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Reply to Letter from Angela Scheuerle:

Thank you for allowing us the opportunity to respond to the letter from Dr. A. Scheuerle in response to our article in *Genetics in Medicine* (June 2007; “A Gender Assessment Team: experience with 250 patients over a period of 25 years”). We agree that issues of gender assignment in newborns with truly ambiguous genitalia and related disorders of sex development (DSD) are challenging. In our Team practice, when providing guidance to parents for sex assignment of their child, we try to avoid judgmental statements and focus on reviewing the currently available research evidence in an effort to provide parents with information that will help to guide them in this difficult process.

Regarding our approach to the discussion with parents about gender roles and intrauterine hormone exposure, we engage with the families, many of whom have already garnered considerable information via the Internet, in an educational process. In this context, we discuss the three different but overlapping behavioral areas to consider: gender identity, gender role behaviors, and sexual orientation. We emphasize for the family that gender identity (i.e., whether a child thinks of himself or herself as boy or girl) is very different from gender role (the behaviors that are traditionally associated with boys or girls). We further differentiate gender role behaviors from sexual orientation, that is, the sex of the preferred sexual partner of the individual. We emphasize that almost no scientific data are available regarding how these three behavioral realms (gender identity, gender role, and sexual orientation) are determined. In fact, most of the published behavioral data come from studies of youth with congenital adrenal hyperplasia (CAH). Despite high levels of circulating testosterone during fetal development in 46,XX individuals with CAH, the vast majority self-identify as female in adulthood. However, there is a suggestion of increased tomboyish behaviors and slightly increased incidence of homosexual orientation in some of these women. Thus, the observed behaviors in these women with CAH would suggest that hormonal imprinting by testosterone exposure in utero affects gender role behaviors rather than gender identity.

In our discussions with families, we try to normalize the situation in which a girl may be a tomboy, for example, by reflecting that many girls without a DSD have more traditionally boy-related gender role behaviors and that for any child, the spectrum of “normal” behaviors is broad. Likewise, we emphasize that sexual orientation cannot be predicted for ANY child in infancy, and a certain proportion of individuals without a DSD will be homosexual; in fact, the majority of individuals who are homosexual do not have a DSD.

In our experience, the decision regarding sex of rearing in children with true ambiguity for whom the assignment could be either male or female has been concordant with the child’s ultimate gender identity when the children are followed over time. We emphasize for families that the most crucial element for a well-adjusted child with a DSD is dependent on the comfort level and acceptance of the gender assignment by the family and honest disclosure regarding the condition to the child in an age-appropriate manner.

We acknowledge that these are challenging situations, and more longitudinal data are necessary to provide information and guidance for parents of infants and children with DSD.

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