SECONDARY GENDER IDENTITY DISORDER
- A CASE REPORT

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

DISCUSSION

Transsexualism and gender dysphoria
occurring along with 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.

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