

- Richelson E (1999), Receptor pharmacology of neuroleptics: relation to clinical effects. *J Clin Psychiatry* 60(suppl 10):5-14
- Sallee FR, Kurlan R, Goetz CG et al. (2000), Ziprasidone treatment of children and adolescents with Tourette's syndrome: a pilot study. *J Am Acad Child Adolesc Psychiatry* 39:292-299
- Stamenkovic M, Schindler SD, Aschauer HN, Kasper S (1998), Olanzapine in Gilles de la Tourette syndrome patients. *Eur Neuropsychopharmacol* 8(suppl 2):S301
- Tauscher J, Kueffler B, Barnas C, Asembaum S, Bruecke T, Kasper S (1997), Premedication influenced D2 receptor occupancy with quetiapine and sertindole. *Biol Psychiatry* 41(7S):13 S Abs 40

## GENDER IDENTITY DISORDER IN DSM?

*To the Editor:*

The legitimacy of gender identity disorder (GID) as a psychiatric diagnosis for children has been questioned in some quarters. For example, some have argued that it should not be in the *DSM*, because in most cases (66%) (Zucker and Bradley, 1995) it is just a manifestation of a normal homosexual orientation (Isay, 1997; Menvielle, 1998). Others claim that clinic-referred children with GID always suffer significantly from their being a boy or a girl and that there is much comorbidity in these children, which is not only a consequence of the GID (Zucker, 1999). We believe that there is another reason for not abandoning GID for children as a *DSM* diagnosis. In six North American follow-up studies of boys with GID, comprising 99 boys, 6% were found to have a transsexual outcome (see Zucker and Bradley, 1995, for an overview). This is probably an underestimation of the true numbers, because the clinicians involved usually had lost contact with their patients over the years, the questions involved are sensitive, and in some studies there was reliance on mothers' reports only. Zucker and Bradley (1995) report that 20% of 45 GID children seen at the Child and Adolescent Gender Clinic of the Clarke Institute of Psychiatry in Toronto still were gender-dysphoric in adolescence and that 14% had a wish for sex reassignment. It is conceivable that a large portion of these children would be eligible for hormone treatment (according to the Standards of Care of Harry Benjamin International Gender Dysphoria Association, a professional organization in this field). The policy of the Clarke Institute, however, is to refrain from medical treatment until adulthood.

The Gender Clinic for Children and Adolescents at the University Medical Center Utrecht, Department of Child and Adolescent Psychiatry, is the only specialized treatment center in the Netherlands in this field. Adolescent transsexuals can be referred for hormone treatment, provided that they meet certain strict criteria (Cohen-Kettenis and van Goozen, 1997). Because of the availability of (hormone) treatment, adolescent patients with a very-early-onset and extreme form of GID will probably apply for sex reassignment at a relatively early age, provided that their parents are supportive. Children who were assessed and treated psychologically when they were prepubertal are even more likely to return to the Clinic when their gender dysphoria increases around puberty, because of the bond with clinicians of the clinic. Thus the number of applicants will probably more

closely approach the actual numbers of GID children becoming transsexuals than was the case in the earlier studies.

At present, 74 of the 129 children who were referred before the age of 12 are now older than 12 and therefore are potential applicants for sex reassignment. Of the 74, 17 intensely gender-dysphoric adolescents (23%; 8 girls and 9 boys) applied for sex reassignment. Their mean age at assessment in childhood was 9 years (range 6-12). Reapplication occurred on average 3 years later (range 0-9 years; the 0 refers to three children who already had a strong wish for sex reassignment at the first assessment and were still in contact with the clinic when they turned 12). Of the 17 children, 3 adolescents have started cross-sex hormone treatment. Eight adolescents are eligible for using luteinizing hormone-releasing hormone agonists to prevent further masculinization or feminization, of which six actually have started taking the hormones. One girl delayed the diagnostic procedure after the sudden death of her father, and in five eligibility for hormone treatment is likely but not yet certain. Eight of the 17 are living full-time in the cross-gender role, 1 without having started hormone treatment.

The percentage of children with GID who come to our clinic as adolescents wanting sex reassignment is much higher than the reported percentages in the literature and probably is comparable with the data from the Clarke Institute. Our data show that GID in childhood is associated with more than just one long-term trajectory. Continuation of GID into adolescence by no means seems to be a rare exception. We believe that treatment should be available for all children, regardless of their eventual sexual orientation, and should depend only on the severity of suffering experienced by the child.

**Peggy T. Cohen-Kettenis, Ph.D.**

Department of Child and Adolescent Psychiatry  
University Medical Center Utrecht, The Netherlands

- Cohen-Kettenis PT, van Goozen SHM (1997), Sex reassignment of adolescent transsexuals: a follow-up study. *J Am Acad Child Adolesc Psychiatry* 36:263-271
- Isay R (1997), Remove gender identity disorder in *DSM*. *Psychiatr News* 32:13
- Menvielle EJ (1998), Gender identity disorder (letter). *J Am Acad Child Adolesc Psychiatry* 37:243-244
- Zucker KJ (1999), Gender identity disorder in the *DSM-IV*. *J Sex Marital Ther* 25:5-9
- Zucker KJ, Bradley SJ (1995), *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents*. New York: Guilford

The Letters column is a corner of the *Journal* that encourages opinion, controversy, and preliminary ideas. We especially invite reader comments on the articles we publish as well as issues or interests of concern to child and adolescent psychiatry. The Editor reserves the right to solicit responses and publish replies. All statements expressed in this column are those of the authors and do not reflect opinions of the *Journal*. Letters should not exceed 750 words, including a maximum of 5 references. **They must be signed, typed double-spaced, and submitted in duplicate, accompanied by an electronic copy on diskette.** All letters are subject to editing and shortening. They will be considered for publication but may not necessarily be published nor will their receipt be acknowledged. Please direct your letters to Mina K. Dulcan, M.D., Editor, Journal of the AACAP Editorial Office, Children's Memorial Hospital, 2300 Children's Plaza #156, Chicago, IL 60614-3394.