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Genetic basis for transsexualism

SIR: In their brief report on a female monozygotic twin pair discordant for transsexualism (*Journal*, December 1992, **161**, 852–854), Garden & Rothery have drawn the surprisingly sweeping conclusion that "this case ... refutes the notion that there is a simple genetic basis for the disorder". Their evidence shows a much more modest conclusion, namely that in this single case of transsexualism, genetic factors are irrelevant.

Garden & Rothery go on to offer a "psychodynamic hypothesis" to explain this case, namely that "in the father's absence, the mother uses the child as a confidante". As the child in question was a mere five years old when he first noticed that he was really a boy, he was hardly old enough to be his mother's "confidante".

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'Hidden' spending on community services

SIR: As a clinician manager in our mental health directorate, I was interested to read James Raftery's article (*Journal*, November 1992, **161**, 589–593). I work in a district general hospital (DGH) and all the psychiatric in-patient facilities are concentrated there, all the community services reach out from there, and we have had no dependent link upon Hellesdon Hospital in Norwich for eight years. My registrar and I hold six clinics a week in a community hospital 15 miles away, and I and another consultant in general psychiatry hold clinics in nearby general practices. Our community psychiatric nurses (CPNs) have personal attachments to local practices, are hospital-based for coordination, but work from three (hopefully soon five) community resource centres which host weekly multidisciplinary meetings of the community mental health teams.

We are aware that our community facilities are comparatively well developed, so I was surprised when performance indicator figures for the East Anglian region put us in the lowest ranking insofar as money is spent on working in the community.

Being a budget holder now, and since we are attached to a hospital trust, I winced at the information and looked into it. We are not a community unit but provide virtually all the community services with some help from voluntary bodies and local social services. The Health Authority puts money into two of the day centres and into a Drugs and Alcohol Advisory Service. It seems that that is the only part of our budget deemed to be devoted to community work. My salary and those of our CPNs and my consultant colleagues are all designated as hospital costs – not community – although our DGH is not outside the community but very much part of the community it serves. If 80% of my salary was listed as devoted to community work, which is a correct reflection of how my time is spent, this then would be a more accurate performance indicator.

Our beds are not 100% full, and as I transfer patients to CPN care with periodic out-patient reviews, my clinic numbers may fall and the problems of misinformation may expand. There are not many finished clinical episodes (FCEs) because we have an extensive rural network of support for those in need of long-term care.

Hence, I feel that James Raftery, when he writes "Direct spending on mental health services remains largely in-patient based and has not fallen with bed numbers", has failed to unravel the problems accountants and information systems have of keeping track of where the work is really done.

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Professional scepticism towards multiple personality disorder

SIR: The diagnosis of multiple personality disorder (MPD) remains controversial and the correspondence (Fahy, *Journal*, August 1992, **161**, 268–270), in