

Case Report

Gender dysphoria with homosexuality and comorbid depressive disorder: complexities in concept and management

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ABSTRACT

Gender identity disorder (GID) and homosexuality are complex entities debated over decades, whether should be categorized as a disorder or not. There are a number of problems specifically related to the criteria of the GID diagnosis like differences in the terms trans-sexualism and GID, failure of the proposed criteria in conceptualizing the whole spectrum of gender variance phenomena, the potential risk of physically invasive examinations to rule out intersex conditions and the application of diagnosis even after hormonal and surgical treatment. We hereby report complexities faced in the case of a male to female transsexual with homosexuality and depressive disorder and its management.

Keywords: Gender dysphoria, Gender identity disorder, Homosexuality, Nosology, Management

INTRODUCTION

Gender identity disorder (GID) and homosexuality are complex entities known since ancient times, which have been debated over decades, if they should be categorized as a disorder or not.¹ GID or trans-sexualism according to International Classification of Diseases 10th revision² 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 one's own anatomic sex and a wish to have hormonal treatment and surgery to make one's body as congruent as possible with the preferred sex. While homosexuality has been removed from classification by American Psychiatric Society in 1973, Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) has retained the category of GID as "Gender Dysphoria". The sub-classifications regarding sexual orientation have been deleted. DSM-5 has included criteria that significant distress due to the gender incongruence should be present to be included as disorder.³ It no longer implies that one

is disordered, if there is gender variance, indicating that GID as diagnosis is now re conceptualized.

There are a number of problems specifically related to the criteria of the GID diagnosis like differences in the terms trans-sexualism and GID, failure of the proposed criteria in conceptualizing the whole spectrum of gender variance phenomena, the potential risk of physically invasive examinations to rule out intersex conditions and the application of diagnosis even after hormonal and surgical treatment.⁴ Gender Dysphoria in DSM 5, by including the presence of distress, seems to address some of these issues. GID now seems to follow and parallel the issues in the diagnosis of homosexuality, which led to removal of homosexuality from DSM in 1973. There are arguments that it is not appropriate to label expressions of gender variance as symptoms of a psychiatric disorder as it would further stigmatize and cause harm to transgender individuals. Others in the trans community are concerned that deleting GID would lead to refusal of medical and surgical care for transgender adults.⁵

Another issue in gender variance which is often debated is homosexuality. Multiple longitudinal studies reveal that gender-atypical behaviour in childhood often leads to a homosexual orientation in adulthood but only a small minority i.e. 2.5% to 20% of cases persists as gender identity disorder, even in children who manifest major aversion to their own genitalia.⁶⁻⁸

As the transgender child develops and grows into an adult, problems faced due to cross-gender identification increase. The problems of stigma, marriage, child bearing faced by these individuals lead to the development of psychosocial problems, which may require additional interventions. Psychiatric disorders such as depression, anxiety, adjustment disorders, substance abuse disorders and personality disorders are frequently co-morbid with GID.^{9,10} Because of these issues, this diagnosis is almost incomparable in the complexity of its social, ethical, and political ramifications and management also becomes equally difficult.¹¹

According to various theories development of gender also follows bio-psychosocial model and hence the management should address all the issues related to its development. Developmental psychology theories say that influences of cognitive and affective learning interaction with parents, peers, and other aspects of the social environment play an important role in the development of gender, emphasizing that gender development is influenced directly by reinforcing or discouraging gender-role behaviours and indirectly by serving as role models.¹² So, targeting family and social issues become an important part of the management. According to biological theories, there is substantial evidence from animal and human research that sex hormones, androgens in particular, play an important role in the development of gender preferences,¹² reflecting the role of hormonal and surgical treatment in GID.

We hereby report complexities faced in the case of a male to female transsexual with homosexuality and depressive disorder and its management.

CASE REPORT

A 23-year-old biological male, graduate, unemployed, presented to psychiatry outpatient department with complaints of persistent and pervasive sadness of mood, irritability, loss of interest in earlier pleasurable activities, decreased sleep and appetite from last two months. He also reported disturbed concentration, ideas of hopelessness, worthlessness and self-harm. In addition to these complaints, the patient (referred to as "he/his" in this report) reported that from early childhood, as far as he remembers, he is uncomfortable with his biological sex as male. He feels that he should have been a girl and likes to be treated as girl. He would like to wear frocks, make up, play indoors with girls of his neighbours, and like to dance like them. He never felt interested in playing outdoor games with boys. When family members

started discouraging him from doing these activities, he would not do in front of them but as soon as he would get a chance, he will take clothes and accessories of his sisters to wear and dance. In the school he was always teased by other students as he used to sit and have lunch in the company of girls and avoided boys completely. He would often say that though he looks like a boy but he feels like a girl inside. On many occasions he was caught wearing nail paint and lipstick and therefore scolded by teachers and parents. Because of this persistent resistance from all the members of society, he started suppressing his wishes of becoming a female and tried behaving like boys.

By the adolescence, he completely stopped those activities, at least socially, but he feels very uncomfortable and trapped in a male body. In the adolescence he started getting attracted towards males of his class and had relationship with a guy. They also started having physical relationship and during the intercourse he would imagine himself a female and felt so. On many occasions he requested his partner to act male, and he would act female, by wearing female clothes and make up and his partner would comply. After 2 years of relationship, his partner got into a relationship with some other girl and hence refused him to see anymore. He was broken by the fact that his partner wanted to leave him and requested him to stay in relation with both, but slowly things didn't work out and he was ignored.

Patient's mother was suffering from lung cancer and was terminally ill. She requested him to get married as soon as possible and family members started looking for a girl match. He was very upset and wanted to be with that guy only but he did not reveal this fact to anyone. Finally under pressure of his family, within a month, he got married to a girl, whom he never liked. He was able to make successful physical relationship with his wife only on one occasion and had complaint of erectile dysfunction on other occasions. Within a month of marriage, dispute started. His wife revealed to other family members that he is impotent, while the fact was that, he never liked to be with her. Meanwhile, that previous guy again started meeting him and they started having physical relationship again. He would complain of no penile erection when his wife demands for physical relations and no dysfunction when meeting with his guy friend. Soon his male friend made a demand, that he should ask and force his wife to have sex with both of them. Patient refused to such demands, and felt that it is not morally right. His male friend started blackmailing him, that he should bring his wife else he is going to tell his wife about his gay relationship. He started avoiding his male friend also, because of his undue demands overtime.

One year passed, patient started to remain sad most of the time and felt trapped and messed up in the relations. He lost interest in his work and complaint of lethargy, hopelessness, worthlessness, decreased sleep and

appetite. He frequently had ideas of ending his own life as only measure to come out of all these problems. He stopped working and started having financial constraints also. He had complaints of loss of libido and erectile dysfunction. He was very indecisive, as to how to handle the emotional turmoil and was very much concerned about the erectile dysfunction. This is when he decided to visit the psychiatrist.

Personal history revealed that he was born as full term normal vaginal delivery with no antenatal or postnatal complications. He was the youngest sibling with one brother and two sisters. His motor, social, and language development was normal. The patient had developed secondary sexual characters normally during adolescence.

General physical and systemic examination including genital examination was normal. He was referred to an endocrinologist and physician for an expert assessment of any hormonal dysfunction and intersex and they did not find any abnormality. There was no history of substance abuse and no past or family history of any psychiatric disorder.

On mental status examination, Patient was well groomed with decreased psychomotor activity. Speech was reduced in amount, rate, tone and reaction time was increased. Mood was reported as persistently sad. Affect was depressed and he was tearful, several number of times while narrating his problems. Thought assessment showed preoccupation with his biological sex and repeated displeasure with the same. He expressed persistent desire to live as a female and felt entrapped in a body of male. There were feelings of guilt for unsuccessful married life and wish to die. There was evidence of homosexual orientation and persistent dissatisfaction with female partner. His concentration was poor with intact judgment and insight. He was diagnosed as a case of GID of childhood (F64.2) with severe depressive episode without psychotic symptoms (F32.2) as per the diagnostic criteria of ICD-10.

He was thoroughly assessed with laboratory investigations including complete blood count, liver function tests, kidney function tests, blood sugar, and serum testosterone, Follicle stimulating hormone, luteinizing hormone, thyroid function tests, and serum prolactin. All the investigations were within normal range. The neuropsychological testing revealed an Intelligent Quotient of 102.

The initial focus of the treatment was to remove depressive symptoms and suicide risk. Patient was started on tablet escitalopram 10 mg and clonazepam 0.5 mg daily. Patient's family members were psycho educated about the increased risk of suicidality and were advised to follow the high risk precautions.

Along with that management was planned to help the patient in improving his coping abilities and communication skills. Issues of homosexuality and

erectile dysfunction were discussed. Sessions were planned with his wife and other close family members to psycho-educate them regarding the condition and they were given ample amount of time to ventilate their emotions. After 2 weeks patient reported minimal improvement in depressive symptoms, so escitalopram was increased to 20 mg. A session was also held to discuss the options of available hormonal and surgical treatment. However, the patient declined for any such intervention. Patient insisted that he wants to spend his life with his wife and bear children as per his family expectations. He wanted to suppress his wishes to be a female.

Next we targeted the family members and psycho-educated them about the differences between sex and gender and the spectrum of sexual orientation and gender identity. It was emphasized during these sessions that this does not necessarily mean that patient is suffering from a psychiatric illness. Patient and family members do not have to blame self or each other for these conditions. Several sessions were devoted in emphasizing the fact that focus should be acceptance of their child gender and sex orientation as it is and not to change it according to biological sex, which may deteriorate his mental health. Patient and family members were given full opportunity to discuss their doubts and approach without any hesitancy.

At 6 weeks, there was significant improvement in patient's mood and coping abilities. He reported that there is a change in attitude of her family members and they have stopped criticizing him and now started to accept him as he is. To our surprise, he reported that he was able to make successful relationship with his wife without any erectile dysfunction. At 2 months follow up, he reported that he is now better able to handle his emotions and feelings and started doing his job also. Patient and family members were advised to follow up regularly in future to maintain the improvement and reinforcement of positive attitude.

DISCUSSION

This is a case of Gender Dysphoria complexed with presence of depressive disorder, and homosexuality. Transgender issues remain in debate for their inclusion as psychiatric disorder and nobody seems to pay attention to the other psychiatric problems faced by these transgender individuals. They are obviously more prone to these psychiatric disorders because of the criticism, stigma and discrimination; they get from society since their childhood. There are studies showing that lifetime prevalence of psychiatric disorders in GID is very high. We as clinicians should be aware of other mental health problems, co morbid with GID, as the management priorities will depend upon them. Reducing psychiatric morbidity will definitely help reducing peer and social ostracism.^{9,10,13} There are strong indicators of increased suicidality among people with GID and presence of

depressive symptoms should be alarming and efforts should be made to address the suicide risk and behaviour at utmost priority.¹⁴

The issue of homosexuality in the transgender individuals of course complicate the situation. According to some authors, homosexual transsexuals are ego-dystonic homosexuals trying to resolve some kind of guilt, over their same sex attraction and according to others they tend to be comfortable with their sexual orientation and is a measure through which people with transgender issues try to harmonize their mind and body.⁶⁻⁸ In this case, patient had homosexual relations from adolescence, and emotional turmoil started soon after getting married to a female, under social pressure, resulting in erectile dysfunction. It is important to raise and address these issues and respect one's sexuality. Patient started to live with his wife in harmony after the intervention and once he decided to come over his sexual orientation, reflecting that it is more of his choice rather than gateway of his gender preference.

There are two approaches to the management, one approach does not recommend surgical and hormonal treatment, until the patient's complete somatic and psychosexual development and other opinion favours the early use of luteinizing hormone-releasing hormone analogues, that block gonadotropin secretion and inhibit the sex steroids.¹⁵ In this case, after the amelioration of depressive symptoms, we respected his decision of not undergoing any hormonal and surgical treatment. Psychosocial approach in the form of building his coping abilities, psycho education and involving family remained the main stay of management. He improved significantly, in the form that he was able to perform his social role with mental satisfaction and harmony, suppressing his gender and sexual orientation.

CONCLUSION

This case support the fact that theoretical constructs and concepts should not be forced rather we should make use of multiple explanatory, necessary approaches at the same time depending upon the individual case,¹⁵ giving due respect to patient's priorities and preferences in the treatment.

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