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Case Report

Need for gender affirming clinics- a case report on gender dysphoria in India

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ABSTRACT

Evidence suggests that individuals with gender dysphoria/gender incongruence often experience a disproportionately high burden of disease, including in the domains of mental, sexual and reproductive health. Very few of the Lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ) population seek medical or surgical treatments, others do not speak up for their condition because of the societal taboo and suffer from illnesses which fully impact the potential and well-being of the individual. We present a case of a 24-year old boy who never got treated for gender dysphoria and was ignored by the family, was made fun of by the society and ended up having Paranoid disorder secondary to gender dysphoria. This clearly indicates the need specialist health care professionals who can identify the individual for proper treatment and connect him to support groups, who can guide and educate the family and the society on the need to accept the individual in a way in which he wants to be accepted.

Keywords: Dysphoria, Gender incongruence, LGBTQ, Health care professionals, Paranoid disorder

INTRODUCTION

A decision to disclose that one's perceived gender feelings are not the same as the ones assigned to them by birth is a tough one and is often either neglected or completely shattered and put away by the societal norms especially in developing countries like India, Pakistan, Bangladesh, and other countries of south Asia. Very few individuals illustrate the courage and stand up for their decisions, which is influenced by the complexities of family honour, tightly integrated family network, social obligation to get married, and prevalent religious beliefs in the society.[1] All these not only pull back the individuals potential but also deprive them of their self-respect and basic human rights.[2] Gender incongruence (GI) is defined as a condition in which the gender identity of a person does not align with the gender assigned at birth. If GI causes significant distress or problems in functioning lasting for at least 6 months it is described as gender dysphoria (GD) (DSM-V). This case study advances understanding of how gender dysphoria can lead to personality disorders like paranoid personality disorder and how removing the taboo and accepting the individual with their perceived gender is the need of the hour.

CASE REPORT

We present the case of a 24-year-old boy, who presented to the emergency department by police as he was found on the footpath with a bleeding wrist.

While trying to take the vitals of the patient and asking for history he was very incorporative and kept on shouting on the staff saying "you are all the same". "Nobody can ever understand me and I don't trust anyone of you" repeatedly. Measures to calm him down by offering food and drink items failed and he tried escaping the emergency department by hitting the staff while getting abusive. He was restrained and was administered Haloperidol injection

to calm him down so that wrist could be sutured. His blood pressure (BP) was noted to be a 142/95, respiratory rate (RR) after haloperidol was 18 bpm, pulse rate-102 and he had a temperature of 38.2, complete blood count (CBC), and fasting blood sugar (FBS) were in normal limits.

Following that day, his family was contacted who informed the doctors that he never wanted to be a boy ever since he understood the reality of his gender and has run-away from home earlier as well because he feels he doesn't belong there. "All he wanted to do was wear short dresses and put some make-up with false eye-lashes and nail paint". It was noted that the boy's siblings and friends at school made fun of him and he felt too distressed about his feelings. His family always thought he would out-grow such feelings and kept educating him about the ideal behaviours of being a boy. They even supressed his feelings of dressing up like a girl and were embarrassed of him each time he wore short skirts and shaved his legs. They also reported that they were ashamed to talk about this with their family doctor so they started to ignore him assuming he will soon out-grow this behaviour when he understands that he's not being accepted in the family.

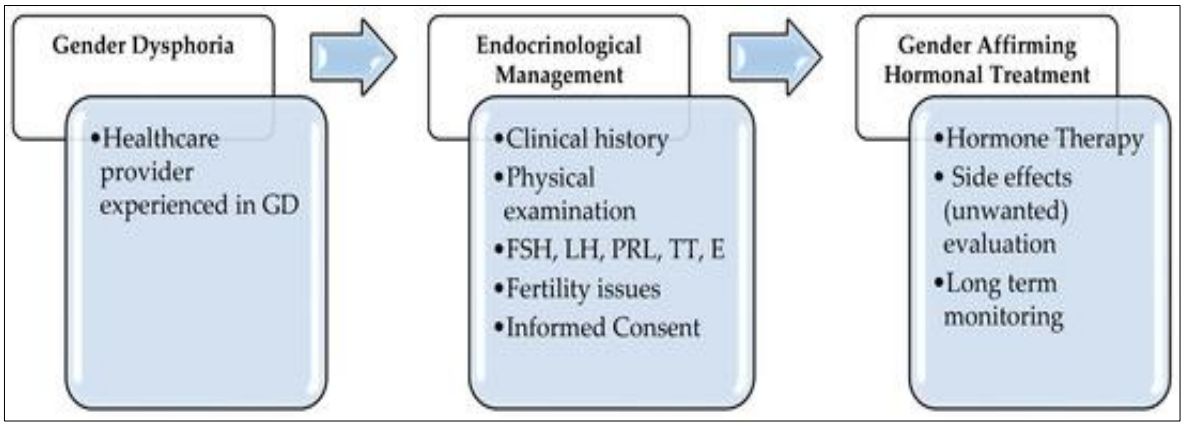

Figure 1: Following a schematic flowchart of the services offered at gender affirmation clinics.[16]

As his peer group at school never missed a chance to make fun of him which led to dropping out school in his 11th grade. Ever since then he felt he was not accepted in the society.

Family also informed that the boy has had trust issues and paranoia since the past 8-9 years and that he doesn't talk to anyone about his feelings as he thinks everyone is going to harm him in some way and he perceives every act of kindness by his family as an act of planning against him.

On obtaining such history a diagnosis of gender dysphoria was made and the it was understood that the boy has also developed a paranoid personality disorder secondary to gender dysphoria.

The boy was referred to a transgender specialist, endocrinologist for treatment and psychiatrist for psychotherapy and counselling.

DISCUSSION

Developmental traumas in which the individuals are made to question the validity or reality of their experiences by caregivers are believed to play a role in the eventual development of paranoia, leading the individual to constantly question what is "really" going on in their world and to anticipate danger and shame in their everyday interactions.[3]

Failure to provide support by a sense of understanding the individual can lead the child to doubt their perceptions, making the child vulnerable to later developing psychosis.[4]

Another prominent influence in the development of paranoia may be the experience of humiliation and shame during childhood.[5]

Individuals experiencing paranoia constantly question surface experiences, seemingly on the lookout for the potential to be humiliated. They end up perceiving others as being enraged and threatening towards their own self, leaving the individual to constantly expect maliciousness from others and to adopt a hypervigilant stance against perceived threats in their social world.[6]

In recent years, the number of children and adolescents seeking help with GI and GD has increased sharply and especially in children not all persons with GI represent with symptoms of GD.[7-9]

In early childhood, gender disparities and preferences start out small and generally ignored by the family as it is thought that child will out-grow such behaviour. Children are developmentally on track, and are just as likely to participate in school as they were doing up till now and like all the other students around them. Among those who do not out-grow such explorative behaviour and get distressed by their body changes at the time of puberty start facing problems with activities of daily living and lack a full potential of further growth and development.[10-12]

Challenges in management

Sadly, just a few numbers of patients of GD/GI in India are able to make a visit to the psychiatrist as they have always faced rejection and have been supressed by the societal norms to discuss the need of any treatment or proper counselling. Such individuals struggle daily for their identity and lose their self-respect along with their dignity. All this eventually leads to morbid disorders like obesity due to binge eating in stress, low self-esteem, high blood pressure, depression and social isolation along with personality disorders. and increased rate of mortality in this population.

Although some resourceful patients who can get treatment and are able to obtain proper therapy and hormonal treatment, some individuals who can't obtain treatment from their health care specialist due to societal taboos seek surgical treatment options from local practitioner and have been subjected to "inferior surgical techniques and post operation care with outcomes anecdotally reported as "horrifying". All this leads to increased probability of a poor outcome, with an increase in morbidity and mortality including post-operative suicide.[21]

CONCLUSION

The onset of adolescence can bring significant barriers and stress to the individuals who do not perceive their gender as the one assigned to them. Gender norms and discrimination heighten their risk of unwanted pregnancy, HIV and AIDS, malnutrition, and risky behaviour like attempt to suicide and running away from home as in our discussed case.[13]

All this asks for a passionate and friendly paediatrician, an adolescent medicine specialist and a child and Adolescent Psychiatrist along with psychologist who can adequately diagnose the condition and give appropriate treatment during the early years of GI/GD.[14] Adequate guidance to the patient as well as the family in the best way possible is required to make the society understand the need to accept the individual in a way in which they want to be accepted.[15]

Special attention is needed regarding the language in which the child or adolescent is addressed to. Words with a gender statement such as "boy," "girl," "son," "daughter," "he," and "her" can be experienced as uncomfortable for both children with GI and their parents. It is important to be aware of these emotions and to take a step towards gender-sensitive work by asking how someone wants to be addressed. The assessment procedure in children and adolescents is similar. All this can be possible at a tertiary level of care as in a gender affirmation clinic.[16]

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