GENDER IDENTITY DISORDER: A CASE REPORT

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ABSTRACT

We report a case of gender identity disorder in a 22 years old male, who confined himself to his house, dressing, walking, talking and behaving like females. His testes were smaller than normal and his breasts were bigger than the normal size. He was taking estrogens and was reluctant to check his sexual hormone levels. He wanted to undergo genital reassignment and was in a regular contact with a trans-sexual that had already undergone genital reassignment surgery and was aiming to get married to a male. This created a social problem for parents, specially for his father.

Key Words: *Gender Identity Disorder, Sex*

INTRODUCTION

Gender identity is a psychological state that reflects a person's use of being male or female. It develops in most of the people by the age of two or three years and usually corresponds with one's biological role. Gender identity develops from an innumerable series of cues received from the parents and the cultures at large that are themselves reactions to the infant's genitalia. Gender role is the external behavioral pattern that reflects a person's inner sense of, "I am male" or "I am female". While there is some flexibility regarding what behaviors are considered masculine or feminine, the culture respects men and women (boys or girls) to have a sense of maleness or femaleness that reflects their anatomical sex. Gender identity disorders involve the persistent desire to be or the insistence that one is of the other sex and extreme discomfort with one's assigned sex and gender role.

Gender identity disorders in children and adolescents are uncommon and complex conditions. They are often associated with emotional and behavioral difficulties. Intense distress is often experienced, particularly in adolescence. Treatment and prevention of the emotional and behavioral problems are essential, even if the atypical gender development remains unchanged.

In this context, we are reporting this case of a 22 year old male to make our colleagues aware of the condition as a separate entity and diagnose it as early as possible to manage the patients effectively.

CASE REPORT

Mr. X a 22 years old, 3rd year medical student was referred by his mother, a doctor herself, for staying away from the college and remaining confined to his room for the past three months.

The mother, informed that he had always been living, talking, playing and behaving as a girl. He used to wear a sari using her head scarf (dupatta) and would apply whatever cosmetics he could find. He only played with the girls and only the games specific to the girls and in the 1st year F.Sc., he bought his own cosmetics using the money stolen from his grandmother. He has never shaved but pulls out his facial hair. Due to these habits and practices, his father has beaten and humiliated him with the help of the paternal family members in order to make him change his behavior. As a reaction to one of such incidents, he took an over dosage of some sleeping pills. The mother recalls him masturbating and the father recalls him having nightfalls but the patient himself does not remember any such events. The patient's parents had a very violent relationship when he was growing up in his early childhood and he hated his father for aggression towards his mother and in those times, there was no one for him to confide. He has always been devoted to his mother and felt very close to her family. His maternal aunts always praised his feminine looks and wished he was a girl. During the examination and interview sessions, it was noted that his hair were cut and styled in a way to make him appear like a lady, pants and shirts cut and worn in a manner to accentuate his hips and

his face always covered with makeup. He walked with a sway and his voice could have easily been misjudged for that of a woman. He enjoyed attention from men and when people address him as madam.

His testes were smaller than normal and his breasts were bigger than the normal size. He took Estrogens for almost two months, about two years ago and did not have his sexual hormone levels checked despite instructions. He abhorred his male genitals and once used a mechanical device to castrate himself. He was convinced that he wanted to undergo genital reassignment and was in a regular contact with a trans-sexual that had already undergone genital reassignment surgery.

He had fantasies of getting married to a man as a woman after genital reassignment surgery and was willing to live with all the implications of his present status and of the status he hopes to acquire. He aspired to work for women's rights. When he was offered an explanation, during a counseling session, that *his behavior was directed against his father who had been violent towards his mother and who had repeatedly humiliated him. So he wanted to deny him the pleasure of having a son,* He appeared to accept the explanation but soon changed the stance. He then repeatedly requested, “do not ask me to become a boy”.

He unfortunately left the therapy and declined to continue follow up.

DISCUSSION

This case illustrates the essential features of gender identity disorder. Before 1955, the word 'gender' had been confined almost exclusively to the domain of grammar to indicate male or female when defining nouns, pronouns and adjectives. Gender had hardly been used in literature. The first definition of the term 'gender role' was given by *Money J*[1] in an article on *'Hermaphroditism, gender and precocity in hyperadrenocorticism: psychological findings'* published in the *Bulletin of the John Hopkins Hospital* in 1955. Money wanted to differentiate a set of feelings, assertions, and behaviors, which identified a person as being a boy or a girl, a man or a woman, from the contrasting conclusion one could have reached by considering only their gonads. The term 'gender identity' appeared in the middle 1960's in association with the establishment of a gender identity study group at the University of California. Stoller[2] defined it as: 'A complex system of beliefs about oneself: a sense of one's masculinity and femininity. It implies nothing about the origins of that sense (e.g. whether the person is male or female). It has, then, psychological connotations only: one's subjective state”.

The incidence of childhood cross-gender identification in the general population and in the psychiatric population has not yet been definitely established. The studies that have been carried out have used different criteria, such as single behaviors or identity statements. No large- scale investigation with standardised criteria has yet been conducted.

Zuger and Taylor[3] interviewed the mothers of boys approximately 7 years old with regard to the presence of six cross-gender behaviours. They found that different types of cross gender behaviours varied from 3% to 13%. They found that these behaviours were not frequent in a given child (73% never engaged in any of them).

Feinblatt and Gold (1976)[4] found that out of 193 children referred to a Connecticut Child Guidance Clinic, 4 boys and three girls (3.6%) were referred primarily because of 'gender role inappropriate behavior'.

The epidemiological behavior suggest that “extreme forms of cross-gender behavior are uncommon among boys in the general population” [5]. One could fairly confidently say that cross-gender behavior is not 'a common phase in boyhood behavior”[6]. There is insufficient epidemiological research regarding girls to be able to make a similar statement.

Green[7] has conducted the most

LONG-TERM FOLLOW-UP STUDIES OF CHILDREN WITH GENDER IDENTITY DISORDERS

Outcome	No. of Cases	% of total cases
Transsexual	5	5.3
Homosexual Or bisexual	43	45.7
Transvestite (heterosexual)	1	1.1
Heterosexual	21	22.3
Uncertain	24	25.5
Total	94	100

From Zucker (1985)[5].

Table 1

scientifically accurate follow-up study. 'Two thirds of 66 males in the original "feminine boy" group have been interviewed in adolescence or young adulthood. Three-fourths of them are homosexual or bisexual'. Only one boy in this study has had a trans-sexual outcome.

Zucker[5] has put together all the long-term follow-up studies of cross-gender identified children referred to mental health professionals (Table 1).

Money and Russo[8], explaining the low incidence of a transsexual outcome, suggest that 'the natural history of trans-sexualism is disrupted by the child's contact with the mental health profession'.

Green et al[9] examined five groups of behaviours in boys: role/doll play, cross-dressing, female peers, rough and tumble play and wish to be a girl. They found that doll play and role-play as a girl associated more strongly with a homosexual outcome.

Coates et al [10] have shown that children with gender identity disorders also present separation anxiety, depression and emotional and behavioral difficulties. In a number of cases referred to our clinic, learning difficulties and school refusal are also present. In a small percentage of cases, child sexual abuse has been associated with a gender identity disorder. Suicidal attempts in adolescence are frequent and this is how adolescents with gender identity disorders come to professional attention in some cases.

No single cause has yet been found with certainty for the development of a gender identity disorder. Hereditary (Bailey and Pillard)[11] and genetic factors (Hamer et al)[12] have been identified for male homosexuals. Their contribution to the development of gender identity disorders in children is unclear and further research is needed.

Hormonal influences on the brain during fetal life have been suggested. Androgens would masculine the brain at the critical period of 6 weeks in fetal life.

In humans it has been found that the third interstitial nucleus of the anterior hypothalamus is larger in the male. Levay[13] has shown that in the brain of homosexual men this nucleus is similar in size to that of women and about half the volume of that in heterosexual men.

However, these factors on their own may be insufficient to produce a gender identity disorder.

Stoller[14] has described particular family constellations which associate with gender identity disorders in boys and girls. For the boy there is an over-close relationship to mother and a distant father. For the girl there is a depressed mother during the early months of the child's development and a father who is absent and does not support the mother, but pushes the child to assuage the mother's depression.

Marantz and Coates[15] have described very early maternal influences negatively affecting the early development of the child.

Blieberg et al[16] have linked the development of gender identity disorders in some children to their inability to mourn a parent or an important attachment figure in early childhood.

The parents' wish for a child of the other sex or direct parental pressure in rearing the child in the gender role opposite to the biological sex is not sufficient on its own to produce a marked gender identity disorder.

Some authors[17,18] would agree that many of these factors need to be present at the same time and work together during a critical period to produce a full-blown gender identity disorder. This would explain the rarity of the condition.

Counseling and supportive system establishment are thought to be the best approaches to treating this disorder and in particular individual and family counseling is recommended for children and individual or couples therapy is recommended for adults. Sex reassignment through surgery and hormonal therapy is an option, but often severe problems persist after this form of treatment.

REFERENCES

1. Money J. Hermaphroditism, gender and precocity in hyperadrenocorticism: psychological findings. Bull Johns Hopkins Hosp 1955; 96: 25-364.
2. Stoller R. The hermaphroditic identity of hermaphrodites. J Nerv Mental Dis 1964; 139: 45-37.
3. Zuger B, Taylor P. Effeminate behavior present in boys from early childhood, in comparison with similar symptoms in non-effeminate boys. Pediatrics 1969; 44: 375-80.
4. Feinblatt JA, Gold AR. Sex roles and the psychiatric referral process. Sex Roles 1976; 2: 109-22.
5. Zucker KJ. Cross-gender identified children. In: Steiner B, editor. Gender Dysphoria. New York: Plenum Press,1985; 75-174.
6. Green R. Childhood cross-gender identification. J Nerv Mental Dis 1968; 147:

500-9.

7. Green R. The Sissy Boy Syndrome and the development of homosexuality. New Haven, CT, Yale University Press. 1987.
8. Money J, Russo AJ. Homosexual vs. transvestite or transsexual gender identity/role: outcome study in boys. Inter J Family Psych 1981; 2: 139-45.
9. Green R, Roberts CW, Williams K, et al. Specific cross-gender behavior in boyhood and later homosexual orientation. Br J Psych 1987; 151: 84-8
10. Coates S, Spector-Person E. Extreme boyhood femininity: isolated behavior or pervasive disorder? J Am Acad Child Adoles Psych 1985; 24: 702-9.
11. Bailey JM, Pillard RC. A genetic study of male sexual orientation. Arch Gen Psych 1991; 48: 1089-96.
12. Hamer DH, Hu S, Magnuson VL, et al. A linkage between DNA markers on the X chromosome and male sexual orientation. Science 1993; 261: 321-6.
13. LeVay S. A difference in hypothalamic structure between heterosexual and homosexual men. Science 1991; 253: 1034-7.
14. Stoller R. Male childhood trans-sexualism. J Am Acad Child Adoles Psychi 1968;7:193-201.
15. Marantz S, Coates S. Mothers of boys with gender identity disorders: a comparison to normal controls. J Am Acad Child Adoles Psych 1991; 30: 136-43.
16. Bleiberg E, Jackson L, Ross JL. Gender identity disorder and object loss. J Am Acad Child Adoles Psych 1986; 25: 58-67.
17. Money J. The concept of gender identity disorder in childhood and adolescence after 39 years. J Sex Marital Ther 1994; 20: 163-77.
18. Coates S, Friedman R, Wolfe S. The etiology of boyhood gender identity disorder: a model for integrating temperament, development and psychodynamics. Psychoanaly dialog 1991; 1: 481-523.

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