of the hyponatraemia can cause demyelination of the pons. It is safer to use fluid restriction to allow the hyponatraemia to resolve gradually while supportive measures are used.

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Symptomatic Trans-sexualism

MARTIN COMMANDER and CHRISTINE DEAN

A 24-year-old male schizophrenic had a delusion that he was female and had lived his life as a woman for almost two years. Unlike the only other reported case, his 'symptomatic trans-sexualism' responded to the effective treatment of his schizophrenia.

Ideas of sexual metamorphosis have received little attention in the literature, despite the claims of some authors that they are an invariable and pathognomonic feature of schizophrenia (Macalpine & Hunter, 1955). The only studies of note are those by Gittleson & Levine (1966) and Gittleson & Dawson-Butterworth (1967) who found delusions of sex change in approximately 25% of controlled samples of 57 female and 70 male schizophrenics. There are few individual case reports and, in particular, only two patients have been described in which delusions of sex change have been associated with cross-dressing (Akhtar & Thomspon, 1980; Newman & Stoller, 1974). Such cases of 'symptomatic trans-sexualism' have important implications for the management of trans-sexual patients. Here we present a further case and emphasise the need for caution in assessing individuals who request sex reassignment surgery.

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Case report

W is a 24-year-old Jamaican man with no previous history of physical or psychiatric illness. At the time of his referral, he was in a local prison awaiting a court appearance on a minor charge of wilful damage. The reason for his detention was unrelated to the presenting complaint that he believed himself to be a woman.

On assessment, the most striking feature of his mental state was the fixed delusion that he was female. He was adamant that his penis was a vagina and when asked about his previous heterosexual relationships, said that he was a lesbian. His manner was effeminate and once released from prison he dressed in a skirt, blouse, and high-heeled shoes. His speech had a 'Shakespearian quality' to it and revealed schizophrenic thought-disorder. His response to a question about his self-image was "I see myself as what I do see and nothing else, I see myself as within the right and not the wrong", and when asked directly "are you a woman?" he replied "let me answer that by saying, when you say that you mean several assumptions . . . when that sounds right I don't know . . . am I sensible of it". There was no evidence of any other delusions, passivity experiences, or perceptual abnormalities. He did not appear unduly cheerful or depressed and was said to be eating and sleeping well. His cognitive function was normal. He did not believe himself to be ill, nor did he feel that his experiences were unusual in any way.

W's father said that his son had been dressing and behaving like a woman for over a year. He felt that W had been neglecting himself during this period and, in particular, was concerned that W was not receiving his social security payments because he had insisted on changing his name to that of a woman. He did not know of any family history of psychiatric illness and felt that W was behaving like a woman to imitate his mother, who had died two years previously of cancer.

W was born in Jamaica following an uneventful pregnancy and delivery, and came to the UK at the age of three months. As a boy he had a poor relationship with his parents and at school was described as a loner. He left with no qualifications and apart from a few brief part-time jobs and a year on an employment training scheme has not worked. He has had two major relationships, both heterosexual, and has consistently denied any sexual attraction to men. His first relationship lasted from the age of 16 to 22 when he lived with a woman by whom he has one son, aged five years. After she left him he married another woman but was divorced within a year because of his bad temper. Since then he has lived alone. He acknowledged occasionally using cannabis and at times drinking heavily but denied abusing any other drugs and said he had not suffered from withdrawal symptoms or memory disturbance with his drinking.

A diagnosis of schizophrenia was made applying DSM–III–R criteria (American Psychiatric Association, 1987) and after being fined and released from prison, W was seen as an out-patient and treated initially with fluphenazine decanoate in high dosage every 14 days. Two months later his delusions had resolved and he was no longer thought disordered. He had returned to using his original name and wearing male clothing and had, in general, reverted to approaching life as a heterosexual male. He currently continues to function well on a maintenance dose of fluphenazine decoanate, almost two years after the original diagnosis was made.

Discussion

Delusions of sex change are reported to be more common in unmarried schizophrenics, particularly males, but otherwise no clear relationship has been demonstrated between their occurrence and factors such as age and sex, duration and subtype of schizophrenia, and change of interest in sex (Gittleson & Levine, 1966; Gittleson & Dawson-Butterworth, 1967). There are four categories: delusions of no longer being a man, delusions of being a neuter, delusions of being both sexes simultaneously, and delusions of being of the opposite sex. Of these the latter have received most attention, partly owing to the issue of sex reassignment surgery (Newman & Stoller, 1974) but also because they have been the focus for debates about the relationship between trans-sexualism and schizophrenia (Hyde & Kenna, 1977).

Delusions of sex change as well as delusions concerning the size and shape of the genitals can be associated with genital hallucinosis (Gittleson & Dawson-Butterworth, 1966). This can take the form of simple sensations such as burning, or the patients may feel that people are invisibly masturbating them or attempting intercourse with them. Forty-four per cent of female and 30% of male schizophrenics in the studies of Gittleson & Levine (1966) and Gittleson & Dawson-Butterworth (1967) acknowledged having some kind of genital sensations. Olfactory and gustatory hallucinations are also reported to occur more often among schizophrenics who display delusions of sex change than those who do not (Connolly & Gittleson, 1971).

In our experience, delusions of sex change presenting as floridly as in the case we describe are uncommon. This is supported by the lack of similar cases described in the literature. Of the two previous reports where delusions of sex change have been associated with cross-dressing, only one involved the patient, a male, living openly as the opposite sex and he did not respond to antipsychotic medication (Akhtar & Thompson, 1980). The rarity of such presentations seems difficult to reconcile with the high prevalence of delusions of sex change reported by Gittleson & Levine (1966) and Gittleson & Dawson-Butterworth (1967). However, none of their patients spontaneously complained of such delusions or cross-dressed, suggesting that their phenomenology

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was less overt than in the patient we describe. Delusions of being of the opposite sex are still thought to be experienced by as many as one in five schizophrenics (Lothstein & Roback, 1984). We suspect that many of these cases go undetected and stress the importance of enquiring about sexual beliefs in psychotic patients.

Although florid presentations of delusions of sex change are unusual, particular care is required when assessing patients who request 'sex-change operations'. It is essential to rule out serious psychiatric disorder in these cases (Mate-Kole & Freschi, 1988) and it is worth noting that the only other reported patient who lived openly as the opposite sex because of his delusion (Akhtar & Thompson, 1980) was 'successful' in obtaining sex reassignment surgery.

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Erotomania in Relation to Childbirth

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A case of erotomania in relation to childbirth is reported. There was a good response to treatment and no evidence of relapse at 18-month follow-up.

In de Clerambault's syndrome (erotomania) the subject suffers a delusion of being in amorous communication with a person of higher rank who they believe was the first to fall in love and to make advances. The onset is sudden. The object of the amorous delusions remains unchanged but the subject provides an explanation for the paradoxical behaviour of the loved one. The course is chronic and hallucinations are absent (Enoch & Trethowan, 1979). De Clerambault (1942) defined the syndrome as primary ('pure erotomania') when it occurs in the absence of an associated psychiatric illness, and he also described a secondary form (Ellis & Mellsop, 1985).

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