as a first-line treatment is one of efficacy. They found 23% of patients with severe or very severe social phobia treated with moclobemide for eight weeks were rated as much or very much improved (*v.* 0% in the placebo group), although numbers were too small to reach statistical significance. This finding of greater efficacy in more severe social phobia is also supported by the International Multicenter Clinical Trial Group on Moclobemide in Social Phobia (1997) who found patients with severe social phobia treated with 600 mg moclobemide had a 52% response rate (*v.* 32% on placebo).

International Multicenter Clinical Trial Group on Moclobemide in Social Phobia (1997) Moclobemide in social phobia. A double-blind, placebo-controlled clinical study. *European Archives of Psychiatry and Clinical Neuroscience*, **247**, 71–80.

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Liaison between adolescent and adult services in early-onset schizophrenia

Sir: Pelkonen *et al*'s (1998) follow-up study of occupational functioning of adolescent in-patients emphasises the importance of active intervention in early adulthood in those with psychotic disorders. However, they do not highlight the importance of close liaison between adolescent and adult services in order to achieve this. In clinical practice there is lack of clarity about which service should serve those aged 16–18 years. Traditionally, this had depended on the young person's educational status at the time of presentation. However, some 16 to 18-year-olds may have left school as a result of developing psychosis. Their needs in terms of re-integration into educational services and addressing family issues (such as expressed emotion interventions) may be better met by the resources of adolescent services.

Poor psychosocial outcome in adulthood in those with adolescent psychotic disorders is a robust finding (Gillberg *et al*, 1993). Although early-onset schizophrenia is more likely to be associated with a poor prognosis than adult-onset schizophrenia is (Jacobsen & Rapoport, 1998) this could be partly ameliorated by commencing treatment early (Turetz *et al*, 1997) and the potentially greater compliance with atypical antipsychotics. Familiarity with, and experience of, use of atypical antipsychotics by adolescent psychiatrists can be enhanced by liaison with colleagues in adult services.

Close liaison between services at an early stage, therefore, has potential benefits for both services and, particularly, for the young person in terms of addressing all aspects of care and providing continuity of follow-up into early adulthood. The personal and economic implications of years of functional impairment and disability are too great to ignore.

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Jacobsen, L. K. & Rapoport, J. L. (1998) Research update. Childhood-onset schizophrenia: implications of clinical and neurobiological research. *Journal of Child Psychology and Psychiatry*, **39**, 101–113.

Pelkonen, M., Marttunen, M., Pulkkinen, E., *et al* (1998) Disability pensions in severely disturbed in-patient adolescents. Twenty-year prospective study. *British Journal of Psychiatry*, **172**, 159–163.

Turetz, M., Mozes, T., Toren, P., *et al* (1997) An open trial of clozapine in neuroleptic-resistant childhood-onset schizophrenia. *British Journal of Psychiatry*, **170**, 507–510.

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Somatoform dissociation is unlikely to be a result of indoctrination by therapists

Sir: In a previous letter (Nijenhuis *et al*, 1997) we reported that high scores on instruments measuring dissociation were typical of patients with dissociative disorder and not of those with bipolar disorder. We argued that these data show that dissociative disorders are highly unlikely to be a result of misinterpretation of bipolar disorder. Merskey (1997) commented that our comparison is worthless. Assuming that dissociative disorders results from indoctrination by therapists, he maintained that we have compared un-indoctrinated bipolar patients and indoctrinated 'dissociative' patients.

This assumption is incorrect. For the patients with dissociative disorders we had two groups: one received the Somatoform Dissociation Questionnaire (SDQ-20; Nijenhuis *et al*, 1996) prior to, and the other after, the administration of the Structured Clinical Interview for Dissociative Disorders (SCID-D) and diagnosis of 'dissociative identity disorder' or 'dissociative disorder not otherwise specified'. The former group cannot possibly have been indoctrinated. Interestingly, patients from the first group who were unaware of their diagnosis tended to obtain higher SDQ-20 scores than those who were aware of their psychiatric status and who were exposed to therapy (further details available from the author upon request).

The *a priori* assumption that the diagnosis of dissociative disorders must follow from indoctrination seems to be based on prejudice instead of research findings.

Merskey, H. (1997) Tests of 'dissociation' and mood disorder (letter). *British Journal of Psychiatry*, **171**, 487.

Nijenhuis, E. R. S., Spinhoven, P., van Dyck, R., *et al* (1996) The development and the psychometric characteristics of the Somatoform Dissociation Questionnaire (SDQ-20). *Journal of Nervous and Mental Disease*, **184**, 688–689.

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Can transsexualism remit?

Sir: The subject of the paper by Marks & Mataix-Cols (1987) is a current patient of ours; Professor Marks was aware of this and discussed this before writing his report, though this is not acknowledged in the paper.

Since the paper contains statements at variance with our understanding of the case, we showed the paper to the patient, who told us of cross-dressing since age 7, self-view as female age 12, and active search for gender reassignment since age

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32 on becoming aware that such treatments were possible.

He always lived with parents who had great difficulty in coming to terms with who their son was and that 'he' wished to achieve gender reassignment. The mother died when the patient was 40 from carcinoma of the pancreas, after being nursed by her husband and the patient during the terminal stage of illness.

One year later the patient was admitted to a London university hospital suffering from an atypical grief reaction accompanied by obsessive symptoms, resistant to standard pharmacotherapy. Referral to Professor Marks was accompanied by advice from the professor in charge of his care that 'he' would be wise to postpone the quest for gender reassignment until after recovery from depression. The patient's own present view is that the obsessive–compulsive disorder (OCD) was part of a depressive problem precipitated by the mother's death.

With respect to events during the admission to Bethlem Hospital, the patient reports that he never refused treatment for transsexualism, which was talked about but never offered. He says he never developed a heterosexual relationship with another female in hospital, rather she was just a friend, and is clear that he never masturbated to heterosexual fantasies and never reported that he planned to marry and have children. Indeed, he says that he has only ever experienced masturbation as mutual masturbation from another male sexual partner early on in his sexual career and soon stopped it altogether as he found his own male genitals and their sexual responses too repugnant.

Unfortunately, on discharge from hospital, his father died. Initially he felt liberated and felt he could proceed with gender reassignment unimpeded, but he soon felt guilty and says that out of respect for the memory of his parents he tried to live as he felt they would have wanted him to, namely dressing as a man (albeit 'loosely') and not seeking gender reassignment.

After enduring this for two years, he presented to his general practitioner extremely frustrated to the point of feeling suicidal. Referral to our clinic followed. Professor Marks's review followed some time later. We can report that the patient correctly referred to as 'she' is happily living with a male 'heterosexual' partner who apparently also regards her as a woman and has only ever seen her in the female role. She has recently been given a date for gender reassignment surgery which will allow her to live the remainder of her life in fulfilment of what has always been sought. There are no symptoms of OCD.

This transsexualism never remitted on treatment for OCD and consequently never relapsed on follow-up. There is much to be said for a patient being asked to comment on their case history before publication.

Marks, I. M. & Mataix-Cols, D. (1997) Four year remission of transsexualism after comorbid obsessive–compulsive disorder improved with self-exposure therapy. Case report. *British Journal of Psychiatry*, **171**, 389–390.

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Author's reply: The above letter shows the merit of our paper's use of contemporary case notes recording the observations of several staff over two years of treatment and follow-up, rather than taking a patient's present comments about the past at face value.

The patient's case notes document our paper's main points. Staff observed that at admission the 42-year-old patient was effeminate but in male dress and did not want treatment to change his female identity, only for his OCD, as we noted. The transsexualism was therefore not rated as it was neither to be treated nor expected to change with therapy for OCD. Several staff observed over 17 months of repeated follow-up that the transsexualism remitted when the OCD improved with self-exposure therapy. At follow-up interviews the patient's manner and dress was masculine. His father confirmed his improvement in OCD and in self-assurance. For brevity, our paper did not note that the patient had said that overcoming his OCD had given him confidence to tackle other issues in his life including his sexuality. We did say that at 17-month follow-up he said he felt male, was masturbating three times weekly with fantasies about women, and hope to marry and have children; this fitted observations of his male manner.

Watson & Soutzos assert that "This transsexualism never remitted on treatment for OCD and consequently never relapsed on follow-up", based on the patient's denial five years later, which we had noted ("he now denied his heterosexual affair and masturbatory fantasies of five years earlier', p. 390). When at six-year follow-up we read out to the patient a case note entry dated 4–5 years earlier, that he was having heterosexual masturbatory fantasies and had just ended his first heterosexual relationship, s/he denied all memory of that while showing discomfort and distaste. That denial also went against other contemporary notes of masculine identity made by several staff at discharge and early follow-up.

If the above observations do not attest to remission of transsexualism, what would? During earlier follow-up had the patient lied repeatedly to several staff and merely simulated masculine behaviour and attitudes, and, if so, why? Staff had not expected this remission. It seems more likely that at six-year follow-up the anxious denial of transsexualism having remitted for some years reflected repression of such memories for fear of jeopardising the chance of gender reassignment which was now being sought again.

The patient's male manner at earlier follow-ups was in sharp contrast to his/her female garb and behaviour at six-year follow-up, at which point being referred to as 'he' seemed less appropriate than 'she'. The patient said he had resumed cross-dressing two years earlier (four years after discharge for successful treatment of the OCD).

The *Journal* rightly requires brevity in a case report, so we omitted much of interest: that at six-year follow-up the patient was attending Professor Watson's clinic (which merely confirmed that transsexualism was obvious then); that the transsexualism had returned during prolonged depression starting after the patient's sister insisted they move out of and sell the parental home (the patient did not allow us to contact her); other information noted by Watson & Soutzos but not bearing on our main point about the temporary remission of transsexualism coinciding with the start of lasting improvement of OCD. At six-year follow-up (age 48) when answering the same question asked several times the patient changed some aspects of the story and spoke of being at last in the right 'role'. S/he indeed gave an impression then of acting a feminine role and became distressed when confronted with evidence of having been in a male role at age 42–43.

The contention of Watson & Soutzos is not borne out by the patient's reports and

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