

*Case Report***Gender dysphoria (transsexualism) and schizophrenia: a case report**

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ABSTRACT

Gender dysphoria (GD), previously called as Gender identity disorder (GID), is a rare condition characterized by an incongruity between gender identity and biological sex. We present a case of an adult, biological male diagnosed schizophrenia with gender dysphoria. The present case supports this view as the patient showed features of GD much before the onset of schizophrenia and the latter subsided with the treatment but not the former. This may suggest that the GD is a comparatively stable belief of sex change and the schizophrenic symptoms occurred as florid exacerbation of the trait. This article explores the concept of gender dysphoria and the role of psychological interventions in its management. A case of gender dysphoria with co-morbid schizophrenia is reported here.

Keywords: Gender dysphoria, gender identity disorder, trans-sexualism, schizophrenia.

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INTRODUCTION

Gender identity disorder (GID), recently renamed gender dysphoria (GD), is a rare condition characterized by an incongruity between gender identity and biological sex. Individuals with this condition experience distress related to their biological sex male or female and frequently express a desire to change it by hormonal or surgical means, in simple terms they identify themselves as belonging to the opposite gender, and behave accordingly. The central role played by this dissatisfaction and distress has led to the condition being renamed “gender dysphoria” (GD) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), though the term “gender incongruence” has also been proposed by some authors [1]. GID or trans-sexualism is according to International Classification of Diseases 10th revision (ICD-10 [2]. Both ICD and DSM consider GID to be a medical disorder. DSM-5 has replaced this category with Gender Dysphoria [3]. The estimates of gender dysphoria in adults emanate from European hormonal and surgical clinics with a prevalence of 1 in 11,000 male-assigned and 1 in 30,000 female-assigned people. 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. Most clinical centers report a sex ratio of three to five male patients for each female patient [4-5].

Gender dysphoria improved when their schizophrenia symptoms subsided. The relationship between GD and schizophrenia has been debated. A trans-sexualism or GD is as a schizophrenia spectrum disorder, whereas sexologists consider trans-sexualism and schizophrenia distinct syndromes that can occur simultaneously [6]. Delusions of sex change have been described by some authors in about 20-25% of schizophrenic patients. Patient's "pseudo-trans-sexual" beliefs are usually bizarre and do not cause diagnostic doubts. In some cases complaints of gender dysphoria are predominant and psychotic symptoms can be underestimated or even unnoticed before sex reassignment procedure. A transgender is the one who establishes a permanent gender identity opposite to their assigned sex; with their sex usually having been assigned at birth. The minimum requirements for a person to be considered transgender have been debated. Some feel that hormone induced changes, without surgical changes, are sufficient to qualify for the label transgender. Others, especially health care providers, believe there is a certain set of procedures that must always be completed. The general public often defines "a transsexual" as someone who had or plans to have "sex change" surgery. The current term in widest use for modification of sexual characteristics is gender reassignment surgery, a term which reflects the belief that transgender people do not consider themselves to be changing their sex, but to be correcting their bodies [7]. In GD men and women make, or desire to make, a transition from their birth sex to that of the opposite sex, usually with medical alteration to their body, taking the form of hormone therapy and often gender reassignment surgery. The stereotypical explanation is of a "woman trapped in a man's body" or vice versa. Trans-sexuals show four common characteristics:

- Inappropriateness or incapacity in the anatomically determined gender role.
- The belief that improvement will result from role reversal.
- Choice of sexual partners of the same anatomic sex, and inhibition of heterosexual interest.
- Desire for sex reassignment surgery.

Schizophrenia, depression, dissociative disorders, anxiety disorders, adjustment disorders, substance abuse disorders and personality disorders are frequently co-morbid with gender dysphoria [8-9]. GD has been described in nearly every race and culture. There is no clear-cut relationship between delusions of sex-change and factors such as age, sex, duration and subtypes of schizophrenia. Delusions of sex change can be divided into four sub-categories: delusions of no longer being a male, delusion of being a neuter, delusion of being both sexes simultaneously, and delusion of being of the opposite sex [10] of these, the latter have received most attention, partly owing to the issue of sex-reassignment surgery [11]. DSM-5 reports that persons with late-onset gender dysphoria may have greater fluctuations in the extent of their distress and more ambivalence about and less satisfaction after sex reassignment surgery. Gender dysphoria is associated with high levels of stigmatization, discrimination and victimization, contributing to negative self-image and increased rates of other mental disorders. Adolescents and adults with gender dysphoria are at increased risk for suicide. Gender identity disorder or trans-sexualism has been described in patients with 47, XYY karyotype, klinefelter's syndrome and psychotic disorders [12]. Cases have been described where the patient's gender dysphoria improved after tearing the symptoms of schizophrenia with antipsychotic medication [13].

A combined approach, using psychotherapy and pharmacotherapy, is often useful in the treatment of gender disorder. The stress factors that precipitate the behavior are identified in therapy. The goal is to help patients to cope with the stressors appropriately and, if possible, eliminate them, intrapsychic dynamics about attitudes toward men and women are examined, and unconscious conflicts are identified. Individual therapy can help a person understand and explore his feelings and cope with the distress and conflict. Family therapy may be helpful to improve understanding and to create a supportive environment. Parents of children with gender dysphoria may also benefit from counseling. Peer support groups for adolescents and adults and parent/family support groups can also be helpful. Medication, such as antianxiety and antidepressant agents, is used to treat the symptoms. Because cross-dressing can occur impulsively, medications that reinforce impulse control may be helpful, such as fluoxetine. Behavior therapy and hypnosis are alternative methods that may be of use in selected patients [14].

CASE REPORT

A 18 year-old male 11th standard student was brought to our emergency department with complaint of anger outburst, telling that his father is not his real father, he is a girl of king of kingdom, sleep disturbances and bizarre features such as he saw a devil on bank of sea his upper half body is devil and lower half human being, these symptoms for past one year. In addition to these complaints, the patient repeated persistent dissatisfaction with his biological sex, repeated argument, conflict and adjustment problem with his family member over his biological sex, once he tried to stab his uncle on same issue. He said he is feeling that God has created him girl but circumstances made him boy, but from inside he is a girl, then he started to wearing a girl's attire, doing make up and putting lipsticks every day. He is stealing inner garments of her sister and used to wear it. He is always insisted for sex assignment surgery and hormonal therapy so he will change to girl. He also insisted that he want to do DNA test to confirm his father is not real father. He is a girl of king of kingdom, because he is always seeing king in his house. There was no family history of any psychiatric disorder or any history of substance abuse.

On mental status examination he is having delusion of misidentification and persecution and sometime visual hallucination of seeing king in his house and inappropriate affect. He was feeling sad and anxious at times due to dissatisfaction on his biological gender but this sadness would not be persistent and pervasive. Physical examination revealed normal secondary sexual characteristics. He apparently had normal motor, social, and language development except for feminine behavior since early childhood. He would like to play feminine games like dolls. He is pampered by his mother and elder sister so he would always prefer the company of female friends and always avoids males. We diagnose him as a case of schizophrenia with gender dysphoria according to DSM-5 criteria and schizophrenia with trans-sexualism according to ICD-10 criteria. His laboratory investigations including routine blood investigations, complete blood count, liver and kidney function tests, serum testosterone, Follicle stimulating hormone, luteinizing hormone, thyroid function tests, and serum prolactin were within normal range and magnetic resonance imaging is within normal limit.

We have psycho-educate the patient and family members. The patient was encouraged to develop an attitude of self-acceptance and not to blame anyone for his senses of gender. We also helped the patient to develop appropriate coping strategies to deal with conflict, along with sessions of psychotherapy we started drug therapy olanzapine 10 mg at bed time and escitalopram 10 mg at morning and long acting injection paliperidone sustenna 100 mg every monthly. As sessions progressed there was improvement in patient to accept he is a boy and day to day coping ability showed favorable response in psychiatric symptoms.

DISCUSSION

This case report has a many interesting findings, firstly patient showed features of GD much before the onset of schizophrenia and the latter remitted with the treatment. Since past 3 years patient reported persistence dissatisfaction with his biological sex due to which patient always involve argument, conflict and adjustment problem towards family member. Patient always wear feminine garments, doing make up and even he used to wear feminine inner garments. He wants to do sex reassignment surgery and hormonal therapy, so he was diagnosed case gender dysphoria or trans-sexualism. Later since 1 year he has more anger outburst, sleep disturbances and delusion of misidentification and persecution with bizarre features so was diagnose with schizophrenia, but the patient is still having dissatisfaction with his biological sex and want to change the gender. This case report showed features of GD much before the onset of schizophrenia and the latter remitted with the treatment. This may suggest that the gender dysphoria is a comparatively stable belief of sex change and the schizophrenic symptoms occurred as florid exacerbation of the trait.

We follow the, international guidelines in the management of patient with gender dysphoria recommend a multidisciplinary team approach with psychotherapy and counseling as essential part of their treatment. We have psycho-educate the patient and family members and encouraged the patient to develop the self-acceptance and coping strategies to deal with conflict, simultaneously started pharmacotherapy such as antipsychotics. As sessions progressed there was improvement in patient to accept he is a boy and day to

day coping ability showed favorable response in psychiatric symptoms. Delusions of sex change as a part of schizophrenic syndrome have been reported in the literature. The present case however, is different in that the GD presented as a co-morbid condition and not as a symptom of schizophrenia.

CONCLUSION

Clinical studies could focus on identifying body and gender disturbances in patients with schizophrenia and their first degree relatives and schizotypal-like traits in patients with GID. Personality disorders are common in patients with Gender Identity Disorder who are candidates for sex reassignment. As a result, the assessment of Personality disorders before sex reassignment surgery and offering psychological and medical intervention care, if needed, is strongly suggested. Genetic studies could examine the links between gender dysphoria, schizophrenia spectrum disorders, and related conditions such as autistic spectrum disorders. The consistency of, and correlations between, information obtained through these various methods would either clarify the link between schizophrenia and GD or negate it. The present article systematically assess psychiatric functioning at follow-up. Future follow-up studies should incorporate longer follow-up periods as adolescents and adults with GD appeared to be a psychiatrically vulnerable group, even if the gender dysphoria desists.

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