normal body mass index was 20, these patients gained 10 kg (1.6×1.6×4) in 6 months. An anorexia patient with a body mass index of 16 needs to eat approximately 2500 kcal per day in order to increase her weight at this rate, provided that her level of activity is low. While this marked increase in body mass index is possible, it is not consistent with other clinical reports or observations in clinical practice. For example, one of the authors previously reported that there was no significant increase in body mass index in 20 weeks in anorexia patients with an average body mass index of 17.3 (2).

Retrospective estimates of body mass index reported by Dr. Keski-Rahkonen et al. suggest a level of precision that may not be entirely plausible. The authors referred to two studies supporting the possibility that telephone interviews can provide reliable retrospective information (3, 4). However, one of these studies examined a group comprised of mostly normal weight individuals (3), and in both studies the time interval between the telephone interview and the determination of body weight was shorter than the corresponding interval in the study conducted by Dr. Keski-Rahkonen et al.

Dr. Keski-Rahkonen et al. should have made an estimate of the error associated with recalling body weight many years later and an estimate of the differences between a population of individuals with anorexia and a population of normal-weight individuals in order to address this limitation of their conclusions.

References

1. Keski-Rahkonen A, Hoek HW, Susser ES, Linna MS, Sihvola E, Raevuori A, Bulik CM, Kaprio J, Rissanen A: Epidemiology and course of anorexia nervosa in the community. Am J Psychiatry 2007; 164:1259–1265
2. McIntosh VV, Jordan J, Carter FA, Luty SE, McKenzie JM, Bulik CM, Frampton CM, Joyce PR: Three psychotherapies for anorexia nervosa: a randomized, controlled trial. Am J Psychiatry 2005; 162:741–747
3. Schousboe K, Willemsen G, Kyvik KO, Mortensen J, Boomsma DI, Cornes BK, Davis CJ, Fagnani C, Hjelmborg J, Kaprio J, De Lange M, Luciano M, Martin NG, Pedersen N, Pietiläinen KH, Rissanen A, Saarni S, Sørensen TI, Van Baal GC, Harris JR: Sex differences in heritability of BMI: a comparative study of results from twin studies in eight countries. Twin Res 2003; 6: 409–421
4. Keski-Rahkonen A, Sihvola E, Raevuori A, Kaukoranta J, Bulik CM, Hoek HW, Rissanen A, Kaprio J: Reliability of self-reported eating disorders: optimizing population screening. Int J Eat Disord 2006; 39:754–762

P. SÖDERSTEN, PH.D.
C. BERGH, PH.D.
M. BJÖRNSTRÖM, M.SC.
Huddinge, Sweden

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Disorders of Sex Development: Improving Care for Affected Persons and Their Families

TO THE EDITOR: In their clinical case conference, published in the October 2007 issue of the *Journal*, J. Michael Bostwick, M.D., and Kari A. Martin, M.D., (1) correctly pointed out that clinical management of intersex conditions is highly controversial. They failed to note, however, two recent and important developments aimed at improving care in this area.

One recent development is the Consensus Statement on Management of Intersex Disorders (2). This document, which grew out of a conference of 50 international experts in diverse medical specialties, marked the first time researchers and clinicians thoroughly revisited the medical standard of care for diagnoses of intersex conditions since John Money and his associates first proposed treatment standards in the 1950s. Participants agreed to recommend several important changes to care that demonstrate a significant shift in thinking for the treatment of intersexuality.

Owing to the recognition that patients and parents (and even clinicians) find the terminology and labels surrounding intersex conditions confusing and stigmatizing, participants adopted a new nomenclature in which *intersex* was replaced by the more general descriptor "disorders of sex development," which refers to congenital conditions in which chromosomal, gonadal, or anatomical sex development is atypical. Terms such as hermaphroditism and gender-based diagnostic labels are to be replaced with clinically descriptive terms (e.g., androgen insensitivity syndrome).

Acknowledging that there are minimal systematic outcome data pertaining to genital surgery, that orgasmic capability may be harmed by such surgery, and that there is little documentation to support the widely held belief that early surgery relieves parental distress about atypical genitals, the Consensus Statement on Management of Intersex Disorders states that surgery should only be considered for young girls with "severe" genital virilization. Participants also noted that psychological care should be integral to medical care, that homosexuality should not be construed as an indication of incorrect gender assignment, and that the potential for fertility—originally emphasized for female gender assignment only—should be an important consideration for male gender assignment as well.

The second development is the publication of the *Clinical Guidelines for the Management of Disorders of Sex Development in Childhood* and *the Handbook for Parents* (3, 4). Outlining a patient-centered model of care, these guidelines were developed in consultation with clinical specialists, affected individuals and their families, and patient support groups.

Much remains to be done to improve care for persons and families affected by disorders of sex development. However, these two developments are important steps in that direction.

References

1. Bostwick JM, Martin KA: A man's brain in an ambiguous body: a case of mistaken gender identity. Am J Psychiatry 2007; 164: 1499–1505
2. Lee PA, Houk CP, Ahmed SF, Hughes IA: Consensus statement on management of intersex disorders: International Consensus Conference on Intersex. Pediatrics 2006; 118:e488–500
3. Consortium on Disorders of Sex Development: Clinical Guidelines for the Management of Disorders of Sex Development in Childhood, 2006. www.dsdguidelines.org
4. Consortium on Disorders of Sex Development: Handbook for Parents, 2006. www.dsdguidelines.org

KATRINA KARKAZIS, PH.D., M.P.H.
Palo Alto, Calif.

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Drs. Bostwick and Martin Reply

TO THE EDITOR: We welcome Dr. Karkazis' calling to attention two recent and important publications that modernize and standardize an approach to the management of what is now being called "disorders of sexual development." While Dr. Karkazis purports that the new disorders of sexual development nomenclature—with subcategories for particular developmental aberrations—will reduce stigma and confusion, we feel that the umbrella term "intersex" will remain useful, as it has been in our patient's case.

After decades of feeling neither fully male nor female, she found the intersex label comforting as well as descriptive of the intermediate position on the sex spectrum at which she locates herself in a resolutely bipolar male-female society. In her case, moreover, she was not diagnosed at birth, but made with surgery and hormones into an approximation of a "normal" woman, her "makeover" a mystery to her until she became an adult. By the time she learned at age 48 that the correct tissue diagnosis was mixed-gonadal dysgenesis, her issues were not with having mixed-gonadal dysgenesis but rather with understanding and reconciling her core gender identity. It will probably never be clear whether she is a hermaphrodite or a pseudohermaphrodite because the medical records that could elucidate that question are lost. She finds common cause with individuals who are united not by their specific disorder of sexual development but by their residence in the intersex hinterland between male and female.

In the small Midwestern city where our patient came to a new understanding of her sexual and gendered self, the mixed-gonadal dysgenesis diagnosis would have created even fewer opportunities for common cause with other intersex people with whom she desperately wanted to connect. For her and other patients with whom we have worked, the specific diagnosis is not the key issue; the feeling of being neither fully male nor female is. Our patient is able to connect with other intersex people—regardless of their diagnoses—around what they share, which is a potentially profound estrangement from either/or male/female culture. She is also able to represent herself more readily to members of the majority culture with the blanket descriptor "intersex" than the technically correct but abstruse mixed-gonadal dysgenesis.

Nonetheless, Dr. Karkazis reminds us that the state of the art for patients with disorders of sexual development has transcended the "optimal gender" approach that imposed such heartache and suffering on intersex individuals in the latter decades of the 20th century. Just as our patient found personal liberation via intersex web sites on the Internet, resources detailing the enlightened contemporary clinical approach Dr. Karkazis espouses are only a computer keystroke away.

J. MICHAEL BOSTWICK, M.D.
Rochester, Minn.
KARI A. MARTIN, M.D.
Scottsdale, Ariz.

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Reprints are not available; however, Letters to the Editor can be downloaded at http://ajp.psychiatryonline.org.

Correction

In the January issue, the figure titles and footnotes accompany the wrong images in the article by Christopher S. Monk, Ph.D. et al. (Am J Psychiatry 2008; 165:90–98). In the version that was published online in advance of print, the figures appeared as they were intended. In the print edition, the title and footnote text for Figure 1 should accompany Figure 3. The title and footnote text for Figure 2 should accompany Figure 1. The title for Figure 3 should accompany Figure 2. The footnote text for what should have accompanied Figure 1 should have read "Figures 1 and 2 display group-level data..." Production problems at the time the article was being prepared for inclusion in the January issue caused an older draft version to be used. The PDF version that now appears online has been corrected and it indicates that it differs from what appears in print because the figure titles and footnotes have been corrected. The full-text HTML has also been corrected.

An error during production caused the article by Hisato Matsunaga, M.D., Ph.D., and colleagues ("Symptom Structure in Japanese Patients With Obsessive-Compulsive Disorder," published online November 15, 2007; doi: 10.1176/appi.ajp.2007.07020340) to be posted with some disclosure information missing:

Dr. Stein has received research grants and/or consultancy honoraria from AstraZeneca, Eli Lilly, GlaxoSmithKline, Johnson and Johnson, Lundbeck, Orion, Pfizer, Pharmacia, Roche, Servier, Solvay, Sumitomo, Tikvah, and Wyeth. All other authors report no competing interests.