An individual with misidentified gender: a case report with interventional implications

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ABSTRACT

Children born with ambiguous genitalia have to endure serious and potentially lifelong consequences secondary to wrong assignment of their gender. A 26 year old female presented to psychiatry department with symptoms suggestive of severe depression. On detailed history, and physical examination the patient was found to have grade three hypospadiasis. She was brought up as a female, but had ’male’ patterns of secondary sexual characteristics. This paper discusses about the systematic team management of the above individual.

Key words: ambiguous genitalia, hypospadiasis, depression

INTRODUCTION

To the general public, gender assignment is straightforward, as the majority of these individuals can be easily identified as male or female by virtue of their external genitalia (genital anatomy). In cases of ambiguous genitalia this poses a serious issue to the parents who might be confused as to whether the individual is a male or a female and incorrect assignment of gender could easily take place and can result in rearing the child according to the gender assigned at birth.

Intersexuality represents a rare but vital group of disorders, which present at birth with ambiguity of external genitalia. It is important that these conditions are identified early and appropriate treatment initiated when warranted. The management of such cases can be best managed by a team of professionals comprising of psychiatrist, urologist, paediatrician, radiologist, clinical psychologist and social worker. If the complete team is not available, it is possible for one professional to liaise with the other members of the team and take forward the treatment without delaying the intervention. [1]

Hypospadiasis is one among the commonest congenital urogenital problems. Hypospadiasis is classified into grade I, grade II, grade III and grade IV based on where the urethral opening occurs and whether chordee is present or not. [2] New born babies with severe perineal hypospadiasis and small penis may present as ambiguous genitalia and parents of such babies may be confused whether to assign the child to male gender or female gender and rear them up mistakenly. [1] For example, a person who is genetically male may be reared up socially as a female, leading to lot of psychological distress to the affected individual.

The general guidelines which need to be followed concerning the approach to the newborn with ambiguous genitalia are in place. When the external appearance of the genitalia is ambiguous, it is necessary to conduct certain biochemical, radiographic and chromosomal studies to confirm the gender of the newborn. [3] The parents should be taken into confidence and informed about each and every procedure and steps involved. The parents should also be evaluated for psychological distress or conflicts and clinical depression. The issues of interpersonal conflicts between the parents and the families have to be addressed and handled with utmost care. These kind of intervention may be supportive, educational or both. After diagnosis, management of hypospadiasis is surgical, and aims to i) enable voiding in a standing position, ii) allow a normal sexual life, and iii) obtain a penis with as ’normal’ a cosmetic appearance as possible. [4]

Explanations for the aetiology of hypospadiasis have commonly considered genetic, endocrinological and environmental factors. Reports on the incidence of the disorder are inconsistent, but there is evidence that it has increased over the last decades. Dolk estimates an incidence of approximately 3 per 1000 male births in western countries. [4]

In practice, there are 3 populations of patients with hypospadiasis: those operated on in childhood, those operated on when adults, and those for whom surgery is not considered necessary. [5]

Given below is the account of an individual who is genetically male but was reared as a female by his parents.
who were confused because at birth he had ambiguous external genitalia. He underwent surgery in adulthood.

**Case history**

A 26 year old female (genetically 'male') came to the outpatient psychiatry department of a hospital with presenting complaints of dullness, sadness, ideas of worthlessness, weeping spells, not attending to work regularly. On mental status examination, the patient was depressed. A provisional diagnosis of severe depression without psychotic features was entertained. She was started on antidepressant treatment, and was called for follow up after two weeks.

On follow up significant clinical improvement was noted. The depressive symptoms were better. The patient said that she was 'psychologically a male,' and was in a committed relationship with a girl.

**Clinical examination**

On physical examination the patient had 'male pattern of secondary sexual characteristics,' both testes were present in the scrotum, penis was normal in size, with grade III hypospadiasis (urethra at peno- scrotal junction).

On ultrasound abdomen there was absence of uterus, ovaries and fallopian tubes.

The patient requested the doctor to help 'him' out of this problem and to how to go about the gender reassignment issue. A detailed history was then again taken.

**Personal and development history, and other details**

The patient was born to illiterate parents in a low socio economic class family of sub urban background. His father was physically challenged. The patient had two siblings. 'His' parents could not identify the ambiguous genital pattern and misidentified 'him' as a female. Hence they reared 'him' as a female. He did his schooling in a co-education school until VIII standard and then continued in a girl's school and college up to graduation. He used to stay in a ladies hostel. He secured a job under sports quota (women). He reported that he had to remove his facial hair daily and to practice female voice and gestures all through the years. He had sexual intercourse with his girlfriend. Moreover, he could manage well in his office and in the society.

As he grew and his family members and relatives became aware of his problem they were ignorant and fearful of how to tackle the situation and thus the issue went unaddressed. The severe long term stress led to development of depressive symptoms and suicidal thoughts in the patient. With the worsening of depressive symptoms and poor biopsychosocial and occupational functioning, he approached the psychiatrist.

**Case management**

1. Depression was treated with antidepressants (imipramine up to 100 mg/day) and counselling.
2. Assurance to the patient that he is a male, with absolutely no female morphology
3. His family and girlfriend were educated and counselled about the disorder and the treatment procedure.
4. Referral to the urologist was done where the correction of hypospadiasis and chordee surgery was done.
5. A religious hair cutting ceremony was advised for the societal acceptability.
6. Legal procedures were explained in terms of correcting official records, and name change was advised.
7. Transfer of job to a different location was facilitated with the help of the head personnel of the concerned department where he was working.
8. Regular follow up and counselling has been continuing and the patient is married. The couple has a 5 year old son.

**Discussion**

Gender assignment is perhaps the most complex and certainly the least well understood. It raises the controversies of nature versus nurture and more specifically male or female brain. Management of children with wrongly assigned gender is complex. The criteria for reassigning gender largely depend on the local culture. [6, 7]

This case throws light into the lack of awareness of various disorders among the sub-urban population, and the poorly available health resources, because of which the sex of a newborn could not be identified by the parents. The need for proper guidance by health personnel is also highlighted. There is a vital need of proper health and early identification services to all the people, irrespective of the socio demographic or economic strata. Intersexuality or gender identification disorders or any sexual disorders have been highly stigmatizing in developing countries like India. But statistics and various studies have shown an increasing incidence of such cases. Hence it is important to educate the public about such problems. This in turn will improve the quality of life of
those affected individuals through early detection and treatment. This also will help reduce 'labelling' of such individuals.

**Conclusion**

This case report tries to illustrate how one could manage such cases systematically and scientifically, thereby providing better care to the individual. Even then it has to be noted that most of the time the role of team professionals may overlap or the complete team may not be available due to the lack of supportive health care professionals. It is the obligation of the professionals to make sure that the lack of man power or resources should not hinder with providing the adequate or proper care to the affected individual.

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**References**


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