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Title: Gender "Euphoria": Somatic Delusions versus Gender Dysphoria in Patient with Schizophrenia

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Summary: We will present the case of a 37-year-old cisgender male with a history of schizophrenia and unspecified tic disorder with somatic delusions regarding his genitalia who had previously been referred for gender affirming therapy including consideration of hormonal and surgical interventions.

The patient was admitted to our inpatient adult hospital for evaluation and stabilization after concerns from family for acute decompensation of his schizophrenia after he had discontinued medication and therapy through his previous treatment setting. Of note, the patient denied having a gender identity incongruent with his gender assigned at birth. He exhibited paranoid delusions, disorganized thinking, and acute agitation, and per family, the patient had been noncompliant with medication because he feared his "medications are causing a sex change." During the initial weeks of his admission, he remained extremely resistant to evaluation and treatment, and he was very guarded about his past and his history of mental illness. Outside records indicated past treatment for schizophrenia including somatic delusions that his internal and external sexual characteristics were being manipulated by malignant external forces including a computer with some changes being intermittent while others were progressive and permanent, such as development of a uterus, change of his penis into a clitoris, and development of a vagina from his scrotum. He reportedly expressed concern about these changes including the belief that if he "completed the transition" that his tic disorder would be cured. Records indicated a high degree of distress related to these delusions and he was hospitalized at another facility. Upon that admission, he expressed the chief compliant of "gender euphoria" and was referred for gender affirming treatment including psychotherapy and referral to ob-gyn to discuss hormonal therapy and gender affirming surgery upon discharge from that hospital. While awaiting evaluation, he began purchasing hormone therapy products online. At time of his evaluation by gynecology, the patient expressed belief that his gender identity was male (congruent with sex assigned at birth), denied a desire to be a different gender, and denied a desire to be rid of primary and secondary sex characteristics and maintained his belief that he had developed a uterus and vagina due to malignant external forces. The evaluating gynecologist identified that the patient did not meet criteria for gender dysphoria and recommended further stabilization of the patient's schizophrenia; the patient declined further treatment and terminated all medical and psychiatric treatment leading to his eventual decompensation and admission to our service.

During his treatment at our hospital, an appropriate antipsychotic regimen was started with prolactin sparing medication (lurasidone), and the patient's psychotic symptoms eventually began to improve, although he remained guarded with questionable reliability. Throughout the admission he continued to verbalize a male gender identity and continually denied any changes to his male anatomy, either in the present or the past. He had been compliant with medication for several weeks by time of discharge and denied any concerns about them causing changes to his body.

Discussion: Signs and complaints consistent with gender dysphoria or somatic delusions involving the genitals are relatively common in patients with schizophrenia, with some studies suggesting up to 20-25% of patients (Borras, 2007; Stusiński, 2018). These occurrences may stem from a patient's genuine, established concerns about their gender and sexual identities, from a delusional process and/or hallucinations during periods of inadequate control of psychotic symptoms, or they may exist, to some degree, under both scenarios simultaneously. Clearly identifying the context of gender dysphoria complaints can be a diagnostic challenge in patients with schizophrenia (Meijer, 2017). In general, it is important to adequately address concerns of gender dysphoria in all patients who express incongruence between their expressed gender and the gender that has been socially assigned to them. It is equally important to contextualize these complaints in patients exhibiting psychotic symptoms as certain therapies might do more harm than good if the complaints stem solely from a delusional or hallucinatory process. Complaints that include changes in primary or secondary sex characteristics concurrent with periods of active delusions or hallucinations, might be helpful in making this distinction, especially when they can be verified by physical exam. Patient interpretations of "changes" in sexual anatomy must also be considered given that certain adverse effects (gynecomastia, for example) possible with many antipsychotics might easily be interpreted in this way. Some form of delusions involving changes of sex or sexual organs may persist even after an acute psychotic exacerbation abates (Borras, 2007). Even with confirmation of expected anatomy on physical exam, it is important to consider comorbid gender dysphoria in psychotic patients with these complaints, although quality data on this is limited as actively psychotic patients are typically excluded from research studies. Investigation into onset and timing of gender dysphoria relative to the presence of psychotic symptoms may be particularly important when evaluating patients without complaints of actual anatomic change. Full understanding of these complaints may not be possible until resolution of psychotic symptoms.

Treatments such as gender-affirming therapy are generally not recommended during periods of active psychosis or without thorough observation and evaluation to help clarify understanding of the origin of the patient's gender-based concerns (Byne 2018). Inappropriate use of these treatments increases the risk of unrealistic expectations from treatment, future regret, and potential harm to patients (Meijer, 2017).

References:

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