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Gender Dysphoria in Adulthood: A Case Report Using Projective Analysis

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Abstract

Purpose: Gender dysphoria is a complex and significant problem. It is characterized by a marked incongruence between patient's experienced or expressed gender and the one they assigned at birth. **Approach:** This report describes a case of gender dysphoria. **Findings:** The patient was referred for complete psychometric and personality assessment and possible intervention (s). He was looking for male-to-female (MTF) Sex Reassignment Surgery (SRS).

Keywords: Gender Dysphoria, Expressed and Experienced Gender, Sex Reassignment Surgery, Femininity, Masculinity

Introduction

Gender identity term used for a person's sense of femininity or masculinity. Gender dysphoria is described as a six-month span of pronounced gender inconsistency between one's actual or expressed gender and one's assigned gender and further used other specifiers for the diagnosis of gender dysphoria. **(DSM 5, APA, 2013)** Gender dysphoria, formerly called as gender identity disorder, presents with significant distress associated with it. It is also linked to severe impairments in psychological, educational, interpersonal, and other aspects of life.

Cases of gender dysphoria has been reported in children, adolescents and adults. Gender dysphoria

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has been reported in both the sexes. Gender dysphoria manifests itself in many ways depending on the age group. Cross-gender identification can be seen in role-playing, dreams, and fantasies in people with gender dysphoria. They show little interest in stereotypical acts. In people with gender dysphoria, the difference between experienced gender and physical sex traits is frequently, but not always, followed by a desire to abandon primary and/or secondary sex characteristics in favor of adopting part or all of the features of the other gender. Adults with gender dysphoria can, to some extent, adopt the behavior, clothes, and mannerisms of the experiencing gender. **(DSM 5, APA, 2013)**

People who develop gender dysphoria almost invariably report having had a gender identity problem in childhood, although the onset of full syndrome most often in late adolescence or in early adult years of their lives. **(Spitzer et al., 1989)**

For natal males, the prevalence varies from 0.005 percent to 0.014 percent, whereas for natal females, the frequency ranges from 0.002 percent to 0.003 percent. **(DSM 5, APA, 2013)**

The prevalence data are limited; the best estimates of the Gender Dysphoria/ Transsexualism in adults are from Europe with a prevalence of 1 in 30,000 men and 1 in 100,000 women. The worldwide life time prevalence is estimated to be 0.001-0.002%.2-4 Many researches show a sex ratio of 3 to 5 male for each female patient, so it is less common in females. **(Benjamin H., 1966)**

There are studies on psychiatric co morbidities in children, adolescent and adult. According to a survey **(à Campo et al, 2003)** conducted on 584 patients with cross gender identification, 225 patients (39%) have GID as primary diagnosis. For the remaining 359 (61%) cross gender identification was comorbid with other psychiatric disorder. Depression and anxiety disorder are

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frequently co morbid with GID. However, data specific to India is scanty. The patients suffering from gender dysphoria are persuaded to meet a psychiatrist either by their family and friends or are referred for psychiatric or psychological opinion or interventions by surgeons or gynecologists for fitness for sex reassignment surgery. We hereby report a case of a patient MTF Gender Dysphoria with severe maladjustment to the life events leading to comorbid depression and marked anxiety.

The case

A 24 years male, 8th passed, currently unemployed was referred from Department of Surgery, for psychological assessment and expert opinion. The patient desired to have a sex reassignment for the past several years as he was not satisfied with his male body and especially male genitals. He was feeling this way from last 12 years i.e., since age of 12. He also reported about sadness of mood, crying spells, suicidal ideas without intention, for past two-three months. He wanted a sex reassignment surgery as soon as possible.

At the beginning, he started to feel perplexed about his problem and started to live alone and detached. He could not participate in stereotyped boys' games and sports and was more comfortable in a girl's role. Other students of his school started to tease him about his activities. Except for the 'boy-type' behaviors, personal history revealed seemingly normal motor, social, and verbal development. During his early childhood he preferred to play with girls- in the school as well as in the neighborhood. He used to dress in 'Kurta-pajama' because it felt like 'Salwar-kurta' for him. Whenever he used to be alone at home, he adorned himself in Skirt and Saree to fully live like a girl. During adolescence he started developing male secondary sexual characteristics which he hated like anything. He didn't like his deepened voice and as result of this, he spoke when necessary.

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At that point he could not talk about his condition to others, but, at the same point, he wanted a solution of his problem. Because of his 'strange' behavior, people around him used to question him and often teased him. Because of all the teasing, he used to skip school in between and he limited himself to his home. His father passed awayat that time, so he got a ground for quitting school. So, he could only pass eight standards. He belonged to a remote area of India and his family income was nominal. He could not talk about his experiences to anyone. Slowly and gradually, he started to dress as females when aloneand speak like girls whenever possible. In his late teens, he developed attraction exclusively towards male partners. He even developed an affair with a boy and their intimacy grew, and theylived like partners. He always thought himself to be female in the relationship and enjoyed this role. Because of all these behavioral changes, people started to confront him about his 'so-called' bizarre acts. In starting, he remained defensive and acted as he knows nothing. But, when things started to go out of hands he also wished to marry (which was looking impossible to him), he shared his experiences to his family. All were shocked and stopped him to think about this way anymore but his mother understood him and tried for solutions. Then, with the joint efforts of the patient and his mother they came across internet and listen a whole story of sex reassignment surgery in a YouTube video. Then he came to Department of Surgery then he referred to Department of Psychiatry for psychological evaluation and expert comment. There was no history of any psychiatric illness, no history of physical illness, no history of any surgery and no history of any substance use. There was no family history of any psychiatric disorder. The patient had no history of any substance use. On Mental Status Examination (MSE), he was found to be preoccupied with his biological sex and wanted to get rid of it. He had depressed

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affect, suicidal ideas and feelings of helplessness. He wanted to live and enjoy his life as a female as soon as possible.

Assessment findings

On assessment, there was no evidence of body delusion, effeminate homosexuality or transvestism. The possibility of Paraphilias and other disorders of sexual preferences were also ruled out. A detailed psychological assessment was done in order to see current level of intellectual functioning, personality traits, current level of psychopathology & interpersonal dynamics and conflicts. On IQ assessment, he was found to be average. On personality assessment, he was found as concreate thinker, group-dependent, moralistic, and tender- minded. Traits of anxiety were also present. While assessing interpersonal dynamics and conflicts, fears and guilt-feelings related to his male body were present. On TAT, the main needs were achievement, affiliation and nurturance. The content of the stories was revolving around optimistic views of life and future.

In the stories it also revealed that the patient's identification level with the hero was adequate and gender role was with identified sex. The major conflict was with the need for achievement and rejection. There was good emotional tolerance was seen in the stories. On Rorschach Inkblot Test, few features of anxiety were present, in addition to this finding, no significant findings were found on Rorschach test. He was diagnosed as a case of Gender Dysphoria with Major Depression as per the diagnostic criteria of DSM-5. The initial focus of the treatment was to treat her depression and anxiety. He was given brief psychotherapy, SSRI and benzodiazepines. Later management plan was to strengthen his gender role.

Currently he is living with his mother and planning for sex reassignment surgery with hormonal

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therapy and take some employment after that.

Discussion

Gender dysphoria is a complex and less reported disorder. This is a frequently difficult disorder to deal with. This condition should not be confused with gender atypical conditions. Repeated declarations of being or wanting to be a boy and wanting to grow up to be a man, as well as cross-sex fantasy play, are all red flags, marked aversion to traditionally masculine activities and significant gender dysphoria are important distinguishing features. Dysphoric patients always feel that the assigned sex is ‘‘not their’’ and they belong to other existing sex. Many children with gender dysphoria prefer to dress in gender-neutral attire, play with gender-neutral playmates, and enjoy gender-neutral games and toys. **(Kaplan, et.al. 2014)** Patient with gender identity disorder feel that they are trapped in the wrong bodies. Male patients feel feminine from childhood and often believe they were ‘girl’. This belief is not delusional in nature. The belief is always consistent with their dissatisfaction with once designated birth sex and distaste of their own genitalia which are described as ‘not mine’ as in this case. Initially male to female Gender Dysphoria patients may consider themselves gay during adolescence because of sexual attraction to male partners. However, they recognize the distinctness later, as they consider themselves to be women in their relationships with heterosexual men. This patient also explained his sexual relationships as ‘heterosexual’ because he believed that he belonged to opposite sex. In their adolescence and adulthood, generally, the patients’ sexual relationship is as “heterosexual” as in this case. He believed in all these years that he belongs to opposite sex and identified and enjoyed his part as female partner.

Before diagnosing the patient with Gender Dysphoria, physical signs of intersex or endocrine status

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should also be carefully looked. Laboratory tests apart from complete physical examination might be necessary as a part of the physical workup to rule out above said disorders. Some intersex disorders, such as congenital adrenal hyperplasia in women and partial androgen insensitivity in men raised as females, are more likely to cause gender identity conflict. **(Futterweit et al, 1986)** As a result, inquiries on physical indicators of intersex or endocrine status should be included in the history.

The comorbid psychiatric condition in patients with Gender Dysphoria should be looked by mental health professional. As they may not only increase the distress and disability but also complicate the issue related to further management.

Patients with GID typically report anxiety and depression **(Green R, 1979; Hepp et al, 2005)** and multiple studies have found that those with GID who do seek therapy may have developed secondary diagnoses. (Blanchard & Steiner, 1990) Our patient also developed secondary depression and significant suicidal ideations followed by all the teasing he faced especially during his late teen years. Early identification and intervention for other associated disorder may not only decrease the morbidity. Early identification and timely intervention may lead to the remission of Gender Dysphoria during childhood. If the disorder persists into adolescence there may be periods of remission but usually it tends to be chronic in nature. **(Roberto L, 1983; Smith, 2005; Zamboni et al, 2006)** The patient (the current case) failed to respond to therapies attempting to strengthen his biological sex role. Hence, considering his social circumstances, the patient also tried to involve in the therapy. However, his gender dysphoria increased further and level of satisfaction with his own biological sex decreased. Later on, he stopped cooperating in the therapy process and asserted that

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he is much better with his perceived female role. He started gathering information for sex reassignment surgery after coming across to this procedure and contacted with surgeons regarding this.

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Statement of contribution

H.F has done the case, psychometric assessment, counselling and psychotherapy and case writeup. S.S. has supervised the case throughout.

Declaration of interest

We declare that there is no conflict of interest.

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