Case Report

Social Dichotomy Versus Gender Dichotomy: A Case Report of Gender Identity Disorder

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ABSTRACT

Gender identity disorder is one of the most controversial diagnoses of DSM-IV and almost incomparable in the complexity of its social, ethical and political considerations to any other diagnosis. We present a case of 30 year-old male who presented with complaints of suggestive of depressive disorder with a recent suicidal attempt. Careful history taking reveals underlying conflicts with prominent gender dysphoria and social complexities. The patient is managed primarily by pharmacotherapy and harm reduction model. Our case reflects a unique coping strategy against the present sociocultural values and ambiguity of law in this part of the world.

Key words: *Gender identity, gender role, socio-cultural*

INTRODUCTION

During the 1950s path-breaking work of John Money[1] and Green[2] first brought into scientific conscience the concept of atypical gender identity development. John Money first gave the definition of gender role. He differentiated a set of feelings, assertions and behaviors that identified a person as being a boy or a girl from the contrasting conclusions one could have reached by considering only their anatomical sex. According to Money we are psychosexually neutral at birth and our gender is a consequence of the nurture we receive as children.

The concept of gender identity was defined by Stoller[3] as "a complex system of belief about oneself: a sense of one's masculinity and feminity.

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Gender identity disorder (GID) is one of the most controversial diagnoses of DSM-IV and almost incomparable in the complexity of its social, ethical and political considerations to any other diagnosis.

GID is classified as a medical disorder by the ICD-10 and by the DSM-IV TR. It is likely that the new version of the DSM will replace this category with "Gender Dysphoria." Some authorities do not classify gender dysphoria as a mental illness.

We present a case that prefers to live a dual role in society.

CASE REPORT

A 30-year-old male presented to the Psychiatry OPD at Safdarjung Hospital unaccompanied, with complaints of living under constant fear of being raped on streets, suicidal ideas and showing other depressive features. Upon exploring his fear, he revealed that if he will approach any male for sexual proposition then he might be brutally assaulted or may even be raped. He vividly imagined himself being raped brutally in such situations. This caused

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great amount of consternation and disruption in the patient's life.

His sexual orientation has always been toward males. Although he had married 4 years ago to a girl (divorced later) due to fear of social ostracization, he had never felt any real attraction toward the female sex. Later his mother revealed that he was third among four male siblings and there was no physical ambiguity about his being a male child at birth. He preferred to play with girls and quickly developed a liking to stereotypical female activities like doll play, skipping, babysitting his younger brother, etc.

The first majorlife-changing event he remembers was at the age of 9 years when he was blinded in the right eye in an accident by a broom twig. He recalls feeling incomplete and inadequate after that. His dominating mother became overprotective and encouraged him for household work like cleaning and washing utensils and he enjoyed this role. His father was always aloof and was usually absent from the house.

During his high school years the subject became especially fond of company of boys who were physically dominating in the class. His first sexual experience was homosexual at the age of 16 years. He had sex once in a while as a passive partner with other boys of his class. In return he gained their attention and their protection.

After school he was unable to be gainfully employed for long because he started acquiring sexual fascination for male staff and customers. He was proficient in English so started taking tuitions at home but after a few months he became involved sexually with his male students, offering them oral sex.

He came into contact with an NGO working for homosexuality where he in became friendly with many homosexual males. He had been in several relationships with males (he counted more than 100 partners), but his current relationship is most satisfying to him. At the same time he reports that his partner has not been equally intense in his relationship with him. He feels abused physically, emotionally and financially. He even made an unsuccessful suicide attempt after his partner threatened to leave him. Patient also admitted to alcohol and nicotine abuse after this incident. He showed restlessness, sadness of mood, helplessness, suicidal ideas and circumstantiality during the interview.

He considered himself to be a female in a male body and derived pleasure from being dominated by a male and playing the role of a subservient female in a sexual act. During his sexual acts, he often dressed as a female, walked as a female and spoke like a female to entice his male partner. His idea of a sex change operation was illegal castration often done in the transgender community, of which he was frightened. On being asked about his future plans the patient said that he will like to be married again in the future in order to fulfill societal obligations. Ideally he will play a dual role for the sake of conformity. Outside his home he will be a homosexual but inside his house he will be a dutiful husband to a wife.

The patient was diagnosed as a case of GID, with depressive episode and alcohol abuse. Patient showed fully developed secondary male characters and his morning serum testosterone level was 620 ng/dl. He was treated with 100 mg desvenlafaxine and 0.5 mg clonazepam with the immediate goal of symptom alleviation. His affective symptoms improved with reduction in HDRS score from 24 to 18 after 4 weeks. He was planned forlong-term individual and family therapy to alleviate his anxiety regarding his gender role.

DISCUSSION

This case does well to introduce the ongoing debate regarding the appropriate place for gender incongruence in the current and upcoming classification like the DSM-V.[4]

The incidence of in the general population is not yet clearly established .2-5% of boys and 15-16% of girls reported sometimes desiring to be the opposite gender but only few seek help.[5] Incidentally our patient did not reveal any information about gender dysphoria during the initial presentation. Controversy also surrounds the pathologization and the treatment of, although there now exist definite management guidelines for GID.[6,7]

Stoller[8] examined differences in family constellations associated with the development of GID. There was an association between an over close relationship with mother and a distant father in males with GID as also apparent in our case. Several authors[9,10] have suggested the simultaneous presence of genetic, hormonal and developmental factors during a critical period for GID to develop in an individual.

There have been only few published case reports[10,11] from, India describing GID. The present case categorically emphasizes to live a dual role life, primarily a self-gratifying female outside house and overtly like a male in the family. This case reflects unique coping strategies against the present sociocultural values and ambiguity of law in this part of the world. The unique diversity in this case also reflects the paradigm shift

away from a binary understanding to a spectrum of transgender identities.[12]

In this country where a trans-sexual individual is often an outcast, where specific guideline for the management of trans-sexualism is also complicated by the ambiguous and often discriminatory law this case calls for more research work and need to develop a dedicated multidisciplinary gender management services in this cultural setting.

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