is extremely controversial and has contributed to a proliferation of terms whose meanings vary over time and within and between studies. The term "gender identity," distinct from the term "sexual orientation," refers to a person's innate, deeply felt psychological identification as a man, woman or some other gender, which may or may not correspond to the sex assigned to them at birth [1]. Stein 1999 stated that, "Someone who has the feeling that they are a different sex than the one that they were born – to some extent" [2]. "Sexual orientation" refers to an individual's physical and/or emotional attraction to the same and/or opposite gender [1].

Keywords: Gender Dysphoria; DSM5; Psychotherapy.

Introduction

Gender dysphoria is a psychological diagnosis recognized by the American Psychiatric Association (APA). This disorder is marked by clinically significant distress caused by a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her. In 2012, the APA announced that the term "gender identity disorder" would be replaced by the more neutral term "gender dysphoria" in the latest version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) [3]. DSM-5 has its own chapter for Gender Dysphoria separated from sexual dysfunction and paraphillias. The term Gender identity disorder is replaced by Gender Dysphoria.

Case History

A 14 yrs old boy studying in ninth standard from middle class family presented to our Out Patient Department accompanied by his parents with the chief complaints of withdrawn behavior, irritability, decrease concentration and deterioration in his academic performances for past several months and depressed mood and suicidal ideation for last 2 months and suicide attempt by poisoning 2 weeks back. Since the age of 5 yrs he thinks that he is unfortunately born as male. He had a body of a male, but from inside, he feels like a female. His thinking is of a female character. He likes to play and spent most of the time with the girls, when his elder sister plays with her friends, he also thinks that he is also among them. He preferred to play with toys like dolls, kitchen items, etc. rather than car or truck. He does not love to play outdoor sports like cricket and football among boys. He loves to play indoor games with his elder sister and her friends. He likes to dress and make-up like a girl. He used to dress in frock and a skirt and top like his sister mostly and prefer to keep his hair style like a girl in a playful manner.

Initially there was no discouragement by his family members for his cross gender behavior considering

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it to be a passing phase. But later when he continued insistence on girl type activities and clothing, and his wish to be a girl and to develop like a female bothered his family members. Whenever, his mother or elder sister tried to impose restrictions on these activities, he would become angry and irritable. Later he used to wear the female dress when he was alone.

In the school also he does not want to mix up with the boys, he does not participate in the boys talk. In the leisure time he usually stays in the classroom. He only reveals his feelings to one of his best friend whom he considers to be his boyfriend that he wants to be a girl. He wished to have a long term relationship with this boy but did not express it to him or others and conceal his relationship as he was afraid to be identified as a homosexual by the society.

As he attends his puberty and started developing male secondary sexual characters like growth of facial hairs, body hairs and enlargement of the testis and penis, which was unwelcoming and embarrassing to him. When he gets erection he does not feel good and becomes uncomfortable. He wishes to cut his penis at times. Gradually he started developing depressive symptoms like lack of interest in pleasurable activities, depressed mood, does not want to go school, crying spells, decreased appetite and suicidal wishes. He tried to commit suicide 2-3 times by poisoning. But by luck, he was taken to the doctor in time and recovered.

There is a positive family history of psychiatric disorder. His paternal aunt is having Schizophrenia and elder sister is having OCD. Both are stable and were on regular medicine. The patient had no history of any substance abuse. There is no history of child abuse. Personal history revealed apparently normal developmental milestones with normal motor, social and language development except for the girl type activities and girlish behavior since early childhood. On thorough physical examination, there were no signs suggestive of hormonal dysfunction and intersex on an expert assessment of physician.

On Mental status examination, he is preoccupied with his biological sex and expresses the desire to live like a female. He had depressed affect, suicidal wishes, and contemplation of suicide. On assessment there was no evidence of body delusion, effeminate homosexuality or transvestism. The possibility of Paraphilias and other disorders of sexual preferences were ruled out. His laboratory investigations (endocrine status) and EEG were within normal range. His psychometric assessment was done and his I.Q was found to be 100. Rorschach test revealed depressive symptoms and no other significant finding. Beck Depression Inventory suggests severe level. He was diagnosed as a case of Gender Dysphoria without the disorder of sex development as per the diagnostic criteria of DSM-5.

Treatment focused on his depression and to save his life due to the impending threat of suicide. He was given SSRI (Sertraline 50mg/day) and psychotherapy for strengthening his biologic sex role as much as possible.

Discussion

The first case of Gender Identity Disorder was described by Friedreich in 1830, although the condition was not considered worthy of further investigation until many years later. Patient with gender identity disorder is convinced that his/her own psychological gender is the opposite of his/her anatomical sex [4]. Patient with a gender identity disorder feel that they are trapped in the wrong bodies. Male patients feel feminine from childhood and often believe they were 'girls'. But this belief is not delusional in nature. The belief is always consistent with their distaste of their own genitalia, as in our case [5]. Male-to-female transsexuality is 1.5 to 3 times more prevalent than female-to-male [6-9]. The prevalence of transsexualism in the Netherlands is estimated to be 1:11900 males and 1:30400 females [10]. The estimates for the USA are 1:100000 for males and 1:400000 for females. No definite figures are available for India [10].

GID is comorbid with a variety of other psychiatric disorders, particularly mood and anxiety disorders, at rates higher than those reported for comorbid schizophrenia. It is not known if these disorders are the psychological consequence of living with GID, if they reflect shared vulnerabilities that need to be examined in their own right, or if patients with GID are at a non-specifically elevated risk for a variety of disorders [11].

Several studies have shown that those with GID who do present for treatment may have developed additional, secondary diagnoses [12]. In case of our patient also, patient had developed secondary depression and significant suicidal ideations following puberty, which was considered extremely stressful life event by the patient. Early identification and timely intervention may lead to the remission of GID during childhood. If the disorder persists into adolescence, there may be periods of remission but usually it tends to be chronic in nature [13]. Our patient is responding well to therapies attempting to strengthen his biological sex role. His family members were very supportive during the therapy process and

considering his social circumstances, the patient also tried to involve in the therapy.

Gender dysphoria patients are frequently difficult disorder to deal with. An ongoing therapeutic relationship is required for patients regarding his distress so that the patient does not go to the next level of treatment like hormone replacement or surgical sex reassignment.

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