Schizophrenia Modifying the Expression of Gender Identity Disorder

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ABSTRACT

Introduction. According to the Brazilian Federal Medical Association, transsexualism is recognized as a gender identity disorder if a long-term diagnostic therapeutic process has demonstrated that the transposition of gender roles is irreversible, and if only hormonal and surgical procedures are appropriate to relieve the stress associated with the gender identity. Although such treatment will only be initiated with caution and after a long phase of intense diagnostic screening, the differentiation between pure identity disorders and transsexual feelings secondary to an ongoing psychopathologic process, such as schizophrenia, can be arduous for many health professionals.

Aim. To report a case of a female patient with schizophrenia and transsexualism and the risks of a potential diagnostic confusion.

Method. A 19-year-old black woman, with an 8-year history of undifferentiated schizophrenia and intense gender dysphoria, was referred for sex reassignment surgery evaluation in the Ambulatory for the Treatment of Sexual Disorders of the ABC Medical School.

Result. After a more adequate antipsychotic treatment, her masculine behavior has persisted, but her desire to change her own genital organs has decreased.

Conclusion. A better acceptance of the multiplicity of possible genders should neither contribute to inadequate interpretations of the signs and symptoms of our patients nor facilitate dangerous clinical or surgical recommendations. **Baltieri DA, and De Andrade AG. Schizophrenia Modifying the expression of gender identity disorder. J Sex Med 2009;6:1185–1188.**

Key Words. Transsexualism; Schizophrenia; Psychosocial Treatment

Introduction

Gender identity disorder (GID) is characterized by a strong and persistent cross-gender identification and persistent discomfort with one's assigned gender [1]. There are many ways in which persistent gender dysphoria might be expressed, including patients who meet the complete the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV) criteria for GID, patients with a primary diagnosis of transvestic fetishism, and patients with a co-occurring disorder of sex development (physical intersex conditions), among others. Transsexualism, one of the most well-known categories, is relatively rare and its prevalence is reported as one per 30,000 for males and one per 100,000 for females [2]. In this category, the desire to change sex is frequently obsessive and may lead to striking situations, such as self-mutilations and suicide attempts [3]. Given the fact that the prevalence of schizophrenia corresponds to 1%, the combination of both disorders is a notable rarity and this association can harm the medical management [4].

Clinicians must always investigate the co-occurrence of these two disorders, because any underlying psychotic disorder must be excluded prior to recommending hormonal or surgical intervention for GID. In schizophrenia, there may rarely be delusions of belonging to the other sex. The insistence of a person with GID that he or she belongs to the other sex is not considered a

delusion, because *what is invariably meant is that the person feels like a member of the other gender instead of truly believing that he or she is a member of the other sex* [1]. However, there are very rare cases where schizophrenia and severe GID may coexist [4]. In fact, we should differentiate between rare cases of true comorbidity of schizophrenia and transsexualism, and other patients for whom the transsexual desire presents itself as a symptom of psychosis [5,6].

The diagnosis of a coexisting psychiatric disorder in GID has implications for the evaluation, prognosis, and appropriate management of the patient. A case of GID in a woman with schizophrenia is related below.

Case Report

GS is a 19-year-old black woman, with an 8-year history of undifferentiated schizophrenia, who was referred by her physician for sex reassignment surgery evaluation in our service. Her existing self-reported problem is that all her life, she wanted to be a man. Dressed in men's clothes, she affirmed that she was born male but her parents had cut her penis off at birth and she wanted to be a man to make her future girlfriend pregnant.

Since her father abandoned the family 14 years ago, she has become progressively detached from the rest of her family. She lived with her elder brother and mother, in a poor socioeconomic condition. Her mother was described as an unhappy, closed-minded, and distant woman. She felt that her brother was her mother's favorite child in the family. GS described her childhood as uncomfortable because she noted that she was a tomboy and always preferred to play games with the boys. From the age of four, she hated being forced to be with girls or to play with dolls at grade school. She refused to wear female clothes and keep her hair long. After her menarche, when she was 12 years old, GS began to withdraw from social contact and became less and less communicative. Sometimes she would be seen smiling and talking all to herself, although she would never explain why. GS accused her family of cutting her penis off at birth and trying to harm her. Every day she asked her mother why her family had decided to mutilate her. Frequently, she got away from home and was always found some days later, in disheveled dirty clothes and unkempt hair. When the patient was 16 years old, her mother's sister, who believed that GS was seriously sick, decided to take her to a psychiatric hospital. There she received antipsychotic treatment and was partially relieved of her symptoms, which were still present at that time but her condition improved enough to permit her family to cope with her. At the same time, she used to bind her breasts downwards as tightly as possible and dressed as a male. GS is sexually attracted to females, but she has never had a girlfriend.

Her behavior has progressively become more masculine, in spite of the antipsychotic treatment. In fact, she had never taken her prescribed medications for more than a few weeks, and when she did not receive them, her desire to become a man grew and her behavior also became more and more disorganized.

In our service, depot intramuscular antipsychotic was administered to GS, and after 3 months, her mental state improved. Presently, this patient comes to our service accompanied by her aunt and receives depot intramuscular haloperidol 450 mg once a month. She participates in a psychotherapy group in a specialized service for the treatment of schizophrenia with other patients who also present psychotic disorders. Although her masculine behavior has persisted, her desire to change her own genital organs has decreased.

Because of the fact that the patient remained in our service manifesting psychotic symptoms for a relatively long period, her intelligence level could not be adequately accessed yet.

Discussion

GS's beliefs that her penis was cut off at birth and that her transformation into a male can capacitate her to make a woman pregnant are delusional, because people with GID understand that sex reversal is a long process of psychologic adaptation and external physical changes induced by medical procedures. However, before these psychotic symptoms appeared, GS had shown intense discomfort with her gender.

Even though GS's GID existed prior to her acute deterioration, schizophrenia affected the course of GID, becoming more prominent with the therapeutic failure and diminishing in response to the adequate pharmacologic therapy. In her case, GID and schizophrenia co-occurred, which is a rarity. There are a few reported cases of patients with both disorders and most of these cases point out that schizophrenia was previous to transsexualism [7].

GS has a long-standing history of gender dysphoria. Her abandonment by her father when she was 4 years old and her mother's preference for her