32 on becoming aware that such treatments were possible.

He always lived with parents who had great difficulty in coming to terms with who their son was and that 'he' wished to achieve gender reassignment. The mother died when the patient was 40 from carcinoma of the pancreas, after being nursed by her husband and the patient during the terminal stage of illness.

One year later the patient was admitted to a London university hospital suffering from an atypical grief reaction accompanied by obsessive symptoms, resistant to standard pharmacotherapy. Referral to Professor Marks was accompanied by advice from the professor in charge of his care that 'he' would be wise to postpone the quest for gender reassignment until after recovery from depression. The patient's own present view is that the obsessive–compulsive disorder (OCD) was part of a depressive problem precipitated by the mother's death.

With respect to events during the admission to Bethlem Hospital, the patient reports that he never refused treatment for transsexualism, which was talked about but never offered. He says he never developed a heterosexual relationship with another female in hospital, rather she was just a friend, and is clear that he never masturbated to heterosexual fantasies and never reported that he planned to marry and have children. Indeed, he says that he has only ever experienced masturbation as mutual masturbation from another male sexual partner early on in his sexual career and soon stopped it altogether as he found his own male genitals and their sexual responses too repugnant.

Unfortunately, on discharge from hospital, his father died. Initially he felt liberated and felt he could proceed with gender reassignment unimpeded, but he soon felt guilty and says that out of respect for the memory of his parents he tried to live as he felt they would have wanted him to, namely dressing as a man (albeit 'loosely') and not seeking gender reassignment.

After enduring this for two years, he presented to his general practitioner extremely frustrated to the point of feeling suicidal. Referral to our clinic followed. Professor Marks's review followed some time later. We can report that the patient correctly referred to as 'she' is happily living with a male 'heterosexual' partner who apparently also regards her as a woman and has only ever seen her in the female role. She has recently been given a date for gender reassignment surgery which will allow her to live the remainder of her life in fulfilment of what has always been sought. There are no symptoms of OCD.

This transsexualism never remitted on treatment for OCD and consequently never relapsed on follow-up. There is much to be said for a patient being asked to comment on their case history before publication.

Marks, I. M. & Mataix-Cols, D. (1997) Four year remission of transsexualism after comorbid obsessive–compulsive disorder improved with self-exposure therapy. Case report. *British Journal of Psychiatry*, **171**, 389–390.

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Author's reply: The above letter shows the merit of our paper's use of contemporary case notes recording the observations of several staff over two years of treatment and follow-up, rather than taking a patient's present comments about the past at face value.

The patient's case notes document our paper's main points. Staff observed that at admission the 42-year-old patient was effeminate but in male dress and did not want treatment to change his female identity, only for his OCD, as we noted. The transsexualism was therefore not rated as it was neither to be treated nor expected to change with therapy for OCD. Several staff observed over 17 months of repeated follow-up that the transsexualism remitted when the OCD improved with self-exposure therapy. At follow-up interviews the patient's manner and dress was masculine. His father confirmed his improvement in OCD and in self-assurance. For brevity, our paper did not note that the patient had said that overcoming his OCD had given him confidence to tackle other issues in his life including his sexuality. We did say that at 17-month follow-up he said he felt male, was masturbating three times weekly with fantasies about women, and hope to marry and have children; this fitted observations of his male manner.

Watson & Soutzos assert that "This transsexualism never remitted on treatment for OCD and consequently never relapsed on follow-up", based on the patient's denial five years later, which we had noted ("he now denied his heterosexual affair and masturbatory fantasies of five years earlier', p. 390). When at six-year follow-up we read out to the patient a case note entry dated 4–5 years earlier, that he was having heterosexual masturbatory fantasies and had just ended his first heterosexual relationship, s/he denied all memory of that while showing discomfort and distaste. That denial also went against other contemporary notes of masculine identity made by several staff at discharge and early follow-up.

If the above observations do not attest to remission of transsexualism, what would? During earlier follow-up had the patient lied repeatedly to several staff and merely simulated masculine behaviour and attitudes, and, if so, why? Staff had not expected this remission. It seems more likely that at six-year follow-up the anxious denial of transsexualism having remitted for some years reflected repression of such memories for fear of jeopardising the chance of gender reassignment which was now being sought again.

The patient's male manner at earlier follow-ups was in sharp contrast to his/her female garb and behaviour at six-year follow-up, at which point being referred to as 'he' seemed less appropriate than 'she'. The patient said he had resumed cross-dressing two years earlier (four years after discharge for successful treatment of the OCD).

The *Journal* rightly requires brevity in a case report, so we omitted much of interest: that at six-year follow-up the patient was attending Professor Watson's clinic (which merely confirmed that transsexualism was obvious then); that the transsexualism had returned during prolonged depression starting after the patient's sister insisted they move out of and sell the parental home (the patient did not allow us to contact her); other information noted by Watson & Soutzos but not bearing on our main point about the temporary remission of transsexualism coinciding with the start of lasting improvement of OCD. At six-year follow-up (age 48) when answering the same question asked several times the patient changed some aspects of the story and spoke of being at last in the right 'role'. S/he indeed gave an impression then of acting a feminine role and became distressed when confronted with evidence of having been in a male role at age 42–43.

The contention of Watson & Soutzos is not borne out by the patient's reports and

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behaviour at age 42–43 and by repeated observations of several staff then. The evidence is strong that the patient remained improved in the OCD over six years' follow-up and that the transsexualism remitted for at least 17 months and probably four years. This was the point of our paper and it still stands. Our correspondence is now almost as long as our case report was, but the record has to be set straight – transsexualism can remit, even if only for a while.

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One hundred years ago

The industrial training of imbeciles

The utility of industrial training for imbeciles has been so well established that the announcement of a gift of £4,000 by the Lord-Lieutenant of Cambridgeshire, Mr. Alexander Peckover, for providing the Eastern Counties Asylum at Colchester with suitable workshops and schools, is a matter for general satisfaction. This is one of the oldest training institutions for imbeciles in the country, having been established nearly forty years. Its directors are to be congratulated on the increased facilities they will now possess for fitting their more promising pupils to earn a livelihood, wholly or in part, or at any rate to employ their time in a useful and interesting manner. The Superintendent and Secretary (Mr. Turner) laid stress in his last annual report upon the necessity of additional accommodation for the technical instruction of the inmates, much progress having of recent years been made in wood carving, carpentry, basket making, tailoring, shoe making, mat making, and even painting and plumbing. In connection with the new workshop block, we understand that additional school accommodation will be provided for the smaller boys, who have hitherto, owing to want of room, not been brought under the beneficial influence of school discipline. A small farm was acquired by the institution a year or two ago, and is reported to have been of the greatest service as a healthy and useful form of occupation for the older lads, and as securing genuine new milk and fresh eggs for sick patients. By the generosity of Sir Savile Crossley a marine branch at Clacton-on-Sea was provided in 1895 for scrofulous and other patients requiring change and bracing air. The Eastern Counties Asylum is fortunate in its friend.

REFERENCE

British Medical Journal, 16 April 1898, 1033–1034.

Research by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

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