Comorbidity of Gender Identity Disorders

To the Editor: Joost à Campo, M.D., et al. (1) reported that a high proportion of subjects with cross-gender identification suffers from comorbidity with other psychiatric disorders and concluded that their sex reassignment will eventually lead to regret. We are sensitive to the issue that patients may regret their sex reassignment (2, 3). However, we have reason to disagree with the authors since their research suffers from major methods shortcomings.

1. A high percentage of psychiatrists (51%) did not return the questionnaire. A likely bias is that those psychiatrists treating patients with a gender identity disorder as a symptom of other psychiatric illnesses completed the questionnaire.

2. In total, 584 patients were reported by 142 respondent psychiatrists, many working in the same clinical centers or areas. Patients may have been counted more than once by the different respondents. Our gender clinic treats over 95% of the Dutch gender-dysphoric patients. On the basis of our information on the number of patients consulting a psychiatrist outside our clinic, the number of 584 patients seems unrealistically high unless proven otherwise.

3. Psychiatric comorbidity must be assessed reliably by means of validated research instruments and not by the clinical impression or recollection of responders.

4. The validity of the conclusions would have been strengthened had the researchers also approached psychologists or general practitioners, who refer the vast majority of patients.

5. Patients seen by the psychiatrists in our center are not representative of the average gender-dysphoric patient. Obviously, patients with psychiatric disorders will be most likely to consult a psychiatrist. Therefore, external validity is limited and does not warrant the generalizations the authors made (1).

6. The patient study group, not having been chosen randomly from the whole population of transsexuals, was biased. This survey cannot make valid inferences beyond the specific group that was surveyed.

Because of these methods flaws, the authors have no solid data to prove that specialized gender teams would not consider psychiatric disorders as a contraindication to cross-sex hormone treatment, a conclusion easily inferred from their report. The Amsterdam gender clinic has psychiatrists on its staff and adheres to strict procedures, and the majority of transsexual patients benefit from sex reassignment (e.g., references 3–5).

References


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To the Editor: Many psychiatrists go through their entire clinical career seeing only a few cases of gender identity disorder, as illustrated by Dr. à Campo et al. When a disorder is this unusual, appropriate practice should be to seek the opinion and experience of physicians and psychologists who have evaluated and cared for many of these patients. The article by Dr. à Campo et al. collected the opinions of nonexperienced individuals.

The Harry Benjamin International Gender Dysphoria Association endorses a thorough psychiatric and psychological evaluation of patients who are seen with gender identity concerns. Comorbid psychiatric conditions are common (1), but they rarely explain the underlying gender identity disorder; also, treatment of these conditions rarely alleviates the symptoms of gender identity disorder. In fact, my colleagues and I (1) found that after the gender disorder is treated, the comorbid mood and anxiety disorders usually do not return.

Furthermore, psychosis (schizophrenia) is rare unless the clinician interprets the statement by the gender-dysphoric person that he is a woman trapped in a male body as a psychotic symptom (1). Also gender identity disorder in persons with schizophrenia is extremely rare (2). Regardless, a thorough psychological/psychiatric evaluation is called for in the Harry Benjamin International Gender Dysphoria Association’s standards of care (3).

These standards of care also outline procedures for dealing with the endocrine management of teenagers seen with gender identity disorder. That procedure combines psychological treatment with a conservative, safe approach to maintaining the adolescent’s treatment options by delaying gender-dysphoric pubertal development until he or she is old enough to make a legal and informed decision. Dr. à Campo et al. should have included information concerning the survey respondents’ experiences in adolescent psychiatry since they were voicing opinions about adolescent conditions and how they should be handled. The article by Dr. à Campo et al. is an unhelpful list of opinions concerning gender identity disorder expressed by psychiatrists who have evaluated few individuals with gender dysphoria. The article appears to this reader to be a political attack on the Dutch gender clinics. So long as