Indian Journal of Psychiatry, 1999, 41 (3),257-259

SECONDARY GENDER IDENTITY DISORDER - A CASE REPORT

NANDINI CHAKRABARTI, V.K. SINHA & A. PARIAL

ABSTRACT

An eighteen year old Christian male, diagnosed as Bipolar Affective Disorder, 2nd manic episode with mood congruent psychotic features presented during the episode with the explicit wish for sex reassignment surgery. He even claimed to be married to a local man. With effective management of the manic episode, his wish for sex reassignment surgery has completely subsided. This report discusses the literature regarding secondary gender identity disorder occurring in psychotic conditions and further implications of the same.

Key words: Secondary, gender identity disorder

Gender identity disorder or transsexualism according to ICD-10 (Clinical Description and Diagnostic Guidelines, WHO,1992) is a desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of ones own anatomic sex and a wish to have hormonal treatment and surgery to make ones body as congruent as possible with the preferred sex.

For the diagnosis to be made, the transsexual identity should have been present persistently for at least 2 years and must not be a symptom of another mental disorder, such as schizophrenia or associated with any intersex, genetic or sex chromosome abnormality.

DSM-IV (APA, 1994) criteria for gender identity disorder :

A) A strong and persistent cross gender identification (not merely a desire for any cultural advantages of being the other sex).
B) Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
C) The disturbance is not concurrent with a physical intersex condition.
D) The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

DSM-IV mentions that in schizophrenia there may rarely be delusions of belonging to the other sex.

The existence of a primary psychiatric condition in gender identity disorder has significant bearing on the appropriate management and prognosis. This case report illustrates the existence of secondary gender identity disorder during a manic episode and the resolution of the same with appropriate treatment of mania. The case stresses the importance of ruling out an underlying psychotic disorder in a case manifesting with gender identity disorder. The central issue in such cases is a proper work-up and diagnosis.

CASE REPORT

S.B., an eighteen years old single Christian male, studying in class 10, coming from a middle socio-economic status family of urban background was brought by his mother to CIP-OPD in August 1998.

The patient had an acute, continuous and deteriorating illness with no precipitating event, of three months duration marked by increased

talk, tall claims, abusive, assaultive and disruptive behaviour, overt cheerfulness. Along with these symptoms he had started to say that he was a female and had married a neighbourhood man. He claimed that he was loved by his alleged 'husband' and liked doing household chores for him. He often insisted on spending most of his time in this man's house.

Past history of mental illness included an episode in 1996 of one month duration with features suggestive of a manic episode with psychotic features. He talked about opening a beauty parlour during that episode but expressed no desire to be a girl. Family history of major mental or physical illness was uneventful.

S.B. was born after an uneventful pregnancy and delivery. He had normal developmental milestones. He was the eighth and youngest of his siblings, all males. His elder brothers were aged eighteen to twenty years. His mother who wished that her youngest child were a daughter, liked dressing him up as a girl in frocks. He usually played with dolls and liked helping in household chores. However such activities stopped by the time he was eight years old. He spent the rest of his childhood and adolescence as any other average boy. He was an average student studying in class 10 when he was brought to CIP. His academic performance had been declining for the past three months.

Physical examination revealed no abnormalities. He had normal external male genitalia, bilateral testicular sensation and secondary sexual characters.

Mental status examination revealed an unkempt, untidy and restless individual with an effeminate manner and female gestures though he was dressed in a shirt and trousers. He had loud overabundant speech, elated affect and flight of ideas. He was under no delusion regarding his existing sex. He knew that he was a male and addressed himself by his true name. However he claimed to have been married at a temple ceremony (which was delusion as revealed on serial mental status examination). He revealed his wish to become a female and enquired about sex re-assignment surgery. His cognitive functions were normal.

A diagnosis of Bipolar Affective Disorder, present episode manic with mood congruent psychotic features (2nd episode) with secondary gender identity disorder, was made according to ICD-10 (WHO, 1992).

At admission his manner was effeminate and seductive towards males. He asked for female clothes and cosmetics and often draped a red veil over his head. He claimed to be desirous of establishing a physical relationship with a man and the inability to have a physical relationship with a woman. His affect was clearly elated and psychomotor activity was more than normal. He was overfamiliar with all examiners whether male or female.

He was started on anti-psychotic (Haloperidol, 10 mg/day) and lithium carbonate (900 mg/day). His seductive behaviour towards males and constant expression of wanting to establish a sexual relationship with them proved to be hazardous within a male open ward system. He was disruptive to the normal ward routine and ordinary restraint had little effect in calming him down. Since he was proving to be difficult to manage and his behaviour was a constant threat to his physical health and integrity, his lithium carbonate was stopped after 1 week and he was put on electroconvulsive therapy on alternate days. After the course of ECT, lithium carbonate was restarted and gradually increased to 1200 mg/day.

In little over a month he said that he no longer wanted a sex change surgery but wanted to marry a girl. But he also wanted to maintain relationships with the man he called his 'husband', simultaneously. His affect was still elated and psychomotor activity was more than normal. There were no cognitive deficits. At the end of two months he only wanted to marry a woman and have no sexual relations with men. He admitted that his behaviour over the past few months had been folly and that he would do as was expected of a man in society. He denied at this stage that he had ever been married. Since no psychotic features remained, his anti-psychotics were gradually tapered off.

At the time of discharge he was still cheerful but not elated. There were no features of gender identity disorder or psychosis. But his manner remained effeminate.He was maintained only on lithium carbonate (1200 mg/day) with a serum lithium level of 0.65 meq/litre.

He has come for follow-up, one and a half

months after discharge. He no longer expresses the wish for sex-reassignment. No psychotic features were noted.

DISCUSSION

Transsexualism and gender dysphoria occurring alongwith a psychotic episode and resolving with management of the primary psychiatric disorder is well recorded. However, most case reports of secondary Gender Identity Disorder show associations with schizophrenia. From India, there is one case report of a twenty year old rural male who developed transsexualism following an acute psychotic episode which was reported by Banerjee et al. (1997) and another by Jiloha et al.(1998) in a case of schizophrenia. Literature regarding the occurrence of secondary Gender Identity Disorder in affective disorders is scarce, which is the uncommon feature of this case.

This case illustrates that patients other than those with true psychosexual inversion may seek sex-reassignment surgery for reasons related to individual psychopathology. The desire for sex change in these patients is transient and short lasting and resolves with the treatment of primary psychosis.

According to Newman and Stoller (1974), since the advent of sex-reassignment surgery, psychiatrists have sought to develop a meaningful orientation to the value of the procedure. Initially, many psychiatrists assumed that individuals seeking such surgery were psychotic and they opposed the procedure in principle as a compromise with a delusional aspiration. However, as experience with patients seeking sex change accumulated, it became clear that there was a group of men characterized by extreme lifelong female orientation and absence of a sense of maleness for whom sex reassignment was followed by greatly improved emotional and social adjustment.

Unfortunately the pendulum of skepticism has swung too far in the direction of acceptance. Many physicians and psychiatrists label anyone requesting sex change as transsexual and presume that surgery is the treatment of choice.

The crucial error lies in the assumption that request for surgery is sufficient for diagnosis of transsexualism. It is not. Although transsexuals do want to change their bodies, the diagnosis should also require evidence of life-long feminity, an inability to live in one's assigned sex and to pass effortlessly and continuously in society as a member of the opposite sex.

The importance of the psychiatrist's role lies in identifying the underlying disorder and permitting sufficient time to test the stability of the patient's desire for sex-reassignment. Particular care and caution is required while assessing a candidate for sex-change surgery. Since many of them may be suffering from serious psychiatric disorders and could be helped with appropriate treatment, surgery could be disastrous in such patients.

REFERENCES

American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV),Washington DC: APA.

Banerjee, A., Nizamie, S.H., Chopra, V.K. & Bagchi, D.J. (1997) Trans-sexualism: Onset after an acute psychotic episode; *Indian Journal of Psychiatry*, 39, 1, 76-78.

Jiloha, R.C., Bathla, J.C., Baweja, A. & Gupta, V. (1998) Trans-sexualism in Schizophrenia : A case report; *Indian Journal of Psychiatry*, 40, 2, 186-188.

Newman, L.E. & Stroller, R.J. (1974) Non-trans-sexual men who seek re-assignment; *American Journal of Psychiatry*, 131, 437-441.

World Health Organization(1992) International Classification of Diseases,Clinical Description and Diagnostic Guidelines, Edn.10, (ICD-10.CTGE).

NANDINI CHAKRABARTI, MBBS, Junior Resident, V.K.SINHA, DPM, MD, Assistant Professor, A. PARIAL, DPM, MD, Senior Resident, Central Institute of Psychiatry, P.O. Kanke, Ranchi - 834 006.*

Correspondence