Conflicts of a 90-year-old transsexual

To be, or not to be?

Yong-Lock Ong and Pam Davies

Within the ageing population there exists a small number of elderly transsexuals. There is a growing impression that they are beginning to require the services of old age psychiatry. Most services are ill equipped to deal with this group and require specialist support. This case history illustrates this need and describes the social dilemmas involved.

> *To be, or not to be: that is the question*: (*Hamlet*, III, i, 56)

Mr B., born in 1906, became aware of the wish to be female at about the age of eight years. In his teenage years he realised this was not socially acceptable. The 'roaring twenties', despite its ribaldry, was a strict and conformist society. He pursued a successful career in insurance and married in 1935. His only child, a daughter, was born in 1950. He considered having fathered a child to be the ultimate 'male accolade'. Four years on he began cross-dressing, which had to be kept secret from his daughter and his mother, both of whom lived with the family. He was apparently treated with 'shock treatment – aversion therapy' when he asked for help. He began to collect shrubs obsessively and was well-known locally for his collection of 300 species. He continued to cross-dress all his adult life and at the age of 72 decided to have the full sex change treatment and attended the Charing Cross Hospital to achieve this. At this stage his wife, being fully aware of his consistent tendencies, apparently reinforced them by allowing him to receive oestrogen medication and by putting up with his breast development. However, he decided against taking any further action. The conflict "to be or not to be" a woman was fully established.

> *Whether 'tis nobler in the mind to suffer*
> *the slings and arrows of outrageous fortune*
> *or to take arms against a sea of troubles*

From the age of 73 to 85 he lived as a man socially and cross-dressed most evenings in the privacy of his home. His wife allowed him to play a female role with her. He was treated during this time by his general practitioner (GP) for an anxiety neurosis. In 1991, his wife was referred to the psychiatric services for the elderly with early dementia of vascular origin. In the initial stages she retained insight into her cognitive impairment and in response to questions on her psychosexual history she offered the information that she had had great difficulties in her married life. Over the next two years her dementia deteriorated and their daughter became increasingly anxious as her mother was reporting daily visits from her dead sister. Mr B.'s cross-dressing, unfortunately, compounded his wife's disorientation. By 1996 he was no longer able to cope with caring for his wife and they were moved into a nursing home by their daughter. Subsequently, the daughter was horrified when she discovered a wardrobe full of dresses and wigs which did not belong to her mother. She then, at the age of 46, uncovered her father's 'deviancy'. She issued him with the ultimatum that he was never again to cross-dress or to talk about his desire to become a woman, or she would withdraw all support. Mr B. developed a reactive-depressive episode and his GP referred him to a community psychiatric nurse (CPN) who offered supportive psychotherapy. As expected, the main recurring theme was his constant wish that he should have "suffered the slings and arrows of outrageous fortune" and gone ahead with the reassignment operation. Another suggestion was a referral to a local transsexual group. His ambivalence was based on a need for support and an admission to fears of marked jealousy and resentment of others who were already reassigned. The psychogeriatrician was then called in. Together with the CPN a behavioural approach was suggested. Mr B. agreed to the idea of sublimating his feelings by writing his autobiography, having already published two short stories. A follow-up review in July of that year was surprising, as he no longer needed to cross-dress, as he was 'cured'.

https://doi.org/10.1192/pb.21.11.720 Published online by Cambridge University Press

To die: to sleep;
No more; and by a sleep to say we end
The heartache and the thousand natural shocks
That flesh is heir to, 'tis a consummation
Devoutly to be wished.

A new life event presented itself. Mr B.'s grandson announced his marriage plans. In response, Mr B. was determined to attend the wedding as a woman. He expressed this wish as his last chance to be 'true to himself'. His daughter objected, supported by the matron of the home, refusing to contemplate his suggestion of being passed off as an aunt. Mr B. developed another depressive episode, this time with suicidal intent. The CPN was called in again and attempted to help him put into perspective his continuous heartache that his deviancy had demanded of him. His GP in consultation started him on yet another antidepressant. Family conflicts increased in their intensity and the professional team became enmeshed. A week before the wedding the situation was still unresolved. Two days before the event Mr B. was admitted to the Medical Admissions Unit with a chest infection. He missed the wedding altogether and died two days later.

To die, to sleep;
To sleep: perchance to dream . . .

Caveat

Most psychiatrists and members of multi-disciplinary teams enjoy the theatre. As this patient's history reads like a play we have effected a theatrical slant in presenting this extended case report. Hopefully, this may encourage trainees and junior nurses to incorporate thespian experiences in their work. The role of Hamlet has been played by great actresses, hence we have used this as our transsexual metaphor. Sarah Bernhardt in classical theatre and Frances de la Tour in contemporary times were, however, not fully accepted either by their audiences or by most critics. Yet pantomime dames are frequently the stars of their productions. Is parody more readily acceptable than perceived impiety, even in a dramatic arena? Variations in gender identity seem to be a source of conflict. Stoller (1975) puts forth a general rule in treating adult male transsexuals which is that whatever one does is wrong, all one can hope for is to do the least harm and assuage the most pain. Unwittingly, we mimicked this principle but did we actually manage to assuage the most pain? Should we have allowed Mr B. to attend his grandson's wedding dressed as a woman? Could he have been passed off as an elderly aunt?

This case raises a number of important points for discussion. Mr B. had been through years of psychiatric assessment and treatment; he ultimately reached the services for the elderly but still had not achieved much relief. This is perhaps surprising as since the 50s transsexualism has been well documented. Diagnostic criteria are now clearly defined in ICD–10 (World Health Organization, 1992) and Mr B. met the criteria laid out in F64.0. There is a clear distinction between primary and secondary transsexualism. Mr B. belonged to the first category. In addition, the phenomenology is well established. The original debate of the male transsexual's apparent gross distortion of reality as being psychotic has been challenged by Rosen (1979). He argued conclusively against their bizarre beliefs as being delusional or hallucinatory. Finally, sexual reassignment surgery is reported to achieve a comfortable target for a person whose identity is then congruous with their body. A follow-up study of 17 transsexuals in Singapore, up to six years post-operatively, established that the majority felt better accepted and reported improved sexual adjustment (Tsoi *et al*, 1995). If Mr B. had gone through with the operation would he have been content and therefore not needed referral to the old age services? Psychogeriatricians are better equipped to deal with sexual disinhibition and deviation caused by frontal lobe impairment. Elderly transsexuals are particularly unfortunate as in their younger days they neither had access to specialist treatment options nor to support groups. In their old age they are inappropriately referred to the elderly services and most will not be considered for surgical intervention but will have to be content with hormonal manipulation. They are a group who have essentially just missed the boat.

The sobering conclusion we reached when treating Mr B. was our inevitable collusion with society's attitudes. His daughter and the matron were adamant that he would not and should not attend the wedding. We did not consult his grandson who may well have been more sympathetic to his grandfather's plight. We acceded to his daughter's wish that her nuclear family must never know her father's psychopathology. She was unfortunately unable to discuss the entire situation with her mother which might have given her a better understanding. Did we fail Mr B.? Has psychiatry, despite a workable definition and several treatment options, not as yet created a mature approach towards these patients? Beemer (1996) notes that even in large tertiary care hospitals the admission of a transsexual patient is often a catalyst for a huge amount of discussion – most of it peripheral to the care of the patient. Transsexuals almost invariably generate an intense curiosity in staff

https://doi.org/10.1192/pb.21.11.720 Published online by Cambridge University Press

that borders on the voyeuristic. Elderly transsexuals fare much worse, carrying with them such stigma and rarity value. Yet with an ageing population and a possibly increasing cohort of such patients, psychiatrists for the elderly need some treatment guidelines to deal with this puzzling behaviour and hopefully to be able to bring some reparation to longstanding unfulfilled dreams.

For in that sleep of death
What dreams may come?

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https://doi.org/10.1192/pb.21.11.720 Published online by Cambridge University Press