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## Gender identity disorders or andromimetic behaviour in a victim of incest – a case study

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### Summary

Nowadays, it is becoming increasingly difficult to clearly classify the issues associated with the phenomenon of gender dysphoria due to the fact that one identifies oneself in the context of increasingly fluid categories of gender identity - an intrinsic sense of being a woman or a man. The authors present a woman, whose internal problems connected with her sexuality and incomplete identification with the role attributed to her gender originate from her family history. Long-lasting, traumatic experiences of incestuous abuse and violence on the part of close relatives disturbed her development in many areas of personality and functioning. The aim of the study was to verify the hypothesis of the existence of gender identity disorder accompanied by depressive disorders. In addition to the medical history, the study of patient's problems included the following diagnostic tools: the Minesocki Multiphasic Personality Inventory (MMPI) and the Rorschach Inkblot Test in a CSR Exner system (TPA). The study revealed that as for sexual identification, the patient unambiguously identifies herself as a woman. Her behaviour to become like a man does not deny her sex, or even involve a temporary need of belonging to the opposite sex. It should be interpreted in the broader context of her traumatic experiences, not just sexual, but also concerning different aspects of a female gender role.

**Key words:** gender identity disorders, gender dysphoria syndrome, incest

### Introduction

#### Outline

It is currently believed that *gender* dysphoria is a multidimensional construct which encompasses various dimensions, such as: corporality, social role, sexuality,

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The study was not sponsored.

The actual autobiographical data have been changed and simplified to avoid identification of the patient.

and gender identity [1]. Gender identification is mostly determined by thoughts and emotions related to performing certain gender role [2, 3]. The main symptom of gender identity disorder is divergence between one's sex and the gender they mentally identify with. The most significant among these disorders is transsexualism, followed by transvestitism, which maintains double gender role [4]. The latter refers to gender identification disorders in adolescence in adult life without the urge to change the sex. Cross-dressing (wearing clothes of the opposite sex) is not permanent and usually is not accompanied by sexual arousal. Passing gender identification issues can result from neurotic processing of the developmental crises, dealing with trauma or be a sign of personality disorders – and therefore they seem to respond to psycho-therapeutic efforts; these issues can arise at various life stages [5–7]. Periodic assumption of the opposite gender role can involve continuous adoption of certain selected aspects typical of the opposite sex, such as masculinized women. Some researchers call for using the term *gender blending* to describe the way in which women combine masculine and feminine personality aspects in various dimensions [8].

### **Patient's treatment history**

The presented study case is based on diagnostic material gathered during numerous hospitalizations of a patient admitted to The Clinical Psychiatry Ward [Oddział Kliniczny Psychiatrii] in Tarnowskie Góry throughout a 5-year period.

The subject is about 50 years old, divorced, and a mother of an adult, married daughter. She lives alone and for the last 15 years has continually drawn a disability pension.

According to her medical records (i.e. medical history kept in the clinic, records from other centres), she has been treated psychiatrically since she was 26 years old due to affective disorders. She was hospitalized for the first time after her daughter's birth. While hospitalized, she was diagnosed with affective disorders (depressive reaction, recurrent depression) and periodic gender identification disorders. She had tried to commit suicide three times. Additionally, the subject suffers from bronchial asthma and insulin-dependent diabetes; periodically, she abuses alcohol.

Patient's hospitalization coincided with a recurring increase of similar symptoms: depression with fleeting suicidal thoughts, decrease in volitional activity, sleep disorders, lack of appetite and speech disorders (stutter), and numerous vegetative symptoms.

Biographical data gathered in medical interviews revealed numerous traumatic experiences of the patient. As a child, the patient lived in a pathological family and was exposed to sexual abuse, physical violence, her father's alcoholism, poor standard of living, chronic malnutrition etc. As an adult, the subject went through her child's death (several months old), two miscarriages, separation and a divorce.

### **Preliminary diagnostic hypotheses**

During numerous hospitalizations, the patient exhibited behaviour pointing to gender identification disorder, which had been assumed in the preliminary diagnoses.

(Gender identity disorder, unspecified, F64.9 according to ICD-10). She used masculine grammatical form, wore trousers, walked boldly and kept her hair very short. All the while, however, she wore feminine accessories such as beads, delicate make-up, and nail polish. This observation led to a hypothesis that the subject displays andromimetic behaviours without actual negation of her sex. Presumably, it is related to traumatic experiences she had endured, i.e. sexual abuse. This observation resulted in doubts whether the diagnosis had been accurate, and therefore a question arose: is this a gender identity disorder or merely a difficulty with fulfilling a socially expected female gender role? Depression symptoms (classified as recurrent depression) additionally complicated the differential diagnosis.

### **Methods of psychological assessment**

The presented diagnostic data was gathered during a few last hospitalizations of the patient. The hypothesis was verified by: an interview with the subject, testing conscious and subconscious experiences of the subject with special attention paid to self-esteem and acceptance of her femininity, her attitude towards the female role – MMPI, Rorschach inkblot test in the Exner's CSR system [9–12].

### **Significant data from the clinic interview in the context of the researched problem**

The subject comes from a poor rural community. She is the oldest daughter, third of 10 siblings. She associates her childhood with hunger and fear and remembers single incidents related to aggressive and vulgar behaviour of her alcoholic father. Her sickly mother was unable to take care of the children and the subject was burdened with household chores at an early age. She never felt a bond with her siblings; at school, she distanced herself from other children. At the age of approx. 7, she was raped by her father; later on, she was abused a few more times. The mother was constantly tense, depressed and easily irritable with her children. The subject tried to avoid being alone with her father; she would run away from home and thus explains her early marriage. Even as a small girl, she avoided wearing dresses. She said she hadn't questioned being a girl, but she preferred to wear trousers and keep her hair very short. She was petite and entered adolescence late; she got her first period at the age of 16. As an adolescent she maintained this boyish style, but emphasized her femininity with clip-on earrings, nail polish etc. Her husband was her first sexual partner and she became pregnant after first intercourse. While pregnant, she expected a son. Having given birth to a daughter, she rejected her and did not want to breast-feed her. Later, her care was limited to nurturing; she never cuddled or praised her daughter. She dressed the girl as a boy and wanted to be called by her first name – she did not want to be referred to as a mother. The same scenario followed her second daughter's birth, who died after a year of congenital heart defect. Later on, she miscarried two pregnancies. Her conjugal life was harmonious at first. Her husband never criticized her manly bearing; he had limited sexual needs. Shortly after the wedding, he started drinking

and rowing. It led to unsuccessful attempts of separations and, in the end, to a divorce. When the couple lived together, the subject commenced her psychiatric treatment due to anxiety and depression. After her second miscarriage she was hospitalized. Some time after leaving the hospital, she started to use masculine grammatical form when she referred to herself. According to the subject, it is a strong urge which she does not understand, although at the beginning she tried to control it. She claims she had gotten used to it. She is aware that her bold walk, choice of clothes, deep voice and masculine grammatical form she uses make other people treat her as a man, but she is offended when people address her in such manner. For this reason she changed her doctor in a local clinic, she doesn't do shopping and rarely goes out. She completely resigned from men's company. After her divorce, she dated a man for a short time; intercourse was described as pleasurable. They split up because her partner started to abuse alcohol. After the divorce, she lived with her daughter until her daughter's marriage. She had ambivalent attitude towards her daughter, which she attributed to behaviour difficulties her daughter caused while growing up. As a mother, she did not accept her daughter's „sexual image”. Currently, she feels their relation is good and their contact is based on partnership.

### **Psychological test interpretation – research hypothesis summary**

#### Rorschach inkblot test according to Exner

The subject presents a simplified, although mainly adequate, vision of reality. It seems to be defensive, resulting from chronic tension and depression, and is used to conceal more personal observations. It derives from painful experiences the subject went through, hence her problems are related mainly to her internal experiences. She defends herself from feeling negative emotions, avoids emotionally unpleasant stimuli and is unable to reveal her deeper feelings without the fear and repression. She excessively controls herself by using defensive mechanisms, mainly negation, projections, rationalization and fantasising. Fear-based limitation of activity is also reflected in her social and personal relations. The subject displays excessive caution towards other people and reserve tainted with reluctance, although she does not isolate herself completely. Her behaviour is passive, directed at fulfilling expectations of others. Her activities are stimulated by her own aspirations to a very limited extent. The subject has imprecise goals and life aspirations, her needs are basic and limited. Internal issues of the subject are clearly related to her sexual experiences, which were repressed by strong fear, although signatures indicate a conflicting desire for greater activity and openness in sexual contacts. The nature of her experiences is somewhat reflected in the analysis of her verbalization, which displays a common theme: cracks in rocks, entrances into spaces between rocks, entrances into caves, lowering oneself into a canyon. These images clearly suggest penetrating, entering the inside of an object and concentrate on natural openings created by force of nature. They indicate penetration and are typical of people with unstable borders with the outside world and a poorly integrated image of themselves. They signal the need to defend oneself from

intrusion of others. Subject's statements are even more significant when her traumatic childhood experiences are taken into account (i.e. sexual abuse). Traumatic nature of her sexual experiences was additionally confirmed by a clearly longer reaction time to images which generated the abovementioned associations.

### B. MMPI test

Despite subject's weak mechanisms of dealing in life, her defensive adaptation potential is sufficient to function properly in everyday life, although her activity is quite poor and hardly diversified. Subject's stress-resistance is low, hence strenuous situations quickly lead to decompensation, which in turn is followed by depression. Gathered information suggests that the subject is not confident about her strengths, and expects to be given help instead of dealing with difficulties on her own. She's dependant on others while maintaining defensive distance tainted with reluctance. This attitude is accompanied by fear of losing control which makes the subject avoid expressing emotions directly and deny undesired impulses. She's got internal problems related to her sexuality, which stem from her family history. Heightened result in the *Mf* scale (masculinity/femininity) indicates lack of acceptance or incomplete identification with the female role. It seems, however, that it pertains to the way of fulfilling this role rather than to the gender itself. In Lahar-Wrobel's critical items test, the subject negates any sexual problems – her responses indicate ability to gain satisfaction in heterosexual relations. It is not, however, certain. Heightened result in Harris's *Mf4* subscale can indicate that the subject displays interest in the same sex. This subscale does not determine the nature of this interest; it rather points to greater emotional freedom in the company of women and indicates certain discomfort experienced in men's company. Therefore it may be assumed that the subject is not able to form a mature heterosexual relation where sexual intercourse would be just one of its elements. This result should be considered in a broader context of her disturbed social relations. One needs to pay attention to her relations with father, which modelled subject's attitude to her sexual partners. Low result in the *FEM*, „feminine” scale suggest that the subject is not against her sex as such, but rather rejects traditional social conventions associated with female role; she prefers instead to engage in typically masculine activities. The presented results indicate a likely conflict between „manly” behaviour preferred by the subject and contradictory personality traits, such as passivity and dependence on others.

### Outline of the psycho-dynamic mechanisms of the disorder

The structure and defensive mechanisms of subject's personality result in impoverishment of her psychological operations based on defensive mechanisms in all aspects of day-to-day activities, including sexual development.

As clinical research proved, this defensive functioning derives from traumatic experiences from her childhood. The subject was sexually abused and beaten by her alcoholic father; she also witnessed her siblings and mother's maltreatment. She grew up in an atmosphere of constant threat, which led to developing not only fear of va-

rious types of violence, but also a sense of helplessness and inability to influence the situation. Both parents contributed to this attitude, as each of them was dysfunctional: the father was the wrongdoer, while the mother was unable to act as a psychological buffer as she was too tense, depressed and passive. In that environment, the subject stood no chance of developing a basic trust towards her parents which would model her sense of safety. Adjusting to such reality demanded continuous vigilance and readiness to escape. Sickly and „busy” with pregnancies, childbirths and care of small children mother was unable to offer the subject any support. Additionally, she burdened the subject – as she was the oldest daughter – with household chores. That way, the subject was doubly expected to perform the role of a grown-up woman at the age of merely seven. It separated her further from her peers and prevented from forging satisfactory relations outside family. This accumulation of numerous traumatic factors she could not solve at such young age forced her to suppress the emerging emotions. She built a defensive psychological system which – even though it could not protect her from the traumatic situations – helped her survive. She learnt how *not* to feel, diminish her needs, subordinate, avoid people etc. The psychological cost of those experiences is clearly visible when one studies subject’s self-image. Having been treated by her father as an object upon which he could release his sexual tension and aggression, as well as having received insufficient care from her mother, it taught the subject to think of herself as not deserving better treatment, and perhaps an accomplice to this situation. It is typical of that development stage to take everything personally; therefore the subject could have subconsciously assumed partial guilt for sexual abuse. A likely reaction to the trauma would have been dissociation followed by symptoms of depression which were the price the subject had to pay for realizing the nature of her problems.

When discussing subject’s ability to function, it is important to note what she was not able to develop properly due to traumatic experiences. Mostly, she was not able to gain skills vital in adult life, such as forming stable relations. As can be expected, an abused child developed into an adult who struggles to comprehend closeness and love [13]. The subject is divorced, her subsequent relationship was superficial, sex-oriented and unsatisfactory. Her partner, similarly to her father, abused alcohol, which may indicate that her choice in men was based on immature motivation. It was also difficult for the subject to accept the model of femininity and man/woman relations exhibited by her parents. The mother was obedient to her husband and denied her own needs for family’s sake. The father taught her that contacts with men are painful, devoid of care and concern, based on demands and force. The subject rejected these patterns by leaving her partners as soon as they started exhibiting her father’s behaviour or posed a threat of such behaviour by excessive drinking.

Another significant emotional deficit resulting from her childhood experiences is the challenge of fulfilling the role of a mother. Although subject’s mother was present in the subject’s life, their relations were mostly task-based, such as shared household chores, strengthened by praising daughter’s „usefulness”. One may say that the subject was not a child in this family, rather she – and her mother – constituted a subsystem of women. This relation was duplicated in the subject’s relations with her daughter: at an early age, she wanted her daughter to address her on first name basis and was not

interested in child's matters. She was very diligent, however, in caring for her baby's basic needs and education. Subject's daughter perceived it as lack of affection, which she tried to extort by disorderly behaviour. The subject reacted by showing concern, which sustained their contact and let it evolve naturally. The most challenging point in their relations was period of adolescence, when the subject was confronted with her daughter's sexuality. She negated all manifestations of her daughter's sex in a very violent and inadequate manner, which led to her daughter's rebellion. The natural ambivalence and competitiveness between generations has revived traumatic experiences of the subject. She identified with her daughter and tried to suppress these memories by forcing asexual style upon her daughter. One may assume that she was afraid her daughter would follow her traumatic fate and simply tried to protect her. She projected upon her daughter her own suffering, discontent with the female role and problems she had with her own mother. By arguing with her mother, who criticized how she raised her granddaughter, the subject was not doing it „for her daughter's sake” – the confrontation gave her a chance to indirectly release memories from her own past relations. Today, subject and her daughter maintain supportive and harmonious relations.

### **Conclusion regarding subject's gender identity**

There is a contradiction between gender identity (indicated by what the subject thinks, feels and experiences) and behaviour she displays, which are typical of men. Therefore her gender identity may be determined as disharmonious [2]. Gender identification and gender role are conflicted, especially during depression episodes when the subject switches to masculine grammatical form when he refers to herself. This aspect of self-perception can be categorized as ego-dystonic. The research which verified whether gender identity disorder actually exists, indicated that sexually she determined herself clearly as a woman. Her masculinized behaviour does not negate her sex; she also feels no need (even temporarily) to belong to the opposite sex (therefore double role transvestitism has been ruled out). Her behaviour should be interpreted in a broader context of her traumatic experiences - not only sexual abuse, but also various aspects of a female role. The subject has been exposed to instrumental and physiological approach to sex, her father's brutality and her mother's inaction which passively consented to coercion, and suffering caused by miscarriages and baby loss. Household chores distribution was also an unattractive model for the subject, especially given the fact that it deprived her of childhood. All these experiences made it hard for the subject to accept not the gender itself, but the social role associated with it. Similarly unacceptable is the male role she's familiar with: hence her andromimetic behaviour is usually accompanied by feminine accessories. Mimicking men may indicate a defensive mechanism – identification with the aggressor can help reduce her fear of men and lets her boost her self-esteem by a symbolic seizure of his power. Subconscious content of subject's experiences, which were revealed through the projection test, also indicates a conflict between a strong fear and desire for greater activity and openness in sexual contacts. Presumably, andromimetic behaviour serves as a concealed method to fulfil these needs.

## Conclusions

Throughout the diagnostic process of a subject whose behaviour is inconsistent with social expectations for their sex or who indicate problems with their sexuality, one should consider difference among gender identity, gender role and sexual orientation, as well as potential divergence among these elements. Diligent and accurate diagnosis of the disorder and problem analysis helps to plan an adequate and effective therapy which often needs to include cooperation of a psychiatrist, psychologist and sexologist.

### Нарушения половой идентификации или андромиметрические поведения у жертвы кровосмешения – представление наблюдения

#### Содержание

В настоящее время все более трудным становится однозначное определение проблемы связанной с явлением дезапробаты пола ввиду собственного определения. Все более неопределенным становится категория половой принадлежности – внутреннего чувства быть женщиной или мужчиной. Авторы представляют наблюдение женщины, у которой внутренние проблемы, связанные с собственной сексуальностью и неполной идентификацией с ролью, приписанной полу связаны с источником семейного прошлого. Длительные, травматические переживания кровосмесительного насилия и жестокость со стороны близких людей нарушили развитие исследованной во многих сферах личности и функционирования.

Заданием работы было описание наблюдения и верификация гипотезы о появлении у женщины нарушения идентификации пола, которое идет в паре с депрессивными нарушениями. В работе над проблемами пациентки, кроме клинического анамнеза, использованы диагностические пособия: Минесотский полимерный глоссарий личности и Тест чернильных пятен Х. Роршаха в системе ЦСР Экснера (ТПА). Исследование показало, что пациентка сексуально определяется как женщина. Показываемые ей поведения, сходные с мужским поведением не отрицают ее пола, а также не связываются с краткой потребностью к противоположному полу. Это явление нужно интерпретировать в широком контексте травматических переживаний, не только сексуальных, а также связанных с различными аспектами роли женщины.

**Ключевые слова:** нарушения половой идентификации, синдром дезапробаты пола, кровосмешение

### Geschlechtsidentitätsstörung oder andromimetisches Verhalten bei Inzest – Opfern – Fallbeschreibung

#### Zusammenfassung

Zur Zeit ist es immer schwerer eindeutig die Problematik zu klassifizieren, die mit der Ablehnung des eigenen Geschlechts im Bezug auf die Selbstbestimmung in einem gewissen Kontext und mit der immer verschwommenen Kategorie der Geschlechtsidentität verbunden sind - inneres Gefühl, Frau oder Mann zu sein. Die Autoren beschreiben den Fall einer Frau, bei der die inneren Probleme mit eigener Sexualität und nicht voller Identifikation mit der ihr durch das Geschlecht zugeschriebenen Rolle, eine Quelle in der Vergangenheit der Familie haben. Langjährige, traumatische Erlebnisse des sexuellen Missbrauchs – Inzest – und der Gewalt seitens der Nächsten störten die Entwicklung der Untersuchten auf vielen Gebieten der Persönlichkeit und der Funktionsweise. Das Ziel der Arbeit war Fallbeschreibung und Verifikation der Hypothese zur Geschlechtsidentitätsstörung, die bei der untersuchten Frau mit der depressiven Störung komorbid ist. Bei der Studie an der Problematik der Patientin wurden auch, außer der Anamnese, folgende Werkzeuge eingesetzt: Minnesota Multiphasic Personality Inventory (MMPI) und Tintenkleckstest von H. Rorschach im CSR Exner-System (TPA).

Die Untersuchung erwies, dass die Patientin sich selbst sexuell eindeutig als Frau bestimmt. Ihre Verhaltensweise ähnelt einem Mann, sie verneint ihr Geschlecht nicht und fühlt sich auch nicht momentan einem anderen Geschlecht zugehörig. Ihr Fall soll in einem breiteren Spektrum ihrer traumatischen Erfahrungen interpretiert werden, nicht nur der sexuellen, sondern auch solchen, die mit unterschiedlichen Aspekten der Rolle einer Frau verbunden sind.

**Schlüsselwörter:** Geschlechtsidentitätsstörung, Syndrom der Geschlechtsablehnung, Inzest

### Les troubles de l'identité sexuelle ou les comportements andromimétiques chez une victime de l'inceste – étude d'un cas

#### Résumé

Aujourd'hui il est de plus en plus difficile de qualifier les problèmes liés avec le phénomène de la dysphorie de genre dans le contexte des catégories de l'identité sexuelle devenant plus fluides – dans le sens interne d'être femme ou homme. Les auteurs décrivent le cas d'une femme dont les problèmes, liés avec sa sexualité et l'identité incomplète avec son rôle lié avec le genre, ont leur origine dans le passé de famille. L'expérience traumatique et durable de l'inceste et de violence en famille trouble son développement dans plusieurs champs de sa personnalité et de son fonctionnement. Ce travail vise à décrire son cas et à vérifier l'hypothèse du trouble de l'identité sexuelle accompagnée des troubles dépressifs chez cette patiente. Les auteurs usent les suivants outils diagnostiques : the Minnesota Multiphasic Personality Inventory (MMPI), the Rorschach Inkblot Test dans le système CSR Exner (TPA) et l'anamnèse (dossier médical de la patiente). L'examen démontre d'une manière indubitable que la patiente s'identifie comme femme. Ses comportements masculins ne contestent pas son genre féminin et ils ne se lient pas avec son besoin, même temporaire, d'être homme. Il faut interpréter ces comportements dans le large contexte de ses expériences traumatiques, non seulement sexuelles, mais liées avec les divers aspects du rôle de femme.

**Mots clés :** troubles de l'identité sexuelle, dysphorie de genre, inceste

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