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Psychoanalysis and psychiatry: the important role played by differential diagnosis in treatment management processes

Abstract

J. Chick Jr.'s case is paradigmatic when it comes to the hard time establishing differential diagnosis. He has been a heavy drinker and drug user since adolescence, and was hospitalized in psychiatric institutions several times, as well as had a vast collection of diagnoses he identified himself to. Based on what he calls his lack of identity, Chick Jr. gives significant importance to diagnoses capable of identifying him and of telling who he is. This lack of identity, which is experienced as non-existence – sometimes he says that he is dead – unfolds into a sexual identity that brings him a lot of suffering. We know that individuals are not defined by their diagnosis, even when it sometimes calms them down. In any case, differential diagnosis is extremely important to help mental health professionals manage patients' treatment; it is what the current study aims at showing, based on the herein reported case.

Keywords: psychoanalysis, psychiatry, psychosis, transgender, differential diagnosis

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Introduction

The herein presented case was treated at the Psychiatry Care Teaching Unit (UDA - Unidade Docente Assistencial de Psiquiatria) of a State University Hospital that has double bias, namely: assistance and academic projects. The aforementioned hospital is staffed by professionals approved in public tenders, by regular staff and professors, as well as by resident specialization students from different health fields. It has a multidisciplinary team that enables articulating knowledge from the Psychiatry and Psychology fields, among others. The current article results from a joint work carried out during the time J. Chick Jr. was treated by our group, which was formed by a psychologist, a psychiatry resident and a professor.

J. Chick Jr. — as, not by chance, we named our patient, since he was named after his father despite being the youngest of three children — has a long psychiatric history. In 1976, at the age of 17, he was already a heavy drinker and drug user, in addition to showing certain sexual behaviors that, as we will show, caused him suffering. In 1979, he was institutionalized for the first time at the age of 20. The aforementioned hospitalization, and many others after it, resulted from his drug abuse.

It is worth emphasizing that the phenomenology presented in drug abuse cases is sometimes quite similar to that presented in psychosis cases, so much so that individuals presenting psychotic phenomenology due to substance abuse are diagnosed with psychotic break,[1] a fact that, from our perspective, leads to the first diagnostic difficulty. Chick Jr. began his treatment at the Psychiatry sector of the aforementioned University Hospital, at the age of 48, in 2008. His medical record comprised different diagnosis types that have followed the ones he had previously received in other institutions. Doctors refer their patients to new residents at the end of their 3-year residency in University Hospitals; thus, in 2019, at the age of 60, Chick Jr. was referred to the psychiatrist described as member of our group, who was beginning his residency at that time. During the clinical supervisions, which were held on a daily basis, Chick Jr.'s narratives to the physician raised certain strangeness about his sexual behavior; the hypothesis of transgenderism was suggested but, as we will show, it was not confirmed. However, the focus of the current research lies precisely on this point, since even if Chick Jr. was transgender, which would not cause strangeness to the physician — although it could lead the patient to conflicts regarding his sexuality, for different reasons associated with social ideals and even with the psychic suffering resulting from it —, something perceived in his reports pointed towards a necessary turn in the treatment provided to him, at that time.

The physician's estrangement was actually triggered by a series of psychotic phenomena that appeared to affect the patient's body. This factor has indicated the need of seeing beyond the alcohol and drug abuse, which led to his countless demands for our service and reduced him to an annoying person. It is a clinical subtlety that had been neglected for 43 years – from the patient's 17 to 60 years of age – and that we herein intend to show through this quite expressive case, given the importance of conducting differential diagnosis; in other words, transgenderism cannot be mistaken by bodily phenomena belonging to the order of psychoses; similarly, alcohol and drug abuse does not define patients' diagnosis.

Discussion

J. Chick Jr.'s case: medical monitoring report

J. Chick Jr. was slightly fidgety in his first consultation. He had been referred to a new psychiatry resident, among many professionals who had treated him in the service, since 2008. He wore loose-fitting clothes like Bermuda shorts and a sleeveless, weatherworn colorful T-shirt printed with old carnival sayings and beer logos. He had short light blond hair, stubble beard and his body showed signs to have been more athletic when he was young. He walked into the room, scuffing his flip-flops on the floor and looking anxious. After he had sat down and the appropriate introductions had taken place, J. Chick Jr. started talking; he complained about his medication, anxiety symptoms and irregular sleep: "My medication does not work! I feel blue, I feel blue… ".

He reported to have had done better with another medication that had been prescribed by some previous doctor: "He [the aforementioned doctor] used to tell me: 'J., you are neurotic. Neurotic, J.'. I am neurotic". He asked to have his medication changed, which his medical record showed to be a recurrent demand. Chick Jr. said that his medication made him "hear his mother's voice in his head" or, sometimes, he heard voices making comments about his actions. His tongue involuntarily moved and rested on his lower lip a few times, as he spoke, in a picture suggestive of tardive dyskinesia due to several years taking neuroleptics.

Then, he started complaining about and describing what he called "depersonalization" while he rubbed his face a few times, saying: "I don't know if I am myself or someone else, I don't know what is real". He said he felt like he was wearing a mask and stated that it was the consequence of not having really grown up, by adding: "I'm a child in an adult's body." He felt immature and complained about it to himself: "Aren't you going to grow up, man?". He often asked rhetorical questions and made existential statements. He once told us that he heard about a philosopher who said that when one thinks, one exists: "How can it be true, if I think all the time and I don't exist?". Chick Jr. easily connected subjects by moving from one topic to another and by leaving little room for the medical questions necessary to the anamnesis process. He reported to have gone through several psychiatric hospitalizations, as well as mentioned certain ideas about himself that we identified as delusional ideas of mystical nature he reported to have certain reservation about, nowadays, although, recently, he was taken over by the thought that he was Jesus Christ. He felt like he was being watched by customers of the bakery near his house, a fact that made him angry, although not to the point of confronting them.

Since the first appointment, Chick Jr. complained about the hard time he had to keep an erection, a symptom he always attributed to his medications: "I cum with a soft dick!". Subsequently, he complained about the anguish deriving from having sex with prostitutes – mainly with transvestite prostitutes – and from masturbating while wearing women's underwear. He confided that, sometimes, he asked his partners to call him by female names during sex: "I'm not homosexual, but I have fetishes. I like to have sex with transvestites because they have breasts and penises; but after I have sex, I'm the one who puts on panties and I keep asking myself why". He reported to have suffered sexual violence in pre-adolescence and described, in details, how he was abused, without looking embarrassed to do so. He told us what a good soccer player he was at that age and he remembered his classmates saying: "Hey Chick, you'll become a rooster, huh!"

The patient reported to have been recently unable to join a football club due to his drug use. Although he used marijuana and cocaine, alcohol was his main addiction. He started drinking at the age of 17, a fact that he attributed to the series of abuses experienced by him. Without specifying the dates, he said that his alcohol abuse got him hospitalized a few times, both due to risky behavior and for detoxification purposes. He mentioned that he thought he was Jesus Christ during one of these hospitalizations and that he opened his arms in the middle of the street, saying: "Come to me, those who have sin, and I will forgive you". At that time, he had been abstemious for 5 years and he regularly attended mutual support groups. Whenever he felt too distressed and anxious, he thought about having a beer: "If I sit at the bar and order an ice-cold Antártica®,[1] I'll drink it and I'll know that I exist, but then I won't be able to stop drinking".

During his treatment, consultations revolved around the following topics: changing his medication, existential anxieties, the death of his parents and sexual issues. Chick Jr. was often anxious, or irritable, and his speech presented theatrical and persevering features; he often repeated ideas and concepts more than once. He handed us a letter that listed his main questions in bullet points: "Who am I? I think I will never die! I do not notice my body! I think my body is not mine! I want to be accepted by others and by myself! This lack of existence has to end! I want to exist! Do I want to be a woman? My libido is fading away! I lost my parents and I lost myself!".

Chick Jr. was born by normal delivery without complications and he did not present neuropsychomotor development changes. Having being named after his father made him angry, because he did not want to be like his father, who was diagnosed with schizophrenia. He spoke tenderly about his mother and remembered the times she always visited him, as well as brought him food and cigarettes, every time he was hospitalized. At a certain point in his life, he had to take care of his parents. First, his father had cancer and, after his death, his mother was diagnosed with Alzheimer's disease. He unashamedly described the way his father exposed his flaccid penis to urinate around the house. According to him, "although my father was not able to teach me how to be a man, I was able to be a son who took care of him at the end of his life". With respect to his mother, he was happy to tell us about the intimate hygiene care procedures he performed on her, such as cleaning her vagina, bath time details and the way he crushed the pizza so she could eat it: "The drug addict, the one who lived on the street, was able to take care of his parents". Despite boasting about having been able to take care of his parents, he felt guilty for have taken financial advantages in doing so and he felt persecuted by his family, based on the idea that they expected him to have an alcoholic relapse and to fail in providing care to his parents.

Chick Jr., in his turn, is also a father and has recently become a grandfather. He has a ticklish relationship with his son, who he feels rejects him, and he believes that he is only remembered when his son needs money. He got even more unstable after the birth of his grandson and his complaints about feeling like a child in an adult's body got more intense, a fact that affected his routine, his sleep and his organization. Nowadays, Chick Jr. lives alone; however, during most of the follow-up time, he lived with a man who, according to him, had been diagnosed with schizophrenia, just like his father, so he acted as his caregiver.

At each consultation, he tried to influence us to change his prescribed medication, by saying that he had tried to take another medication on his own and that it had worked better than the "currently prescribed" one. Every time he tried to keep the aforementioned medication, he contradicted himself and asked to resume the previous prescription. Chick Jr. presented remarkably higher personal organization level after he started attending psychotherapy sessions, on a weekly basis, and kept on taking the prescription medication, namely: Olanzapine doses ranging from 5mg/day to 10mg/day, and 2mg Clonazepam at night. He maintained good personal hygiene and wore clean clothes, in addition to looking visibly less anxious and irritable. He was able to better elaborate his complaints during consultations, although, given his history, it is hard to say how regular his adherence to his medications really was.

Psychoanalysis and Psychiatry: a possible dialogue

According to the *ICD-10 Classification of Mental and Behavioral Disorders*,[1] the item addressing *Disorders Associated with the Use of Psychoactive Substances* is precisely where one finds the term "Psychotic Disorder" (F1x.5), which is defined as:

A cluster of psychotic phenomena that occur during or immediately after psychoactive substance use and are characterized by vivid

[1]Antártica is a popular beer brand consumed in Brazil.

hallucinations (typically auditory, but often in more than one sensory modality), misidentifications, delusions and/or ideas of reference (often of a paranoid or persecutory nature), psychomotor disturbances (excitement or stupor), and an abnormal affect, which may range from intense fear to ecstasy. The sensorium is usually clear but some degree of clouding of consciousness, though not severe confusion, may be present. The disorder typically resolves at least partially within 1 month and fully within 6 months.[1]

The aforementioned manual also uses the term "psychotic" to refer to other disorders, namely: 1) Residual and late-onset psychotic disorders, which also refer to substance using; 2) Acute and transient psychotic disorders, which refer to schizophrenia, schizotypal and delusional disorders; 3) Mood disorders – which comprises both manic and depressive episodes, be them recurrent or not, as well as bipolar disorder –; they are described in items focused on differentiating whether they have psychotic symptoms, or not. However, one can find the following warning in the introduction of the aforementioned manual, most specifically in the item titled "*Neurosis and psychosis*":

The traditional division between neurosis and psychosis that was evident in ICD-9 [...] has not been used in ICD-10. However, the term "neurotic" is still retained for occasional use [...]. Instead of following the neurotic - psychotic dichotomy, the disorders are now arranged in groups according to major common themes or descriptive likenesses, which makes for increased convenience of use [...]. Disorders of adult personality and behavior; similarly, all disorders associated with the use of psychoactive substances are grouped together in F10-F19, regardless of their severity. "Psychotic" has been retained as a convenient descriptive term, particularly in F23, Acute and transient psychotic disorders. Its use does not involve assumptions about psychodynamic mechanisms, but simply indicates the presence of hallucinations, delusions, or a limited number of severe abnormalities of behavior, such as gross excitement and overactivity, marked psychomotor retardation, and catatonic behavior.[1]

The definition of the aforementioned disorder – Acute and Transient Psychotic Disorders (F23) – also presents a kind of warning:[2]

Systematic clinical information that would provide definitive guidance on the classification of acute psychotic disorders is not yet available, and the limited data and clinical tradition that must therefore be used instead do not give rise to concepts that can be clearly defined and separated from each other. In the absence of a tried and tested multiaxial system, the method used here to avoid diagnostic confusion is to construct a diagnostic sequence that reflects the order of priority given to selected key features of the disorder. The order of priority used here is:

a. An acute onset (within 2 weeks) as the defining feature of the whole group;

b. The presence of typical syndromes;

c. The presence of associated acute stress.[1]

At this point, it is necessary making a clarification: the theoretical framework substantiating our clinical practice is that of psychoanalysis, according to which, diagnosis is not understood as a set of signs and symptoms or, as defined above, "arranged in groups according to major common themes or descriptive likenesses" (OMS [WHO], 1993, p. 3), but by the way they are articulated by the subject. In other words, we differentiate clinical phenomenology as it presents itself – as well as its severity level, a fact that implies greater or lesser urgency and, consequently, different forms of intervention – and clinical structure.[3] Therefore, we take into account the fact that drug use, cutting, depression, attempted suicide, certain forms of exercising the sexual act, among others, are clinical phenomena and, as such, they can be very similar to each other; therefore, they do not predict the structure of the subject, as clarified by Sonia Alberti, who addressed attempted suicide in adolescence: An attempted suicide – if analyzed as a phenomenon – is not different from any other attempt, but it corresponds to a structure, based on the subject. Thus, although it is always an emergency, the psychoanalyst, who works on structures rather than on phenomena — be them hallucinations, symptoms or acts — will necessarily have to make a differential diagnosis to avoid equating adolescent crisis with psychosis triggering.[2]

According to the aforementioned author, working based on structures implies articulating these clinical phenomena to neurosis or psychosis, without failing to prioritize the uniqueness of each individual, who is not just a structure. Although this recommendation differs from the ones observed in classification manuals, it is associated with them. In fact, we believe this is an important contribution to the partnership between psychoanalysis and psychiatry, since, besides not excluding the guiding principles of drug therapy, this clinical direction enables thinking about the diagnosis, mainly when it imposes difficulties, as clearly observed in the wide list of diagnoses some cases are subjected to.

Thus, if we return to the interpretation of psychotic outbreak as something caused by psychoactive substances, as defined by ICD-10 (OMS [WHO], 1993), it is a fact that the amount of drugs compulsively consumed by Chick Jr. could cause, or worsen, the hallucinations and delirious ideas reported by him, as seen in his report: he believed he was Jesus Christ. However, it was important further addressing Chick Jr.'s speech about his drug use and sexual behavior, when we asked ourselves what that phenomenology indicated about that particular subject.

J. Chick Jr. reported to have been sexually abused at the age of 10, an event he claimed to have led to his lack of identity. Since then, he no longer knows who he is: "I have a failure in the 'self'". The fact that his father could not help him to form this "self" – because, in Chick Jr.'s words, he was a "poor thing" and "mentally ill" – had, according to him, strong influence both on his drug use and on the exercise of his sexuality. It is worth emphasizing that although Chick Jr. was the third child born in the family, he was still named after his father – a fact that often applies to the firstborn –, as well as that this factor had consequences for the patient. When he was a young man, he often changed his name; he used to tell his friends that his name was Jorge, Joaquim, John, among others, rather than J. These changes happened whenever he knew any man he considered to be a reference to him; so he took the name of this man to himself: "I wanted to be someone".

He started a relationship with a young woman, but, at the same time, he used to go out with men, often as escort. With respect to his relationship with men, he reported that, because he was very handsome and often drew peoples' attention, he was delighted and perplexed at they looked at him. On the other hand, the young woman he had started a relationship with was the one he wanted to marry and have children with, and he expected her to take care of him. Apparently, the fact that this woman broke up with him when he was 17 was the event that triggered his compulsive alcohol intake, because, after the break up, he only existed when he "had an Antártica®". He talked a lot about this woman; he even knew where she lived, he followed her on the internet and, sometimes, he even followed her in real life.

[2]It is noteworthy that this premise was preserved in ICD-11.[3]

[3]We can define clinical structure as the way subjects organize reality.

He often repeated two sentences he attributed to her: "I will always be watching you behind the trees"; "You will not use me for self-affirmation purposes". Chick Jr. has attributed the failure in his attempt to have a "self" to this second sentence since, according to him, a young individual who is trying to assert himself as a man, and who hears that from a woman, becomes nothing, he has no way to affirm, establish and assert himself in life. With respect to the feeling of being watched, he always felt her presence, although he knew it was not her, because she could not always be watching him from "behind"; nevertheless, he attributed this feeling to her.

According to the patient, what he called fetish – i.e., satisfaction resulting from wearing panties and from being called by female names – has increased since the end of the aforementioned relationship. In fact, he reported that, since then, he initially makes his female partner cum and, then, he asks her to treat him as a woman so he can cum, as well. He reported to admire the female body by repeating the following jargon: "May the ugly women forgive me, but beauty is fundamental". Sometimes he believed that his so-called fetish was not a problem, but oftentimes he talked about it as something he could not understand and that brought him a lot of pain. If he was not homosexual, or a woman, why did he like to be looked at as a woman? Why did that make him cum? These questions tortured him.

The patient addressed his habit of masturbating while watching porn movies and revealed that, sometimes, when he stood in front of the mirror, he saw both a penis and a vagina in his body, as well as that he enjoyed watching his vagina being penetrated by his own penis. It is worth emphasizing that he did not present any genetic change in his genitals. Although this body phenomenon was a hallucination that caused him certain strangeness, since he wondered how he could be both a man and a woman at the same time, it did not make him question the phenomenon itself, since he only experienced it as a fact. This is what may have caught the doctor's attention: if he was transgender, he could feel like a man in a woman's body; but could he see this bodily change in front of the mirror as an empirical experience? The clinical practice teaches us that although transgender individuals can feel like a woman in a man's body or vice versa, they do not hallucinate with hermaphrodite image.

The body: psychotic phenomena X transgender

Issues involving the transgender body – such as aesthetic demands and genital gender affirming surgery – have already led researchers, even psychoanalyst researchers, to question whether transgenderism is directly associated with psychotic structure. Catherine Millot,[4] Marcel Czermak[5], Marina Caldas Teixeira[6] and Analícea de Souza Calmon Santos[7] were some of the psychoanalysts who conducted their research around this issue, since the estrangement of the body can be observed in both cases, although in different ways. However, it is worth emphasizing that many of these scholars did not end the issue in a pragmatic way. Catherine Millot, for example, reminds us, in her book *Extrasexo*: *ensaio sobre o transexualismo* [Horsexe: essay on Transsexuality], that we must pay attention to the fact that "[...] the absence of psychotic symptoms does not necessarily exclude the presence of a psychotic structure";[4] this warning was reiterated by Jean-Pierre Jacques, who highlighted, in his article *Le discours transsexuel sur le corps* [The transsexual discourse on the body], that the idea of ordinary psychosis, which lacks hallucinations and delusions, guarantees the possibility of a psychotic functioning in some transgenderism cases that abstain from elementary phenomena.[5]

The fact is, similarly, the incitement to become a woman, or the push-towards-woman,[8] as described by Lacan,[6] can result in a psychotic phenomenon without being a non-conformity issue between individuals' gender at birth and the one they identify with. It is possible seeing in the famous Schreber case, which was deeply analyzed by Freud,[7] that the push-towards-woman does not necessarily imply incongruity between body image and delusion, or even the desire to change that image. Although transgenderism is a recurrent topic in Schreber's delusion, since it plays key role in triggering his psychosis, it was as a woman of God who was chosen to create a new human race that he was able to elaborate his delusional metaphor and to conciliate with the idea of turning himself into a woman.[8] In his delusion, God is the one who wants him to be a woman and he offers his image of a woman without feeling like a prisoner in his body, a fact that annuls the prerogative of the necessary image-idea conformation:

[...] Imaginary is the place where every truth is enunciated and where a denied truth has as much imaginary weight as a confessed truth [...]. What gives the measure of truth itself, i.e., what President Schreber's paranoia shows, after all, is that there is no relationship, except with God. It is the truth![9]

Schreber's issue was not associated with gender incongruity, it was rather associated with the effect of a delusional idea that, like a patch, stabilized the subject and ceased the hallucinatory phenomena. According to Freud:

The delusional formation, which we take to be the pathological product, is in reality an attempt at recovery, a process of reconstruction. Such a reconstruction after the catastrophe is successful to a greater or lesser extent, but never wholly so; in Schreber's words, there has been a 'profound internal change' in the world.[11]

Thus, delusion is "a defense against a possible shattering, therefore, it is an attempt of healing [...]".[11] It is part of the psychotic structure that emerges as an ideational and chained construction that appeases individuals, by differentiating itself from gender incongruity, and that helps adapting the image to the idea – gender affirmation – as means of mitigating the discomfort arising from the dissonance between the body and the gender subjects identify themselves with:

[...] I strongly emphasized that the elementary phenomena are not more elementary than the one underlying the whole delusion construction process [...]. Likewise, analogous structures are observed at delusion composition, motivation and thematization level, as well as at elementary phenomenon level. In other words, it is always the same structuring force – if we can express ourselves that way – working on the delusion, whether we consider it in one of its parts or in its entirety. [...] The delusion is not deduced, it reproduces its own constituent force, and it is also an elementary phenomenon. It means that the idea of element should not be taken differently from that of structure, of a differentiated structure that cannot be reduced to something other than itself.[12]

Certainly, there are cases of psychotic individuals who identify themselves as transgender; however, it does not mean that we can

[4]French Lacanian psychoanalyst and author, Psychoanalysis professor at University of Paris-VIII.

[5]French Psychiatrist and Psychoanalyst, Member of the International Lacanian Association.

[6]Psychoanalyst - Corresponding member of the Brazilian School of Psychoanalysis (EBP-MG) and Psychology Professor at University Center of Belo Horizonte (UNIBH).

[7]Psychoanalyst - Member of the Brazilian School of Psychoanalysis (EBP) and professor at Federal University of Bahia (UFBA).

[8]Push-towards-woman is the way Lacan named - in the sexuality field - the lack of self-feeling in psychosis that, given the impossibility of positioning oneself in existence, makes it impossible for one to position itself about gender sharing, either as a man or as a woman.

directly or indirectly associate transgender with psychosis, since psychosis is a psychic structure, whereas gender incongruity is a trans-structural phenomenon; the *trans* prefix was herein used to designate "what is beyond".[13] The transgenderism topic was observed both in Chick Jr. and Schreber's cases, although without any bet on body image adjustment to the idea. On the contrary, just like Schreber, who looked at the mirror and saw himself with breasts and wearing necklaces, Chick Jr. saw himself with both a penis and a vagina, although he did not identify himself as a woman. There is an explanation for what Schreber saw in the mirror, namely: a delirious appeasing construction; however, when it comes to Chick Jr., this double gender materialized in the reflection on the mirror has evidenced an impossibility with respect to his existence, as well as to his sexuality, with no appeasement possible.

Final considerations

As shown in the current study, the terms "neurosis" and "psychosis" were stripped of their psychodynamic features for differential diagnosis purposes in ICD-10 (OMS [WHO], 1993), a change that remained in ICD-11[3] and that kept these criteria very similar to those described in DSM-5.[14] Likewise, we have previously stated that psychoanalysis does not give up these terms in its theoretical and clinical framework, since they are the two different forms adopted by subjects to structure reality. Therefore, is it possible setting a dialogue between the psychoanalysis and psychiatry fields, which are guided by two different diagnostic principles? We bet it is, based on our professional practice, according to which, psychoanalysts and psychiatrists make such a fruitful effort to articulate different knowledge types.

Therefore, our final considerations about J. Chick Jr.'s case are based on the association of the phenomena highlighted in it. He herein emphasizes the need of differentiating transgender from psychosis, based on the element defined as depersonalization by the patient himself, since this element forces him to try to find a name – both through diagnosis and the names he borrowed from the men he knew – in order to exist.

According to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*,[14] the term "transgender" accounts for the entire spectrum of individuals who identify themselves with a gender other than that of birth, either in a temporary or persistent manner. This definition can be found in the chapter on *Gender Dysphoria*, which is a clinical entity encompassing the suffering and harm that can result from the incongruity between the expressed gender and the one designated at birth. Although several individuals with Gender Dysphoria resort to medical interventions, such as genital gender affirming surgery, this resource is not necessary for its diagnosis. In any case, since the advent of the new International Statistical Classification of Diseases and Related Health Problems,[14] the category associated with *Gender Incongruence* no longer belongs to chapters addressing *Mental Disorders*; it was relocated to item *Sexual Health*. This change, which aims at distancing the transgender condition from pathologizing stigmas, suggests defining *Gender Incongruity* as a sharp and persistent dyssynchrony between the expressed gender – what the person feels and experiences – and the one assigned at birth, which was not Chick Jr.'s case.

We observed, from psychopathological perspectives,[15–17] that the depersonalization phenomenon leads to changes in the consciousness of the self's identity, as well as to experiences that are not understood by subjects as their own. It happens either because they do not recognize themselves as the persons they were before or because they see these experiences as belonging to someone else. Such a manifestation can be transitory, such as panic attacks, but it can also last for long periods-of-time, such as some chronic psychoses and those deriving from organic conditions. The course of symptoms can be recurrent due to stressful events or mood swings; however, *transitivism*, most specifically, only applies to depersonalization frameworks, according to which, subjects understands that they have changed into another person, thing or animal.

DSM-5,[14] in its turn, organizes the depersonalization phenomena in the chapter addressing *Dissociative Disorders*. The *Depersonalization Disorder*, itself, corresponds to the clinical condition, according to which, patients experience strangeness towards their own thoughts, feelings, sensations, body or actions, although they mandatorily maintain their judgment of reality well preserved; thus, depersonalization disorder cannot be attributed to effects of organic diseases or chemical substances. Differenting *Depersonalization Disorders* from *Psychotic Disorders* can be a challenging task, since nihilistic delusions can happen along with ideas that subjects are dead or feel strangeness towards their own identity and reality.

It is true that Chick Jr. experiences strangeness towards his thoughts, which he classifies as invasive, since they reach him like a command voice. The feeling of being looked at is added to the way he experiences his body, sometimes as something dead – which implies that he cannot die – and sometimes seen on the mirror with penis and vagina. His actions are also felt with strangeness, and this is why he says he acts in relationships, since he does not know how to interact with people, who sometimes seem not to exist, just like it happens in dreams.

Given the series of phenomena experienced by Chick Jr., in addition to his lack of preservation of judgment of reality, we could not conduct the case as depersonalization disorder. However, after ruling out the transgender condition and the depersonalization disorder, what would be Chick Jr.'s differential diagnosis? What should be the indicated treatment? Our diagnostic hypothesis points towards a clinical picture of psychosis, although J. Chick Jr.'s speech emphasizes his effort to learn how to deal with "the disorder affecting subjects' most intimate feeling of life"[6] – a disorder that was attributed by Soler to all psychosis cases: "It is necessary saying that this disorder in the feeling of life never lacks in any psychosis case".[18]

This perspective – disorder of the feeling of life – is ratified by several authors. When Czermak[19] addressed the Cotard's syndrome, for example, he referred to patients who said they were immortal. The aforementioned author emphasized that these patients can only say so based on the fact that they already feel dead: "we always find that twilight time, that fruitful time of a psychosis",[19] given the impossibility of dialectizing crossings imposed by life, be them about origin, sex or death.

Since humans are constituted based on language, through which they set relationships with others and with the world's reality – which precedes them –, their body is affected by this constituent aspect, since it is, primarily, spoken and mapped by others.[20] The appropriation of one's own and non-transferable body emerges as effect of subjects' relationship with others and with the world. However, this phenomenon was not observed in Chick Jr., who presented a particular way of structuring reality that was evidenced by his hard time sharing common sense.

Phenomena experienced by Chick Jr. – be them hallucinations with copulation between his penis and his vagina or the persistent idea of being dead – reveal the fragility inherent in his attempts to

respond to sexuality and existence-related enigmas; the feeling of depersonalization was a key phenomenon corresponding to the way this severe disorder of the feeling of life emerges. Hence, drug addiction operates as an attempt to organize this feeling or, as mentioned by Chick Jr., to operate by making it exist.

Certainly, drug use, mainly alcohol intake, led the phenomenology presented by Chick Jr. to be interpreted by those who previously treated him as effect of intoxication by chemical substances – Psychotic disorder F.10.5 –, which, in fact, are quite strong and can result in this type of clinical picture. However, cases giving health professionals a hard time to make differential diagnosis are exactly the ones requiring these professionals to specify the function played by the prescribed drug for that specific subject, based on moving from phenomenology to the clinical structure.[21]

In Chick Jr.'s case, the use of drugs veiled the fact that his phenomenology, or at least part of it, resulted from his psychotic structure — or, if we prefer, from his schizophrenia, as a doctor had once diagnosed him —; in other words, it was the effect of his hard time dealing with a reality that was broken for good when he lost his first girlfriend, with whom he tried to assert himself as a man. Because Chick Jr. lacked the resource of delirious formation as a way of mending reality,[7,10] he resorted to alcohol. This factor made it clear that lack of diagnostic accuracy (attested by multiple diagnoses observed in several of his medical records) forced him to be subjected to different treatments and hospitalizations for several years - sometimes as drug addict, sometimes as an annoying person – without actually helping him to mitigate his psychic suffering.[22–24]

Based on the herein reported case, we emphasize the importance of performing differential diagnosis at the time to manage patients' treatment. It is so, because, despite the necessary sensitivity implied in the process to manage psychotic cases – both by the psychoanalyst and the psychiatrist –, in their clinical and drug aspects, stabilizing patients' clinical picture is the only way to help them better organizing their psychic reality and, consequently, their sexual and existential issues, even if we accept the premise that such stability is frail and that it can shatter at certain times of patients' life.

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Conflicts of interest

Authors declares there is no conflict of interest.

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