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Gender Identity Disorder with Comorbid Psychosis- A Case Report

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Abstract: *Gender Dysphoria (GD) refers to a complex disorder marked by persistent unhappiness with once designated birth sex (natal sex) and a desire to live and be socially identified as an individual of the opposite sex. Such a feeling may result in severe distress and impairment of normal functioning in the individuals, thereby, making them vulnerable to various forms of mental and physical disorders. GD is seen to have onset mostly from the early childhood. However, in many cases the onset of clinically significant symptoms may appear in adolescence or even in adulthood. Clinician, therefore, should not be biased with the presentation of cases. Interview regarding Gender Dysphoria should be made for every case, irrespective of their presentation. Early detection and proper counseling for the individuals and their close ones, can go a long way in reducing the levels of stress in such cases and can significantly improve the outcome.*

Key Words*: Gender identity, Gender Dysphori ,assigned gender, Natal gender*

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I. Introduction

Gender Dysphoria is a relatively newer concept. It is a topic of interest now a day, owing to the significant increase in the number of such cases and the increased awareness regarding the condition, in recent times, worldwide.

Gender Identity signifies one's persistent inner sense of belonging to either the male or female gender categories while Gender Role, simply, is the outward expression of the inner sense of gender Identity.[2]

Gender Dysphoria(GD) refers to persons with a marked incongruence between their experienced or expressed gender and the one they were assigned at birth.[2] Such persons may express their discontent with their assigned sex as a desire to have the body of the other sex or to be regarded socially as a person of the opposite sex. This can lead to significant impairment in social, occupational, interpersonal and other areas of functioning.

Prevalence data for Gender Dysphoria is limited as there is difficulty in defining the target population mostly due to concealment of identity owing to the stigma associated with it. However, researchers estimate that the prevalence of Gender Dysphoria in adults in Europe is 1 in 11,000 male-assigned and 1 in 30,000 female-assigned people[3]. DSM-5 reports a prevalence rate ranging from 0.005 to 0.014 percent for male-assigned and 0.002 to 0.003 percent for female-assigned people.[1.]

Data specific to India and Assam in particular is scanty. Literature available is based mostly on the cases reported. Hence, we hereby report a case of Female to Male Gender Dysphoria with marked incongruence with her assigned gender with co morbid psychosis.

II. The Case

A 19 year old female working in a catering agency was brought by her friend with the chief complaints of smiling and muttering to self, irrelevant talk, aggressiveness, obscene gesturing to people, decreased oral intake and decreased need for sleep for 5 days which was of sudden onset. It was not associated with intake of any psychoactive substance, fever of recent onset or traumatic head injury. There was no past history of any major physical and mental illness. On personal history it was found that she since her early childhood she always wanted to be a boy and be treated like a boy. She preferred to play with boy stereotyped toys like cars and guns rather than dolls or crockery set. Later on she started wearing trousers and shirts and refused to wear skirt and frocks. She even cut her hairs short like boys and used to go to school in trousers. Initially her family members scolded her and forced her to behave like a girl. She would get angry at that and even told them to call her by a male name instead of her original name. She would say that although she has a body of female but from within she feels like a male.

When she attained puberty and started menstruating, she felt embarrassed. She would feel very sad as this would remind her of her feminity. During development of her secondary sexual characters she started feeling ashamed and in order to hide her breasts she would wear loose clothes. During her adolescence she was in relationship with 3 boys but none of her relationships lasted for more than one month and she never had any physical intimacy with them. However, 5 years back, she was in relationship with a girl who was 3 years older to her. The relationship lasted for around 3 years and the patient admitted of having physical intimacy with the girl which was consensual. But later the girl got married and left her. The patient was very much perturbed and broken by the event.

Following the death of her mother, due to breast cancer 2 years back, she moved out from her house and decided to stay with one of her friends whom she met in her workplace. For the past one and a half year she has been staying with her friend who is a bisexual. They have physical intimacy in between them and at times there is public display of affection in the form of hugging and kissing. She even tattooed her friend's name on her left forearm. She gets intimidated when any male talks with her friend and acts like the male partner in the relationship. She wants to socially marry her friend and live as her husband. Patient said that if she gets a lot of money she will do gender reassignment surgery to put male genitalia on her body and get rid of her breast. She even thought of selling one of her kidneys to procure the money needed for the expensive surgery.

There is no family history of any mental illness and the patient had no history of any substance abuse. Her thorough physical and gynaecological examination was normal. There were no signs suggestive of any hormonal dysfunction and intersex on assessment by gynaecologist and endocrinologist.

On mental status examination she was initially irritated but later on she became co-operative. Her affect was dysphoric and in thought part she was preoccupied with her biologically assigned gender and expressed the desire to live like a man. Other disorders of sexual preferences and Paraphilias were ruled out. She was diagnosed to be a case of Gender Identity Disorder with Acute Polymorphic Psychotic Disorder without symptoms of Schizophrenia according to ICD-10. Her Kinsey scale test revealed a score of 6. All her laboratory investigation reports were normal.

Initially she was treated with parenteral antipsychotics and sedatives to control her aggression and restlessness. After about 3 days she was shifted on oral antipsychotics but as there was no improvement in her psychotic symptoms even after 2 weeks of oral antipsychotic she was put on ECT after taking consent from her elder sister. Meanwhile she was continuing the oral antipsychotic. Her psychotic symptoms gradually started decreasing after second session of ECT and she remitted completely of her psychotic symptoms by fifth ECT. She is maintaining well with tablet Olanzapine 20 mg in two divided doses for her psychotic symptoms. For her Gender Identity part she was given psychotherapy. The plan is to strengthen her biologic sex role as much as possible. In the meantime she is allowed to live as her identified gender for a period of one year.

III. Discussion

Gender Dysphoria(GD) can be challenging to diagnose as the patient and family members might be hesitant in revealing the gender incongruence and distress resulting from it. Sometimes, the features of GD can be masked by signs and symptoms of other psychiatric illnesses existing co morbidly and can lead to missed diagnosis of GD and under estimation of the prevalence of GD cases in the population.

In my patient psychotic symptoms were found co-existing with GD, this is similar to the findings of Spack NP et al(2012), Kaltiala-Heino R et al(2015) and de Vries AL et al(2011)[7]. Here, onset of gender dysphoria was in childhood which is similar to the findings of Gray SAO et al(2012)[7]. Also, in this case the GD symptoms got aggravated during puberty, finding similar to the study by Steensma et al(2013), and dissimilar with the findings of Ristori et al(2016) who found that for ~80% of children with GD in Childhood, the GD recedes with puberty. Our patient faced adverse reactions from her family and friends due to her gender incongruence which might have been a contributing factor for the nature of her illness, similar to studies of Meyer KH et al (2014). Moreover, in this case, the patient started having sexual encounter at quite an early age, similar to findings of Bungener SL et al (2017).

Gender Dysphoria is a difficult disorder to deal with. Many children start showing the signs of discomfort with their natal gender at a early age which are usually not tolerated well by the parents, mostly due to lack of understanding on their part. Such differences can lead to trouble for the patient as his/her parents may try to redefine or correct their gender identity by forcing them to dress, talk and act likes a particular gender. This in turn can give rise to conflict in the child's mind making him/her vulnerable to various psychiatric as well as physical illnesses. Hence, an early psychiatric consultation and proper councelling and therapy for both the individual as well as his/her family members are vital in such cases.

Sometimes Gender Dysphoria, particularly of chilhood onset, resolves spontaneously with time. However in other cases the discontent may persist through adolescence and early adulthood and may even increase in severity. Such cases require careful assessment and proper support and guidance for better coping.

They should be provided with all the possible treatment options (hormonal therapies, gender reassignment surgeries etc) and should be given a chance to make their own decision with the help of family and friends.

This case report attempts to add to the sparse literature on the experience of Gender Dysphoria patients, initially presenting with symptoms of psychosis or other psychiatric disorders.

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