

A Mourning Case That Referred with Sexual Identity Disorder Secondary to a General Medical Condition

Ayşegül YILMAZ¹, Özge ÇERİ², Elif TATLIDİL³, Orhan Murat KOÇAK⁴, Atilla SOYKAN⁵

Abstract

D.G. was a 59-year-old male patient who was retired and married, and had 3 children. He reported no psychopathology prior to a myocardial infarction he had in 1996. Following bypass surgery he had erectile dysfunction. Subsequently, gynecomastia developed as a side effect of spironolactone and digoxin treatment. After a long period of depression he claimed was caused by non-adaptation to the changes in his body, he realized differences about himself; he began to feel like a woman. Upon referral to our clinic, he said that he had decided to continue his life as a woman and wished to get pink colored (as opposed to blue for male) identity card issued by the Turkish Government for female Turkish citizens. He reported that his wish was to learn how to become a woman. This is the first case in the medical literature defined as sexual identity disorder secondary to a general medical condition. The case is discussed in terms of pathological grief reaction.

Key Words: Mourning, denial, gynecomastia, sexual function disorder

INTRODUCTION

The mourning process is a psychological response to any kind of loss or change. Eric Lindemann (1944) regards mourning as a syndrome with a specific symptomatology and course. He describes it as, "mourning is an experience and a complex process that starts with a loss and is determined by with changes in emotional, cognitive, behavioral, and social realms; that. It has to be approached and watched carefully."

Vamik Volkan defines mourning as, "a psychological response to any kind of loss or change compromises made to maintain balance between our internal world and reality" (Volkan and Zintl, 1999). We usually associate the word mourning with loss of a loved one, but the mourning process can be experienced after any kind

of loss or threat, such as divorce, organ loss, job loss, or health problems (Freud, 1917; Çevik, 1999; Volkan and Zintl, 1999).

According to Freud, loss of a relative or an object interferes with the person's emotional involvement on the object/person, which leads to diminished self-worth. The person who experienced the loss tries to cope with the concrete loss in his/her imaginations by returning the memories on the loss over and over again and thus keeping the loss alive in his/her mind. In time, the person realizes the gap between his/her thoughts and reality. With this awareness, he/she redirects his/her emotional involvement towards other objects/person, which helps the person to accept his/her loss and complete the mourning process (Freud, 1917; Koçak and Çevik, 2002; Clewell, 2004).

Received: 16.03.2008 - **Accepted:** 27.06.2008

¹MD/Specialist, ²Psychologist, ³MD/Resident, ⁴MD/Prof., Ankara University, Faculty of Medicine, Psychiatry Dept., Ankara. ⁵MD/Assistant Prof., Kırıkkale University, Faculty of Medicine, Psychiatry Dept., Kırıkkale.

Ayşegül Yılmaz MD., e-mail: aysgulyilmaz@yahoo.co.uk

Nevertheless, forming an exaggerated ego ideal of the lost person or object might lead person to be ambivalent in the mourning process. This can complicate and pathologize the mourning process. Moreover, it is known that the complexity of the mourning process can be related to traumatic and unexpected loss (Bowlby 1980; Kersting, 2007; Brickell and Munir, 2008). In the case of sudden loss, the role of the lost relative/object in a person's life is also important. Loss generally leads to a regression characterized by such feelings as hopelessness, incompetence, clumsiness, childishness, or feeling of down (Worden, 1991).

The present study aimed to show that the mourning process which is thought to start after unexpected loss of an object that is valuable for self esteem might affect various psychopathological processes.

CASE

D.G. was a 59-year-old male patient who graduated from collage, retired from a bank, was married, and had 3 children. D.G.'s complaints began in 1997, just after his bypass surgery due to a myocardial infarction (MI) he experienced in 1996. The patient specified that he had no complaints before the MI and that he had never consulted a doctor before this incident. He told that he encountered with the fear of death for the first time in his life on the day of his MI. He reported that until a week before his bypass surgery he had a normal and happy family life, he had sexual intercourse with his wife twice a week, and had no problem with erections, ejaculation, or having sexual pleasure and desire.

The patient consulted to a university hospital in Ankara for angiography following his MI on the advice of his cardiologist and his brother, who is a urologist. The patient reported that his intention was to return home after he learned his angiography results were normal. After he got his results he asked his doctor and his brother about the condition of his blood vessels. They told him that 'there were no problem's. While he was awaiting his discharge from hospital he requested to see his file and then angrily asked to see his doctor and his brother after reading "treatment plan: bypass surgery" in his file. He said to his brother how angry he was at him and wanted to learn the reason he was not told the truth. He learned that 3 of his arteries were obstructed. He agreed to have the bypass surgery, and afterward, thinking that he might need to be looked after, and considering his wife's and children's busy schedules stayed with his sister for 6 months.

He developed erectile dysfunction after starting post bypass surgery medical treatment, which consisted of a diuretic (spironolactone) and a digoxin. At first the patient was not concerned about it, thinking the condition was normal since he was away from his wife and had undergone major surgery. He consulted his doctor and brother after he realized that his breasts enlarged, which they said was an adverse affect of spironolactone and digoxin treatment, but not a big problem. While his erection problem was getting worse and the enlargement of his breasts was disturbing him, he conducted some research and learned from his hormone profile that his estrogen level was above the normal level for a man of his age. With that information in hand he again consulted his brother and doctor and said, "my breasts are enlarging, my hormone levels are increasing, am I going to feel like a woman?" They told him that these were adverse effects of his medications and that estrogen levels may increase, which is in fact the goal of the treatment, due to the protective effects of estrogen on the heart, but that was impossible for these estrogen levels to make him feel like a woman.

The patient did not consult any urologist other than his brother and began arguing with him after his brother said, "stopping the medications is very dangerous, adding testosterone to these medications will increase your risk, and you cannot use medications like sildenafil (Viagra) due to the risk of cardiac failure. Men your age are faced with similar problems, so you'd better to get used to continuing with a less active sexual life". Of the first few years of medication use, he said that he did not enjoy his life, the activities he got used to doing (meeting with his friends, going coffee house with them, playing backgammon, etc.) were not enjoyable any more, and he did not want to go out. He decided to separate from his social environment and leave there without telling his family and came Ankara. He said that he stopped taking his medication with suicidal intention. His family could not reach him for several months, during which time his body weight reached 130 kilos due to edema (his normal weight was around 75 kg).

Despite these physical problems, he said that he was "not able to die" and returned to his home after his family located him. He promised his family that he would not attempt suicide again. The patient reported that he'd always kept his promises and never go back on his words, but he added, "if I knew more about meds, I would take 3 digoxins instead of stopping the treatment". The patient did not have any sexual relations with his wife for 5 years after his surgery. When he returned home in 2002

he wanted his wife to try to stimulate him in order to see erection will be or not. He said she could not stimulate him and he did not get aroused. In the same period he began to realize that he did not appeal to women as much as he used to and that imagining a woman and the idea of being with a beautiful woman did not excite him anymore.

Subsequently, he began to be annoyed by his male friends' ongoing salacious conversations and then he stopped seeing them. He developed ideas about liking men and began to imagine himself as a woman while being sexually stimulated by a man (after obtaining more details we began to realize that he did not mean sexual activities like erection, ejaculation, or orgasm. In fact, his erection problem never improved. We realized he was referring to emotional experiences more than physical ones when referring to sexual stimulation). During this time he purchased some women's underwear and a dildo without his wife's and children's knowledge. While home alone he wore the women's underwear and attempted anal penetration with the dildo to see whether or not it excited him.

He said he loved the anal experience and wearing women's underwear, he loved to watch himself in the mirror while wearing those clothes. D.G. did not share his experiences with his family, he wore tight clothing that showed his body contour, wore a bra, and let his hair grow long, while those in his social circle slowly began to realize the change in his preferences about himself and dressing. He consulted a psychiatrist in his town at the request of his friends and family. Although his wife and children were tolerant of his preferences and accepted him, they started to want him to not visit them at their school or office. Regarding these comments he realized that living in a small town with his family would negatively effect their family's concerns on his situation. He decided to leave his family and moved to Ankara. The patient reported that after his arrival in Ankara he regularly made contact with his wife and their relationship was ongoing. In Ankara he consulted another psychiatrist and reported that his relationship with this psychiatrist was better than the one he previously saw. The patient was referred to our clinic by his doctor after he began antidepressant treatment (sertraline 100 mg/day). He reported that he was unhappy, but at peace with his current situation.

He reported that he had decided to continue his life as a woman and wanted to start a new life without his wife and children. With the help of his friends in An-

kara that had surgically become women, he decided to get pink colored (as opposed to blue for male) identity card issued by the Turkish Government for female Turkish citizens. The patient reported that the reason of his hospitalization was his wish to learn "how to become a woman" and to learn the necessary surgeries for it.

Psychiatric examination of the patient (who had no psychopathology prior to his bypass surgery, no finding indicating homosexuality in his history, and no psychotic symptoms) is summarized below.

PSYCHIATRIC INSPECTION

Our patient was a dark skinned portly male 175 cm tall and weighing 75 kg. His clothing was compatible with his sociocultural status at the time he consulted us. Gynecomastia was noticeable due to his tight-fitting clothes during the first interview. In the first interview he was talking in a fast tempo and loud voice, while avoiding direct eye contact. His anger was especially noticeable while he was answering questions about his doctor and his brother, who is a doctor. He did not describe any problems or anxiety. There was nothing pathological about his orientation, memory, attention, perception, thought (structure, flow), or psychomotor activity other than repetitive themes about "being a woman" in his thought. It was understood from his history that he met the diagnostic criteria for depression for nearly 6 months. We did not detect any other psychopathology.

PERSONAL HISTORY

The personal history of the patient, who lives in a small town, is presented in a limited fashion due to ethical concerns.

The patient was born in 1949 incity. His mother and father had an arranged married. They had no gender expectations for their children. There was no psychological or physical problems described in the patient's infancy and childhood. The patient's mother died when she was 93 years old, his father died at age 83 years.

During his childhood D.G.'s environment was very complicated because of political conditions during that period. Much of his days were spent at home because of curfews, which occurred quite often. Because he was the oldest child in the house, he was the one who were listened by others. The patient, who spent most of his time with his grandfather reported that the last time he cried was the time of his grandfather's sudden death due to

MI, which occurred when he was 9 years old. He had a sister who was 2 and a brother who was 6 years younger. He was a successful student in life and his first sexual experience took place in a brothel at the age of 16 years; he did not describe any difficulty with this relationship or those that followed.

In 1960 after the coup d'état in his city, there were less political events that severely affected the daily lives of the citizens and thus in 1964 he enlisted in the military when he was in the high school. Despite his young age he became the commander of his squad and he said there were soldiers older than him that were under his command; however, he made decisions that resulted in the death of 2 soldiers under his command and subsequently he could not eat meat for 3–4 years after these deaths. He stayed in the military after high school, for 7 years in total. He explained his current decisiveness as, “if people who experienced war like me make a decision on something, they should not have hesitations or even think about this decision again; otherwise, you cannot survive”.

In 1969, he began attending a university business administration program. In 1970 he began working during the day and attending school in the evening. He married his wife, whom he met through his sister, in 1975. The patient had 1 daughter and 2 sons. He said that his relationship with his wife was happy, she was his best friend and he never hid anything from her. He reported that he still loved her, but could not see her as a wife.

There was no history of psychiatric disorder in the patient's family. The patient had been smoking 20 cigarettes per day for 20 years.

PSYCHOMETRIC TESTS

Tests administered to the patient included the Mini Mental Status Examination (MMSE), Short Cognitive Evaluation Chart (SCE), Bender-Gestalt Visual Motor Perception Test, Benton Visual Memory Test, Minnesota Multiphasic Personality Inventory (MMPI), Beier Sentence Completion Test, Thematic Perception Test, Beck Depression Inventory, Beck Anxiety Scale, Beck Hopelessness Scale, State-Trait Anger Scale, Maudsley Obsessive-Compulsive Check List, Young Schema Scale, and Experiences in Close Relationships Inventory.

All organic test results were within normal ranges (MMSE was 30, SCE was 57) and the patient outperformed his age group. Results obtained from other tests are shown below.

MMPI

The reliability scales of the test indicate that the patient tried to present himself at his best; he avoided and denied unacceptable feelings, urges and problems. His MMPI test profile showed that he viewed the world as a dichotomy, good or bad; he needs to be loved, accepted, and show others that he is in control of his life. In line with this, he worried about the possibility of social rejection. He avoided feelings such as anger and rage, and confrontational situations that involved self-disclosure. He was generally optimistic, despite experiencing disasters and failures. This profile indicates that the patient identified with the male role and he had masculine interests and behaviours.

His defensiveness and denial were reflected on other tests. He scored 2 on the Beck Depression Inventory, 0 on the Beck Anxiety Scale, 2 on the Beck Hopelessness Scale, and 1 on the Maudsley Obsessive-Compulsive Check List.

On the Beier Sentence Completion Test he provided few word answers, such as “I fear *nothing*”, “the worst thing I have ever made *does not happen*”, “I *do not get nervous*” and continued to demonstrate repressiveness and denial. On this test he defined men as his lovers and women as his kind. His problem areas resided around having a woman's body and legalization of sexual identity.

The most striking schema derived from the Young Schema Scales was “penalization”. This scheme is related to beliefs that one has to be punished for his/her misdeeds. He showed tendency to become angry, to feel pitiless, to be punishing others, not to be able to endure people (including him) who do not behave in accord with his expectations, and standards. He thought that people must be perfect and this attitude was valid for both him and others. He tried to cope with feelings, thoughts, and events he wanted to avoid by repressing anger, idealizing his childhood, denying sorrow, repressing memories, and workaholism. He avoided talking about his feelings and thoughts about his mother and father.

The Experiences in Close Relationships Inventory showed that he had positive mental models about himself and negative models about others. In such a pattern attachment needs are not accepted, and there is insecure bonding. There is an obsessive self-esteem and aloofness from others. This complicated mechanism derives from the fact that the only way to maintain a positive self-concept against rejection of others is to remain detached and

build a self-model that minimizes negative feelings. His relationships were not very close and he avoided close relationships with others by emphasizing the importance of independence. In this way he tried to protect himself from rejection and disappointment. He displayed a self-model of high self-esteem and competence in every area. In anxiety generating situations he had a tendency to physically and psychologically withdraw from his wife instead of seeking her support.

Using TAT cards the patient interpreted a tail-like stimulus as a wild animal that had to be destroyed for survival. Analytically, this stimulus can be interpreted as a phallic image and penis, and therefore indicates that the patient made a connection between manhood and death. When all test results were evaluated, the patient was considered to have a narcissistic personality organization, and following his experience of sexual dysfunction and gynecomastia, the integrity of his sexual identity was disturbed. Thus, his wish to change his sex represented his effort to form a perfect and integrated identity.

CLINICAL COURSE

We planned a course of clinical treatment that included pharmacotherapy, individual psychotherapy 2 times per week (30 min/day), and group psychotherapy 3 times per week (45 min/day) at the inpatient clinic of Ankara University Medical Faculty, Psychiatry Department, Consultation Liaison Psychiatry Division in February 2008. The following tests were conducted to him: complete blood count, biochemistry tests (blood sugar, electrolytes, and cholesterol levels with kidney and liver function tests), thyroid function tests, hepatitis markers, sedimentation, complete urine tests, electrocardiography, chest X-ray. The results of these tests were normal. Moreover, cranial MRI (magnetic resonance imaging), EEG (electroencephalography), hormone profile tests [estrogen, testosterone, LH (luteinizing hormone), FSH (follicle-stimulating hormone), and prolactin], breast USG (ultrasonography) and urology consultations were conducted.

Cranial MRI

Enlargement of the extraaxial space and hyperintense signal characters in T2AGs fields are seen in the right cerebellum hemisphere, which may be indicative of chronic ischemia.

EEG

Normal trace.

Hormone Profile

Hormone levels were normal, except prolactin, which was 40.16 nanograms/milliliter (upper limit: 21.4).

Breast USG

There was bilateral gynecomastia because of glandular breast tissue in 35×9 mm dimensions. But there weren't any solid or cystic lesions producing the contour; any pathologic lymph node were not found in the bilateral axillary space.

Urology Consultation

Examinations that are focusing on the pathology of organic problem were still continuing.

The patient was treated with the antidepressant drug sertraline (100 mg/day) which he reported that he thought it was effective. We aimed to provide him a context in which he can talk about his loss after the surgery and can express his anger and sadness in group and individual therapies. The patient was cautious during the first days of hospitalization because there were other patients and he preferred being called by his first name. Additionally, he specified that he could not share his bathroom and toilet with other male patients. The other patients respected his demands and despite the way he dressed, which was became more flamboyant (i.e. a pinafore dress that accentuated his breasts), he was accepted by the other patients.

The treatment team informed him that they will continue calling him "Mr. D". It was observed that patient was not shy while he was telling his story to other patients. He explained his situation in terms of changes that occurred after his operation, was not due to his choices. His expressed attitude that, "either I am going to die or be a woman", received much attention. When he was asked about his choices he explained that, "I cannot stop this medication, I promised not to commit suicide and they cannot give me testosterone". He said that he wanted a series of operations due to the suggestions of a new friend that got his pink identity card for female citizens after successful vaginoplasty at the age of 20 years. First, he wanted his beard depilated, then he wanted to have vocal cord surgery in order to have a more female voice, and then he would seek vaginoplasty and get a pink identity card from the government which is given to female citizens in Turkey and go on his life as a woman.

While telling his story in group therapy he was calm

and happy when people agreed that it was his choice. When other patients said that his situation was a remark of disorder, he could not be woman at this age, he could not get permission from any health organization/government to become a woman, or evaluated his main problem as impotence, he got angry and defensive and told about examination results, adverse effects of medications, and maximum estrogen levels in the adult male body. When he was encouraged to talk about his death anxiety, sadness, anger and disappointment after the MI and surgery, he undermined these questions by using medical terms.

In individual psychotherapy, which aimed him to mourn, it was observed that the intensity of his denial and suppression (existing defense mechanisms) began to decrease. Follow-up of the patient is ongoing.

DISCUSSION

The basis of the mental problems of 10%-15% of patients that present to mental health clinics is reported to be an unresolved mourning reaction (Batemann, 1992). Our reactions to loss are important for the healthy resolution of mourning. This type of developmental loss is a part of life. The reactions to developmental losses early in life are models that provide clues about how mourning reactions will be experienced later in life (Volkan and Zintl, 1999). Babies must be weaned off mother's breast milk and drink from a glass. When he/she begins to walk, he/she gives up the safety of being held on a lap. After resolution of the Oedipal phase, a child stops fantasizing about the cross-gender parent as a taboo love object. Thus, there are several losses (Freud, 1917; Volkan and Zintl, 1999).

Although different authors define different processes with this theory, there is a common opinion that there are various steps to the mourning process. Elisabeth Kubler-Ross reported that after a loss, a person passes through 5 stages: denial, anger, bargaining, depression, and acceptance (Kubler-Ross, 1969). Similarly, Parkes suggested that just after a loss people experience a sudden shock and dullness (phase 1). According to this author, phase 1 is followed by a period that involves intense grief, anger, and denial about the loss (phase 2), and then disorganization and desperation (phase 3). It was observed that a patient's mental structure is re-organized while he/she passes through those stages (Parkes, 1970).

The phases of the mourning process do not have to be experienced in a sequential order. The stages do not have definitive boundaries. A person may vacillate

between stages. Generally, a single cycle (denial, anger, bargaining, depression, and acceptance) is not sufficient and may be repeated (Kubler-Ross, 1969).

According to Freud, loss of a relative or an object interferes with the investments a person made in that object or person. This situation leads to loss of self-worth (Freud, 1917). It has been suggested that when one has a high need for an object to feel to be valuable, giving up this object become harder (Volkan and Zintl, 1999). According to Parkes, "exactly what has been lost is rarely obvious". For example, the death of a husband may mean losing a sexual partner, friend, accountant, gardener, baby sitter, bed warmer, listener, etc., depending on the special role of the husband in the wife's life (Parkes, 1972). Nevertheless, when the loss is of an exaggerated ego ideal and is traumatic and unexpected, the mourning process could become more complicated and pathological (Bowlby, 1980; Kersting, 2007; Brickell and Munir, 2008).

Lindemann defined the pathological mourning process as a person's over activation, repetition of themes related to the loss, disruptions in relationships, unexpectedly hostile attitudes toward specific people, acting like a robot in order to deal with hostile attitudes and unacceptable anger, insufficient social relationships, engaging in harmful behaviors (in social and economical contexts), the presence of agitated depression, which is associated with a high risk of suicide, maladaptive behaviors, speaking in medical terms, and recounting every detail of the results of every examination of him/herself or of the person that was lost (Lindemann, 1944).

Our patient had normal results on all organic tests, and even outperformed his age group. Ischemia was detected with MRI of the cerebellum region. Regarding these findings, a diagnosis of dementia was unlikely. At the same time, with exception of the periods of depression and preoccupation (over evaluated thoughts) about sexual identity, there was no period that met the criteria of mania or hypomania. The formulation of the case could be made on grief background, although he had persistent thoughts, which may indicate a preoccupation with sexual identity and point to a psychotic process. Although he did not use antipsychotic medication, it was observed that these thoughts disappeared after several interviews with the patient.

D.G.'s history met the criteria in Lindeman's definition about mourning. He described himself as perfectionist, fussy, having high expectations, skillful, a man of his word, a person that views the world as black and

white, and a person who has authority over other people. The patient did not have any difficulties in sexual, social, or family relationships before his bypass surgery, with the prediagnosis of atherosclerotic heart disease. The patient came to Ankara with no expectation of surgery and then learned he needed to have bypass surgery. After the surgery he began to experience erectile dysfunction, unexpectedly. While studies suggest that factors like erectile dysfunction before surgery and age are the most important predictors of erectile functioning post surgery, heart disease, medications, accompanying anger and depression, dominant personal characteristics, and cigarette smoking seem to have been the predictors of erectile dysfunction in our patient (Feldman and Goldstein, 1994; Heaton and Evans, 1996; Hızlı and Isler, 2007).

The patient's stated "loss of feeling like a man", which began with the experience of erectile dysfunction, is what he was mourning. Gynecomastia, which was the result of adverse effects of medication and high estrogen levels, seemed to be effective in changing the patients thoughts from, "I am not a man as I am used to be", which began with the patient's erectile dysfunction, to, "if I am not a man as I used to be, am I a woman"? Studies suggest that there is no elevation of estrogen in patients using digoxin for up to 1-2 years for heart failure or after bypass surgery, but there are some studies suggesting the opposite (Stoffer and Hynes, 1973; Marcus, 1976; Persson and Landahl, 1982; Kley and Abendroth, 1984). Moreover, there is a 30% decrease in the death rate after adding digoxin and spironolactone treatment, and a gynecomastia frequency rate of 0.5%-9% has been reported (Wolfe, 1975; Nielsen, 1990; Thompson, 1993; Nolan, 2004).

This patient generally used denial and suppression as a defense, and had a low capacity to mourn, as understood from his previous life, preferred to deny feelings like anger, disappointment, and sadness, instead of expressing them in general. Sentences like, "bad decision is better than having no decision", or, "I have to be in control of my life, I cannot stand to watch while others make decision on my life", were pointing out his regret of giving the control of his life to others like his brother before the surgery without any explanation. The patient was observed to avoid expressing his feelings, were not letting himself to experience his feelings freely, which was needed to resolve his mourning properly (Trunnell and Holt, 1974; Worden, 1991). Despite the fact that D.G. promised his family that he would never again attempt suicide, he left them and decided to continue his life with a new identity so this must alert us to evaluate and follow-up the patient for suicide risk. Treatment

aimed at helping those with difficulties in the mourning process to understand that their loss is real, to recognize their feelings, to express their feelings, to help them continue their lives without the person or the object they lost, and to encourage them to live their pain by providing support to them (Worden, 1991).

Vamik Volkan developed the concept of re-mourning treatment after Freud, who drew attention to the importance of "withdrawing emotional energy from loss and investing it in another relationship" in the mourning process (Freud, 1917). This method focuses on the reactions to loss with a concrete approach instead of person's general psychological existence. With this therapy method it is aimed to detect what stage of the mourning process a patient has not been able to complete, then to diminish this obsession and, starting from that point, enable them to "mourn again" for the loss. It has been observed that people can mourn more effectively after interviews, which generally occur 3-4 times a week during a 2-4-month period (Volkan, 1992). A mother who lost her son in the Pan-Am plane crash of 1988 said that, "the problem was not finding an answer, the problem was living without an answer", after she finally began to mourn for him ((Schuhter and Zisook, 1986).

Researchers that draw an analogy between mourning process and fetishism specified that in both situations patients use some objects as if they are magical, they use their connective objects to aid their separation anxiety, mostly for castration in fetishists (Volkan, 1992). In our patient fetish objects (underwear, etc.) were seemed to be used both for castration and separation anxiety. Our patient, whose castration and separation anxiety were evaluated together, is still being followed-up.

Our patient was a mourning case that was referred to our clinic with a sexual identity disorder secondary to a general medical condition, which has not previously appeared in the literature. Despite the existence of the description of a sexual dysfunction secondary to general medical condition in DSM-IV, identity disorder has not been defined. The literature does contain erectile dysfunction cases following bypass surgery and gynecomastia secondary to medication, but there are no sexual identity disorders reported. It is suggested that this case has to be evaluated as 'a sexual identity disorder secondary to a general medical condition' related to mourning. We think that adding a description of the diagnostic category "sexual identity disorder secondary to a general medical condition" in DMS-V will make a contribution to literature.

REFERENCES

- Bateman A, Broderick D, Gleason L et al (1992) Dysfunctional grieving. *J Psychosoc Nurs Ment Health Serv.* 30(12):5-9
- Bowlby J. (1980) Attachment and loss. Anxiety and Mourning. NewYork, Basic Books. Vol.2
- Brickell C, Munir K. (2008) Grief and its complications in individuals with intellectual disability. *Harv Rev Psychiatry.* 16(1):1-12
- Clewell T. (2004) Mourning beyond melancholia: Freud's psychoanalysis of loss. *J Am Psychoanal Assoc.* 52:43-67
- Çevik A. (1999) Avrupa'daki göçmen Türklerde kimlik sorunlarının reaktivasyonu ve bunun kliniğe yansması: yas, kimlik sorunları ve somatizasyon. *Türkiye Klinikleri J Psychiatry* 1:55-61
- Feldman HA, Goldstein I, Hatzichristou DG et al (1994) Impotence and its medical and psychosocial correlates: results of the Massachusetts Male Aging Study. *J Urol.* 151(1):54-61
- Freud S. (1917) Mourning and Melancholia, Standart Edition. p.243-258
- Heaton JP, Evans H, Adams MA et al (1996) Coronary artery bypass graft surgery and its impact on erectile function: a preliminary retrospective study. *Int J Impot Res.* 8(1):35-9
- Hizli F, İşler B, Güneş Z et al (2007) What is the best predictor of postoperative erectile function in patients who will undergo coronary artery bypass surgery? *Int Urol Nephrol.* 39(3):909-12
- Kersting A, Kroker K, Steinhard J et al (2007) Complicated grief after traumatic loss: A 14-month follow up study. *Eur Arch Psychiatry Clin Neurosci.* 257(8):437-43.
- Kley HK, Abendroth H, Hehrmann R et al (1984) No effect of digitalis on sex and adrenal hormones in healthy subjects and in patients with congestive heart failure *Klin Wochenschr.* 16;62(2):65-73
- Koçak OM, Çevik A. (2002) Obsesif Kompulsif Bozukluk Tanısını Alan iki Hastada Komplike Yas. *Türkiye Klinikleri J Psychiatry.* 3:6-11
- Kubler-Ross E. (1969) On Death and Dying. New York:Macmillan
- Lindemann E. (1944) Akut yasin semptomatolojisi ve yaklaşım. Çev. Uslu R. *Kriz Dergisi,* 1997. 1(2):104-9
- Marcus R, Korenman SG. (1976) Estrogens and the human male. *Annu Rev Med.* 27:357-70
- Nielsen BB. (1990) Fibroadenomatoid hyperplasia of the male breast. *Am J Surg Pathol.* 14(8):774-7
- Nolan PE Jr. (2004) Integrating traditional and emerging treatment options in heart failure. *Am J Health Syst Pharm.* 1;61(2):14-22
- Parkes CM. (1970) The first year of Bereavement: A kongitudinal study of the reaction of London widows to death of husbands. *Psychiatry* 33:444-467
- Parkes C.M. (1972) Bereavement: Studies of grief in adult life. NewYork: International Universities Press .
- Persson G, Landahl S, Svanborg A. (1982) Metabolic effects of digitalis. *Age Ageing* 11(4):261-5
- Schufter SR, Zisook S. (1986) Treatment of spousal bereavement: A multidimensional approach. *Psychiatric Annals.* 16;295-305
- Stoffer SS, Hynes KM, Jiang NS et al (1973) Digoxin and abnormal serum hormone levels. *JAMA.* 24;225(13):1643-4
- Trunnell EE, Holt WE. (1974) The concept of denial or disavowal. *J Am Psychoanal Assoc.* 22(4):769-84
- Volkan V. (1992) Psikanaliz yazıları. Çev. Çevik A, Ceyhan B. Hekimler Yayın Birliği. s.58-95
- Volkan VD, Zintl E (1999) Kayıptan Sonra Yaşam (Çev. Vahip I, Kocadere M). Halime Odağ Psikanaliz ve Psikoterapi Vakfı Eğitim Notları No:1, İzmir, 1999, s.57-77
- Wolfe CJ. (1975) Case report. Gynecomastia following digitalis administration. *J Fla Med Assoc.* 62(12):54-5
- Worden JW. (1991) Yas danışmanlığı ve yas terapisi; Ruh sağlığı çalışanları için el kitabı. Çev. Öncü B. (2003) Ankara Üniversitesi Tıp Fakültesi Yayınları No:452
- Thompson DF, Carter JR.(1993) Drug-induced gynecomastia. *Pharmacotherapy.* 13(1):37-45