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*Letter to the Editor*

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## **Response to Milton Diamond<sup>1</sup> and Cheryl Chase<sup>2</sup>**

In our article, "Long-Term Psychological Evaluation of Intersex," in *Archives of Sexual Behavior*, Vol. 27, No. 2, 1998, we presented our results of 10 years' experience with clinical management of children born with ambiguous genitals. On the grounds of these results we reconsider the criteria for sex assignment and made recommendations. These recommendations were based on a high percentage (13%) of gender identity disorder and cross-gender behavior in our group of children born with ambiguous external genitals.

In his critique of our article, Diamond assumes incorrectly that we are of the opinion that the policy for sex assignment we exhibited in the 10 years of our treatment is still valid. On the contrary, we propose that assignment to the biological sex is more reasonable for neonates with cloacal extrophy, with severe translocation of the penis, and patients with partial disturbance in the production (or synthesis) of androgens since these patients virilize normally in puberty, if necessary, with the help of hormones. On the basis of our results we could not recommend assignment to the biological sex in patients with partial androgen insensitivity syndrome (PAIS) since these patients will virilize poorly in adulthood even with hormone treatment. Of the eight patients with PAIS, only one was assigned to the male sex and raised as a boy. Although this boy is doing psychologically well (due to the support of his parents and our team) and his gender identity and gender role are male, he is still a child, which means that we do not know how he will evaluate his sex assignment in adulthood and how he will function sexually as a male. Of the seven PAIS patients raised as girls, two manifested a deviant gender role and one a gender identity disorder as well as a deviant gender role.

We disagree with Diamond and Chase that cosmetic surgery in neonates born with ambiguous genitalia should be postponed till these children can decide for themselves. Diamond and Chase are of the opinion that children with an intersex condition should be raised as either a girl or a boy but that their external genitals should be left ambiguous. There are enough examples described in the literature indicating how extremely harmful it is for these patients to be raised with ambiguous

<sup>1</sup>Diamond, M. (1998). Letter to the Editor: Intersexuality: Recommendations for management. *Arch. Sex. Behav.* 27: 634–641.

<sup>2</sup>Chase, C. (1999). Letter to the Editor. *Arch. Sex. Behav.* 28: 103–105.

genitals. It prevents them from developing a clear gender identity and it opens all possibilities for stigmatization. One of the many good things John Money did for these patients is to convince their parents, doctors, and psychologists of the necessity of cosmetic correction of the genitals as early as possible in the life of these children. In our opinion, it is difficult, if not impossible, for parents to raise their child as either a boy or a girl when the genitals are left ambiguous, and especially difficult as the parents are not convinced that the decision they made about the sex assignment is correct. So in our opinion, parents must take the responsibility to make a decision about sex assignment for their child, to raise their child in this assigned sex, and to let the child be operated on to correct the genitals according to this sex.

This does not mean that an enlarged clitoris must always be corrected. Diamond and Chase are of the opinion that you cannot rely on the expressions of young children about the appearance and functioning of their external genitals in relation to cosmetic surgery. In our study genital surgery was discussed with the child only when it was a reason for concern for the child and the parents. In our experience, most girls are capable of expressing their feelings about the length of the clitoris or its erectile functioning (from the age of 4). Girls with an enlarged clitoris have strong erotic feelings due to frequent erections, so they can indicate if they enjoy the erections of their clitoris, whether they are proud of it, or whether they feel pain due to constant irritation and feel miserable about it. This does not mean that the decision to correct or to refrain from correction (which was most frequent) was up to them. Every medical decision is, in the end, the decision of the parents until the child is 12 years old (in The Netherlands), but the opinion of the child and the advice of the psychologist can be very helpful for the parents. Postponement of clitoris reduction in a child who is suffering from it physically and psychologically makes the child miserable.

In his critique of our psychotherapeutic help for intersex children with gender dysphoria, Diamond tries to put our treatment in an unfavorable light by interpreting it as "intimidation" or "brow beating." It is clear to me that Diamond is very badly informed about the goal of psychotherapy in general and about the psychotherapy of our intersex patients in particular. The goal in our psychotherapy with these patients has always been to give them the possibility to express their cross-gender feelings only and to help them find a solution for these conflicting feelings. Since we know these patients for years, often from early infancy on, they feel safe enough to express their conflicting feelings. In the whole group there was only one child (a child who was sex reassigned twice) who seriously considered the possibility of sex reassignment in adolescence. This girl, who is now a young woman, told me recently that she has decided to live as a female.

Diamond states that the high incidence of psychopathology might be due, in part, to the lack of support for the individual's desire of sex reassignment or cross-gender identification. This conclusion is unjust:

- (1) The high incidence might be due in part to cross-gender identification as we stated in our article but not due to a lack of support for

- sex reassignment, since there was adequate support for individuals with gender-dysphoric feelings.
- (2) General psychopathology was equally in evidence in all four groups, which means also in the group of completely female patients who had neither deviant gender role behavior nor gender identity disorder. Thus general psychopathology cannot be explained exclusively by cross-gender identification.
  - (3) The conclusion must be that the explanation of the high incidence of psychopathology is much more complicated than Diamond suggests. In our article we discussed this in detail (congenital vulnerability and developmental interferences such as sex reassignment, hospitalization, sex operations, lifelong dependency on hormone substitutes, and infertility).

Diamond wonders why we did not consider XXY individuals in our study. The answer is that they do not have a physical intersex condition; the development of their external and internal genitals is male (naturally we see a lot of these patients; some are even diagnosed prenatally). Diamond has some questions about the data in our Table III. Table III gives information about general psychopathology ( $N = 24$ ) in connection with gender identity disorder (GID) and deviant gender role (DVR), which means that Table III does not concern the total group of patients. In the total group of girls ( $N = 54$ ), 25 (46%) had DVR behavior; 87% of the girls with a physical intersex condition developed in line with the assigned sex, which means that they did not have cross-gender identifications.

Chase states, "Today there are individuals who 'slipped through the cracks.'" According to Chase, these individuals express profound gratitude to have escaped early surgery. We know, however, that there are many more individuals who express profound gratitude for being operated on at an early age: individuals who were able to have a carefree childhood because their genitals were clearly male or female. Chase and Diamond do not consider the possibility that refraining from cosmetic surgery at an early age can also lead to damage of the psychological and gender identity development of these patients and leave them with bitterness and resentment toward their parents, physicians, and psychologists.

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