

CASES THAT TEST YOUR SKILLS

In public, Mr. C is a “he-man.” In private, he wears lingerie, sees himself as a woman in sexual fantasies, and longs to develop breasts. Can you detect his problem?

Gender dysphoria: ‘I’m a man, but ...’

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HISTORY NORMAL ON PAPER

Mr. C, age 65, presents to an endocrinologist complaining of hot flashes and low libido. Initial testing shows low male testosterone, but a repeat test shows normal levels. No medical cause is found for his symptoms.

“My testosterone might be normal on paper,” Mr. C tells the endocrinologist, “but *I’m* not. I think I’m a woman.”

Mr. C requests referral to a female psychiatrist because he feels more comfortable discussing sexual issues with a woman. The endocrinologist refers him to me for evaluation.

Over 7 years, Mr. C’s other psychiatrist—a man—has been treating him for obsessive-compulsive disorder (OCD), anxiety disorder, and bipolar disorder type II. Mr. C takes paroxetine, 60 mg/d, for depressive symptoms and was taking divalproex, 1,500 mg/d, to stabilize his mood. He recently stopped divalproex because it was causing nausea and sedation.

During our initial visit, Mr. C says he’s “through pretending to be a man.” He says he first ques-

tioned his sexual identity in early childhood, when he sometimes dressed in his mother’s clothes for play. As an adult, he mostly cross-dresses in lingerie; he wears a woman’s tank top in public once or twice weekly underneath his polo dress shirt. Fifteen years ago, he suffered anorexia and bulimia while trying to look as svelte as a woman.

At 6 feet, 2 inches with good muscle tone and short, wavy black hair, Mr. C looks strikingly masculine. Now retired, he served in the Air Force and later worked as a commercial pilot and in construction. In private, however, he prefers gardening and cooking over sports and cars.

Mr. C is married but seldom has sexual intercourse with women. He gains sexual fulfillment by visualizing himself as a woman having sex with other women or with himself as a man. He denies interest in male-male sex.

The patient has been masturbating since age 5, mostly by rubbing his scrotum against a swing set pole he still keeps in his utility shed. He often tucks his penis to mimic female genitalia and makes believe his rectum is a vagina.

continued

Box

Gender dysphoria encompasses these sexual identity disorders

- **Transsexualism**
- **Pure transvestism** (having a firm gender identity but becoming sexually aroused by cross-dressing)
- **Dual-role transvestism** (cross-dressing solely to experience temporary membership in the opposite sex)
- **Stress-related** cross-dressing
- **Men who desire** penectomy or castration but no other gender-reassignment interventions
- **Congenital intersex conditions**, such as hermaphroditism

Mr. C's sexual identity and intimacy problems destroyed three marriages. His first two lasted 6 months and 2 years; the third ended after 10 years when his then-wife accused him of being gay. His fourth marriage has lasted 22 years and harbors much affection and foreplay but little intercourse.

Mr. C's Mini-Mental State Examination score of 30 indicates no underlying dementia. He shows stable affect with no evidence of derailment, paranoia, thought blocking, or auditory hallucinations.

Medical examination results are normal. Negative urine toxicology screen rules out substance abuse, and negative rapid plasma reagin rules out syphilis. Testosterone is not rechecked because levels were normal 2 days before.

Mr. C's symptoms suggest:

- a) pure transvestism
- b) primary transsexualism (gender identity disorder of adulthood)
- c) transsexualism secondary to psychosis
- d) sexual obsession and compulsion of OCD

The author's observations

I suspect gender dysphoria, which describes a heterogeneous group of persons who express varying degrees of distress with their anatomic sex and sometimes desire secondary opposite-gender sexual characteristics (*Box*).

Sexual identity in gender dysphoria is often fluid. Symptoms might suggest transvestism, then evolve to transsexualism. Recognizing this heterogeneity and fluidity is crucial to diagnosis and treatment.

Primary transsexualism. The term "transsexualism" describes persons who want to live and be accepted within the opposite sex.¹ The transsexual identity persists for ≥ 2 years and is not caused by another mental disorder or intersexed condition. Fetishism is classically absent and cross-dressing is not sexually gratifying. Most transsexuals want surgical and hormone treatment to make their bodies as congruent as possible with the preferred sex.

In 1994, DSM-IV recognized that some late-onset transsexuals showed features of comorbid transvestism and were sexually aroused by female dress and behaviors. Gender identity disorder (GID) replaced the term "transsexualism" and includes these individuals. A secondary diagnosis of transvestism is applied.

Secondary transsexualism. Case reports² describe psychosis-induced transsexual desires in patients with schizophrenia. Gender dysphoria improved as their schizophrenia symptoms lessened.

The relationship between transsexualism and schizophrenia has been debated. Hyde and Kenna³ view transsexualism as a schizophrenia spectrum disorder, whereas sexologists consider transsexualism and schizophrenia distinct syndromes that can occur simultaneously.

Affective disorders might also alter contentment with gender role, but the relationship is unclear. Case reports of patients with bipolar disorder suggest that gender dysphoria intensity fluctuates.

tuates with affective excursions.⁴ O’Gorman,⁵ however, described a bipolar patient whose gender dysphoria was mitigated during manic episodes.

Paraphilias are sexual disorders with recurrent intense urges and fantasies that do not follow normative arousal patterns and can diminish capacity for sexual intimacy.⁶ Manifestations include exhibitionism, fetishism, frotteurism, pedophilia, masochism/sadism, voyeurism, and transvestic fetishism.

Dividing transsexualism and pure transvestism paraphilia into discrete categories is simplistic, as transvestites can develop secondary components of transsexualism. Hoenig and Kenna⁷ assert that transsexualism—though not an anomalous erotic preference—is almost always preceded by transvestism or accompanied by cross-gender fetishism.

Nonparaphilic sexual addiction—included in DSM-IV-TR as sexual disorder not otherwise specified—describes culturally acceptable sexual interests and behaviors that are frequent or intense enough to reduce capacity for sexual intimacy. Such behaviors include compulsive masturbation, repetitive promiscuity, and dependence on anonymous sexual encounters.

An addiction model conceptualizes paraphilia as a form of pleasure seeking that has become habitual and self-destructive. Treatment involves directing patients to 12-step groups patterned after Alcoholics Anonymous.

Other models place paraphilias and related disorders within the OCD spectrum.⁸⁻¹³ Persons with OCD often are obsessed with sexual content and might grapple with religious and moral concerns about sexual issues. They typically consider their symptoms intrusive or senseless. Selective serotonin reuptake inhibitors—the standard medication for OCD—might alleviate paraphilia, but results are mixed.¹⁴

Mr. C’s symptoms. Mr. C shows features of GID and transvestism. His strong, persistent cross-



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gender identification and sense of inappropriateness with being a man indicate GID. His recurrent sexual urges and fantasies and impaired capacity for sexual intimacy suggest a paraphilia or transvestism.

The significance of Mr. C’s comorbid bipolar disorder and OCD is unclear. Both appeared controlled, but the potential for mania-induced hypersexuality cannot be ignored.

DIAGNOSING GENDER DYSPHORIA

A thorough medical, psychiatric, and sexual history can reveal sexual identity symptoms’ source.

Consider a medical cause. Your medical workup may include a genital exam to check for irregularities such as hermaphroditism that can compound questions of sexual identity, and karyotyping to probe chromosomal anomalies, such as mosaicism or chimerism.

Consider schizophrenia or bipolar disorder, as mania or psychosis can cause aberrant sexual behavior. In gender-dysphoric patients with either disorder, treating the psychiatric comorbidity might alleviate the dysphoria. Watch for fluctuations in gender dysphoria intensity when you treat other psychopathologies.

Take a thorough sexual history. Being matter-of-fact while discussing unusual sexual acts will help the patient “open up” about his sexual problems. Ask him if he:

- showed gender-atypical behavior as a child, which can predict transsexualism or homosexuality

continued

- has engaged in heterosexual, homosexual, or abnormal sexual acts; ask about frequency and preference

- is married or has a girlfriend. If so, are they getting along? How often do they have sex?

- cross-dresses. Does his partner cross-dress as well and, if so, do they cross-dress for sexual gratification or to identify with the opposite gender? Has this response changed over time? Where and how often do they cross-dress?

- is achieving sexual gratification. If so, how?

- has sexual fantasies involving breast-feeding, giving birth, or forced feminization through gender-changing surgeries or other means

- “tucks” his penis, urinates sitting down, or mimics other stereotypical feminine behavior.

Also find out how long these behaviors have persisted. Have they fluctuated? Have relationships, life stressors, or other factors influenced them?

The answers will uncover a motivation behind these behaviors, which is key to diagnosis. Sexual gratification as a motive suggests paraphilia, whereas a desire to live as a woman points to transsexualism. Because of the myriad presentations, multiple patient visits are necessary for a specific diagnosis.

DIAGNOSIS: 'I ENJOY WOMANHOOD, BUT ...'

I diagnose gender dysphoria, but because Mr. C's mood is euthymic, I cannot discern how his

mood instability might affect his dysphoria. His sexual fantasies are mood-congruent and evoke no shame.

Mr. C then states that he adamantly opposes living outwardly as a woman, and fears that an overt sex change would destroy his marriage and other relationships. Even so, he desires hormone therapy and surgical breast implants so he can more closely mimic physical womanhood and make masturbation more pleasurable. He says he would flatten his breasts with gauze while in public so he can continue to look like a man.

Though comfortable with his sexual fantasies, Mr. C laments that presenting himself as an “alpha male” drains his psychic energy.

Which clinical condition most closely applies to Mr. C?

- a) autogynephilia
- b) character pathology
- c) gender identity fluidity

The author's observations

Mr. C meets criteria for GID and transvestism. Some transvestites also meet criteria for autogynephilia and report erotic arousal upon seeing oneself as a woman. Character pathology, specifically sexual fantasies associated with schizoid personality, might also contribute to unusual gender presentation. Sexologists also propose fluidity in gender identification across populations and over a person's life span.

Autogynephilia—by which a man becomes sexually aroused by imagining or seeing himself as a woman¹⁵—usually is associated with transvestism. Autogynephiles often have sexual fantasies of possessing female anatomical structures, engaging in feminine behaviors, or performing female bodily functions such as lactation, menstruation, or childbirth.

Autogynephilia may be a misdirected heterosexuality and is more prevalent among male-to-female transsexuals who are attracted to women,

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▶ **How to take a sexual history (without blushing)**
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both sexes, or neither sex than among those attracted only to men.¹⁶

Gender identity fluidity. Clinicians have recorded fluidity in gender identity (sense of masculinity or femininity) and sexual orientation (the sex to which one is attracted). Sexologists have tried to create scales that gauge these changes.

The Kinsey Heterosexual-Homosexual Rating Scale¹⁷ is based on Kinsey's theory that men are not strictly heterosexual or homosexual. Scores between 0 and 6 indicate some degree of both (*Table*).

The Benjamin Gender Disorientation Scale, which measures gender identity variations, recognizes variability of gender dysphoria expression and underscores the difficulty of classifying patients who—like Mr. C—present with varied symptoms. The scale is available at www.hbgda.org (see *Related resources*).

I did not administer the Kinsey or Benjamin scales to Mr. C. Although his case shows how innate sense of masculinity or femininity can vary among patients with gender dysphoria, his presentation has been stable, albeit unusual.

Mr. C's symptoms. Mr. C shows autogynephilic features. He lacks the schizoid's emotional inertness and his gender presentation is static, though dramatic. He appears to meet criteria for GID and transvestism, autogynephilic variant.

Schizoid and other personality disorders are associated with unusual sexual fantasies. Mr. C lacks primary schizoid features, such as flattened affectivity and indifference to close relationships.

I would refer Mr. C for hormone treatment and breast implantation:

- a) now
- b) after extensive psychosocial treatment
- c) I would not recommend these treatments

The author's observations

Mr. C is a poor candidate for hormone therapy or gender reassignment surgery because of his cir-

Table

Kinsey Heterosexual-Homosexual Rating Scale

Score	Indicates ...
0	Exclusively heterosexual
1	Predominantly heterosexual, incidentally homosexual
2	Predominantly heterosexual, more than incidentally homosexual
3	Equally heterosexual and homosexual
4	Predominantly homosexual, more than incidentally heterosexual
5	Predominantly homosexual, incidentally heterosexual
6	Exclusively homosexual

Source: Reference 17. Reprinted by permission of The Kinsey Institute for Research in Sex, Gender, and Reproduction, Inc., Indiana University, Bloomington.

cumscribed desire to live as a woman at home. Also, sexual gratification is his primary motivation for wanting to develop breasts.

TREATING GENDER DYSPHORIA

Serotonergic agents such as fluoxetine have shown effectiveness for treating paraphilias and nonparaphilic sexual addiction in case reports.^{18,19}

Behavioral techniques, however, might have a more definite impact on gender dysphoria. Marks¹⁹ reported a 4-year remission of transsexualism in a patient after comorbid OCD improved with self-exposure therapy.

Psychotherapy will not resolve gender identity disorder but can promote a stable lifestyle and improve the patient's chances for success in relationships, education, work, and gender identity expression.²⁰ Psychotherapy can also help determine patients' readiness for sexual reassignment surgery.

continued

TREATMENT: LEARNING TO ACCEPT

I refer Mr. C back to his primary psychiatrist, who adds aripiprazole, 5 mg/d, to address grandiosity and hypomania that emerged months after my initial evaluation.

I also refer Mr. C to a gender disorder specialist for psychotherapy directed at examining his history, understanding his dilemmas, and identifying unrealistic ideas and maladaptive behaviors. The therapist has been teaching Mr. C coping skills and educating him on gender disorders and normal gender variations in activities and interests. He has been attending weekly sessions for 4 months.

To address his resentment over trying to look manly, I assure him that he doesn't need to assume additional "masculine" behaviors and attitudes, and that his height and features make him appear masculine.

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Diagnosing sexual identity disorders is difficult. Distinctions between transvestism and transsexualism are often arbitrary, and patients show behaviors suggesting multiple gender identity disorders. Until a more specific diagnosis can be teased out over multiple visits, an inclusive diagnosis of gender dysphoria better serves patients.

BottomLine

Related resources

- ▶ World Professional Association for Transgender Health, formerly the Harry Benjamin International Gender Dysphoria Association (offers links to transgender resources, gender programs, and sexologists). www.hbgda.org.

DRUG BRAND NAME

Divalproex sodium • Depakote
Fluoxetine • Prozac
Paroxetine • Paxil

DISCLOSURES

Dr. Martin reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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