sex, says Chase, but that label should not be surgically enforced. "Labeling a child a girl does not require a clitoridectomy," she says.

Elders, who has been quoted as saying, "I can't make a good boy, but I can make a pretty good girl," believes a child isn't equipped to make such a decision. Glassberg agrees: "There are

PER BREIEHAGEN/BLACK STAR FOR THE ADVOCATE

rare mistakes in gender assignment. For the most part we are making the correct gender assignment and reconstructing genitalia in infancy so that cosmetically they appear as normal boys or girls and can function satisfactorily as adults in the gender assigned."

Not so, according to Chase. "We don't try to alleviate the social ill of racism by forcing everyone to be white by lightening their skin at birth," she says. "But it's current medical policy to inflict mental and physical harm on anyone who is born differently gendered."

It's all about homophobia, says Chase, who points to statistics showing that intersexual children are more likely to grow up gay than a child born with unambiguous genitalia. "Doctors forward the belief that a child sent home from the hospital with a giant clitoris can't be loved or might turn out to be homosexual," she says. "Parents are told that performing genital surgery will ensure that their child grows up heterosexual. But all it ensures is that we'll grow up scarred and ashamed of who we are." ■

THE GENDER BLEND

Boys in the dollhouse, girls with toy trucks

Effeminate boys and masculine girls: Is *gender identity disorder* just another term for *gay*?

BY ROBERT L. PELA

Camille's voice fills with rage and pain when she talks about her childhood. "My punishment for being a feminine little boy was that I was dumped in a state hospital at age 6," she recalls. "I was given electroshock treatments and other forms of torture as punishment for acting like a girl. This was the 1950s, and the treatment for little gay boys back then was torture. And the treatment today is exactly the same."

What has changed, some experts say, is the means by which the mental health industry has perpetuated homophobia and the abuse of gay children. According to frontline activists, the American Psychiatric Association has invented mental health categories—specifically, gender identity disorder—that are meant to pathologize homosexuality and to continue the abuse of gay youth.

GID is defined in the APA's *Diagnostic and Statistical Manual of Mental Disorders* as "a strong and persistent cross-gender identification," one that is manifested in such activities as a preference for cross-dressing in boys or a predilection for male playmates in girls. Health professionals who treat the supposed disorder and those individuals who have been treated for it agree that GID is merely another means of categorizing effeminate boys and masculine girls as emotionally disturbed and in need of treatment.

"It's all semantics," says Shannon Minter, staff attorney for the San Francisco–based National Center for Lesbian Rights, an orga- ▶

"PATIENT"
The paintings of lesbian artist Daphne Scholinski tell of a life crippled by a GID diagnosis.

APRIL 18, 1995 PRESENTATION BEFORE GLBT COMMITTEE HUMAN RIGHTS COMMISSION BY CAMILLE GENDERELLA LIBERTY

Psychiatric oppression is still very much part of queer history for gay, lesbian, bisexual, and transgender children and youth.

If they survive the ultimate indoctrination of self hatred they may still be automatic throwaways, susceptible to suicide and having unsafe sex, and they may have been subjected to some psychiatric drugs that may be immuno-suppressant.

Any child would be lost in a world where denial of their experience is as wide as the sea.

Any young person is confused when living in that space without language to describe that what you are in your heart and mind and feelings and dreams is the true sky, and the image of your soul the world wants to force on you is the real delusion.

Calling a child of difference a sickness instead of a natural occurrence is humanity's loss and they are missing the gift of us on earth.

If there were counselors made available to reinforce the dignity of the humanity of children and youth no matter how different they are from the rest of the crowd, that would be fine.

The gender identity disorder label is profiteering child abuse that comes with the human rights violations of behavior modification. It is power smashing against a powerless child, and it is intended to murder the spirit, to make the child conform to shadows and silence, to be ashamed of existing, and to accept oppression as justified.

Gender identity disorder implies feminine boys and masculine girls. The more feminine the child is the deeper they are buried in the nightmare vision and the more brutal the treatment is. To look away from this mirror that projects the fears of the world diminishes the identity of every human being.

The statement we make that sexual orientation and gender identity are not the same is not the truth for some of us. It wipes out history, and it ignores the reality of the plight of young people. Whether gay or transsexual, the assault on their bodies, brains, and souls is deeply homophobic.

To be willing to sacrifice any of our own to gain acceptance, especially the most vulnerable and powerless, is the pit of assimilation, and it won't make anyone safer longer. We are all locked inside the pink triangle together forever.

This the first presentation of the Children and Youth Issues Committee of the Transgender Community Task Force.

APRIL 18, 1995 PRESENTATION BEFORE GLBT COMMITTEE HUMAN RIGHTS COMMISSION BY CAMILLE GENDERELLA LIBERTY

Psychiatric oppression is still very much part of queer history for gay, lesbian, bisexual, and transgender children and youth.

If they survive the ultimate indoctrination of self hatred they may still be automatic throwaways, susceptible to suicide and having unsafe sex, and they may have been subjected to some psychiatric drugs that may be immuno-suppressant.

Any child would be lost in a world where denial of their experience is as wide as the sea.

Any young person is confused when living in that space without language to describe that what you are in your heart and mind and feelings and dreams is the true sky, and the image of your soul the world wants to force on you is the real delusion.

Calling a child of difference a sickness instead of a natural occurrence is humanity's loss and they are missing the gift of us on earth.

If there were counselors made available to reinforce the dignity of the humanity of children and youth no matter how different they are from the rest of the crowd, that would be fine.

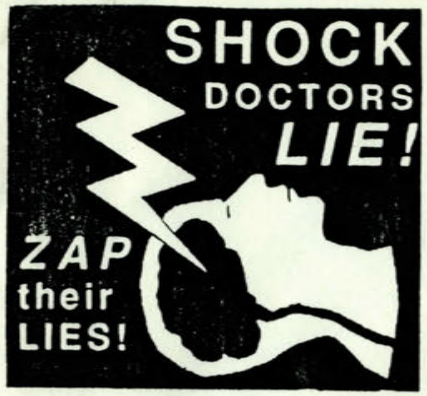
The gender identity disorder label is profiteering child abuse that comes with the human rights violations of behavior modification. It is power smashing against a powerless child, and it is intended to murder the spirit, to make the child conform to shadows and silence, to be ashamed of existing, and to accept oppression as justified.

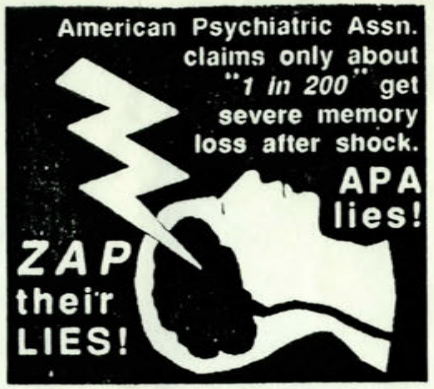
Gender identity disorder implies feminine boys and masculine girls. The more feminine the child is the deeper they are buried in the nightmare vision and the more brutal the treatment is. To look away from this mirror that projects the fears of the world diminishes the identity of every human being.

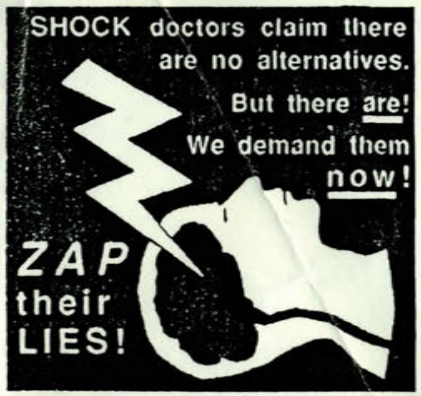
The statement we make that sexual orientation and gender identity are not the same is not the truth for some of us. It wipes out history, and it ignores the reality of the plight of young people. Whether gay or transsexual, the assault on their bodies, brains, and souls is deeply homophobic.

To be willing to sacrifice any of our own to gain acceptance, especially the most vulnerable and powerless, is the pit of assimilation, and it won't make anyone safer longer. We are all locked inside the pink triangle together forever.

This the first presentation of the Children and Youth Issues Committee of the Transgender Community Task Force.







ZAP BACK! Get your Zap Stickers with these six "ZAP THEIR LIES" themes from The Support-In. Made to last with good ink & all-weather peel-off labels. Same size as shown: about 2 1/2 inch square. Each sticker is 10 cents. A complete set is 50 cents. A packet of ten sets (that's 60 Zaps!) is only $4. Get lots of packets for fundraising, gifts, etc. You must send self-addressed stamped envelope with payment: The Support-In; PO Box 11284; Eugene, OR 97440.

We demand: 1) Accurate informed consent. 2) Offer a full range of healthy, empowering alternatives. 3) Zero coerced or forced shock.

Lie: "With new improved ECT, memory loss is infrequent: When appropriate we give a smaller jolt with a better type of current we call 'brief pulse.' We use anesthesia & muscle relaxants. Plus, we sometimes just stimulate the half of the brain less involved with memory."

Zap: New? Improved? Electricity & the brain are still the same. A threshold must still be reached to cause the convulsion. Anesthesia and muscle paralyzers may lessen bone-breaking, but can increase brain-frying, because these drugs (which have risks themselves) often raise the convulsion theshhold. When doctors shock just one half of the brain (called "unilateral shock"), they choose the nonverbal side. Memory tests are usually verbal so slightly less memory loss is at times apparent. But memories, of course, are everywhere in the brain. Better tests show brain damage is often even more severe on this nonverbal side, less valued in our technological society. No matter what the "improvement," memory loss and brain damage are still common.

Lie: "Today it's not like it was in One Flew Over the Cuckoo's Nest. Now, patients' rights are carefully protected. Everyone signs a lengthy informed consent form before ECT."

Zap: If someone refuses to sign for shock, many states allow the person to be forcibly shocked simply by obtaining the signature of a relative, a judge or even just a second psychiatrist. Forced shock is happening in the U.S. and internationally today! Even when a person signs for shock, it is often under duress. Pressure, lies & threats are routine. All known informed consent procedures in use today cover up the high likelihood of long term memory loss & brain damage. The person shocked is statistically most likely an extremely sad, vulnerable elder, who has been drugged and locked on a ward. Twice as many women as men are shocked. Shock is still about social, mental, emotional and political control.

Lie: "We've tried all the alternatives. And that leaves ECT."

Zap: Shock doctors usually just try drugs and traditional talk therapy first. Countless empowering, healthy alternatives to shock are working for people every day. The psychiatric profession — based on control and emotional repression — has largely refused to learn from these successful mutual support peer groups, retreats, advocacy programs for basic human needs, user-run community & residential centers, wholistic approaches (such as meditation, massage, exchange counseling, nutrition, exercise), etc. Therefore, it is up to all of us to demand these less harmful alternatives be made readily available to everyone who chooses them.

Lie: "Only about 1 in 200 people get severe memory loss after shock."

Zap: This statistic from the American Psychiatric Association 1990 Task Force on shock is a Big Lie. The APA gives absolutely no citation for any medical study to back up these numbers. On the other hand, many studies have shown memory loss is common. For instance, the U.S. National Institutes of Health cites a study showing more than 50% of people report memory problems even three year after shock.

Lie: "ECT works, though we don't know why. It is one of the most effective psychiatric techniques in lifting depression. It is life saving."

Zap: Neurologists know that many people experience a period of euphoria, confusion and apathy after a head injury. Shock is a psychiatrist-caused head injury, and the resulting trauma is labeled 'recovery.' According to studies, six months after shock about 50% 'relapse.' That's why some shock doctors now give monthly 'maintenance' shock. The APA recommends shock for a wide variety of emotional distress. In the big picture, shock does nothing about people's real life problems in living — such as poverty, oppression and loneliness. In fact, shock can even make problems worse by permanently impairing thinking and memory. Shock is destructive. There are better ways to help.

Lie: "Patients, their families and medical experts approve of the way we administer shock."

Zap: Hundreds of shock survivors have testified to shock's damage. Psychiatrists, neurologists and other medical professionals have verified these complaints. But even many of the few who say they benefited from shock agree with these three human rights' demands: 1) Accurate informed consent. 2) Offer a range of alternatives. 3) No coerced shock.

Shock doctors stand nearly alone in their opposition to these common sense demands. They should stop lying to the public about shock and these three, common-sense requests. Since shock doctors refuse to tell the truth, it's up to YOU to ZAP THEIR LIES!

SPEECH FOR THE ALTERNATIVE FAMILY PROJECT PANEL DISCUSSION
ON GENDER DEVELOPMENT IN CHILDREN - APRIL 29, 1996

by Camille Genderella Liberty

If only the eyes and nothing else of a child was visible, people would zero in and attack the vulnerability in the eyes that is the heart of the spirit of the feminine child. A child's ability to go through pain resurrected

For some of us born queer-based sissy transsexuals, our gender identity is also a necessary survival technique in a world where the features of a child, and a child's beautiful desire to nurture, and the natural movements and mannerisms connected to the physical brain, are obsessively scrutinized and condemned. And with the hatred of the feminine comes power smashing against the powerless.

Some transsexual gay kids are sacrificed to the nightmare vision of psychiatric blame and torment, sexual violation, and physical tortures at a very young age because sometimes misogyny is homophobia, and sometimes sexual orientation is gender identity.

If these children survive, they may spend the rest of their lives looking for similar pain like a returning stone, and it is only the illusion of the consolation of identity that gives witness to their existence.

The alternative is for genuine parents to develop their own intelligence of consciousness to enable them to create an environment that sustains the safety of the soul in a needed home of refuge for a child of difference.

I have no concept of what the luxury of having gender issues means. I only know what gender oppression is, and gender joy. But I do know that reconciling identities is a natural and perpetual process that gathers emotional light and does not diminish being.

A child's ability to go through pain with resurrection and still always be vulnerable and not rock is like tears falling upwards and is not allowed on earth.

To be

EARTH AND SKY

Because I live in a child's dream world
I can fly out of my body and never come down.
Because I fly away from pain I will forgive you
for being as strong as fear and starless,
for giving brand without words.
Nevertheless, I loved you over earth and sky.

Because I sigh with orgasmic pleasure
in your magic room of chains and whips
doesn't mean that silence is praise and worship
of the vision of the healing power that dwells
in the shamanistic rituals of your princely heat.

But if you would rock me to sleep in your arms
and be a father with a lap like a grave of flowers
to lay the ghost of pain down into dreams, wingless,
I would be your dancer of follow forever.
Nevertheless, I want you, blood, stone, and hammer
over earth and sky falling like a cloud of cold fire.

-- Camille Genderella Liberty

Gay youth, activists slam psychiatric abuse

by DENNIS MCMILLAN

The Children and Youth Issues Committee of the Transgender Community Task Force gave a presentation April 18 on the abuse of queer youth within the psychiatric system.

The presentation was held in the offices of the Lesbian/Gay/Bisexual/Transgender Advisory Committee of the Human Rights Commission.

Speakers included queer youth who had been institutionalized because of their sexuality, queer rights activists and members of the HRC.

Notes from the Inside, a 'zine published by Students and Teens Opposing Psychiatric Abuse Network, was included in the presentation. "Queer youth by the thousands are being locked up, forced to undergo therapy, homophobic counseling and sometimes even aversion therapy," asserted an article written by one teen, whose name and institution was withheld.

Shannon Minter, a staff attorney with the National Center for Lesbian Rights and volunteer with the Project to Stop Mental Health Care Abuse of Lesbian, Gay, Bisexual and Transgender Youth, said, "Although the American Psychiatric Association removed homosexuality from its official list of mental disorders in 1973, lesbian, gay, bisexual and transgender adolescents are being committed to psychiatric facilities and subjected to mental abuse in unprecedented numbers, in an attempt to change their sexual orientation or gender identity."

Minter cited the definition of Gender Identity Disorder, from the 1994 Diagnostic and Statistical Manual of Mental Disorders published by American Psychiatric Association. The manual describes lesbian and gay youth as veering from the norm.

"In boys, the cross-gender identification is manifested by a marked preoccupation with traditionally feminine activities; there is a strong attraction for the stereotypical games and pastimes of girls.

"Girls with GID display intense negative reactions to parental expectations or attempts to have them wear dresses or other feminine attire. They prefer boys' clothing and short hair, and share interests in contact sports and rough-and-tumble play. They show little interest in dolls or any form of feminine dress up."

Minter pointed out that the APA admits "there is no diagnostic test specific for GID..." but "the adolescent may be referred [committed] because the parents or teachers are concerned about social isolation or peer teasing and rejection." Minter said that such reasoning "basically pathologizes anyone who in any way deviates from what is considered normal."

Camille Liberty, of the TCTF, described the dangers faced by lesbian and gay youth. "Even in a haven such as San Francisco we find terrible oppression of lesbian, gay, bisexual and transgendered children ... If they survive the ultimate indoctrination of self hatred, they may still be automatic throwaways, susceptible to suicide and having unsafe sex, and they may be subjected to some psychiatric drugs that may be immuno-suppressant. Assimilation won't make anyone safer. We are all locked inside the pink triangle together forever."

Cynthia Goldstein, a commissioner with the Lesbian/Gay/Bisexual/Transgender Advisory Committee, said the group will seek more information on the issues presented.

Appendix A. Public Hearing Flyer

PUBLIC HEARING

SAN FRANCISCO HUMAN RIGHTS COMMISSION

INVESTIGATION INTO DISCRIMINATION AGAINST THE TRANSGENDER COMMUNITY

Public Testimony will be heard:

Date: Thursday, May 12, 1994
Time: 4:30 - 8:30 p.m.
Place: Board of Supervisors Chambers
San Francisco City Hall, 2nd Floor

Agenda:

Overview: Definitions, Current Legislation, & History
Discrimination: Employment, Housing, Services, & Business Practices
Policies and Practices of City Departments
Agencies and Organizations Serving the Transgender Community
Transgender Communities of Color
Youth and Family Members
Testimony from the General Public (sign up at the hearing)

For further information, please contact Larry Brinkin or Cynthia Goldstein at (415)252-2500.

American Sign Language interpreters and an FM Amplification System will be provided at the hearing. Assistive listening devices are available for use with 72 hours advance request. The Chamber is wheelchair accessible. The closest accessible BART station is Civic Center, 2 1/2 blocks from City Hall. Accessible MUNI line serving this location is the #42 Downtown Loop as well as the METRO stations at Van Ness and Market and at Civic Center. For more information about MUNI accessible services, call 923-6142. There is accessible parking in the vicinity of City Hall adjacent to Davies Hall and the War Memorial Complex. In order to assist the City's efforts to accommodate chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City to accommodate these individuals. To make arrangements or for information, contact Gail P. Roberts at (415) 252-2508 (voice) or (415) 252-2550 (TDD).

Appendices

A. Public Hearing Flyer
B. News Release Announcing Public Hearing
C. Public Hearing Agenda
D. A Glossary of Gender
E. The Transgender Umbrella (diagram)
F. Letter Regarding On-the-Job Transition
G. Newspaper Coverage of the Public Hearing
H. Transgender Services and Resources
I. Reference Bibliography

Written Testimony

Dr. Sandra Hernandez, Director, San Francisco Health Department

Dr. Hernandez submitted testimony recognizing the unique difficulties transgendered people experience when seeking health care. She acknowledged that more work must be done to ensure transgendered people a safe and supportive place to get medical care, and described the various programs within the health department that attempt to address their needs. These include the Transgender Clinic at the Tom Waddell Clinic, a transgender self-help group at the Tenderloin Self-Help Center, and the Center for Special Problems.

Leo O'Farrell, Senior Supervisor

Department of Social Services, City and County of San Francisco

The Department of Social Services supplemented its oral testimony by submitting a copy of its policy regarding transgendered individuals who seek shelter at the North of Market Multi-Service Center. The policy states that all transgendered people applying for shelter must provide a referral from one of several agencies serving the transgendered and that a transsexual woman must be living full-time as female in order to be so classified.

Camille, individual testimony

Camille supplemented her oral testimony with a written statement that said her gender confirmation surgery took place in a garage on Lombard Street because back when she had the procedure transsexuals were not permitted in hospitals. She attached to her testimony suggestions for improving the lot of transgendered people within the mental health system of San Francisco.

Carrie Drake, individual testimony

Ms. Drake saw an announcement about the hearings and submitted a lengthy letter discussing discrimination by the gay community against transgendered people. She writes that she has had problems working within the Department of Health, apparently with agencies that serve the gay male population. She has filed claims of sexual harassment that were later perceived to be claims of discrimination based on her transsexualism. Ms. Drake writes that these experiences have caused her mental anguish.

Roberta (Bobbi) Dunne, individual testimony

Ms. Dunne supplemented her oral testimony with a written statement detailing the discrimination she has experienced in the field of sheetmetal construction. Briefly: when she began her transition from male to female, Ms. Dunne was called gay and

suspected of having AIDS. Eventually she was laid off, and a short time later was told that she might lose part of her pension. She received a new insurance policy which excluded transsexualism from coverage.

In trying to combat these injustices, Ms. Dunne could find no legal recourse. The U.S. Equal Opportunity Commission wrote to Barbara Boxer, whose assistance Ms. Dunne had requested, stating that it could not intervene on Ms. Dunne's behalf because there is no Federal protection for transsexuals. At this point, writes Ms. Dunne, she has been reinstated on a part-time basis and her pension is secure, but her insurance coverage is still to be determined. The conditions of her rehire are that she not talk about her personal or private life at work, and that she keep her hair tied back (for safety). She has hired an attorney and filed discrimination complaints with the Commission.

Dianna Inmon, individual testimony

Ms. Inmon, having seen notice of the hearings in the newspaper, wrote to say that she believes a person who changes sex is going against the laws of nature, and adds that gay people are sick. Ms. Inmon bases her thesis on the fact that homosexuals, like heterosexuals, become bald. She states that this proves sexual preference derives from mental rather than glandular sources.

Gianna Eveling Israel, Counselor, Center for Special Problems

Ms. Israel is a counselor at the Gender Identity program of the Center for Special Problems in San Francisco. She writes that one of the main reasons people seek her services is abuse. Many of her clients have encountered harassment and violence as well as discrimination in housing and employment. Ms. Israel cited many examples of discrimination, including: a 21-year-old transsexual who was slapped and threatened on the street and could get no help from police; a 26-year-old transsexual with excellent secretarial skills who was refused employment specifically because her employer felt his gay male clientele would not accept her; a 38-year-old transgenderist who was refused service at a restaurant; and a 24-year-old transsexual who was thrown out of a Castro Street store for being "flamboyant."

Ms. Israel pointed out that discrimination, harassment and violence against transgendered people goes unrestrained legally or socially within the City and County of San Francisco. She urged the Commission to enact legislation specifying "Gender Identity and/or Transgender individuals" as a protected class; to specify that this legislation protects against discrimination in public and private industry and businesses, housing, medical and mental health care, and social services; and that it initiate a mandate that public health services provide specialized medical and mental care and social services to the transgendered population. Ms. Israel attached a paper explaining gender dysphoria that included various profiles of transgendered people.

S.F Board of Supervisors Resolution
VOTE: UNANIMOUS Sponsored by Tom Ammiano
Signed by Mayor Brown

WHEREAS, Youth who identify as transsexual have a particular need for supportive counseling and for competent, appropriate health care; and

WHEREAS, Fear of coercive and inappropriate treatment prevents many lesbian, gay, bisexual, transgendered, transsexual, queer, and questioning youth from accessing supportive health care and mental health care services; and

WHEREAS, Gender atypical children and youth have a fundamental human right to self-determination and to be treated with dignity and respect; and so therefore be it

RESOLVED, That the San Francisco Board of Supervisors calls on the American Psychiatric Association and the American Psychological Association to take immediate steps to stop coercive and inappropriate treatments of gender atypical children and youth based on GID or under the guise of any other diagnosis, and to oppose any treatment designed to manipulate a young person's sexual or gender identity (while understanding that some treatment programs for adults require the diagnosis of GID); and be it

FURTHER RESOLVED, That the San Francisco Board of Supervisors calls on all mental health and health care professionals to investigate and speak out against coercive and inappropriate treatments of children and youth based on GID or under the guise of any other diagnosis; and so therefore be it

FURTHER RESOLVED, That the San Francisco Board of Supervisors calls on all federal, state, and local legislators and other decision makers to ban government or public funding for coercive, manipulative treatment of children and youth based on GID diagnosis, when such treatment is designed to arbitrarily or forcefully modify a young person's sexual orientation or gender identity.

Dear GLMA Board of Directors,

Thank you for voting against the Gender Identity in Children and Adolescents diagnosis. I am very proud of you.

I hope you will agree that to wait six years for the APA to review this matter is unacceptable. It means more children being tortured in the shadows, more dead gay kids. It will have a continuing effect on the suicide rate, drugs, homelessness, and early HIV infection.

There is an invisible universe of pain and despair without healing out there, because the world truly despises feminine little gay and transsexual kids. The persecution is relentless. That is not a delusion, it is reality, it is a sorrow. So I would lobby your hearts to not fall silent again on this issue.

It would be a joy for me to be a volunteer of yours for the rest of my life, but I need to ask you a favor. Could you please send me a sincere message that you will not let this matter be pushed into oblivion for six more years. I certainly won't. I am not willing to call the political torture of a child anything else.

Love,

Camille

Camille Moran
[redacted]
or you can reach me at GLMA

<<letter>>

- Sample letter of support to be returned to GLMA
- A list of key quotes from clinical literature supporting our position
- An article that explores the issue GIDC from a community newspaper
- Testimony of a psychiatric survivor who was abused under the GIDC diagnosis
- Two excerpts from Gender Shock, an investigative book about GIDC
- Bibliography of GIDC literature

We urge <<Organization Name>> to support the removal of GIDC from the DSM by sending a letter of support to the GLMA Board of Directors, such as the sample letter included this packet. Your action on this matter is crucial in our effort to demonstrate to the APA that a united coalition of child advocates recognizes that the inclusion of the GIDC diagnosis in the DSM stands in the way of gender non-conforming children's ability to access mental health and social services resources without being labeled mentally ill.

GLMA thanks you for your dedication to advocating for the human rights of young people by challenging the current usage of the GIDC diagnosis. We believe that an alliance with Organization Name is instrumental to our movement and we look forward to working with you on this issue. For more information on GLMA and GIDC, please contact us at (415)255-4547.

Sincerely,

Marj Plumb, Director of Public Policy

Angela Garcia, Public Policy Assistant

Meg Rothman, Public Policy Intern

Camille Maran, Community Advisor

Camille-

please bring your copy of the GIDC packet to work on Thursday so I can see the letter Angela wrote. (I can't find my copy.) And also bring a book for me.

Thank you Thank you

Meg

hi-fy
health initiatives for youth

1242 market street. s.f. ca 94102
tel 415. 487. 5777 fax 415. 487. 5771

Camille Moran
Seth Ubogy
Tom Hilton

Dear Tom, Camille and Seth,

Thanks for coming to the APA event on Saturday Morning. I am sorry that the event was not quite what it was billed as. The materials described a community/APA forum on current issues and challenges. As you know, the actual event was all about managed care, not an unimportant topic BUT not what we were promised. (And that 1st speaker, oh my GAWD!!)

Oh well, at least Camille got to speak and we got the info packet into the hands of the President and a couple of other key APA officers. Let's hope we made a bit of an impact.

Thanks again for coming, next time we'll check the agenda more carefully. It was nice to see you and have breakfast together. I am off to my vacation and will see you all at QUASAR when I get back from Ireland.

Cheers
Steven

PS- My New CD is great
Ahmad Jamal !!!

hi-fy
health initiatives for youth

Tierney

1242 market street. s.f. ca 94102

SAN FRANCISCO CA PM 17 AUG 1998

SAN FRANCISCO CA AUG 17'98 ≈ 0.32 PB METER 8210686 U.S. POSTAGE

Camille Morrow

[redacted]

LEGAL SERVICES FOR CHILDREN

1254 MARKET STREET, 3RD FLOOR, SAN FRANCISCO, CA 94102

Vitaly, J.D.

TEL 415/863-3762 #319 FAX 415/863-7708

Committee Report
APA Committee on Gay, Lesbian and Bisexual Issues
September 12, 1997

on
The Diagnostic Category Gender Identity Disorder (GID)

DRAFT

NOT AN OFFICIAL APA DOCUMENT
Submitted to Council on National Affairs
9/20/97

The current debate surrounding transgender issues is wide ranging and complicated. One particular aspect of this dialogue is the current diagnosis of Gender Identity Disorder (GID). Although our committee is not expert in childhood or adult GID, we have researched some of the conceptual problems and treatment concerns about GID.

The following report presents a history of the diagnosis of Gender Identity Disorder (GID) and outlines some of the conceptual difficulties with the diagnosis and some of the alleged treatment misuses associated with it. Criticisms of the *DSM-IV* GID diagnosis by various activists' organizations and their demands for changes in the next *DSM* are summarized in chronological order. Finally, the committee offers its recommendation.

I. History of Diagnosis

Gender Identity Disorder is a relatively new diagnosis. It did not appear in *DSM-I* and *DSM-II.* [1]

The *DSM-III* (1980) listed four categories of Psychosexual Disorders:

gender identity disorders,

paraphilias ("characterized by arousal in response to sexual objects or situations that are not part of normative arousal-activity patterns and that in varying degrees may interfere with the capacity for reciprocal affectionate sexual activity"),

psychosexual dysfunctions,

"other" psychosexual disorders.

Although the 1973 APA decision to remove homosexuality from the *DSM-III* as a pathological condition meant that it did not appear among the paraphilias, a new diagnosis, ego-dystonic homosexuality, was included under Psychosexual Disorders. In the *DSM-III*, transsexualism appeared for the first time and was listed under Gender Identity Disorders.

The *DSM-IIIR* (1987) moved gender identity disorders into a section entitled "disorders usually first evident in infancy, childhood, or adolescence."

The *DSM-IV* (1994) made several changes to the diagnostic classification of GID and to the criteria necessary to make the diagnosis. Gender Identity Disorder appeared under a new section, "Sexual and Identity Disorders." The other two disorders listed in this section were

---

[1]The first *DSM*, published in 1952, listed "sexual deviations" as a subset of sociopathic personality disturbance under the larger category of "Personality Disorders." The sexual deviations included homosexuality, transvestism, pedophilia, fetishism, and sexual sadism. The second *DSM*, published in 1968, put "sexual deviations" as a separate category under the larger category of "Personality Disorders" and expanded the list of sexual deviations to include exhibitionism, voyeurism, masochism, and "other sexual deviations."

paraphilias (e.g. exhibitionism, pedophilia, and transvestic fetishism[2]) and sexual dysfunctions (e.g. premature ejaculation). The *DSM-IV* also collected the previous three *DSM-III* diagnoses -- GID of childhood, transsexualism, and GID of adolescence or adulthood, nontranssexual type -- into one overarching diagnosis, Gender Identity Disorder.

GID has separate diagnostic criteria for children vs. adolescents and adults.

DSM-IV Diagnostic criteria for Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

In children, the disturbance is manifested by four (or more) of the following:

(1) repeatedly stated desire to be, or insistence that he or she is, the other sex

(2) in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing

(3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex

(4) intense desire to participate in the stereotypical games and pastimes of the other sex

(5) strong preference for playmates of the other sex

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion

---

[2]Meyer and Schwartz (1995) in their discussion of GID, note that:

> A related diagnosis, classified under the Paraphilias, is Transvestic Fetishism; when associated with discomfort with one's sex it is specified as "with gender dysphoria." The main difference between Transvestic Fetishism and GID is that the former (1) is limited to cross-dressing behavior, not a fuller range of atypical gender role behavior, and (2) is a sexual fetishism, requiring that the cross-dressing behavior (e.g., wearing lingerie) is for the purpose of sexual excitement.

that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Code based on current age:

302.6 Gender Identity Disorder in Children

302.85 Gender Identity Disorder in Adolescents or Adults

Specify if (for sexually mature individuals):

Sexually Attracted to Males

Sexually Attracted to Females

Sexually Attracted to Both

Sexually Attracted to Neither

II. Conceptual Difficulties in the GID Diagnosis and in the GID Literature.

A. The GID diagnosis confuses the concepts of "gender role" and "gender identity." One of the most instructive discussions of some of these conceptual difficulties has been made by Meyer and Schwartz (1995) from the Columbia University School of Public Health, Division of Sociomedical Sciences (See Appendix, Notes on Gender Identity Disorder). They say:

> It is impossible to differentiate between gender identity and gender roles because cultural notions of gender identity (indeed the notion that there are only two genders) are intimately tied to our notions of gender roles. That is, a culture defines what it is to be a "man" by the roles it assigns men. In fact, DSM confuses these issues in describing the [GID] criteria: four of the five behaviors described under the cross-gender identity criterion refer to cross-gender roles.

B. The diagnosis Gender Identity Disorder (GID) relies on hypothesized, yet-to-be-established biologically determined sex-dimorphic behaviors. The currently most cited text on GID is Zucker and Bradley's (1995) *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents*. As Coates (1997) points out in her review of their book, "the longest chapter . . . is devoted to biological research on gender identity disorder and related psychosexual conditions" even though Coates notes that Zucker and Bradley ultimately conclude "that this particular body of research has not, in fact, thrown any discernible light on what is happening to these children."

Assertions that a biological basis for GID exists are scientifically unfounded at this point. Unfortunately, belief in such assertions serves to legitimize GID as a valid diagnosis..

C. Associated with the hypothesized connection between biology and sex- dimorphic behavior is the assumption of a developmental line from childhood GID to adult homosexuality.

Richard Green's (1987) research is repeatedly and inaccurately reported to support this line of development in males. The GID literature repeatedly asserts that 3/4ths of Green's sample of "sissy boys" became homosexual. In fact, what Green said was:

> follow-up interviews with 2/3s of the original group of "feminine" boys reveal that 3/4ths of them are homosexually or bisexually oriented. By contrast, only one of the 2/3s of the previously "masculine" boys on whom we have follow-up data is homosexually or bisexually oriented (p. 370).

Green's original sample consisted of 66 feminine boys and 56 masculine boys. Therefore, 2/3 of the original group of 66 = 44. And 3/4 of that group of 44 = 33. So, in fact, what Green found at follow-up was that 1/2 of his original sample of 66 (i.e., 33) "sissy boys" were not homosexual, but "homosexually or bisexually oriented." Since 22 boys were also lost to follow-up, we cannot use the 3/4 figure. Relating to the *original* sample, we can only say that at least half of them were "homosexually or bisexually oriented." (For an example of the repeated misunderstanding of the Green research, see Appendix, letter from K. Kendall, Exec. Dir. NCLR, where she inaccurately maintains that "the great majority of children and a significant percentage of youth who are diagnosed with GID grow up to be lesbian, gay, or bisexual." See also Appendix, Meyer and Schwartz's Notes on Gender Identity Disorder, in which they state: "For example, DSM indicates that childhood GID itself usually gets resolved, but that 75% of boys with GID may grow up to be homosexual men.") The small n of the sample also makes generalization difficult.

they (APA?) do not include the primary transsexuals. If added it would raise the no. of gay kids.

The literature that addresses childhood GID in girls and its alleged development into adult lesbianism relies on research on girls with congenital adrenal hyperplasia (CAH). The claim is made that a prenatal hormonal abnormality leads to gender nonconformity in childhood, evidenced by "cross-gender" behaviors and to adult lesbianism.

There are 10 pertinent studies of CAH girls, only 5 of which address homosexuality in CAH subjects.

None of the five studies, which in all had approximately 152 subjects, reported any of the CAH females exclusively homosexual. In general, the researchers' conclusions are represented by Dittmann's 1992 comments: "Only a certain percentage of patients in the present study and in previously reported studies showed a bi- or homosexual orientation. Thus it is important to point out that prenatal hormone effects do not determine the sexual orientation of an individual." Nevertheless, Dittmann clung to the assumption concluding "that prenatal hormonal conditions play a significant predispositional role. . . in the development of sexual orientation" (p. 164). Although CAH girls have not been found to grow up to be lesbian in any significant numbers, a number of articles misrepresent this data and some researchers concluded that more CAH girls would have been homosexual, if early cortisol treatment had not intervened.

Sometimes the lack of direct evidence for adult lesbian identity and relationship is minimized while concepts such as "cross-sex latency play and homosexual fantasies" are emphasized. Friedman and Downey (1993) stress that CAH girls have more cross-sex latency play and homosexual fantasies than other girls, due to the influence of prenatal androgen. "Prenatal androgens influence childhood play and interest in certain other sex-dimorphic activities. Indeed, this latter effect supports the conclusion that prenatal androgen influences postnatal nonsexual behavior, as well as postpubertal sexual behavior. Three unproved assumptions are offered here as scientific facts: 1.) play is a "sex dimorphic activity" which is 2.) biologically determined 3.) by prenatal androgens [Magee and Miller, 1997].

D. Associated with the hypothesized connection between biology and sex- dimorphic behavior is the assumption of a developmental line from childhood GID to adult transsexualism. There is no data to support this connection. Wrong.

Primary Ts (the feminine ones whose sexual orientation is towards those of their own birth sex, gay.) They are feminine across their whole life span.

This report seems to try to purge the feminine and the effeminate from gay culture.

III. Complaints regarding treatment associated with the GID diagnoses.

A. The GID diagnosis is used to "treat" homosexuality in adolescence.

Claims have been made that homosexual adolescents, or those perceived to be gay by parents or physicians, are being hospitalized under the GID diagnosis and that the "treatment" offered is actually aimed at "curing" them of their homosexuality. Such claims need specific documentation. At present, such documentation has not been brought forward. FALSE

Although clinicians treating those with GID do not state explicitly that a cure for homosexuality is their treatment goal, Zucker and Bradley (1995), as Coates points out in her review, seem "unable to keep clear the distinction between sexual orientation and gender identity." Addressing the treatment of GID, they are equivocal about prevention of homosexuality as a treatment goal.

B. There have also been criticisms of some of the treatment interventions in children diagnosed with GID. These criticisms claim that stereotypic and normative prescriptions of appropriate gender behaviors lead to oppressive treatment. These claims also lack specific supporting documentation; however, Zucker and Bradley's (1995) statements about appropriate treatment goals, such as instituting limit-setting in regards to the cross-gender behaviors in patients diagnosed with GID, can be read as reason for such concerns. FALSE

C. Some transgender activists claim that the GID diagnosis is used to "treat" transgendered persons. This issue is particularly complicated. Although transgendered activists understandably object to the implication of pathology through the use of this psychiatric diagnosis, some transgendered persons do not want to relinquish a medical diagnosis, because such medical diagnoses have been useful in helping them obtain desired sexual surgeries and hormonal treatments.

IV. Conclusions:

This paper has briefly reviewed some of the most salient and problematic features of GID as a diagnosis. Although at present, scant data exist to support the contention that GID is being misused, considerable anxiety exists in the gay, lesbian, and transgendered communities. This discomfort extends to the gay and lesbian medical community. In part, the anxiety stems from the facile manner in which GID of childhood and adult homosexuality and transsexuality are conflated, sometimes implicitly and sometimes explicitly.

As lesbian, gay and bisexual psychiatrists, who have been involved in the scientific work which led to the removal of homosexuality from the DSM and the continuing battle to educate our colleagues about homosexuality, we believe that the diagnosis of GID, similarly, requires a thoughtful and scientific reassessment.

V. Recommendations:

The Committee recommends:

1. That the assumptions fueling the conceptual confusions in the GID diagnosis be examined through the creation of an APA task force composed of members from APA Committees on Women, Abuse and Misuse of Psychiatry in the US, DSM, Gay, Lesbian and Bisexual Issues, Components of the Council on Children, Adolescents and Families, and transgendered members of the APA.

former straight men don't care about GIDC kids.

2. That documentation of possible misuses of the GID diagnosis must be substantiated. Misuses should be addressed, perhaps by the Ethics Committee ← boy guarding henhouse

3. A clear distinction between homosexuality and GID must be made in the next DSM.

So they can say they're not gay kids and ignore the oppression.

4. To avoid nosologic confusion between GID categories in adults and children and to remove unfounded etiologic links between the two, we should separate the diagnosis of GID of children from GID in adults.

FALSE →

5. that a scientific dialogue be established among members of the transgendered community, interested APA members, and the *DSM-V* committee on GID.

This draft sure isn't scientific.

Appendix

Chronology of Conceptual and Organizational Criticisms of the GID Diagnosis

1. September 26, 1995

NOTES ON GENDER IDENTITY DISORDER

Ilan H. Meyer, Ph.D. and Sharon Schwartz, Ph.D.
September 26, 1995

Under "Sexual and Identity Disorders" the Diagnostic and Statistical Manual (DSM-IV, American Psychiatric Association, 1994) lists three classes of disorders: *Sexual Dysfunctions* (e.g., premature ejaculation), *Paraphilias* (e.g., exhibitionism, pedophilia), and *Gender Identity Disorder* (GID). GID is separately diagnosed in children and in adolescents and adults. In adolescents and adults the diagnosis is specified as involving sexual attraction to males, females, both, or neither.

The main features of GID are: a "strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex," "persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex"' and "clinically significant distress or impairment in social, occupational, or other important areas of functioning."

A related diagnosis, classified under the Paraphilias, is Transvestic Fetishism; when associated with discomfort with one's sex it is specified as "with gender dysphoria." The main difference between Transvestic Fetishism and GID is that the former (1) is limited to cross-dressing behavior, not a fuller range of atypical gender role behavior, and (2) is a sexual fetishism, requiring that the cross-dressing behavior (e.g., wearing lingerie) is for the purpose of sexual excitement.

General/Conceptual Issues in GID Diagnosis

The American Psychiatric Association's DSM-IV is one of several available systems for classifying mental disorders; another system is the International Classification of Diseases (ICD, 10th edition, 1992) sponsored by the World Health Organization. Other systems have been used primarily by researchers. Although
there have been efforts to coordinate DSM and ICD, the two do not always agree. In the United States, especially since its 1980 third edition, DSM has become the predominant classification system and it is now used almost universally in clinical settings. It is often required in filing for insurance reimbursement. Despite this predominance, it is important to note that DSM is a

classification system that is constantly subject to revision and changes. For example, in 1973 homosexuality was removed as a mental disorder from DSM-II. In the 1980's several controversies arose. Most notable "ego-dystonic homosexuality" was removed as a mental disorder from DSM-III, and there were debates over the inclusion of premenstrual mood disorders (it has finally been included as a research-only category, suggested for further study, but is not a classifiable mental disorder yet).

All this comes to say that DSM (or other) psychiatric categories are not written in stone--they are socially constructed categories. That is, they do not hold an intrinsic truth, but reflect culturally relevant negotiated categories that are agreed upon based on consensus among psychiatrists and researchers. Because of the need for consensus and agreement, power relations play an important part in the process; only those who are in relatively powerful social positions are able to shape the discussion. As such, psychiatric diagnoses reflect values and norms accepted by the dominant culture, but may contrast with subcultural norms and values. By defining abnormal behavior, DSM (like other classification systems) implies a definition of "normal" behavior. In that, it has an important proscriptive power. Psychiatry and psychiatric diagnoses have therefore been described as agents of social control. Debates over inclusion of criteria for mental disorder are, therefore, not "pure" scientific debates, but reflect underlying social perceptions about what are acceptable (normal) feelings, thoughts, and behaviors. Critics of the medicalization of diagnosis process have noted for example, that psychiatry has never developed any physiological tests (e.g., blood assays, brain scans) that may objectively classify psychiatric disorder.

GID is no exception to this process. Several features of the diagnosis reflect cultural biases that are often accepted as "truth" because they are shared by a majority of people and the dominant culture. But the definition of GID is not consistent with feminist and gay-affirmative values and norms. Because of this incongruence, and because of the powerful position that psychiatric diagnosis assumes in American society and its medical system, psychiatric diagnoses have the potential of harming people who do not share it's moral and ideological base. Two main issues are:

1. GID diagnosis confuses gender identity (desire to be a different gender) with gender role issues. Gender roles are roles assigned by a culture to people of different genders; they are continuously challenged and changing. GID assumes that gender roles are biologically-determined and inherently associated with biological sex. The diagnosis fixes gender roles as stable and desirable, and, in effect, "punishes" innovators who challenge existing gender roles (e.g., a girl who wants to be in football team, a boy who wants to grow up to be a 'mom,' a woman applying to become a fighter pilot. . .) by stigmatizing them.

Moreover, GID assumes that gender identity and roles have independent meanings, but it is impossible to differentiate between gender identity and gender roles because cultural notions of gender identity (indeed the notion that there are only two genders) are intimately tied to our notions of gender roles. That is, a culture defines what it is to be a "man" by the roles it assigns men. In fact, DSM confuses these issues in describing the criteria: four of the five behaviors described under the cross-gender identity criterion refer to cross-gender roles.

Conceptually, gender roles also come close to sexual orientation issues: Perhaps the strongest gender role assigned to men and women is that they should express their sexuality heterosexually. Both gender (biological sex) assignment and a heterosexual orientation are assumed to have a natural predetermination and purpose. Socially defined gender roles reflect and conform to such a naturalistic, biological definition of gender and sexuality. Both homosexuality and nonnormative gender roles are seen, from this perspective, as aberrant. For this reason there is some affinity between gender role nonconformity (diagnosable as GID) and sexual orientation. A child or adult who perceives that he or she is attracted to a person of the same sex may experience some gender identity "confusion" because by definition their sexuality deviates from assigned gender roles. For example, a boy who feels same-sex attraction, having internalized societal values, may feel that he is girl-like in that attraction. This may indicate nothing but the beginning of a process of questioning social norms, but can be labeled a disorder according to DSM's categories.

2. Because of increasing critique of the proscriptive, social control aspects of psychiatric diagnosis, and in a continuing struggle to define mental disorder, DSM-IV has included a requirement for "subjective distress" in many of its diagnostic definitions. In GID there is a requirement that it cause the subject of the diagnosis "clinically significant distress or impairment in social, occupational, or other important functioning." But subjective distress is so widely defined--it could be, for example, interpersonal problems one has with parents because of one's nonconforming behavior--that it is hard to imagine any person who is somewhat different who would not experience some distress, at least related to others' reactions to his or her nonnormative behavior. A

child who is taunted for being a "sissy," or who is socially isolated because he is "feminine," will clearly experience subjective distress, but the source of the distress is oppression and intolerance--analogous to ethnically-based taunting, for example--not an inherent disorder.

It has been argued that to remove a diagnosis (e.g., GID) would be unfair to people who experience distress because of the condition. But this argument is not valid because people who experience distress related to gender issues may still be classifiable by describing the nature of their distress directly (e.g., mood disorder--depressive). If GID describes a phenomena that is not inherently a disorder, but that may lead to distress through, say, others' reaction, it is really a *cause* of distress, a stressor. DSM does not classify other stressors (e.g., marital problems) as disorders, and it need not classify GID.

Public Policy/Social/Legal Implications

Treatment/Involuntary Psychiatric Incarceration

The inclusion of GID in DSM allows treatment and third-party payment to correct gender nonconformity (i.e., GID). The possible confounding with sexual orientation certainly opens the possibility for abuse. For example, DSM indicates that childhood GID itself usually gets resolved, but that 75% of boys with GID may grow up to be homosexual men. Parents and physicians concerned about homosexuality many see GID as a precursor, or even a "risk factor" for homosexuality, and may seek to treat it aggressively. Although I am not familiar with any epidemiological data on the use of the diagnosis for treating homosexuality (in fact, epidemiological data is almost nonexistent on any aspect of GID), reports in popular press suggest that this might be an issue.

The effect of DSM's inclusion of GID, rather than general public attitudes, is not clear, though. Psychiatrists may treat a variety of conditions, whether they are classifiable disorders of not. Thus, even though homosexuality is no longer listed as a mental disorder in DSM, consumers may seek treatment from psychiatrists (and other mental health professionals) who claim to "reverse" homosexuality. Similarly, persons troubled by confused gender identity, and parents concerned about their children's gender identity, may seek treatment regardless of DSM. Removing GID from DSM will make it harder to receive third party payment for such treatment, though. Also, DSM's definitions provide the basis for psychiatric education; removal of GID will have important educational effects on psychiatrists and other mental health professionals in training. With GID in DSM, mental health professional can find an easy justification and an available mechanism for treating nonconformist gender behavior.

A possible advantage of GID is that it may allow third party reimbursement for gender reassignment (sex-change) treatments (I'm not sure to what extent this is currently reimbursable). If GID is not classified as a disorder, transgendered people who seek psychiatric therapy, hormonal treatment, or sex reassignment surgery may be denied third party payments.

On the issue of involuntary psychiatry incarceration, a diagnosis with GID, or any other mental disorder, is not sufficient for involuntary admission for a psychiatric institution. Involuntary admission requires that patients will be dangerous to self or others, in addition to having a psychiatric conditions. Nevertheless, the availability of GID as a diagnosable disorder provides a prerequisite for involuntary hospitalization if the danger criteria is also met. (Abuse of the "danger" criteria is not out of the question, though. It is not inconceivable that judges will be convinced by such bogus danger arguments as related to sexual risk taking behavior, overuse of hormonal therapy, etc.)

Civil Rights

In general, through its proscriptive social-control function, the inclusion of GID in DSM defines traditional gender roles as stable, desirable, and normal. This definition is likely to be taken by the judiciary as an indication of acceptable standards of social norms. In deciding civil rights cases GID may provide a rationale for denying rights related to gender nonconformity. DSM clearly indicates that gender nonconformity is abnormal; could a behavior that is classified a disorder be granted protection in civil rights laws?

Also, although DSM does not define homosexuality as a disorder GID may prove a liability for gay rights causes if gender nonconformity issues arise in conjunction with gay rights issues. Sine the judiciary is not confined by DSM's boundaries, it would not be inconsistent to conclude that GID implies that homosexuality itself is unacceptable (because, as suggested earlier, homosexuality departs from normative gender sexual roles).

On the other hand GID's inclusion in DSM may provide transgendered people some legal protection under the Disability Act. Such rights, if extended to transgendered people, may be withdrawn in GID is eliminated as a classified mental disorder.

---

*Address communications to : Ilan H. Meyer, Ph.D., Columbia University, School of Public Health, Division of Sociomedical Sciences, 600 West 168th St., New York, NY 10032. Telephone (212) 639-3667. E-mail: im15@columbia.edu

2. September 12, 1996.

Human Rights Commission, City of San Francisco
Resolution Condemning Use of Gender Identity Disorder Diagnosis Against Children and Youth

Whereas, the American Psychiatric Association established the psychiatric disorder of "Gender Identity Disorder of Childhood" (GID) in 1980 and continues to recognize GID of childhood and adolescence as a disorder in the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994); and

Whereas, the diagnosis of GID in children and youth was established to identify so-called "pre-homosexual" and "pre-transsexual" children for the purpose of preventing them from growing up to be gay or transsexual; and

Whereas, GID of childhood and adolescence is currently used to subject children and youth to coercive treatments and therapies, including forced institutionalization, for the purpose of preventing adult homosexuality and transsexualism; and

Whereas, GID of childhood and adolescence is also used to stigmatize and scapegoat children and youth who have been harassed or abused because of their gender nonconformity and/or perceived sexual orientation of gender identity; and

Whereas, children labeled with GID are frequently subjected to behavior modification, counseling, or psychoanalysis to force them to conform to sexist and heterosexist norms; and

Whereas, the misuse of GID of childhood and adolescence reinforces and perpetuates bias and discrimination against gender atypical children and youth, as well as against lesbian, gay, bisexual, transgendered, and transsexual people; and

Whereas, youth who identify as transsexual have a particular need for supportive counseling and for competent, appropriate health care; and

Whereas, fear of coercive and inappropriate treatment prevents many lesbian, gay, bisexual, transgendered, transsexual, queer, and questioning youth from accessing health care and mental health care services; and

Whereas, gender atypical children and youth have a fundamental human right to self-determination and to be treated with dignity and respect;

Therefore, be it resolved, that the San Francisco Human Rights Commission calls on the American Psychiatric Association and the American Psychological Association to take immediate steps to stop coercive and inappropriate treatments of gender atypical children and youth based on GID or under the guise of any other diagnosis, and to oppose any treatment designed to manipulate a young person's sexual or gender identity (while understanding that some treatment programs for adults require the diagnosis of GID); and

Therefore, be it further resolved, that the San Francisco Human Rights Commission calls on all mental health and health care professionals to investigate and speak out against coercive and

inappropriate treatments of children and youth based on GID or under the guise of any other diagnosis; and

Therefore, be it further resolved, that the San Francisco Human Rights Commission calls on all federal, state, and local legislators and other decision makers to ban government or public funding for coercive, manipulative treatment of children and youth based on a GID diagnosis, when such treatment is designed to arbitrarily or forcefully modify a young person's sexual orientation or gender identity.

Adopted by Commission September 12, 1996

Signed: Maria Cordero, Commission Clerk

3. October 1996 at APA Meeting in Chicago

Margie Sved and Diana Miller, acting as APA representatives, met with members of Transgender Menace, an activist group of transgendered people. Although there was much negative feeling about the current GID diagnosis, particularly its implied pathology regarding transsexualism, no one had a practical alternative to offer. The dialogue was lively.

4. November 13, 1996

Some 50 bi, trans, gay and lesbian activists picketed outside the national headquarters of the APA during a torrential downpour. The protest was one of the first times that mainstream gay, lesbian and bisexual groups, including NGLTF, International Gay and Lesbian Human Rights Commission, National Center for Lesbian Rights, Gay and Lesbian Alliance Against Defamation and BiNet USA, joined transgender activists for a jointly-coordinated action. The activists protested the use of Gender Identity Disorder to pathologize transgender people and gender-variant youth as "mentally ill."

5. December 11, 1996

Robert Bray, the National Gay and Lesbian Task Force (NGLTF) Communications Director, forwarded a copy of the NGLTF statement of GID, transgenders, and the APA to Lowell Tong, Chair of the APA Committee on Gay, Lesbian and Bisexual Issues. Mr. Bray also requested a December meeting with Dr. Tong.

NGLTF STATEMENT ON GENDER IDENTITY DISORDER AND TRANSGENDER PEOPLE

The statement itself is attributable to Kerry Lobel, NGLTF executive director.
Prior to the statement is background information and additional resources.

Background

The subject of Gender Identify Disorder (GID) has emerged in the media and within the gay and lesbian movement as transgender visibility and activism continues to grow.
GID is listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA). While some transgender people use a GID diagnosis to qualify for hormone treatment, surgery and, in limited cases, anti-discrimination protections based on disability, the diagnosis can be used to pathologize transgender people and "gender-variant" youth -- i.e., those children who exhibit behavior that may be viewed as "pre-homosexual" or "pre-transsexual."
GID is a controversial subject that deserves sensitive treatment. It has broad implications for the civil rights, health and well-being of transgender people.

NGLTF has worked in conjunction with Transsexual Menace, International Conference on Transgender Law and Employment (ICTLEP), National Center for Lesbian Rights (NCLR), International Gay and Lesbian Human Rights Commission, FTM (Female-To-Male) International, Intersex Society of North America ("Hermaphrodites With Attitude"), International Foundation For Gender Education, GenderPAC, BiNet USA, Gay and Lesbian Alliance Against Defamation, and other gay/lesbian/bi/transgender organizations and individuals on the subject of transgenderism, transgender visibility in our society, and GID.

A useful resource on GID and its use against children is the in-depth "Information Sheet" produced by National Center For Lesbian Rights staff attorney Shannon Minter, 415-392-6257, shanminter@aol.com. A copy of the joint NCLR and International Conference on Transgender Law and Employment Policy (ICTLEP) statement on GID may also be obtained from Shannon Minter at NCLR.

The City of San Francisco Human Rights Commission recently passed a proclamation opposing the use of GID against children by the APA. For a copy, contact the Commission at (415)252-2500. Transsexual Menace has background information, a Q&A and other facts about GID and transgenders; contact Riki Anne Wilchins, (212)645-1753, riki@pipeline.com.

As NCLR and ICTLEP point out, there is a growing number of jurisdictions with civil rights policies that prohibit discrimination against transgendered people without reference to GID. These include the state of Minnesota and well as its cities, Minneapolis and St. Paul; San Francisco and Santa Cruz, Calif.; Seattle, Wash.; and Cedar Rapids, Iowa. In addition, the European Court of Justice recently held that employment discrimination against transsexual people violates the fundamental human right to be free of discrimination based on sex. Many transgender activists believe these laws represent the beginning of a new era in transgender liberation -- a time in which they can attain equality and health care not through a diagnosis of "mental illness," but through a progressive and comprehensive civil rights agenda.

NGLTF Statement

The following statement is attributable to Kerry Lobel, NGLTF executive director.

"NGLTF is sensitive to the differences of opinion within the transgender community on GID and the implications of GID on insurance payments, civil rights and other issues of concern to transgender people. Thus, instead of supporting wholesale GID eradication, we support GID reform. Reform means another diagnosis -- possibly medical -- that does not pathologize transgender people or gender-variant youth and children. Reform also means increased funding for research on transgenderism and full participation by transgender people in policy decisions that affect their lives.

"We are particularly concerned with the use of GID against children. Gender-variant youth, whether they grow up to be gay, lesbian, bisexual, transgendered or not, should not be stigmatized or mistreated because of a GID diagnosis.

"The struggle for transgender people in 1996 invokes the struggle of gay and lesbian people in the early Seventies when the National Gay Task Force (NGTF) was successful in helping remove homosexuality as a mental disease. We are aware that transsexual people have unique concerns in their lives, including medical treatments such as hormones and surgery, that are different from being gay or lesbian. However, we believe no one -- whether gay, lesbian, bisexual, transgender or intersex (hermaphrodite) -- should have to accept being pathologized as mentally ill in order to attain wholeness, completeness and civil equality.

"NGLTF strongly supports civil rights protections and affordable health care for transgenders. We loathe discrimination and violence perpetrated against transgenders and stand in solidarity with transgender people in their struggle for visibility, inclusion, equality and justice."

The National Gay and Lesbian Task Force is a progressive organization that has supported grassroots organizing and pioneered in national advocacy since 1973. Since its inception, NGLTF has been at the forefront of virtually every major initiative for lesbian and gay rights. In all its efforts, NGLTF helps to strengthen the gay, lesbian, bisexual and transgender movement at the state level while connecting these activities to a national vision for change.

This message was issued by the National Gay and Lesbian Task Force Field Organizing Department. If you have any questions regarding this post, please direct them to <ngltf@ngltf.org>.

6. March 3, 1997

Kathryn D. Kendall, Executive Director of National Center for Lesbian Rights (NCLR) in a letter to Dr. Eist, President of APA, repeated the prior request for a meeting with APA representatives by Kerry Lobel, Executive Director of NGLTF.

Dear Mr. Eist:

I am writing to encourage you to respond to the request of Kerry Lobel, Exec. Dir. of NGLTF to facilitate a meeting between APA staff and representatives from the lesbian, gay, bisexual, and transgendered communities to discuss the impact of the psychiatric diagnosis of gender identity disorder on transgendered adults and gender variant children and youth. . . . As indicated in K. Lobel's letter of Dec 12, 1996, the purpose of the proposed meeting is to provide a non-confrontational forum in which representatives from the lesbian, gay, bisexual and transgendered communities can share some of the specific issues and concerns raised by the def. of transsexualism and transgenderism as a psychiatric disorder. These concerns include, among others, the impact of characterizing transsexualism and transgenderism as a psychiatric disorder on:

(1) access to and reimbursement for hormones, sex-reassignment surgeries and other transition-related health care, as well as on access to primary health care and health insurance;

(2) marriage, child custody, adoption and other parenting and family-related issues;

(3) discrimination against transgendered persons in employment, prisons, the military, social services, and public education.

The impact of the diagnosis of GID on gender variant children and youth, including lesbian, gay, and bisexual youth, is especially troubling. As you may be aware, the great majority of children and a significant percentage of youth who are diagnosed with GID grow up to be lesbian, gay, or bisexual. Current clinical approaches to children and youth who are treated for GID are typically focused on eliminating or minimizing cross-gender behavior and identification, with the long term goals of preventing adult homosexuality and/or transsexualism. This focus is dramatically inconsistent with the recommendations of mental health professionals who specialize in counseling lesbian, gay, bisexual, and transgendered youth. It is also inconsistent with the specific needs of transsexual youth, who are often deterred from seeking counseling and/or medical care because of fear of encountering disapproval or aversive treatment from providers, and who confront enormous an in most cases insuperable obstacles to accessing medically supervised hormone therapy, even where such therapy would be literally life-saving. It is long past time for the APA to reexamine the assumptions that inform the diagnosis and treatment of GID of childhood and adolescence and to listen to the perspectives of lesbian, gay, bisexual, transgendered, and transsexual individuals who have been damaged by the clinical treatments that follow from these assumptions.

7. April 7, 1997

A letter from Margaret Cawley Dewar, Office of the President and President-Elect (APA) to Kathryn D. Kendall, Exec. Dir. NCLR, dated April 7, 1997 acknowledging receipt of request.

8. May 7, 1997

Letter to James Krajeski MD and Lowell Tong MD from Robert Cabaj MD (GLMA). Enclosed were copies of the recent material the Gay and Lesbian Medical Assoc. used to undertake a review of Gender Identity Disorder.

> "GLMA has been asked to sign on with both NGLTF and NCLR in requesting a meeting with the APA to discuss GID, how it has been misused against youth--especially gay, lesbian, bisexual and transgendered youth--and how to look at transsexualism in a way that will allow people seeking sex corrective surgery to still receive psychiatric and medical benefits without being labeled mentally ill."

9. May 28, 1997 Item from NGLTF "Legislative Update"

TRANSGENDER:

In Washington there was a measure that would undo a court decision including transgender people under the American with Disabilities Act (ADA). In some states, transgender people are included in the ADA because of the psychiatric diagnosis Gender Identity Disorder. This is one of two transgender-related bills tracked by NGLTF this year. The other was a bill in Missouri that would use a parents' transgender status against them in custody cases.

10. July 24, 1997 Teleconference Call Meeting on GID

Lowell Tong, chair of the APA Committee on Gay, Lesbian and Bisexual Issues, spoke with representatives of the Human Rights Campaign, National Gay and Lesbian Task Force, National Center for Lesbian Rights, GenderPAC and other Washington, D.C. based political organizations interested in transgender and GID issues. Information was shared including what the DSM is and how changes are made, as well as exchanging the complicated and diverse opinions about GID and other transgender issues.

References

Bailey, M. & Zucker, K. (1995). Childhood sex-typed behavior and sexual orientation: A conceptual analysis and quantitative review. *Developmental Psychology* 31(1):43-55.

Billings, Dwight B. and Urban, Thomas (1982). The socio-medical construction of transsexualism: An interpretation and critique. *Social Problems* 29: 266-82. Reprinted in Ekins, Richard and King, Dave (Eds.) (1996). *Blending Genders: Social Aspects of Cross-Dressing and Sex-Changing.* New York: Routledge.

Bradley, S. & Zucker, K. (1997). Gender identity disorder: A review of the past 10 years. *J. Am. Acad. Child Adolesc. Psychiatry* 36(7): 872-880.

Coates, S., Friedman, R., & Wolfe, S. (1991). The etiology of boyhood gender identity disorder: A model for integrating temperament, development, and psychodynamics. *Psychoanalytic Dialogues* 1(4): 481-523.

Coates, S. (1997). Review of Zucker and Bradley's *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents*. Contemp. Psychol, 42: 549-552.

Coates, S. (1997). Is it time to jettison the concept of developmental lines? Commentary on de Marneffe's Paper "Bodies and Words." *Gender and Psychoanalysis* 2(1): 35-53.

Dittmann, R. W., Kappes, M. E. & Kappes, M. H. (1992), Sexual behavior in adolescent and adult females with congenital adrenal hyperplasia. Psychoneuroendocrinology., 17:153-170.

Ekins, Richard and King, Dave (Eds.) (1996). *Blending Genders: Social Aspects of Cross-Dressing and Sex-Changing.* New York: Routledge.

Friedman, R. C. & Downey, J. (1993), Psychoanalysis, psychobiology, and homosexuality. J. Amer. Psychoanal. Assn., 41:1159-1198.

Green, R. (1987). *The "Sissy Boy Syndrome" and the Development of Homosexuality* New Haven, CT: Yale University Press.

Hanson, Graeme & Hartmann, Lawrence. (1996). Latency development in pre- homosexual boys. In R. Cabaj & T. Stein (Eds.) *Textbook of Homosexuality and Mental Health.* Washington, DC: American Psychiatric Press, pp. 253- 266.

Hausman, Bernice L. (1995). *Changing Sex: Transsexualism, Technology, and the Idea of Gender*. Durham, N.C.: Duke University Press.

Hubbard, Ruth. (1996). Gender and Genitals: Constructs of Sex and Gender. Presented at AGLP Symposium, May 1996, New York City.

King, Dave. (1996). Gender Blending: Medical perspectives and technology. In Ekins, Richard and King, Dave (Eds.) (1996). *Blending Genders: SociaL Aspects of Cross-Dressing and Sex-Changing.* New York: Routledge.

Magee, M. & Miller, D. (1997). *Psychoanalysis and Lesbian Lives: Narratives Old and New.* Hillsdale, NJ: The Analytic Press (in press).

Meyer, I. H. & Schwartz, S. (1995). Notes on Gender Identity Disorder. Unpublished.

Peplau, L.A., Garnets, L, Spalding, L; Conley, T.; & Veniegas, R. (1996-paper unpublished). A critique of Bem's "exotic become erotic" theory of sexual orientation.

Seil, D. (1996). Transsexuals: The boundaries of sexual identity and gender. In R. Cabaj & T. Stein (Eds.) *Textbook of Homosexuality and Mental Health.* Washington, DC: American Psychiatric Press, pp. 743-763.

Zucker, K. J. & Bradley, S. (1996). *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents.* New York: Guilford Publications.

DSM-IV COMMITTEE REPORTS

Bradley, Susan; Blanchard, Ray: Coates, Susan; Green, Richard; Levine, Stephen; Meyer-Bahlburg, Heino; Pauly, Ira; and Zucker, Kenneth. (1991). Interim Report of the DSM-IV Subcommittee on gender identity disorders. *Archives of Sexual Behavior* 20(4): 333-343.

Shaffer, David; Campbell, Magda; Cantwell, Dennis; Bradley, Susan; Carlson, Gabrielle; Cohen, Donald; Denckla, Martha; Frances, Allen; Garfinkel, Barry; Klein, Rachel; Pincus, Harold; Spitzer, Robert; Volkmar, Fred; and Widiger, Tom. Brief Communication. Child and Adolescent Psychiatric Disorders in DSM-IV: Issues Facing the Work Group. (1989). *J. Amer Acad Child & Adol Psychiatry* pp. 830-835

ESKIND BIOMEDICAL LIBRARY DOCUMENT DELIVERY SERVICE Order # 95-1728

Date: 12/3/94

Patron: [redacted], M.D.

Person placing order (if different from above):

[redacted]

Phone: [redacted] ext. 291

FAX: [redacted]

Status at VU (check one):

linical _X Faculty __Staff __ Student
__ NAM __Other VU

Library ID: _____

NOTE: non-affiliated Health Professionals use green form.

Fill out ONE only

Campus Address	Off-Campus Address
_____ Department	275 Cumberland Be Street, etc.
_____ Room # Building	Nashville, TN 372 City, State, ZIP
ZIP + 4 _____	

I agree to pay Eskind Biomedical Library for the provision of this item and to be bound by the conditions stated herein.

Signature: Will pay for with 1180 Fo Psy De

(Please initial signature if signing for someone.)

DELIVERY

_X Pick-up (Payment is required at pick-up.)
__ Mail __ FAX
(Payment for mailed or faxed items is due upon receipt.)

AMOUNT DUE

$4.00 Eskind $8.00 Non-Eskind

JOURNAL ARTICLE REQUEST

Please print, type, or attach the citation from your computer search.

ARCHIVES OF SEXUAL BEHAVIOR

Give journal title in full, including any sub-title, or give standard NLM abbreviation.

20 — vol. #

INTERIM REPORT OF THE DSM-IV SUBCOMMITTEE ON GENDER — article title

4 — issue #

IDENTITY DISORDERS.

1991 AUG — year

article author(s) BRADLEY SJ. BLANCHARD R. COATES S. GREEN R. LEVINE SB. MEYER-BAHLBURG HF. PAULY IB. ZUCKER KJ.

333 to 343 — page page

92061533 — Medline UI #

_____ citation source (optional, but helpful to us)

WARNING CONCERNING COPYRIGHT RESTRICTIONS

The copyright law of the United States (Title 17, United States Code) governs the making of photocopies or other reproduction of copyrighted material.

Under certain conditions specified in the law, libraries and archives are authorized to furnish a photocopy or other reproduction. One of these specified conditions is that the photocopy or reproduction is not to be "used for any purpose other than private study, scholarship, or research." If a user makes a request for, or later uses, a photocopy or reproduction for purposes in excess of "fair use," that user may be liable for copyright infringement.

This institution reserves the right to refuse to accept a copying order if, in its judgment, fulfillment of the order should involve violation of copyright law.

LAC

LIBRARY STAFF ONLY

Order received by: _____

Payment received by: _____

__ Cash __ Check __ 1180

MC/VISA _____ Exp. _____

Date: _____

__ Eskind __ VMCL __ Other VUL: _____

X Not at VU Locations: _____

NLM/OCLC #: _____

Request received: DEC 0 9 1994

Article received: _____

DEC 1 3

Archives of Sexual Behavior, Vol. 20, No. 4, 1991

Interim Report of the DSM-IV Subcommittee on Gender Identity Disorders

Susan J. Bradley, M.D.,[1,9] Ray Blanchard, Ph.D.,[2]
Susan Coates, Ph.D.,[3] Richard Green, M.D., J.D.,[4]
Stephen B. Levine, M.D.,[5] Heino F. L. Meyer-Bahlburg, Dr. rer. nat.,[6]
Ira B. Pauly, M.D.,[7] and Kenneth J. Zucker, Ph.D.[8]

This article summarizes the discussions and recommendations of the DSM-IV Subcommittee on Gender Identity Disorders, a subcommittee of the Child Psychiatry Work Group, regarding diagnostic issues. The issues reviewed include placement in the nomenclature, the concept of a spectrum of gender dysphoria rather than discrete levels of symptomatology, criticisms of current diagnostic criteria, subtyping by sexual orientation, and proposed changes in diagnostic criteria for the current DSM-III-R diagnoses of Gender Identity Disorder of Childhood, Transsexualism, and Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type.

KEY WORDS: DSM; diagnosis; gender identity disorder; transsexualism; transvestic fetishism.

The views expressed in this article are those of the authors and do not represent the official positions of the DSM-IV Task Force of the American Psychiatric Association.

[1]Chair, DSM-IV Subcommittee for Gender Identity Disorders, Department of Psychiatry, The Hospital for Sick Children, 555 University Avenue, Toronto, Ontario M5G IX8, Canada.
[2]Gender Identity Clinic, Clarke Institute of Psychiatry, Toronto, Ontario, Canada.
[3]Childhood Gender Identity Unit, Department of Psychiatry, St. Luke's-Roosevelt Hospital Center, New York, New York.
[4]Department of Psychiatry, University of California at Los Angeles, Los Angeles, California.
[5]Department of Psychiatry, Case Western Reserve University, University Hospital, Cleveland, Ohio.
[6]Program of Developmental Psychoendocrinology, Division of Child Psychiatry, New York State Psychiatric Institute, New York, New York.
[7]Department of Psychiatry, University of Nevada School of Medicine, Reno, Nevada.
[8]Child and Adolescent Gender Identity Clinic, Child and Family Studies Centre, Clarke Institute of Psychiatry, Toronto, Ontario, Canada.
[9]To whom all correspondence should be addressed.

0004-0002/91/0800-0333$06.50/0

INTRODUCTION

Concern about adequate diagnosis of individuals with gender identi disorders developed as such patients began presenting themselves, in the ear 1960s, requesting sex reassignment surgery (SRS). Earlier work natural focused on formulating diagnostic criteria permitting clinicians to make sa judgments about who should and should not have surgery. The DSM-III- (American Psychiatric Association, 1987) clearly reflects this tradition in th it divides disorders into Transsexualism and Gender Identity Disorder Adolescence or Adulthood, Nontranssexual Type.

As clinicians were exposed to a broad range of children, adolescent and adults with gender identity disorders, it became apparent that patien vary greatly with regard to the severity, constancy, and natural history of the gender dysphoria. For example, only a small minority of cross-gender-ide tified children followed prospectively go on to develop transsexualism (e.g Green, 1987); in contrast, a much larger percentage of cross-gender-identifie persons who present in adolescence will remain gender dysphoric or eventual receive a diagnosis of transsexualism (e.g., McCauley and Ehrhardt, 1984). is also clear from referrals to adult gender identity clinics that differences b tween individuals who proceed towards SRS and those who do not may b more quantitative than qualitative.

Members of the Subcommittee on Gender Identity Disorders, a sul committee of the Child Psychiatry Work Group for DSM-IV (see Shaffe *et al.*, 1989), began meeting in March 1989. The initial task of this con mittee was to examine category and criterion issues. Recommendatio for change are to be based on a review of the literature or on analys of data sets or, where neither exist, on the grounds that widely accepte clinical experience would clearly support such change. The remainder this article summarizes the issues so far addressed by the subcommitte its purpose is to stimulate discussion and to solicit feedback from men bers of the sexological community.

PLACEMENT IN THE NOMENCLATURE

A basic issue considered by the subcommittee, but one that was n in its jurisdiction to alter, was the diagnostic category in which gender ide tity disorders should be placed. In DSM-III (American Psychiatric Associ tion, 1980), Transsexualism and Gender Identity Disorder of Childhoc were placed under the larger category entitled *Psychosexual Disorders.* DSM-III-R, the category *Psychosexual Disorders* was eliminated, with mar of the former diagnoses placed under a new category termed *Sexual Di*

Table I. DSM-III-R Diagnostic Criteria for Gender Identity Disorder of Childhood

For females

A. Persistent and intense distress about being a girl, and a stated desire to be a boy (not merely a desire for any perceived cultural advantages from being a boy), or insistence that she is a boy.
B. Either (1) or (2):
   (1) persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing, e.g., boys' underwear and other accessories
   (2) persistent repudiation of female anatomic structures, as evidenced by at least one of the following:
      (a) an assertion that she has, or will grow, a penis
      (b) rejection of urinating in a sitting position
      (c) assertion that she does not want to grow breasts or menstruate
C. The girl has not yet reached puberty.

For males

A. Persistent and intense distress about being a boy and an intense desire to be a girl or, more rarely, insistence that he is a girl.
B. Either (1) or (2):
   (1) preoccupation with female stereotypical activities, as shown by a preference for either cross-dressing or simulating female attire, or by an intense desire to participate in the games and pastimes of girls and rejection of male stereotypical toys, games, and activities
   (2) persistent repudiation of male anatomic structures, as indicated by at least one of the following repeated assertions:
      (a) that he will grow up to become a woman (not merely in role)
      (b) that his penis or testes are disgusting or will disappear
      (c) that it would be better not to have a penis or testes
C. The boy has not yet reached puberty.

orders. Transsexualism and Gender Identity Disorder of Childhood were placed under the larger category entitled *Disorders Usually First Evident in Infancy, Childhood, or Adolescence.*

The subcommittee recognized some advantages for the DSM-III-R placement, in that such an arrangement forced more attention to and recognition of gender identity disorders on the part of child and adolescent clinicians. On the other hand, adult clinicians felt that such placement was inappropriate for transsexualism, particularly given that behavioral precursors of some cases of adult transsexualism are not evident in childhood. On balance, the subcommittee agreed that a distinct diagnostic category, Gender Identity Disorders, should be created in DSM-IV. Such a category would have the same status as, for example, Anxiety Disorders and Mood Disorders, in which there may be childhood precursors, if not identical symptoms, to what is observed in adults (see Shaffer *et al.,* 1989).

Table II. DSM-III-R Diagnostic Criteria for Transsexualism

A. Persistent discomfort and sense of inappropriateness about one's assigned sex.
B. Persistent preoccupation for at least two years with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex.
C. The person has reached puberty.

Specify history of sexual orientation: asexual, homosexual, heterosexual, or unspecified

SPECIFIC CATEGORY AND CRITERION ISSUES

Gender Identity Disorder of Childhood

The Subcommittee has identified two substantive concerns about t present criteria: (i) differences in the criteria for boys and girls and (ii) t distinctness of the criterion pertaining to the wish to be of the opposite se

Diagnostic Criteria for Boys and Girls

In DSM-III-R, a girl is required not only to have "persistent and inten distress" about being a girl but also to have a "stated desire" to be a bc Boys must also have a "persistent and intense distress" about being a boy, b only need to have an "intense desire" to be a girl. In other words, girls mu state their desire to be a boy, whereas boys need not verbalize such wishe Moreover, for boys, the desire must be "intense," whereas for girls no specific tion regarding intensity is made with regard to the verbalized wish to be boy (Table I).

The subcommittee has taken the position that the reasons for thes distinctions are not clear. It was felt that whatever criterion was adopte regarding the verbalized wish to be of the opposite sex should be the sam for boys and girls. The subcommittee also felt that the *desire* to be of th opposite sex would be difficult to infer independently of other aspects the criteria as they stood in DSM-III-R.

Another issue involving girls concerns the statement in Point A th the desire to be a boy is not due to "perceived cultural advantages fro being a boy." The subcommittee took the position that it was inap propriate to place such an exclusion rule in the criteria themselves, there may be many reasons why a child adopts a cross-gender identit and that these issues should be dealt with in the text (for further discu sion of these points, see Zucker, 1991).

Table III. DSM-III-R Diagnostic Criteria for Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT)

A.	Persistent or recurrent discomfort and sense of inappropriateness about one's assigned sex.
B.	Persistent or recurrent cross-dressing in the role of the other sex, either in fantasy or actuality, but not for the purpose of sexual excitement (as in Transvestic Fetishism).
C.	No persistent preoccupation (for at least two years) with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex (as in Transsexualism).
D.	The person has reached puberty.

Specify history of sexual orientation: asexual, homosexual, heterosexual, or unspecified

Should the Desire to be of the Opposite Sex Be a Distinct Criterion?

Clinical experience suggests that children may manifest significant cross-gender identification without verbalizing the wish to be of the opposite sex. This appears particularly true of children over the age of 6 or 7, perhaps because of the social opprobrium that ensues (Zucker, 1991). Currently, the subcommittee is analyzing data sets from Green's (1987) study and from the data base of the Child and Adolescent Gender Identity Clinic at the Clarke Institute of Psychiatry to examine the similarities and differences between children referred for gender identity concerns who do and do not verbalize the wish to be of the opposite sex.

It was the recommendation of the subcommittee that the explicit wish to be of the opposite sex be combined with other behavioral markers of gender identity disorder into one criterion. This would eliminate the pivotal role that the verbalized wish to change sex plays in the DSM-III-R criteria.

Transsexualism and Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT)

The DSM-III-R diagnostic criteria for Transsexualism and GIDAANT are presented in Tables II and III. These categories are similar except that Transsexualism appears designed for gender-dysphoric individuals who have decided upon surgical sex reassignment as the solution to their inner distress (Levine, 1989). The desire to uncouple the clinical diagnosis of gender dysphoria from criteria for approving patients for SRS was one factor in the subcommittee's recommendation that these categories be merged under the

single heading of Gender Identity Disorder. The subcommittee was also in fluenced by the perception of many clinicians that there are no distinct boun daries between gender dysphorics who request sex reassignment surgery an those whose cross-gender wishes are of lesser intensity or constancy (Benjamin 1966; Fisk, 1973; Freund *et al.*, 1982; Person and Ovesey, 1974a, 1974b Specific issues addressed within this broad category have included (i) th present exclusion of fetishistic cross-dressers, (ii) subtypes of gender-dysphori adults, and (iii) the diagnostic classification of physical intersexes.

Exclusion of Fetishistic Cross-Dressers from the Present Transsexual and GIDAANT Categories

In DSM-III-R, any individual who reported that he was currently gende dysphoric and currently aroused by cross-dressing would necessarily be diag nosed as Gender Identity Disorder Not Otherwise Specified (GIDNOS). Th GIDNOS label is the only one applicable because gender dysphoria preclude the diagnosis of Transvestic Fetishism, whereas fetishistic arousal preclude the diagnoses of Transsexualism and GIDAANT. This diagnostic rule is dis cordant with both clinical experience and the available research literature which suggests that about half of even the most strongly gender-dysphoric non homosexual men acknowledge that they still become sexually aroused or mas turbate at least occasionally when cross-dressing (Blanchard and Clemmensen 1988). Because of the excessive number of cases currently classified as GID NOS, our subcommittee and the Sexual Disorders Work Group (Wise, 1989 agreed that the current arrangement was unsatisfactory.

The Sexual Disorders Work Group proposed to subtype Transves tic Fetishists with and without gender dysphoria (Wise, 1989). Our sub committee found that proposal problematic because many such individuals appear to lose the fetishistic arousal as the gender dysphoria develops (Benjamin, 1966; Buhrich and Beaumont, 1981; Buhrich and McConaghy, 1977; Person and Ovesey, 1978; Wise and Meyer, 1980) Subtyping transvestic fetishists according to the presence of gender dys phoria could then require changing the diagnosis from transvestic fetishism to gender identity disorder in those individuals whose fetishis tic arousal has diminished. This would appear to be unduly cumbersome

The Subcommittee on Gender Identity Disorders recommends tha fetishistic arousal should *not* be an exclusion criterion for Gender Iden tity Disorder. Individuals who currently experience erotic arousal in as sociation with cross-dressing as well as gender dysphoria would receive two diagnoses: Gender Identity Disorder and Transvestic Fetishism.

Subtypes of Gender Identity Disorder

After reviewing Blanchard's (1985, 1988, 1989a, 1989b) analyses of the various subtypes presenting at the (adult) Gender Identity Clinic of the Clarke Institute of Psychiatry in Toronto, the subcommittee agreed that there are two common routes leading to a gender identity disorder in adolescence or adulthood. The first group of cases progresses from Gender Identity Disorder of Childhood and are sexually oriented toward members of their own biological sex; the second appears to progress from Transvestic Fetishism over time to a full-blown gender identity disorder. The latter group may have had, or may still have, erotic attraction to members of the opposite biological sex; mixed within this group are others who might be described as bisexual or asexual.

The subcommittee debated the utility of subtyping, various methods of subtyping, and the diagnostic labels to apply to subtypes. There was consensus that it is important for clinical management as well as research purposes to note gender dysphorics' sexual preferences (e.g., Blanchard *et al.*, 1989). With regard to method of subtyping, the subcommittee felt that, notwithstanding the above-mentioned evidence that there may be only two fundamentally different types of gender identity disorder, it was better to anchor subtyping at the descriptive level and to distinguish four different subtypes.

A great deal of discussion was devoted to the question of subtype labels. Many patients object to being labeled "homosexual" or "heterosexual," and many professionals appear confused about the reference point (the patient's anatomic sex or subjective gender identity) in applying such terminology (Pauly, 1990). The subcommittee's recommendations were intended to make the principles of subtyping clear to professionals and the language inoffensive to the patients themselves. The recommended system of subtyping is as follows: (i) sexually attracted to males, (ii) sexually attracted to females, (iii) sexually attracted to both, (iv) sexually attracted to neither, and (v) unspecified.

The subcommittee further agreed that, because the rationale for subtyping is not entirely clear to those not working in this area, explanation of the need for this will be provided in the text.

Intersexuality and Gender Dysphoria

The subcommittee debated whether individuals who appear to be cross-gender-identified and have a history of ambiguous genitalia or some significant chromosomal anomaly should be given a psychiatric diagnosis. The subcommittee was not unanimous in recommending a

Table IV. Proposed DSM-IV Diagnostic Criteria for Gender Identity Disorder[a]

A. A profound and persistent cross-gender identification.
   In *children,* as manifested by at least 4 of the following:
   1. *repeatedly* stated desire to be, or insistence that he or she is, the opposite sex
   2. in girls, insistence on wearing stereotypical masculine clothing; in boys, preference for cross-dressing or simulating female attire
   3. *strong and persistent preferences for cross-sex roles in fantasy play or persistent fantasies of being the opposite sex*
   4. intense desire to participate in the games and pastimes of the *opposite* sex
   5. *strong preference for playmates of the opposite sex*
   In *adolescents and adults,* as manifested by symptoms such as *a stated desire to be th opposite sex, frequent passing as the opposite sex, desire to live as or be treated as the opposite sex, or the conviction that one has the typical feelings and reactions of the opposite sex.*

B. Persistent discomfort with one's assigned sex or sense of inappropriateness in *that gender role.*
   In *children,* manifested by any of the following:
   In boys, assertion that his penis or testes are disgusting or will disappear, or assertion that it would be better not to have a penis, or *aversion towards rough and tumble play* and rejection of male stereotypical toys, games, and activities
   In girls, rejection of urinating in a sitting position or assertion that she does not want to grow breasts or menstruate, assertion that she has or will grow a penis, or persistent marked aversion towards normative feminine clothing
   In *adolescents and adults,* manifested by symptoms such as preoccupation with gettin rid of one's primary and secondary sex characteristics (e.g., *request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the opposite sex*) or belief that one was born the wrong sex
   For sexually mature individuals, specify history of sexual attraction: towards males, females, both, neither, unspecified

[a]Italicized sections are new.

solution. Concern was expressed that, although there may be etiologic and phenomenological differences, the evidence is not yet strong enough to suggest that such disorders differ from gender identity disorders in physically normal individuals. Thus it was recommended that we continue to use the present classification scheme, that is, to give a psychiatric diagnosis of gender identity disorder but to include, as is present practice, the physical anomaly on Axis III. It was suggested that there is a need for further research in this area to clarify whether the factors thought to be relevant in the development of gender identity disorders in physically normal individuals are essentially the same as those in individuals with clear-cut physical or biochemical abnormalities.

Gender Identity Disorder Not Otherwise Specified (GIDNOS)

This category, as presently described, includes disorders that differ both qualitatively and quantitatively from the major disorders in this sec-

TEXT ISSUES

In the next phase of the subcommittee's work, a review of the text will be undertaken, with suggestions for revisions of its separate headings: associated features, age of onset and course, complications, impairment, prevalence, sex ratio, familial pattern, predisposing factors, and differential diagnosis. Investigators possessing data bases of potential relevance to these various topics are urged to contact the Chair of the Subcommittee, if they feel that they can offer empirical findings that would support revisions of the text.

ACKNOWLEDGMENTS

The subcommittee thanks the following individuals who have offered comments and suggestions: Neil Buhrich, Charles W. Davenport, Michael B. First, Richard C. Friedman, John Money, Thomas N. Wise, and Bernard Zuger.

REFERENCES

American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders,* 3rd ed. APA, Washington, DC.

American Psychiatric Association. (1987). *Diagnostic and Statistical Manual of Mental Disorders,* 3rd ed., rev., APA, Washington, DC.

Benjamin, H. (1966). *The Transsexual Phenomenon,* Julian Press, New York.

Blanchard, R. (1985). Typology of male-to-female transsexualism. *Arch. Sex. Behav.* 14: 247-261.

Blanchard, R. (1988). Nonhomosexual gender dysphoria. *J. Sex Res.* 24: 188-193.

Blanchard, R. (1989a). The classification and labeling of nonhomosexual gender dysphorias. *Arch. Sex. Behav.* 18: 315-334.

Blanchard, R. (1989b). The concept of autogynephilia and the typology of male gender dysphoria. *J. Nerv. Ment. Dis.* 177: 616-623.

Blanchard, R., and Clemmensen, L. H. (1988). A test of the DSM-III-R's implicit assumption that fetishistic arousal and gender dysphoria are mutually exclusive. *J. Sex Res.* 25: 426-432.

Blanchard, R., Steiner, B. W., Clemmensen, L. H., and Dickey, R. (1989). Prediction of regrets in postoperative transsexuals. *Can. J. Psychiat.* 34: 43-45.

Buhrich, N., and Beaumont, T. (1981). Comparison of transvestism in Australia and America. *Arch. Sex. Behav.* 10: 269-279.

Buhrich, N., and McConaghy, N. (1977). The clinical syndromes of femmiphilic transvestism. *Arch. Sex. Behav.* 6: 397-412.

Fisk, N. (1973). Gender dysphoria syndrome (the how, what, and why of a disease). In Laub, D. R., and Gandy, P. (eds.), *Proceedings of the Second Inderdisciplinary Symposium on Gender Dysphoria Syndrome,* Stanford University Press, Stanford, CA, pp. 7-14.

Freund, K., Steiner, B. W., and Chan, S. (1982). Two types of cross-gender identity. *Arch. Sex. Behav.* 11: 49-63.

ESKIND BIOMEDICAL LIBRARY DOCUMENT DELIVERY SERVICE Order # 95-1720

Date: 12/3/94

Patron: [redacted]

Person placing order (if different from above):

[redacted]

Phone: [redacted]

FAX: [redacted]

Status at VU (check one):

inical _X Faculty __Staff __Student
__NAM __Other VU

Library ID:

NOTE: non-affiliated Health Professionals use green form.

Fill out ONE only

Campus Address Off-Campus Address

Department

275 Cumberland Bend
Street, etc.

Nashville, TN 37228
City, State, ZIP

Room # Building

ZIP + 4

I agree to pay Eskind Biomedical Library for the provision of this item and to be bound by the conditions stated herein.

Signature: Will pay with 1180 from Psych Dept
(Please initial signature if signing for someone.)

DELIVERY

_X Pick-up (Payment is required at pick-up.)
__ Mail __ FAX
(Payment for mailed or faxed items is due upon receipt.)

AMOUNT DUE

$4.00 Eskind $8.00 Non-Eskind

JOURNAL ARTICLE REQUEST

Please print, type, or attach the citation from your computer search.

CANADIAN JOURNAL OF PSYCHIATRY-REVUE CANADIENNE DE PSYCHIATRIE
Give journal title in full, including any sub-title, or give standard NLM abbreviation.

35 vol. #

GENDER IDENTITY DISORDER AND PSYCHOSEXUAL PROBLEMS IN CHILDREN AND ADOLESCENTS.
article title

6 issue #

1990 Aug year

BRADLEY SJ. ZUCKER KJ.
article author(s)

477 to 486 page page

91003819 Medline UI #

citation source (optional, but helpful to us)

WARNING CONCERNING COPYRIGHT RESTRICTIONS

The copyright law of the United States (Title 17, United States Code) governs the making of photocopies or other reproductions of copyrighted material.

Under certain conditions specified in the law, libraries and archives are authorized to furnish a photocopy or other reproduction. One of these specified conditions is that the photocopy or reproduction is not to be "used for any purpose other than private study, scholarship, or research." If a user makes a request for, or later uses, a photocopy or reproduction for purposes in excess of "fair use," that user may be liable for copyright infringement.

This institution reserves the right to refuse to accept a copying order if, in its judgment, fulfillment of the order should involve violation of copyright law.

LIBRARY STAFF ONLY

Order received by:

Payment received by:

__ Cash __ Check __ 1180

MC/VISA Exp.

Date:

__ Eskind __ VMCL __ Other VUL:

V Not at VU Locations:

NLM/OCLC #:

Request received: DEC 09 1994

Article received:

the 92nd Annual Convention of the American Psychological Association, Toronto, 1984.
11. Jaffe P, Wilson S, Wolfe D. Promoting changes in attitudes and understanding of conflict resolution among child witnesses of family violence. Can J Behav Sci 1986; 18(4): 356-366.
12. Urgain ES, Kendall PC. Review of social-cognitive problem-solving interventions with children. Psychol Bull 1980; 88: 109-143.
13. Jaffe P, Wilson S, Wolfe D. Specific assessment and intervention strategies for children exposed to wife battering: preliminary empirical investigations. Canadian Journal of Community Mental Health 1988; 7(2).
14. Wolfe D, Edward B, Manion I, et al. Early intervention for parents at risk for child abuse and neglect: a preliminary investigation. J Consult Clin Psychol 1988; 56: 40-47.
15. White M. The externalizing of the problem and the re-authoring of lives and relationships in selected papers. Adelaide, South Australia: Dulwich Centre Publications, 1989.
16. James K, McIntyre D. A momentary gleam of enlightenment: towards a model of feminist family therapy. Journal of Feminist Family Therapy 1989; 1(3): 3-24.
17. Schechter S, Gary LT. In: Strauss M, ed. Abuse and victimization across the life span. Baltimore MD: Johns Hopkins University Press, 1988.
18. James K, McIntyre D. The reproduction of families: the role of family therapy. Journal of Marital and Family Ther 1983; 9: 119-129.
19. White M, Epston D. Literate means to therapeutic Adelaide, South Australia: Dulwich Centre Publications,
20. White M. The conjoint therapy of men who are violent the women with whom they live. Adelaide, South Au Dulwich Centre Publications, 1989.

Résumé

Cet article examine les implications cliniques de recherche existante sur les enfants qui sont témoins de lence. On souligne plusieurs scénarios typiques dans les les professionnels de la santé mentale ont réagi de inadéquate aux problèmes de la violence. D'autres stra gies possibles pour évaluer et traiter les enfants témoins violence sont proposées, ces dernières ayant une valeur la fois thérapeutique et préventive. Enfin, on suggère ég ment une approche d'évaluation et de traitement axée la famille, une approche qui pourrait être appropriée de nombreux cas.

Gender Identity Disorder and Psychosexual Problems in Children and Adolescents*

SUSAN J. BRADLEY, M.D.[1] AND KENNETH J. ZUCKER, PH.D.[2]

This article provides a selected overview of the literature on gender identity disorder and psychosexual problems in children and adolescents, with a focus on diagnosis, clinical course, etiology, and treatment.

This article will provide an overview of the broad range of gender identity disorders and psychosexual problems of childhood and adolescence. During childhood, the DSM-III-R (1) diagnosis of gender identity disorder of childhood (GIDC), or its subclinical variants, constitutes the major psychosexual disorder that the child psychiatrist will confront. During adolescence, however, gender identity disorders and psychosexual concerns appear much more similar to their adult counterparts and thus will be discussed in sections on transsexualism, transvestic fetishism, and homosexuality.

Both retrospective and prospective studies have now established that GIDC, or its subclinical variants, are strong precursors to the emergence of transsexualism (homosexual subtype, see Blanchard et al (2)) or a homosexual erotic orientation (3) in adolescence or adulthood. Many adult individuals experiencing severe gender dysphoria or homosexual concerns, however, will not have been seen clinically during childhood nor will they all have bona fide histories of GIDC, particularly transsexuals whose sexual orientation is nonhomosexual (2) and homosexual men and women, many of whom have childhood cross-gender histories that would not meet the complete DSM-III-R criteria for GIDC (4). Moreover, the majority of children who have been followed prospectively do not display post-pubertal gender dysphoria and a minority appear to develop a heterosexual erotic orientation (3). Accordingly, the presenting concerns will be dealt with as though they were distinct entities although the connections among these disorders will be discussed more fully later in this article.

Gender Identity Disorder of Childhood

In the DSM-III-R (1), it is stated that:

> The essential features of this disorder are persistent and intense distress in a child about his or her assigned sex and the desire to be, or insistence that he or she is, of the other sex. (This disorder is not merely a child's nonconformity to stereotypic sex-role behavior as, for example, in 'tomboyishness' in girls or 'sissyish' behavior in boys, but rather a profound disturbance of the normal sense of maleness or femaleness.) In addition, in a girl there is either persistent marked aversion to normative feminine clothing and insistence on wearing stereotypic masculine clothing, or persistent repudiation of her female anatomic characteristics. In a boy, there is either preoccupation with female stereotypic activities, or persistent repudiation of his male anatomic characteristics. This diagnosis is not given after the onset of puberty.

Revisions of the DSM-III-R criteria for GIDC are currently being considered by the DSM-IV Subcommittee on Gender Identity Disorder of Childhood and Transsexualism, under the auspices of the working group on child and adolescent psychiatric disorders (5). The changes, if accepted, will include 1. identical criteria for boys and girls; 2. elimination of the stated desire to be of the other sex as a distinct criterion; and 3. more specific behavioural criteria that characterize both the cross-gender identification and the discomfort and distress regarding one's assigned sex. A more detailed discussion of some of the problems with the current diagnostic criteria may be found elsewhere (6).

Epidemiology

No studies have formally assessed the prevalence of GIDC in the general population. Conservative estimates of prevalence might be inferred from data regarding the prevalence of transsexualism, which are usually based on the number of persons attending clinics serving as gateways for surgical and hormonal sex reassignment. Since not all gender-dysphoric adults make themselves known, this method may underestimate the prevalence of gender identity disorder (GID); in any case, the number of transsexuals

*Manuscript received April 1990.
[1]Consultant Psychiatrist, Child and Adolescent Gender Identity Clinic, Child and Family Studies Centre, Clarke Institute of Psychiatry; Psychiatrist-in-Chief, Department of Psychiatry, Hospital for Sick Children; Head, Division of Child Psychiatry, University of Toronto, Toronto, Ontario.
[2]Head, Child and Adolescent Gender Identity Clinic, Child and Family Studies Centre, Clarke Institute of Psychiatry; Assistant Professor, Departments of Psychology and Psychiatry, University of Toronto, Toronto, Ontario.
Address reprint requests to: Dr. Susan J. Bradley, Child and Family Studies Centre, Clarke Institute of Psychiatry, 250 College Street, Toronto, Ontario M5T 1R8

is small — according to one summary account, one in 24,000 to 37,000 men and one in 103,000 to 150,000 women (7).

The prevalence rate of gender identity disorder might also be derived from data regarding the prevalence of homosexuality. Unfortunately, this literature presents two main problems: first, the true prevalence of exclusive, or near exclusive, preferential homosexuality remains a matter of debate (8); second, the retrospective literature on childhood cross-gender behaviour in homosexual men and women often does not specify how to determine a cutoff score to dichotomize cases as cross-gendered versus not cross-gendered; and, as was noted earlier, cases classified as cross-gendered would not necessarily meet the complete DSM-III-R criteria for GIDC. Despite these problems, one could argue that GIDC, or its subclinical variants, may occur in two percent to five percent of children in the general population. Zucker (9) has reviewed studies that have assessed specific cross-gender behaviours in nonclinical populations, and Meyer-Bahlburg (7) has emphasized the importance in identifying the "zone of transition between clinically significant cross-gender behavior and mere statistical deviations from the gender norm."

Apart from issues of prevalence, there has been a consistent observation that boys are referred more often than girls for concerns regarding gender identity. Our clinic has probably the most systematic data on this point, with a referral ratio of 5.6:1 (N=146) of boys to girls. The true prevalence of GID may well be greater in boys than in girls, but social factors also appear to influence the higher referral rate for boys, since there are data suggesting that both peers and adults are more likely to tolerate cross-gender behaviour in girls than in boys. In addition, adults are less likely to predict atypical outcomes, such as homosexuality, in masculine girls than in feminine boys and are therefore less likely to be concerned about cross-gender behaviour in girls (9-11).

Clinical Course

Most parents report that the onset of cross-gender behaviours occurs during the preschool years, sometimes even prior to the age of two (12). This age period coincides, of course, with the appearance of more typical gender behaviours. From a conceptual standpoint, this would suggest that the underlying mechanisms for both patterns may be the same, albeit mirror images of each other (13).

In boys, the most common first signs of GID include cross-dressing, such as an interest in and wearing of the mother's clothing, shoes, and jewelry; cognitive gender confusion or mislabelling (for example, insisting that one is a girl); and preoccupation with feminine toys, such as Barbie dolls. In girls, the most common first signs of GID include intense anatomic dysphoria (for example, repetitive requests for a penis or insistence that she has one); cognitive gender confusion or mislabelling; and an intense aversion to wearing culturally typical feminine clothing, particularly dresses.

Over time, boys with GIDC develop a preference for girls as playmates and avoid the rough-and-tumble activities that more typically characterize the play of boys. Role playing is often that of a mother or other female figure; toy play often exclusively feminine and quite frequently includes preoccupation with combing the hair of female dolls (or even the mother herself); heroines, such as She-Ra, Gem, Wonder Woman (prominent television characters), are emulated and admired. Girls with GIDC develop a preference for boys as playmates, particularly in conjunction with stereotypical masculine role activities, such as fantasy aggression and competitive sports. Fantasy dress-up play is somewhat less prominent, in part because the "regular" clothing of these girls is sometimes so masculine that they naturally pass as boys. A common clinical concern of parents is that these girls have incredibly intense temper tantrums if required to wear feminine clothing, even if only for special occasions (for example, to attend religious services or a wedding). When interacting with non family members, these girls often invent boy's names or masculinize their given names.

These children often verbalize the wish to be of the opposite sex. When younger, a minority have even claimed to be of the opposite sex. Some of the boys attempt to emonstrate the fantasy of being female by hiding their genitalia between their legs. Lothstein (14) reported cases of three young boys who even went so far as to consider self-mutilation of their genitalia. Similarly, girls will insist that they have a penis or indicate that it is "hidden inside." In our clinic, the average age at assessment has been around seven to eight years of age. By this time, almost all children know that they are boys or girls, but may continue to present with some cognitive gender confusion, such as thinking that wearing the clothing of the opposite sex will actually change their gender status.

In our clinic, about half the referrals have been initiated by the parents because of their concern about their child's gender development (15). The other half are often referred on the suggestion of significant others, including teachers, pediatricians, and mental health professionals. Although parental ambivalence about the issue is commonly a part of the clinical picture (and must be addressed assuch), it appears to be more common when the referral is initiated from outside the family. We have also found that children who are referred at an earlier age have higher IQs, come from families who have higher socioeconomic backgrounds, and are more likely to live with both of their parents (6).

In our experience, some parents have had concerns about their child's gender identity development only to have these minimized by health professionals as being silly or exaggerated. Because this disorder does not typically appear to remit spontaneously, some parents will renew their concerns and eventually are referred for an assessment. Lothstein (16) has speculated on secular changes in gender role expectations for children and has suggested that this has inadvertently led to problems for some youngsters. He described mothers who had attempted to "masculinize" their daughters and "feminize" their sons in order to prepare them for ideologically new social roles." Unfortunately, they were not producing "androgynous" children, as they had hoped, but rather children who were evidencing a "stereotypical" opposite gender role which was frightening to their parents.

By middle childhood, the presence of effeminate vocal and motoric traits in boys, such as a high-pitched voice and exaggerated dorsiflexion of the wrist (17), often results in severe peer ostracism, which is clearly one correlate of the general behavioural psychopathology, such as depression and social withdrawal, that is part of the clinical picture (18). Chronic peer conflicts and social ostracism often lead school authorities to recommend clinical referral. By late childhood, however, many of these boys do not meet the complete criteria for GIDC (6,15), in part because these youngsters are more circumspect in describing gender dysphoric feelings in the presence of parents and significant others. In many cases, however, these boys would have met the DSM-III-R diagnostic criteria for GIDC when they were younger. It remains a matter of some debate whether the clinical picture has actually changed in these cases or whether it has been merely clouded by social desirability factors.

At the threshold of adolescence, many boys with GIDC (particularly those who have not been assessed or treated) have had profound failures in developing enduring same-sex friendships, continue to display some effeminate mannerisms, retain certain cross-gender interests and, in the most extreme cases, continue to wrestle with the fantasy of being a girl. Social isolation can become very prominent as these boys find that it is harder to interact socially with girls, who seem less interested in having a boy be part of their female peer group.

The course of GID during girls' childhood has been less well studied and described. Some of the girls are able to assimilate their intense interest in sports by joining all-girl's sports teams. Because of the greater flexibility in the gender role behaviour of girls, it is possible to enjoy same-sex friendships, as long as the behaviour of the peer group is not too conventionally feminine, as this remains difficult for gender dysphoric girls to tolerate. In extreme cases, however, girls with GIDC continue to socialize almost exclusively with boys, their masculine appearance is tolerated, if not reinforced, and the underlying wish to be of the opposite sex remains intact. Conflict with parents and peers about extensive cross-gender behaviour appears to emerge more intensely in early adolescence when it becomes apparent that the girl is experiencing acute uncertainty about her gender status and sexual orientation.

Green's (3) prospective study of extremely feminine boys found that 75% to 80% were either bisexual or homosexual at the time of their follow-up in adolescence or young adulthood. Other follow-up studies by Money and Russo (19), Zuger (20), and Davenport (21) have also yielded high rates of homosexuality — 100% in the series reported by Money and Russo (19)! Transsexualism, or at least intense gender dysphoria, has occurred at a rate much lower than would be predicted from retrospective studies, but at a rate higher than would be expected based on general population prevalence rates (6,22). Green (3) has provided some information on the predictors of a homosexual versus a heterosexual outcome. Several variables distinguished the subgroups; for example, the homosexual subgroup was more likely to continue to display feminine behaviours throughout childhood and to have spent less time with their fathers in the first two years of life (as gauged by parent report at the time of assessment during childhood).

Our own preliminary follow-up data of children with GIDC (23) and our clinical experience with transsexual adolescents (24) have led us to believe that the risk for post-pubertal gender dysphoria is greatest among those children living in families in which their has been a high tolerance for the continuation of the cross-gender behaviour. This often results in the child not being referred (among our adolescent transsexual cases, almost none were seen clinically during childhood) or the treatment is severely hampered by parental ambivalence or outright resistance. The lack of intervention or limit-setting on the part of the parents faciliates, in part, the development of a fixed fantasy of the self as of the opposite sex. When this continues into the adolescent years, request for hormonal and surgical sex reassignment is seen by the adolescent as the only solution to his or her gender dysphoria. Gay adolescents with a history of GIDC are also at risk for gender dysphoria. If they move into the "drag queen" subculture or are unable to find a niche in the more conventional parts of the gay community, then the fantasy of changing sex becomes more prominent.

Differential Diagnosis

During childhood, several differential diagnostic issues related to GIDC should be considered. There is a type of cross-dressing in boys that appears to be qualitatively different from the type of cross-dressing that characterizes GIDC. In the latter, cross-dressing typically involves outerwear, such as dresses, shoes, and jewelery, that helps enhance the fantasy of being like the opposite sex. In the former, cross-dressing involves the use of undergarments (for example, panties and nylons). Clinical data show that such cross-dressing is not accompanied by other signs of cross-gender identification; in fact, the appearance and behaviour of boys who engage in it are conventionally masculine. Clinical experience suggests that this type of cross-dressing has some sort of self-soothing function. Many male adolescents and adults who display fetishistic transvestism recall such cross-dressing during childhood. It should be noted, however, that prospective study has not verified the assumption that this behaviour pattern is contiguous with later transvestism.

When all the clinical signs of GIDC are present, it is not difficult to make the diagnosis. Clinical experience suggests, however, that one must also be sensitive to the psychological problems experienced by youngsters who display muted versions of the full clinical picture. Boys in this more ambiguous zone do poorly in male peer groups, avoid rough-and-tumble play, are disinclined toward athletics and other conventionally masculine activities, and feel somewhat uncomfortable about being male; however, these boys do not wish to be girls and do not show an intense preoccupation with femininity. Friedman (4) coined the term "juvenile uamasculinity" to describe such boys who, he argued, suffer from a "persistent, profound feeling of masculine inadequacy

which leads to a negative valuing of the self." It is not clear whether this behaviour pattern actually constitutes a distinct syndrome or is simply a mild form of GIDC; in any case, the residual diagnosis gender identity disorder not otherwise specified (1) could be employed in such cases.

In girls, the primary differential diagnostic issue concerns the distinction between GIDC and "tomboyism". The study of a community sample of tomboys by Green et al (25) found that these girls shared a number of cross-gender traits observed in clinic-referred gender-disturbed girls (26). In part, the DSM-III-R (1) criteria for GIDC in girls were modified in the hope of better differentiating these two groups of girls. At least three characteristics may be most useful in making the differential diagnosis: 1. by definition, girls with GIDC indicate an intense unhappiness with their status as females, whereas this should not be the case for tomboys; 2. girls with GIDC display an intense aversion to the wearing of culturally defined feminine clothing under any circumstances, whereas tomboys do not manifest this reaction, although they may prefer to wear casual clothing, such as jeans; 3. girls with GIDC, unlike tomboys, manifest a verbalized or acted-out discomfort with sexual anatomy.

Psychological Assessment

Various psychological assessment procedures have been developed for use with cross-gender identified children (6). These procedures include structured parent interviews regarding specific sex-typed behaviours, parent report on questionnaires, measurement of overt and covert sex-typed play in standardized situations, assessment of sex-typed motoric behaviour, and sex-typed indices on projective tests, such as the Draw-a-Person and Rorschach tests.

As noted in detail elsewhere (6), these procedures have been effective in discriminating index groups of gender-referred children from comparison groups, which have included sibling, psychiatric, and normal controls. Green (3), for example, found that a discriminant function analysis of parent interview data required six of 16 sex-typed behaviours to classify correctly all boys as members of either the feminine boy group or the male control group.

In general, it is important to note that tests utilized in isolation are particularly likely to yield both false positive and false negative "diagnoses". For these and other reasons, the use of psychological assessment procedures should attempt to identify patterns of cross-gender behaviour, rather than isolated elements (6), much as is done in a clinical assessment.

Etiology

Both biological and psychosocial factors have been considered relevant for a comprehensive understanding of the genesis and perpetuation of GIDC. Various ideas and models have been advanced by Green (3,10), Stoller (27-29), Rekers (30), Coates (31-33), Friedman (4), and Bates et al (34).

Several lines of investigation implicate the importance of biological factors (35-37). Animal studies in which the genetic female has been exposed to exogenous administrations of androgen have established that phenotypical masculine behaviours can be induced at a level greater than what would be found in controls. These behaviours include higher rates of aggressivity, rough-and-tumble play, and mounting. These changes can be induced only at certain times during fetal development, suggesting some type of sensitive period effect. This line of research has led to a great deal of theorizing regarding the organizing role of pre-natal sex hormones on the post-natal display of sex-dimorphic behaviour (38).

The influence of pre-natal sex hormones on human psychosexual behaviour has been studied through "experiments of nature," most notably several intersex conditions, and from the exogenous administration of sex steroids during pregnancy. Perhaps the studies of most interest have been of girls and women with congenital adrenal hyperplasia (CAH), in this genetically determined abnormality the adrenal gland fails to produce normal amounts of corticosteroids. The resultant increase in adrenocorticotropic hormone secretion causes an increase in testosterone production and the subsequent masculinization of the external genitalia. The greater amount of cross-gender behaviour observed in girls with CAH has been attributed, at least in part, to the elevation of testosterone production in utero (39,40). Although they are more masculine in gender-role behaviour, the evidence is much less clear with regard to frank gender identity disorder (41), particularly for those youngsters treated for the condition with post-natal cortisone therapy and who were assigned to the female sex early in life. Money (42) has attributed severe gender identity conflict, when it is present, to poor medical management of cortisone therapy, lack of cosmetic corrective surgery on the genitalia, and chronic parental uncertainty regarding the child's true sex. Because many CAH girls express at least some ambivalence regarding their gender status (39), it is probably advisable to do some monitoring of their gender identity development. The most recent long term follow-up studies of girls with CAH suggest that there is a higher than expected rate of bisexual and homosexual fantasy and behaviour (43,44) and lowered rates of marriage and sexual experience (45).

Drawing primarily on animal experiments, Dörner has proposed that both transsexualism (homosexual subjects) and homosexuality are the result of a hormonal abnormality in utero which produces a differentiation of the hypothalamic centre contrary to the individual's genetic sex. Some support for this position has come from estrogen challenge studies which have shown that homosexual men have a luteinizing hormone response between that of heterosexual men and women (47,48). Other studies have not replicated the pattern (49,50), but methodological issues may be part of the explanation; in general, the status of Dörner's theory remains hotly debated (35,51-54) and more empirical data are required.

Despite the obvious relevance of this work for the understanding of GID, it is important to note that it is quite rare for a specific hormonal anomaly to be found in children with GIDC. Nevertheless, there has been speculation that more pronounced variations in pre-natal hormonal influences account, in part, for intrasex differences in the expression of sex-dimorphic behaviour. Consider, for example, rough-and-tumble play (RTP) and activity level (AL) in boys. Boys with GIDC usually dislike RTP (3,10) and appear to have a relatively low AL. In contrast, girls with GIDC have a high AL and appear to enjoy RTP (26). Both of these behaviours show a strong sex dimorphism (55). It is likely that these two behaviours, which are probably closely related, are at least partly determined by biological factors. The high energy level of both boys and girls with CAH lends some support to this suggestion (40).

The predisposing role of biological factors in psychosexual development is accepted by the majority of contemporary sex researchers. Psychosocial factors have also been the subject of study and it is the integration of biological and psychological factors that has become the subject of diverse enquiry. Nevertheless, it is important to note that in certain aspects of psychosexual development, psychological processes may have the upper hand. Based on the research done by Money et al (56) on intersex children in the 1950s, for example, it is generally believed that sex of assignment and consistent, unambivalent rearing patterns override biological factors in the establishment of gender identity.

There has, however, been a recent challenge to this perspective by Imperato-McGinley et al (57), based on their studies of individuals with 5-alpha-reductase deficiency. They studied a multigenerational family pedigree in the Dominican Republic, in which many individuals were affected with this condition. Although "assigned" at birth to the female gender, these individuals experienced physical masculinization at puberty and the majority showed a "reversal" in gender identity and began to live socially as males. Similar findings have been reported by Rösler and Kohn (58) among an Arab population living in the Gaza Strip. The main interpretive criticism of the findings of Imperato-McGinley et al (57) has been that their patients were, in fact, reared ambiguously and that this contributed heavily to the reversal in gender identity subsequent to pubertal virilization (59).

Psychosocial factors have been posited as being particularly salient in the development of GIDC. Stoller (27) has argued that some of these boys have an overly close "blissfully symbiotic" relationship with a mother who herself has had gender identity conflicts. For Stoller, GID is a kind of "developmental arrest...in which an excessively close and gratifying mother-infant symbiosis, undisturbed by father's presence, prevents a boy from adequately separating himself psychically from his mother's female body and feminine behavior" (29). Coates and her colleagues (31-33,60) also have emphasized the intense relationship with the mother but question Stoller's concept of blissful symbiosis. In fact, they argue that the relationship is characterized by much unpredictability, which induces severe separation anxiety in the boy (33). Cross-gender behaviour then emerges to "restore a fantasy tie to the physically or emotionally absent mother. In imitating 'Mommy' [the boy] confuse[s] 'being Mommy' with 'having Mommy.' [Cross-gender behaviour] appears to allay, in part, the anxiety generated by the loss of the mother" (33). Maternal depression and personality psychopathology appear to form an important part of the clinical picture in the first few years for a significant percentage of cases (27,60,61).

Parental tolerance, or even encouragement, of the nascent cross-gender behaviour also appears to be an extremely important part of the clinical picture (3,10). Green (10) has shown that the degree of approval of initial cross-gender behaviour in boys correlated with a composite index of cross-gender behaviour at the time of the initial assessment. In our experience, such toleration or reinforcement appears to be accounted for by many factors, including parental attitudes and values regarding psychosexual ideals, feedback from professionals that the behaviour is normative or "just a phase," and parental psychopathology and discord, which render the parents less available to cope with their children's developmental needs.

Empirical studies on parent-child relationships in girls with GID have not been conducted. Clinical observations (10,26,62,63) suggest that the mother-daughter relationship is often impaired, leading to what might be described as a "disidentification" from the mother. During the girl's early years, a variety of factors appear to impair the development of a close mother-daughter relationship. In our own clinic, severe maternal depression or personality psychopathology has been an important part of the familial situation; as a result, there is a devaluing of femininity and an overvaluing of masculinity. In part, these processes seem to be encouraged by the parents.

The role of fathers has been more variable. In some instances, the girls seem to connect more with their fathers simply because they are more available, given the maternal dysfunction. In other cases, the girls seem to adopt a masculine stance as a defensive solution to perceived or actual paternal aggression — the term "identification with the aggressor" has been used in the clinical literature to describe this phenomenon. These preliminary clinical studies suggest, therefore, that the quality of parent-child relationships are quite different in gender-disturbed boys and girls. The tolerance of cross-gender behaviour as it first appears, however, appears to be characteristic of the parents of both gender-disturbed boys and girls.

Certain child characteristics, including undue sensitivity, poor anxiety tolerance, and borderline personality traits, have also been considered to be part of the clinical picture (61,64). Children with GIDC have been shown to score as highly as clinical controls on various measures of behavioural disturbance (9,18,33,65).

Based on these varied factors, Bradley (61,66) has developed the following conceptual framework which hopefully will have heuristic clinical value in understanding individual cases. In boys, the scenario is viewed as follows: The boy has a temperamental predisposition to poor anxiety tolerance. During his infancy, his mother feels depressed and overwhelmed in relation to her own difficulty dealing with the demands of parenting, her husband's nonsupportiveness, or other difficulties related to either illness in the child or in other members of the family. More often than not, this mother has ambivalent feelings towards males, which her

sensitive son perceives. As well, this child may observe his mother's preference of female siblings or experience a sense that his mother would prefer him as "female" and as "nurturing" or supportive of her. In this context, the boy, who is in the midst of consolidating his gender identity, may, in an effort to obtain his mother's valuing, begin to act in a feminine manner. Parental conflict, often revolving around the father's absence or nonsupport of the mother, further increases the child's insecurity. Difficulty with affect regulation reinforces the child's need to diminish his felt distress and to find ways of feeling more secure, a function which the cross-dressing and other feminine behaviours seems to serve. When this behaviour is not discouraged, the child begins to develop a sense of himself as being valued for the feminine characteristics that he displays and as devalued for the masculine characteristics that he might have. As the child enters the world of peers, his predisposition to avoid rough-and-tumble play and nascent interest in feminine activities leads him to join in the play of girls. Parental reactions, such as the father's withdrawal, further his sense of devaluation. Usually, parents start to become uncomfortable with what they have been perceiving as a "phase" that the child has not outgrown. Their discouragement of the behaviour at this point, if not accompanied by other manifestations of their valuing of the child, may drive the behaviour "underground", leaving the child clinging to an internal but valued feminine self. As the child moves through middle childhood, he becomes increasingly isolated because of peer rejection and may spend considerable time in a fantasied elaboration of his female self.

In girls, the scenario is viewed as follows. The girl has a temperamental predisposition to poor anxiety tolerance, but she is also oriented to activity and motion. She lives in a family in which the mother is seen as depressed or inadequate while the father tends to be aggressive or to have a negative or devalued view of women. There may be overt conflict interpreted as threatening to a mother who is seen as unable to defend herself. As a way of defending herself against overwhelming anxiety, she utilizes the maneuveur of "identifying with the aggressor." She may then in fantasy both protect herself and her mother. If the need for this defense continues and is not discouraged by parents, the girl will begin to consolidate a fantasied self as a male. Because of the greater acceptance of masculine behaviour in girls, she may not experience the same negative effect on her self-esteem that boys with GIDC endure.

Treatment

Several therapeutic strategies have been employed to treat children with GIDC, including behaviour therapy, psychotherapy, family therapy, parental counseling, group therapy, and eclectic combinations of these approaches (3,9,10,67,68). As reviewed elsewhere (9,67,68), it would appear that all of these strategies have shown clinical utility; unfortunately, formal comparative studies have not been conducted, so the most efficacious types of treatment remain unclear.

Three general (rather than specific) comments on treatment will be made. First, clinical experience suggests that intervention during childhood can more readily reduce gender identity conflict than intervention during adolescence or adulthood. The prognosis is rather poor for reducing severe gender dysphoria after puberty. Accordingly, the earlier treatment is begun, the better. Second, there has been much discussion in the literature regarding the importance of working with the families of children with GIDC. When there is a great deal of family discord and parental psychopathology, treatment of these problems will greatly facilitate more specific work on the gender identity issues. Management of the child's cross-gender behaviour in his daily environment requires that the parents have clear goals and a forum in which to discuss difficulties. Because parental dynamics and ambivalence about the child may contribute to the perpetuation of the disorder (66), it is important for the therapist to have an appropriate relationship with the parents in order to address and work through these issues. Lastly, the therapist needs to consider closely the goals of treatment (3,9,10,67,68,70). In part, this issue will be conceptualized within the therapist's own theoretical framework, but will also be a function of parental concerns and, to a lesser extent, the concerns of the child. Two short term goals have been discussed in the literature: the reduction or elimination of social ostracism and conflict and the alleviation of underlying or associated psychopathology. Longer term goals have focused on the prevention of transsexualism and/or homosexuality. In the clinical literature, there has been little discussion about the advisability of preventing gender dysphoria in adolescence or adulthood. Contemporary and secular-minded clinicians are, however, much more sensitive to the importance of helping people integrate a homosexual orientation into their sense of identity (3,4). Not surprisingly, however, the development of a heterosexual orientation is probably preferred by most parents of children with GIDC. It is important, therefore, that clinicians point out that, as of yet, there is no clear evidence either way as to the effectiveness of treatment for sexual orientation. Both authors, as well as other experienced clinicians in the field, have preferred to emphasize the goal of reducing childhood gender identity conflict per se and orient the parents to the short term goals of intervention.

Gender Identity and Psychosexual Problems in Adolescence

The DSM-III-R (1) does not adequately address the spectrum of psychosexual concerns during the adolescent years. Based on our clinical experience with 130 adolescents referred for gender identity or psychosexual problems, we have developed a practical classification system, consisting of four categories: 1. transsexuals or gender dysphorics; 2. transvestites; 3. homosexuals; and 4. uncertain or undifferentiated. Each of these patient groupings will be discussed in turn.

Transsexuals

About 25% of our adolescent sample presented with a request for sex reassignment or with severe gender identity confusion. As with some adult transsexuals, the wish for sex reassignment seems to serve as a way of "normalizing" unacceptable homosexual feelings. With supportive therapy, some of these individuals will accept themselves as homosexual and relinquish the cross-sex wish. Others will decide that no matter why they feel the way that they do (that is, no matter how much "insight" they may have), being able to "be" who they feel they are internally is the only way that they can live comfortably.

Most adolescents who present with the request for sex reassignment have had a history of early cross-gender behaviour and the majority would have met DSM-III-R (1) criteria for GIDC. As noted earlier, these youngsters have rarely been seen for therapy in childhood and their parents have hardly ever attempted to limit their cross-gender behaviour. These youngsters often are psychosocially impaired and suicidal ideation and/or attempts are common (24). Supportive therapy can help reduce psychosocial impairment and help the patient develop a more realistic understanding of what hormonal and surgical sex reassignment can achieve. Referral to adult gender identity clinics is usually appropriate between the ages of 16 and 18.

Transvestites

About 30% of our adolescent sample were males who had been engaging in various degrees of fetishistic cross-dressing. They are almost never self-referred. More commonly, they are discovered by a parent or parental surrogate to be stealing female undergarments or cross-dressing. As with adults, the use of cross-dressing serves both sexual and anxiety-reducing functions. Some of the younger adolescents, however, claim that they are not sexually aroused by the cross-dressing, but simply like to hold or wear the undergarments or even to have them nearby. Unfortunately, the percentage of patients for whom transvestism represents a transient phenomenon or is actually the beginning of a paraphilic disorder is not yet clear.

Our sample of adolescent transvestites has shown a rather consistent set of associated features. In general, their parents or parental surrogates describe them as having a great deal of behavioural psychopathology and many meet diagnostic criteria for conduct disorder or other externalizing disorders. There is often a longstanding history of school related difficulties and evidence for relative deficits in verbal intelligence, including expressive language disorder. Unlike our other three groups of adolescent patients, the transvestite youngsters do not show a childhood history of gender identity disorder, although about 35% manifested a pre-pubertal onset of fetishistic cross-dressing. Their sexual orientation is almost always heterosexual. In adults, it is well known that transvestism can evolve into transsexualism (non-homosexual type) (2). Because this usually does not occur until middle age, it may explain why only a very small number of our adolescents acknowledge frank gender dysphoria. It is not clear whether these youngsters will continue to feel this way or whether it is simply a phenomenon secondary to the cross-dressing.

Clinical experience suggests that these boys have marked conflicts with their mothers or maternal surrogates. Bradley (66) has observed that these boys have considerable difficulty asserting themselves, especially in relationships with their mothers, whom they often perceive as impossibly dominating. We have not found these boys to have been cross-dressed by their parents as a form of punishment during childhood, which is part of the clinical folklore regarding adult transvestism (1).

The motivation for therapy in this group is quite varied. One strategy is to assist the adolescent in finding more functional ways to deal with feelings of anger. Therapy needs to address the long term consequences of using clothing for erotic purposes. Development of masturbatory fantasy sequences without the use of clothing is an important part of the therapeutic intervention.

Homosexuals

About 25% of the adolescent patients in our sample were referred because they experienced their sexual orientation as ego-alien or because significant others were distressed by it. As has been found in retrospective studies of adults, the majority of our adolescent homosexual sample has a significant clinical history of cross-gender behaviour (24).

Some male adolescents who experience homosexual attractions have, however, had little earlier cross-gender behaviour except for avoidance of rough-and-tumble activities and involvement in competitive sports. Nevertheless, they feel somewhat estranged and different from their adolescent same-sex peers. If involved in homosexual experiences, some of these youngsters become quite confused and distressed about their sexual orientation. Anxious and obsessive adolescents may be particularly prone to overinterpret the significance of these experiences.

Assessment of this subgroup involves exploration of the extent of their earlier cross-gender history and their present and past erotic experiences in both fantasy and behaviour. As has been found with adults, it is highly unlikely that an adolescent who presents with a primary homosexual erotic orientation will show a substantive shift in a heterosexual direction, even if the individual is motivated to do so. Accordingly, therapy should be primarily supportive in helping the youngster develop a gay-positive identity and to help the family accept their adolescent's sexual orientation.

For adolescents who are uncomfortable with homoerotic feelings or who have had extensive bisexual experiences or fantasies, therapy can prove useful in helping the youngster understand the meaning of his or her feelings of attraction to same-sex individuals, some of which may be motivated more by the desire for closeness than for pure erotic purposes. For some adolescents, supportive therapy can help them explore their most comfortable sexual orientation. The approach described by Masters and Johnson (71) with homosexual adults may be used with adolescents wishing to explore the possibility of a heterosexual adaptation.

Uncertain

The remaining 20% of our adolescent sample were youngsters who do not fit into any of the first three categories.

They were referred at an earlier mean age than the other groups of youngsters. Clinically, they appeared to show behavioural characteristics most like that of the transsexual and homosexual groups. The most common reason for referral was that they were experiencing considerable social ostracism because of the continued expression of several cross-gender traits. In boys, for example, continued effeminacy and alienation from the male peer group resulted in considerable stress. At the time of referral, there was clear evidence of cross-gender identification which is, in a sense, a continuation of GIDC or its subclinical variants. At the time of the assessment, however, the adolescent youngster did not voice gender dysphoric feelings sufficient to receive a DSM-III-R diagnosis nor did they acknowledge a homosexual erotic orientation. Accordingly, it is not possible to classify these youngsters in either the transsexual or the homosexual categories. Preliminary follow-up data on some of these youngsters showed that most became homosexual, and a couple have become gender dysphoric (72).

Some of these adolescents are interested in getting help to control their effeminate mannerisms, in order to become less obvious targets for social teasing. In general, it has been our experience that very few of these youngsters are interested in therapy to explore their gender identity or sexual orientation. Supportive therapy dealing with social skills, assertiveness, and eventually their emerging sexuality, has proven helpful in some cases.

References

1. Diagnostic and statistical manual of mental disorders, third edition, revised. Washington DC: American Psychiatric Press, Inc., 1987.
2. Blanchard R, Clemmensen LH, Steiner BW. Heterosexual and homosexual gender dysphoria. Arch Sex Behav 1987; 16: 139-152.
3. Green R. The "sissy boy syndrome" and the development of homosexuality. New Haven CT: Yale University Press, 1987.
4. Friedman RC. Male homosexuality: a contemporary psychoanalytic perspective. New Haven CT: Yale University Press, 1988.
5. Shaffer D, Campbell M, Cantwell D, et al. Child and adolescent psychiatric disorders in DSM-IV: issues facing the work group. J Am Acad Child Adolesc Psychiatry 1989; 28: 830-835.
6. Zucker KJ. Gender identity disorder. In: Hooper SR, Hynd GW, Mattison RE, eds. Assessment and diagnosis of child and adolescent psychiatric disorders: current issues and procedures, volume I. Hillsdale NJ: Erlbaum (in press).
7. Meyer-Bahlburg HFL. Gender identity disorder of childhood: introduction. J Am Acad Child Psychiatry 1985; 24: 681-683.
8. Fay RE, Turner CF, Klassen AD, et al. Prevalence and patterns of same-gender sexual contact among men. Science 1989; 243: 338-348.
9. Zucker KJ. Cross-gender-identified children. In: Steiner BW, ed. Gender dysphoria: development, research, management. New York: Plenum Press, 1985.
10. Green R. Sexual identity conflict in children and adults. New York: Basic Books, 1974.
11. Zucker KJ. Gender identity disorders. In: Last CG, Hersen M, eds. Handbook of child psychiatric diagnosis. New York: John Wiley and Sons, 1989.
12. Green R. One-hundred ten feminine and masculine boys: behavioral contrasts and demographic similarities. Arch Sex Behav 1976; 5: 425-446.
13. Cicchetti D. The emergence of developmental psychopathology. Child Dev 1984; 55: 1-7.
14. Lothstein LM. Selfobject failure and gender identity. In: Goldberg A, ed. Frontiers in self psychology, volume 3. Hillsdale NJ: Analytic Press, 1988.
15. Zucker KJ, Finegan JK, Doering RW, et al. Two subgroups of gender-problem children. Arch Sex Behav 1984; 13: 27?
16. Lothstein LM. Female-to-male transsexualism: historical, clinical, and theoretical issues. Boston MA: Routledge & Kegan Paul, 1983: 248.
17. Rekers GA, Morey SM. Sex-typed body movements as a function of severity of gender disturbance in boys. Journal of Psychology and Human Sexuality 1989; 2: 183-196.
18. Zucker KJ. Psychosocial and erotic development in cross-gender identified children. Can J Psychiatry 1990; 35: 487-495.
19. Money J, Russo AJ. Homosexual outcome of discordant gender identity/role longitudinal follow-up. J Pediatr Psychol 1979; 4: 29-41.
20. Zuger B. Early effeminate behavior in boys: outcome and significance for homosexuality. J Nerv Ment Dis 1984; 172: 90-97.
21. Davenport CW. A follow-up study of 10 feminine boys. Arch Sex Behav 1986; 15: 511-517.
22. Zucker KJ. Gender identity disorders in children: clinical descriptions and natural history. In: Blanchard R, Steiner BW, eds. Clinical management of gender identity disorders in children and adults. Washington DC: American Psychiatric Press, Inc. (in press).
23. Zucker KJ, Bradley SJ. Gender identity and sexual orientation in cross-gender-identified children: a follow-up in adolescence. Paper presented at the meeting of the Society for Research in Child and Adolescent Psychopathology, Miami, February, 1989.
24. Bradley SJ, Zucker KJ, Gladding J, et al. Gender-dysphoric adolescents: presenting and developmental characteristics. Paper presented at the joint meeting of the American Academy of Child Psychiatry and Canadian Academy of Child Psychiatry, Toronto ON, October, 1984.
25. Green R, Williams K, Goodman M. Ninety-nine "tomboys" and "non-tomboys": behavioral contrasts and demographic similarities. Arch Sex Behav 1982; 11: 247-266.
26. Zucker KJ. Girls with the gender identity disorder of childhood. Paper presented at the meeting of the Society for Therapy and Research, Tucson AZ, March 1989.
27. Stoller RJ. Sex and gender, volume I. The development of masculinity and femininity. New York: Science House, 1968.
28. Stoller RJ. Sex and gender, volume II. The transsexual experiment. London: Hogarth Press, 1975.
29. Stoller RJ. Presentations of gender. New Haven CT: Yale University Press, 1985.
30. Rekers GA. Assessment and treatment of childhood gender problems. In: Lahey BB, Kazdin AE, eds. Advances in clinical child psychology, volume 1. New York: Plenum Press, 1
31. Coates S. Extreme boyhood femininity: overview and research findings. In: DeFries Z, Friedman RC, Corn R, eds. Sexuality: new perspectives. Westport CT: Greenwood, 1985.
32. Coates S. Ontogenesis of boyhood gender identity disorder. J Am Acad Psychoanal (in press).
33. Coates S, Person ES. Extreme boyhood femininity: isolated behavior or pervasive disorder? J Am Acad Child Psychiatry 1985; 24: 702-709.
34. Bates JE, Skilbeck WM, Smith KVR, et al. Gender role abnormalities in boys: an analysis of clinical ratings. J Abnorm Child Psychol 1974; 2: 1-16.
35. Meyer-Bahlburg HFL. Psychoendocrine research on sexual orientation: current status and future options. Prog Brain Res 1984; 61: 375-398.
36. Gladue BA. Psychobiological contributions. In: Diamant L, ed. Male and female homosexuality: psychological approaches. New York: Hemisphere Publishing Corporation, 1987.
37. Zucker KJ, Green R. Gender identity disorders in children and adolescents. In: Lewis M, ed. Child and adolescent psychiatry: a comprehensive textbook. Baltimore MD: Williams & Wilkins (in press).
38. Keverne EB, Vellucci SV. Social, endocrine and pharmacological influences on primate sexual behavior. In: Sitsen JMA, ed. Handbook of sexology, volume 6. The pharmacology and endocrinology of sexual function. Amsterdam: Elsevier, 1988.
39. Ehrhardt AA, Baker SW. Fetal androgens, human central nervous system differentiation, and behavior sex differences. In: Friedman RC, Richart RM, Vande Wiele RL, eds. Sex differences in human behavior. New York: John Wiley and Sons, 1974.
40. Berenbaum SA. Congenital adrenal hyperplasia: intellectual and psychosexual functioning. In: Holmes CS, ed. Psychoneuroendocrinology: brain, behavior, and hormonal interactions. New York: Springer-Verlag, 1990.
41. Zucker KJ, Bradley SJ, Hughes HE. Gender dysphoria in a child with true hermaphroditism. Can J Psychiatry 1987; 32(7): 602-609.
42. Money J. Psychologic approach to psychosexual misidentity with elective mutism: sex reassignment in two cases of hyperadrenocortical hermaphroditism. Clin Pediatr 1968: 7: 331-339.
43. Money J, Schwartz M, Lewis VG. Adult erotosexual status and fetal hormonal masculinization and demasculinization: 46,XX congenital virilizing adrenal hyperplasia and 46,XY androgen-insensitivity syndrome compared. Psychoneuroendocrinology 1984; 9: 405-414.
44. Dittman RW. Pranatal wirksame Hormone und Verhaltensmerkmale von Patientinnen mit den beiden klassichen Varianten des 21-Hydroxylase-Defektes. New York: Peter Lang, 1989.
45. Mulaikal RM, Migeon CJ, Rock JA. Fertility rates in female patients with congenital adrenal hyperplasia due to 21-hydroxylase deficiency. N Engl J Med 1987; 316: 178-182.
46. Dörner G. Neuroendocrine response to estrogen and brain differentiation in heterosexuals, homosexuals, and transsexuals. Arch Sex Behav 1988; 17: 57-75.
47. Dörner G, Rohde W, Stahl F, et al. A neuroendocrine predisposition for homosexuality in men. Arch Sex Behav 1975; 4: 1-8.
48. Gladue BA, Green R, Hellman RE. Neuroendocrine response to estrogen and sexual orientation. Science 1984; 225: 1496-1499.
49. Gooren L. The neuroendocrine response of luteinizing hormone to estrogen administration in heterosexual, homosexual and transsexual subjects. J Clin Endocrinol Metab 1986; 63: 583-588.
50. Hendricks SE, Graber B, Rodriguez-Sierra JF. Neuroendocrine responses to exogenous estrogen: no differences between heterosexual and homosexual men. Psychoneuroendocrinology 1989; 14 177-185.
51. Baum MJ, Caroll RS, Erskine MS, et al. Neuroendocrine response to estrogen and sexual orientation (letter). Science 1985; 230: 960-961.
52. Gladue BA. Hormones in relationship to homosexual/bisexual/heterosexual gender orientation. In: Sitsen JMA, ed. Handbook of sexology, volume 6. The pharmacology and endocrinology of sexual function. Amsterdam: Elsevier, 1988.
53. Gooren LJG. An appraisal of endocrine theories of homosexuality and gender dysphoria. In: Sitsen JMA, ed. Handbook of sexology, volume 6. The pharmacology and endocrinology of sexual function. Amsterdam: Elsevier, 1988.
54. Money J. Gay, straight, and in-between: the sexology of erotic orientation. New York: Oxford University Press, 1988.
55. Eaton WO, Enns LR. Sex differences in human motor activity level. Psychol Bull 1986; 100: 19-28.
56. Money J, Hampson JG, Hampson JL. Imprinting and the establishment of gender role. Arch Neurol Psychiatry 1957; 77: 333-336.
57. Imperato-McGinley J, Peterson RE, Gautier T, Sturla E. Androgens and the evolution of male gender identity among male pseudohermaphrodites with 5-alpha-reductase deficiency. N Engl J Med 1979; 300: 1233-1237.
58. Rösler A, Kohn G. Male pseudohermaphrodites due to 17β-hydroxysteroid dehydrogenase deficiency: studies on the natural history of the defect and effect of androgens on gender role. J Steroid Biochem 1983; 19: 663-674.
59. Rubin RT, Reinisch JM, Haskett RF. Postnatal gonadal steroid effects on human behavior. Science 1981; 211: 1318-1324.
60. Marantz SA. Mothers of extremely feminine boys: psychopathology and childrearing patterns (dissertation). New York: New York University, 1984.
61. Bradley SJ. Gender dysphorias in childhood: a formulation. In: Steiner BW, ed. Gender dysphoria: development, research, management. New York: Plenum Press, 1985.
62. Bradley SJ. Female transsexualism: a child and adolescent perspective. Child Psychiatry Human Devel 1980; 11: 12-18.
63. Stoller RJ. Etiological factors in female transsexualism: a first approximation. Arch Sex Behav 1972; 2: 47-64.
64. Tuber S, Coates S. Indices of psychopathology in the Rorschachs of boys with severe gender identity disorder: a comparison with normal control subjects. J Pers Assess 1989; 53: 100-112.
65. Bates JE, Bentler PM, Thompson SK. Gender-deviant boys compared with normal and clinical control boys. J Abnorm Child Psychol 1979; 7 243-259.
66. Bradley SJ. Gender dysphorias of childhood and adolescence. In: Garfinkel BD, Carlson GA, Weller EB, eds. Psychiatric disorders in children and adolescents. Philadelphia PA: W.B. Saunders Co., 1990.
67. Zucker KJ, Green R. Gender identity disorder of childhood. In: Karasu TB, ed. Treatments of psychiatric disorders, volume 1. Washington DC: American Psychiatric Press, Inc., 1989.
68. Zucker KJ. Treatment of gender identity disorders in children. In: Blanchard R, Steiner BW, eds. Clinical management of gender identity disorders in children and adults. Washington DC: American Psychiatric Press, Inc. (in press).
69. Newman LE. Treatment for the parents of feminine boys. Am J Psychiatry 1976; 133: 683-687.
70. Coates S, Zucker KJ. Gender identity disorders in children. In: Kestenbaum CJ, Williams DT, eds. Handbook of clinical assessment of children and adolescents, volume II. New York: New York University Press, 1988.

71. Masters WH, Johnson VE. Homosexuality in perspective. Boston MA: Little Brown and Co., 1979.
72. Zucker KJ, Bradley SJ, Gladding JA. A follow-up study of transsexual, transvestitic, homosexual, and "undifferentiated" adolescents. Paper presented at the meeting of the International Academy of Sex Research, Amsterdam, September 1986.

Résumé

Dans cet article on trouve un résumé sélectif de la littérature traitant des troubles de l'identité sexuelle et des problèmes psychosexuels chez l'enfant et l'adolescent. On met l'accent sur le diagnostic, le tableau clinique, l'étiologie et le traitement.

Psychosocial and Erotic Development in Cross-Gender Identified Children*

KENNETH J. ZUCKER, Ph.D.[1]

This article reviews certain aspects of psychosocial and erotic development in cross-gender identified children. Consideration is first given to the hypothesis that cross-sex affiliation preference and its attendant social ostracism is one factor that accounts for the presence of behavioural psychopathology in cross-gender identified boys. Next, the strong relation between patterns of childhood sex-typing and later sexual orientation is discussed. It is concluded that more attention should be given to the study of erotic development in its own right.

Children who identify strongly with the sex-typed characteristics of the opposite sex have been the subject of both research and clinical study since the early 1960s (1). The following vignette describes the main behavioural characteristics of such children:

Andy, age three and one half (IQ=138), was referred for assessment at the suggestion of the staff at his daycare and with his parents' agreement. Since the age of two and one half, Andy had shown a wide range of cross-gender behaviours. He liked to wear long scarves and beads on his head to simulate long hair, and to wear women's clothing (for example, skirts to daycare and a nightgown to bed). He played primarily with female dolls, such as Barbie and Princess Leah, identified with the female role during story-time and fantasy play, and associated exclusively with girls. He stated repeatedly to his parents that he wanted to grow up to be a mommy, that he would never be a daddy, and that he hated men. During the months preceding the referral, Andy had insisted that he was a girl and had a vulva, not a penis, and he always sat to urinate.

Psychological testing generally confirmed the clinical impression of marked cross-gender identification. On the Draw-a-Person test, Andy was unable to draw humans, although he did identify his first "lines" as a girl. When asked to draw his parents, he commented that there were "no boys in my family; I have two mommies." On a sex-typed free play test, his behaviour was exclusively feminine. He spent most of the time combing a Barbie doll's hair and wearing female dress-up apparel. Tests of gender constancy indicated that Andy could discriminate males from females; however, he identified himself as a girl, thought of himself as a girl when he was a "little baby," and expected to be a "mommy" in adulthood. He denied that he was a boy. Not surprisingly, he claimed that he (or a hypothetical boy) would be a girl if he played girls' games or wore girls' clothes. On the Rorschach test, gender identity themes were prominent: the gender of the percepts fluctuated ("it's a girl crab; no, it's a boy crab"), femininity was positively connoted ("ohh, a beautiful butterfly...just the white and the butterfly with long wings, that's a girl), and masculinity was negatively connoted ("a cat...no, it's a girl wolf...boy wolves aren't good, they're bad", "it's a big giant, and it's ugly...he's coming to gets ladies...and scares them.").

This child's behaviour represents the extreme of cross-gender identification — there appears to be a misclassification of gender identity and a strong preference for cross-gender role behaviour. The main difference between Andy's behaviour and the behaviour of other cross-gender identified children involves his misclassification of gender — when initially assessed, most of these children know which sex they are, although they wish to be of the other sex (2-4). Although Andy's misclassification of gender is probably age-related, his high IQ would militate against it (5). The purpose of this article is to focus on some of the psychosocial and psychosexual characteristics of such children.

As noted by Cicchetti (6), many developmental psychopathologists employ a working model in which normality and deviance are viewed as two sides of the same coin. Thus, in the study of childhood cross-gender identification, reference is often made to the mechanisms that purportedly underlie "conventional" gender development. Consider, for example, the long line of research on the relation between father absence and sex role behaviour in boys. A primary assumption has been that father presence was crucial for "normal" gender development to occur. Empirical study has only weakly supported this broad claim (7), though it is of interest that the prevalence of father absence in the families of extremely feminine boys is rather high (8,9). Subsequent approaches have focused on more specific aspects of the father-son relationship, including both the quantity and

*Portions of this paper were presented at the meetings of the American Orthopsychiatric Association, Toronto, April 1984 and the International Academy of Sex Research, Tutzing, West Germany, June 1987.

Manuscript received September 1989.

[1]Head, Child and Adolescent Gender Identity Clinic, Child and Family Studies Centre, Clarke Institute of Psychiatry, Toronto, Ontario.
Address reprint requests to: Kenneth J. Zucker, Ph.D., Child and Family Studies Centre, Clarke Institute of Psychiatry, 250 College Street, Toronto, Ontario M5T 1R8

April 24

DSM IV

Amer. Psychiatric Assoc

1994

Gender Identity Disorders

Gender Identity Disorder

Diagnostic Features

(1) There are two components of Gender Identity Disorder, both of which must be present to make the diagnosis. There must be evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex

(Criterion A). This cross-gender identification must not merely be a desire for an perceived cultural advantages of being the other sex. There must also be evidence o persistent discomfort about one's assigned sex or a sense of inappropriateness in th gender role of that sex (Criterion B). The diagnosis is not made if the individual has concurrent physical intersex condition (e.g., androgen insensitivity syndrome or con genital adrenal hyperplasia) (Criterion C). To make the diagnosis, there must be evidenc of clinically significant distress or impairment in social, occupational, or other importar areas of functioning (Criterion D).

(2) Delete

In boys, the cross-gender identification is manifested by a marked preoccupation with traditionally feminine activities. They may have a preference for dressing in girls or women's clothes or may improvise such items from available materials when genuin articles are unavailable. Towels, aprons, and scarves are often used to represent lon hair or skirts. There is a strong attraction for the stereotypical games and pastimes girls. They particularly enjoy playing house, drawing pictures of beautiful girls an princesses, and watching television or videos of their favorite female character Stereotypical female-type dolls, such as Barbie, are often their favorite toys, and girl are their preferred playmates. When playing "house," these boys role-play female figure most commonly "mother roles," and often are quite preoccupied with female fantas figures. They avoid rough-and-tumble play and competitive sports and have little interes in cars and trucks or other nonaggressive but stereotypical boy's toys. They may expres a wish to be a girl and assert that they will grow up to be a woman. They may insist o sitting to urinate and pretend not to have a penis by pushing it in between their leg More rarely, boys with Gender Identity Disorder may state that they find their penis testes disgusting, that they want to remove them, or that they have, or wish to have, vagina.

Girls with Gender Identity Disorder display intense negative reactions to parent expectations or attempts to have them wear dresses or other feminine attire. Some ma refuse to attend school or social events where such clothes may be required. They pre boy's clothing and short hair, are often misidentified by strangers as boys, and m to be called by a boy's name. Their fantasy heroes are most often powerful male figu such as Batman or Superman. These girls prefer boys as playmates, with whom th share interests in contact sports, rough-and-tumble play, and traditional boyhood game They show little interest in dolls or any form of feminine dress up or role-play activit A girl with this disorder may occasionally refuse to urinate in a sitting position. She ma claim that she has or will grow a penis and may not want to grow breasts or to menstruat She may assert that she will grow up to be a man. Such girls typically reveal marke cross-gender identification in role-play, dreams, and fantasies.

Adults with Gender Identity Disorder are preoccupied with their wish to live as member of the other sex. This preoccupation may be manifested as an intense desi to adopt the social role of the other sex or to acquire the physical appearance of th other sex through hormonal or surgical manipulation. Adults with this disorder a uncomfortable being regarded by others as, or functioning in society as, a member their designated sex. To varying degrees, they adopt the behavior, dress, and mannerism of the other sex. In private, these individuals may spend much time cross-dressed a working on the appearance of being the other sex. Many attempt to pass in public the other sex. With cross-dressing and hormonal treatment (and for males, electrolysis many individuals with this disorder may pass convincingly as the other sex. The sexu activity of these individuals with same-sex partners is generally constrained by th preference that their partners neither see nor touch their genitals. For some males wh

present later in life, (often following marriage), sexual activity with a woman is accompanied by the fantasy of being lesbian lovers or that his partner is a man and he is a woman.

In adolescents, the clinical features may resemble either those of children or those of adults, depending on the individual's developmental level, and the criteria should be applied accordingly. In a younger adolescent, it may be more difficult to arrive at an accurate diagnosis because of the adolescent's guardedness. This may be increased if the adolescent feels ambivalent about cross-gender identification or feels that it is unacceptable to the family. The adolescent may be referred because the parents or teachers are concerned about social isolation or peer teasing and rejection. In such circumstances, the diagnosis should be reserved for those adolescents who appear quite cross-gender identified in their dress and who engage in behaviors that suggest significant cross-gender identification (e.g., shaving legs in males). Clarifying the diagnosis in children and adolescents may require monitoring over an extended period of time.

Distress or disability in individuals with Gender Identity Disorder is manifested differently across the life cycle. In young children, distress is manifested by the stated unhappiness about their assigned sex. Preoccupation with cross-gender wishes often interferes with ordinary activities. In older children, failure to develop age-appropriate same-sex peer relationships and skills often leads to isolation and distress, and some children may refuse to attend school because of teasing or pressure to dress in attire stereotypical of their assigned sex. In adolescents and adults, preoccupation with cross-gender wishes often interferes with ordinary activities. Relationship difficulties are common and functioning at school or at work may be impaired.

Specifiers

For sexually mature individuals, the following specifiers may be noted based on the individual's sexual orientation: **Sexually Attracted to Males, Sexually Attracted to Females, Sexually Attracted to Both,** and **Sexually Attracted to Neither.** Males with Gender Identity Disorder include substantial proportions with all four specifiers. Virtually all females with Gender Identity Disorder will receive the same specifier—Sexually Attracted to Females—although there are exceptional cases involving females who are Sexually Attracted to Males.

Recording Procedures

The assigned diagnostic code depends on the individual's current age: if the disorder occurs in childhood, the code 302.6 is used; for an adolescent or adult, 302.85 is used.

Associated Features and Disorders

Associated descriptive features and mental disorders. Many individuals with Gender Identity Disorder become socially isolated. Isolation and ostracism contribute to low self-esteem and may lead to school aversion or dropping out of school. Peer ostracism and teasing are especially common sequelae for boys with the disorder. Boys with Gender Identity Disorder often show marked feminine mannerisms and speech patterns.

The disturbance can be so pervasive that the mental lives of some individuals revo only around those activities that lessen gender distress. They are often preoccupied v appearance, especially early in the transition to living in the opposite sex r Relationships with one or both parents also may be seriously impaired. Some males v Gender Identity Disorder resort to self-treatment with hormones and may very ra perform their own castration or penectomy. Especially in urban centers, some m with the disorder may engage in prostitution, which places them at high risk for hu immunodeficiency virus (HIV) infection. Suicide attempts and Substance-Related Di ders are commonly associated.

Children with Gender Identity Disorder may manifest coexisting Separation Anx Disorder, Generalized Anxiety Disorder, and symptoms of depression. Adolescents particularly at risk for depression and suicidal ideation and suicide attempts. In ad anxiety and depressive symptoms may be present. Some adult males have a histor Transvestic Fetishism as well as other Paraphilias. Associated Personality Disorders more common among males than among females being evaluated at adult gender cli

Associated laboratory findings. There is no diagnostic test specific for Ger Identity Disorder. In the presence of a normal physical examination, karyotyping for chromosomes and sex hormone assays are usually not indicated. Psychological tes may reveal cross-gender identification or behavior patterns.

Associated physical examination findings and general medical conditic Individuals with Gender Identity Disorder have normal genitalia (in contrast to ambiguous genitalia or hypogonadism found in physical intersex conditions). Adoles and adult males with Gender Identity Disorder may show breast enlargement resu from hormone ingestion, hair denuding from temporary or permanent epilatio other physical changes as a result of procedures such as rhinoplasty or thyroid shaving (surgical reduction of the Adam's apple). Distorted breasts or breast rashes be seen in females who wear breast binders. Postsurgical complications in ger females include prominent chest wall scars, and in genetic males, vaginal stricu rectovaginal fistulas, urethral stenoses, and misdirected urinary streams. Adult fem with Gender Identity Disorder may have a higher than expected likelihood of polycy ovarian disease.

Specific Age and Gender Features

Females with Gender Identity Disorders generally experience less ostracism becaus cross-gender interests and may suffer less from peer rejection, at least until adolesce In child clinic samples, there are approximately five boys for each girl referred with disorder. In adult clinic samples, men outnumber women by about two or three ti In children, the referral bias toward males may partly reflect the greater stigma cross-gender behavior carries for boys than for girls.

Prevalence

There are no recent epidemiological studies to provide data on prevalence of Ger Identity Disorder. Data from smaller countries in Europe with access to total popula statistics and referrals suggest that roughly 1 per 30,000 adult males and 1 per 100 adult females seek sex-reassignment surgery.

Course

For clinically referred children, onset of cross-gender interests and activities is usually between ages 2 and 4 years, and some parents report that their child has always had cross-gender interests. Only a very small number of children with Gender Identity Disorder will continue to have symptoms that meet criteria for Gender Identity Disorder in later adolescence or adulthood. Typically, children are referred around the time of school entry because of parental concern that what they regarded as a "phase" does not appear to be passing. Most children with Gender Identity Disorder display less overt cross-gender behaviors with time, parental intervention, or response from peers. By late adolescence or adulthood, about three-quarters of boys who had a childhood history of Gender Identity Disorder report a homosexual or bisexual orientation, but without concurrent Gender Identity Disorder. Most of the remainder report a heterosexual orientation, also without concurrent Gender Identity Disorder. The corresponding percentages for sexual orientation in girls are not known. Some adolescents may develop a clearer cross-gender identification and request sex-reassignment surgery or may continue in a chronic course of gender confusion or dysphoria.

In adult males, there are two different courses for the development of Gender Identity Disorder. The first is a continuation of Gender Identity Disorder that had an onset in childhood or early adolescence. These individuals typically present in late adolescence or adulthood. In the other course, the more overt signs of cross-gender identification appear later and more gradually, with a clinical presentation in early to mid-adulthood usually following, but sometimes concurrent with, Transvestic Fetishism. The later-onset group may be more fluctuating in the degree of cross-gender identification, more ambivalent about sex-reassignment surgery, more likely to be sexually attracted to women, and less likely to be satisfied after sex-reassignment surgery. Males with Gender Identity Disorder who are sexually attracted to males tend to present in adolescence or early adulthood with a lifelong history of gender dysphoria. In contrast, those who are sexually attracted to females, to both males and females, or to neither sex tend to present later and typically have a history of Transvestic Fetishism. If Gender Identity Disorder is present in adulthood, it tends to have a chronic course, but spontaneous remission has been reported.

Differential Diagnosis

Gender Identity Disorder can be distinguished from simple **nonconformity to stereotypical sex role behavior** by the extent and pervasiveness of the cross-gender wishes, interests, and activities. This disorder is not meant to describe a child's nonconformity to stereotypic sex-role behavior as, for example, in "tomboyishness" in girls or "sissyish" behavior in boys. Rather, it represents a profound disturbance of the individual's sense of identity with regard to maleness or femaleness. Behavior in children that merely does not fit the cultural stereotype of masculinity or femininity should not be given the diagnosis unless the full syndrome is present, including marked distress or impairment.

Transvestic Fetishism occurs in heterosexual (or bisexual) men for whom the cross-dressing behavior is for the purpose of sexual excitement. Aside from cross-dressing, most individuals with Transvestic Fetishism do not have a history of childhood cross-gender behaviors. Males with a presentation that meets full criteria for Gender Identity Disorder as well as Transvestic Fetishism should be given both diagnoses. If gender dysphoria is present in an individual with Transvestic Fetishism but full criteria

for Gender Identity Disorder are not met, the specifier With Gender Dysphoria can be

The category **Gender Identity Disorder Not Otherwise Specified** can be for individuals who have a gender identity problem with a **concurrent congen intersex condition** (e.g., androgen insensitivity syndrome or congenital ad hyperplasia).

In **Schizophrenia,** there may rarely be delusions of belonging to the other Insistence by a person with a Gender Identity Disorder that he or she is of the othe is not considered a delusion, because what is invariably meant is that the person like a member of the other sex rather than truly believes that he or she is a mem the other sex. In very rare cases, however, Schizophrenia and severe Gender Id Disorder may coexist.

Diagnostic criteria for Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desi for any perceived cultural advantages of being the other sex).

In children, the disturbance is manifested by four (or more) of th following:

(1) repeatedly stated desire to be, or insistence that he or she is other sex
(2) in boys, preference for cross-dressing or simulating female at in girls, insistence on wearing only stereotypical masculine clot
(3) strong and persistent preferences for cross-sex roles in believe play or persistent fantasies of being the other sex
(4) intense desire to participate in the stereotypical games and pa of the other sex
(5) strong preference for playmates of the other sex

In adolescents and adults, the disturbance is manifested by symp such as a stated desire to be the other sex, frequent passing as the sex, desire to live or be treated as the other sex, or the convictio he or she has the typical feelings and reactions of the other sex

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

In children, the disturbance is manifested by any of the following: i boys, assertion that his penis or testes are disgusting or will disappea or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys games, and activities; in girls, rejection of urinating in a sitting position assertion that she has or will grow a penis, or assertion that she doe not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

(continued

☐ **Diagnostic criteria for Gender Identity Disorder** (*continued*)

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Code based on current age:

302.6 Gender Identity Disorder in Children
302.85 Gender Identity Disorder in Adolescents or Adults

Specify if (for sexually mature individuals):

Sexually Attracted to Males
Sexually Attracted to Females
Sexually Attracted to Both
Sexually Attracted to Neither

302.6 Gender Identity Disorder Not Otherwise Specified

This category is included for coding disorders in gender identity that are not classifiable as a specific Gender Identity Disorder. Examples include

1. Intersex conditions (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia) and accompanying gender dysphoria
2. Transient, stress-related cross-dressing behavior
3. Persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex

302.82 Voyeurism

The paraphiliac focus of Voyeurism involves the act of observing unsuspecting individuals, usually strangers, who are naked, in the process of disrobing, or engaging in sexual activity. The act of looking ("peeping") is for the purpose of achieving sexual excitement, and generally no sexual activity with the observed person is sought. Orgasm, usually produced by masturbation, may occur during the voyeuristic activity or later in response to the memory of what the person has witnessed. Often these individuals have the fantasy of having a sexual experience with the observed person, but in reality this rarely occurs. In its severe form, peeping constitutes the exclusive form of sexual activity. The onset of voyeuristic behavior is usually before age 15 years. The course tends to be chronic.

■ Diagnostic criteria for 302.82 Voyeurism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

302.9 Paraphilia Not Otherwise Specified

This category is included for coding Paraphilias that do not meet the criteria for any of the specific categories. Examples include, but are not limited to, telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine).

Gender Identity Disorders

Gender Identity Disorder

Diagnostic Features

There are two components of Gender Identity Disorder, both of which must be present to make the diagnosis. There must be evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex

(Criterion A). This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex (Criterion B). The diagnosis is not made if the individual has a concurrent physical intersex condition (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia) (Criterion C). To make the diagnosis, there must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion D).

In boys, the cross-gender identification is manifested by a marked preoccupation with traditionally feminine activities. They may have a preference for dressing in girls' or women's clothes or may improvise such items from available materials when genuine articles are unavailable. Towels, aprons, and scarves are often used to represent long hair or skirts. There is a strong attraction for the stereotypical games and pastimes of girls. They particularly enjoy playing house, drawing pictures of beautiful girls and princesses, and watching television or videos of their favorite female characters. Stereotypical female-type dolls, such as Barbie, are often their favorite toys, and girls are their preferred playmates. When playing "house," these boys role-play female figures, most commonly "mother roles," and often are quite preoccupied with female fantasy figures. They avoid rough-and-tumble play and competitive sports and have little interest in cars and trucks or other nonaggressive but stereotypical boy's toys. They may express a wish to be a girl and assert that they will grow up to be a woman. They may insist on sitting to urinate and pretend not to have a penis by pushing it in between their legs. More rarely, boys with Gender Identity Disorder may state that they find their penis or testes disgusting, that they want to remove them, or that they have, or wish to have, a vagina.

Girls with Gender Identity Disorder display intense negative reactions to parental expectations or attempts to have them wear dresses or other feminine attire. Some may refuse to attend school or social events where such clothes may be required. They prefer boy's clothing and short hair, are often misidentified by strangers as boys, and may ask to be called by a boy's name. Their fantasy heroes are most often powerful male figures, such as Batman or Superman. These girls prefer boys as playmates, with whom they share interests in contact sports, rough-and-tumble play, and traditional boyhood games. They show little interest in dolls or any form of feminine dress up or role-play activity. A girl with this disorder may occasionally refuse to urinate in a sitting position. She may claim that she has or will grow a penis and may not want to grow breasts or to menstruate. She may assert that she will grow up to be a man. Such girls typically reveal marked cross-gender identification in role-play, dreams, and fantasies.

Adults with Gender Identity Disorder are preoccupied with their wish to live as a member of the other sex. This preoccupation may be manifested as an intense desire to adopt the social role of the other sex or to acquire the physical appearance of the other sex through hormonal or surgical manipulation. Adults with this disorder are uncomfortable being regarded by others as, or functioning in society as, a member of their designated sex. To varying degrees, they adopt the behavior, dress, and mannerisms of the other sex. In private, these individuals may spend much time cross-dressed and working on the appearance of being the other sex. Many attempt to pass in public as the other sex. With cross-dressing and hormonal treatment (and for males, electrolysis), many individuals with this disorder may pass convincingly as the other sex. The sexual activity of these individuals with same-sex partners is generally constrained by the preference that their partners neither see nor touch their genitals. For some males who

present later in life, (often following marriage), sexual activity with a woman is accompanied by the fantasy of being lesbian lovers or that his partner is a man and he is a woman.

In adolescents, the clinical features may resemble either those of children or those of adults, depending on the individual's developmental level, and the criteria should be applied accordingly. In a younger adolescent, it may be more difficult to arrive at an accurate diagnosis because of the adolescent's guardedness. This may be increased if the adolescent feels ambivalent about cross-gender identification or feels that it is unacceptable to the family. The adolescent may be referred because the parents or teachers are concerned about social isolation or peer teasing and rejection. In such circumstances, the diagnosis should be reserved for those adolescents who appear quite cross-gender identified in their dress and who engage in behaviors that suggest significant cross-gender identification (e.g., shaving legs in males). Clarifying the diagnosis in children and adolescents may require monitoring over an extended period of time.

Distress or disability in individuals with Gender Identity Disorder is manifested differently across the life cycle. In young children, distress is manifested by the stated unhappiness about their assigned sex. Preoccupation with cross-gender wishes often interferes with ordinary activities. In older children, failure to develop age-appropriate same-sex peer relationships and skills often leads to isolation and distress, and some children may refuse to attend school because of teasing or pressure to dress in attire stereotypical of their assigned sex. In adolescents and adults, preoccupation with cross-gender wishes often interferes with ordinary activities. Relationship difficulties are common and functioning at school or at work may be impaired.

Specifiers

For sexually mature individuals, the following specifiers may be noted based on the individual's sexual orientation: **Sexually Attracted to Males, Sexually Attracted to Females, Sexually Attracted to Both,** and **Sexually Attracted to Neither.** Males with Gender Identity Disorder include substantial proportions with all four specifiers. Virtually all females with Gender Identity Disorder will receive the same specifier—Sexually Attracted to Females—although there are exceptional cases involving females who are Sexually Attracted to Males.

Recording Procedures

The assigned diagnostic code depends on the individual's current age: if the disorder occurs in childhood, the code 302.6 is used; for an adolescent or adult, 302.85 is used.

Associated Features and Disorders

Associated descriptive features and mental disorders. Many individuals with Gender Identity Disorder become socially isolated. Isolation and ostracism contribute to low self-esteem and may lead to school aversion or dropping out of school. Peer ostracism and teasing are especially common sequelae for boys with the disorder. Boys with Gender Identity Disorder often show marked feminine mannerisms and speech patterns.

The disturbance can be so pervasive that the mental lives of some individuals revolve only around those activities that lessen gender distress. They are often preoccupied with appearance, especially early in the transition to living in the opposite sex role. Relationships with one or both parents also may be seriously impaired. Some males with Gender Identity Disorder resort to self-treatment with hormones and may very rarely perform their own castration or penectomy. Especially in urban centers, some males with the disorder may engage in prostitution, which places them at high risk for human immunodeficiency virus (HIV) infection. Suicide attempts and Substance-Related Disorders are commonly associated.

Children with Gender Identity Disorder may manifest coexisting Separation Anxiety Disorder, Generalized Anxiety Disorder, and symptoms of depression. Adolescents are particularly at risk for depression and suicidal ideation and suicide attempts. In adults, anxiety and depressive symptoms may be present. Some adult males have a history of Transvestic Fetishism as well as other Paraphilias. Associated Personality Disorders are more common among males than among females being evaluated at adult gender clinics.

Associated laboratory findings. There is no diagnostic test specific for Gender Identity Disorder. In the presence of a normal physical examination, karyotyping for sex chromosomes and sex hormone assays are usually not indicated. Psychological testing may reveal cross-gender identification or behavior patterns.

Associated physical examination findings and general medical conditions. Individuals with Gender Identity Disorder have normal genitalia (in contrast to the ambiguous genitalia or hypogonadism found in physical intersex conditions). Adolescent and adult males with Gender Identity Disorder may show breast enlargement resulting from hormone ingestion, hair denuding from temporary or permanent epilation, and other physical changes as a result of procedures such as rhinoplasty or thyroid cartilage shaving (surgical reduction of the Adam's apple). Distorted breasts or breast rashes may be seen in females who wear breast binders. Postsurgical complications in genetic females include prominent chest wall scars, and in genetic males, vaginal strictures, rectovaginal fistulas, urethral stenoses, and misdirected urinary streams. Adult females with Gender Identity Disorder may have a higher than expected likelihood of polycystic ovarian disease.

Specific Age and Gender Features

Females with Gender Identity Disorders generally experience less ostracism because of cross-gender interests and may suffer less from peer rejection, at least until adolescence. In child clinic samples, there are approximately five boys for each girl referred with this disorder. In adult clinic samples, men outnumber women by about two or three times. In children, the referral bias toward males may partly reflect the greater stigma that cross-gender behavior carries for boys than for girls.

Prevalence

There are no recent epidemiological studies to provide data on prevalence of Gender Identity Disorder. Data from smaller countries in Europe with access to total population statistics and referrals suggest that roughly 1 per 30,000 adult males and 1 per 100,000 adult females seek sex-reassignment surgery.

Course

For clinically referred children, onset of cross-gender interests and activities is usually between ages 2 and 4 years, and some parents report that their child has always had cross-gender interests. Only a very small number of children with Gender Identity Disorder will continue to have symptoms that meet criteria for Gender Identity Disorder in later adolescence or adulthood. Typically, children are referred around the time of school entry because of parental concern that what they regarded as a "phase" does not appear to be passing. Most children with Gender Identity Disorder display less overt cross-gender behaviors with time, parental intervention, or response from peers. By late adolescence or adulthood, about three-quarters of boys who had a childhood history of Gender Identity Disorder report a homosexual or bisexual orientation, but without concurrent Gender Identity Disorder. Most of the remainder report a heterosexual orientation, also without concurrent Gender Identity Disorder. The corresponding percentages for sexual orientation in girls are not known. Some adolescents may develop a clearer cross-gender identification and request sex-reassignment surgery or may continue in a chronic course of gender confusion or dysphoria.

In adult males, there are two different courses for the development of Gender Identity Disorder. The first is a continuation of Gender Identity Disorder that had an onset in childhood or early adolescence. These individuals typically present in late adolescence or adulthood. In the other course, the more overt signs of cross-gender identification appear later and more gradually, with a clinical presentation in early to mid-adulthood usually following, but sometimes concurrent with, Transvestic Fetishism. The later-onset group may be more fluctuating in the degree of cross-gender identification, more ambivalent about sex-reassignment surgery, more likely to be sexually attracted to women, and less likely to be satisfied after sex-reassignment surgery. Males with Gender Identity Disorder who are sexually attracted to males tend to present in adolescence or early adulthood with a lifelong history of gender dysphoria. In contrast, those who are sexually attracted to females, to both males and females, or to neither sex tend to present later and typically have a history of Transvestic Fetishism. If Gender Identity Disorder is present in adulthood, it tends to have a chronic course, but spontaneous remission has been reported.

Differential Diagnosis

Gender Identity Disorder can be distinguished from simple **nonconformity to stereotypical sex role behavior** by the extent and pervasiveness of the cross-gender wishes, interests, and activities. This disorder is not meant to describe a child's nonconformity to stereotypic sex-role behavior as, for example, in "tomboyishness" in girls or "sissyish" behavior in boys. Rather, it represents a profound disturbance of the individual's sense of identity with regard to maleness or femaleness. Behavior in children that merely does not fit the cultural stereotype of masculinity or femininity should not be given the diagnosis unless the full syndrome is present, including marked distress or impairment.

Transvestic Fetishism occurs in heterosexual (or bisexual) men for whom the cross-dressing behavior is for the purpose of sexual excitement. Aside from cross-dressing, most individuals with Transvestic Fetishism do not have a history of childhood cross-gender behaviors. Males with a presentation that meets full criteria for Gender Identity Disorder as well as Transvestic Fetishism should be given both diagnoses. If gender dysphoria is present in an individual with Transvestic Fetishism but full criteria

for Gender Identity Disorder are not met, the specifier With Gender Dysphoria can be used.

The category **Gender Identity Disorder Not Otherwise Specified** can be used for individuals who have a gender identity problem with a **concurrent congenital intersex condition** (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia).

In **Schizophrenia,** there may rarely be delusions of belonging to the other sex. Insistence by a person with a Gender Identity Disorder that he or she is of the other sex is not considered a delusion, because what is invariably meant is that the person feels like a member of the other sex rather than truly believes that he or she is a member of the other sex. In very rare cases, however, Schizophrenia and severe Gender Identity Disorder may coexist.

Diagnostic criteria for Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

In children, the disturbance is manifested by four (or more) of the following:

(1) repeatedly stated desire to be, or insistence that he or she is, the other sex
(2) in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
(3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
(4) intense desire to participate in the stereotypical games and pastimes of the other sex
(5) strong preference for playmates of the other sex

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

(continued)

☐ **Diagnostic criteria for Gender Identity Disorder** (*continued*)

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Code based on current age:
302.6 Gender Identity Disorder in Children
302.85 Gender Identity Disorder in Adolescents or Adults

Specify if (for sexually mature individuals):
Sexually Attracted to Males
Sexually Attracted to Females
Sexually Attracted to Both
Sexually Attracted to Neither

302.6 Gender Identity Disorder Not Otherwise Specified

This category is included for coding disorders in gender identity that are not classifiable as a specific Gender Identity Disorder. Examples include

1. Intersex conditions (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia) and accompanying gender dysphoria
2. Transient, stress-related cross-dressing behavior
3. Persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex

302.9 Sexual Disorder Not Otherwise Specified

This category is included for coding a sexual disturbance that does not meet the criteria for any specific Sexual Disorder and is neither a Sexual Dysfunction nor a Paraphilia. Examples include

1. Marked feelings of inadequacy concerning sexual performance or other traits related to self-imposed standards of masculinity or femininity
2. Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used
3. Persistent and marked distress about sexual orientation

Conservatives Brand Homosexuality a 'Tragic Affliction'

By Carolyn Lochhead
Chronicle Washington Bureau

Washington

Hoping to unleash a major challenge to the growing acceptance of homosexuality in American society, conservative scholars said yesterday that gays and lesbians suffer from "gender disturbances" and an "infantile refusal to accept reality."

The remarks were made on the first day of a three-day conference at Georgetown University sponsored by the American Public Philosophy Institute, a group of conservative intellectuals. The conference drew 350 people from around the country, including academics, "ex-gay" religious ministries and advocates of traditional family values. The speaker roster includes such conservative luminaries as Bill Kristol, editor of the Weekly Standard.

Organizers said their purpose is to understand homosexuality "as a tragic affliction, with harmful consequences for both individuals and society, and the appropriate stance for society — the truly compassionate choice — is to recognize this fact and to try to encourage prevention and treatment for it."

Gay rights groups staged a small rally near the conference to protest Georgetown's decision to allow the program to be held on its campus.

"The purpose of this conference is to spread myths and lies about the gay community," said Winnie Stachelberg, a Georgetown alumna and political director of the Human Rights Campaign, a large gay lobbying group.

Georgetown officials have eschewed any affiliation with the meeting, saying it is merely being held on campus at a building belonging to the Marriott hotel chain. Marriott officials said earlier that they book meeting rooms without any implied endorsement.

Conference organizers maintain that they are trying to help gays and lesbians escape a deviant and troubled lifestyle.

"This is not something negative," said Christopher Wolfe, president of the group. "We're here to help. Understanding homosexuality as a disorder and how we deal with that is a position that hasn't been well represented."

Acceptance and tolerance is no answer to homosexuality or the difficulties gays have in society, Wolfe said. He compared acceptance of homosexuality to acceptance of alcoholism. "It is a source of a lot of unhappiness, and you don't resolve a problem by covering it up," he said.

George Rekers, a professor of neuropsychiatry and behavioral science at the University of South Carolina School of Medicine, opened the conference with a discussion of gender roles in childhood and adolescence.

His work has been heavily subsidized by the federal government through research grants from the National Institute of Mental Health.

> ***'There is no such thing as a gay person,' because homosexuality is 'a fictitious identity that is seized on to resolve painful emotional challenges'***
>
> — JOSEPH NICOLOSI, Executive Director, Association for the Research and Treatment of Homosexuality

Rekers said lesbians tend to be tomboys in childhood, identify too closely with their fathers, prefer to play with "masculine" toys and demonstrate a "distinct dislike for doll play and various other female activities."

Male homosexuals, Rekers said, "report the opposite pattern," preferring the company of girls and wanting to wear lipstick and dresses.

Rekers characterized both behaviors as "gender disturbances" that can be corrected through 18 to 22 months of weekly therapy during childhood and adolescence.

Rekers did not elaborate on his techniques even when asked. But according to Mark Pietrzyk, a doctoral candidate in political science at Georgetown University and a member of the Log Cabin Republicans, a gay group, Rekers advocates "aversion therapy." The technique punishes nonconforming behavior (such as limp wrists in boys or swaggering in girls) and rewards conforming behavior (girls playing with dolls; boys playing baseball).

The practice is opposed by the American Psychiatric Association.

Another panelist, Joseph Nicolosi, executive director of the National Association for the Research and Treatment of Homosexuality, maintained that "there is no such thing as a gay person," because homosexuality is "a fictitious identity that is seized on to resolve painful emotional challenges."

Nicolosi argued that homosexual boys are unable to identify with their fathers, who tend to be cold or distant. As a result, they engage in "a narcissistic refusal to (accept) a gendered world and the human biological reality on which that world is based."

Nicolosi said gay men are "disconnected" from other people and live in an unreal world. After quoting Oscar Wilde, he said this is one reason why many gay men like theater.

He also described coming out of the closet as a "heady, euphoric, pseudo-rite of passage" where gay people discover other gay people and "mask their collective hurts."

Another speaker, Jeffrey Satinover, author of "Homosexuality and the Politics of Truth," said evidence of a biological basis for homosexuality is weak, and that the search for a "gay gene" has been seized upon by gay activists as a way to gain public sympathy and ally themselves with the civil rights movement for African Americans.

If homosexuality had a genetic basis, Satinover said, "it would die out" eventually because gays do not reproduce as much as heterosexuals.

Satinover dismissed charges that the conference discussions are bigoted and intolerant, saying it is gay activists who are intolerant for refusing to acknowledge that some gays want to go straight.

"If somebody says they have homosexual impulses and they don't want to have them anymore, they're vilified. That is intolerant," Satinover said. "As soon as somebody says, 'I was a homosexual and I'm not anymore,' they're called a liar. That's bigoted. As soon as somebody says it's possible for some people to change, he's accused of being utterly out of touch with the truth. That's rigid. The rigidity, the bigotry, the intolerance that is predominant in the current public debate has now shifted to the side of the activists."

[Youth suicide]

URGING THE SAN FRANCISCO YOUTH COMMISSION AND THE DEPARTMENT OF PUBLIC HEALTH AND THEIR MENTAL HEALTH SERVICES DIVISION TO EXAMINE YOUTH SUICIDE AND MAKE RECOMMENDATIONS TO THE SAN FRANCISCO BOARD OF SUPERVISORS AS TO HOW TO BEST ADDRESS THE ISSUE.

WHEREAS, Suicide is the sixth leading cause of death in San Francisco, with 845 lives lost between 1990 and 1995; and

WHEREAS, Although suicides occurred across all ages, suicide is the second leading cause of death for young people aged 15 to 24 years; and

WHEREAS, Youth suicide is problem, but is further escalated in the lesbian, gay, bisexual, transgender, queer and questioning youth community; and

WHEREAS, Researchers have identified discrimination against gender variant children and youth as one of the most important risk factors in Lesbian, Gay, Bisexual, Transgendered (LGBT) youth suicide; and

WHEREAS, Perhaps no risk factor is as insidious or unique to the suicidal behavior of gay and lesbian youth than receiving professional help; and

WHEREAS, San Francisco is not immune from the problem of psychiatric abuse of gender variant children and LGBT youth; and

WHEREAS, Despite the large number of homeless and runaway youth who flee to San Francisco from other places in order to escape from unnecessary or abusive psychiatric placements or to recover from homophobic or transphobic therapies, there are no publicly funded programs or services of any kind that specifically serve this population; now therefore, be it

RESOLVED, That the Board of Supervisors of the City and County of San Francisco urges the San Francisco Youth Commission and the Department of Public Health and their Mental Health Services division to examine youth suicide and make recommendations to the San Francisco Board of Supervisors as to how to best address the issue.

SUPERVISOR AMMIANO, BIERMAN

We agreed that it would be good to propose a workshop and have written materials for this conference. Vitaly agreed to draft a workshop proposal.

VI. Asian Pacific Islander Lesbian Conference, Los Angeles, July 4th.

Kar Yin agreed to take written materials to the conference.

VII. Bay Guardian follow-up.

Tom agreed to draft a letter to the editor to bring to the next meeting, if possible.

Seth agreed to explore getting the Guardian to do a follow-up story on this group.

Kar Yin agreed to contact Calendar section to list upcoming activities of this group.

VII. Hearing on Youth Suicide, SF Board of Supervisors

Oren agreed to find out when hearing is scheduled.

Vitaly, Shannon, and Camille agreed to plan a presentation for the hearing.

VIII. Additional suggestions/ideas for future discussion.

Planning an action around APA convention in SF in August.

Organizing a panel/workshop at the SF library.

IX. Mission Statement

We discussed usefulness of having a mission statement. April agreed to take a crack at it, with input from Camille.

Anatolian Kilim (detail), pre-18th century
Slit-tapestry weave, weft-wrapping, wool
34 x 124 5/8 in.
Caroline and H. McCoy Jones Collection, T89.51.2

Printed in Hong Kong

December 15, 1997

Dear Camille -

Thank you for your lovely and thoughtful note. It was a pleasure to meet you; I am sorry it was for such a short time. If I get to the office with extra time, I hope we can discuss things at greater length.

Your support and help is greatly valued - I hope I'll be able to effect those changes you and GLMA are hoping for. Best wishes

Dr. Bob Culley

January 4, 1997

Dr. Cabaj,

Over the holidays I read all of the gay mental health textbook. The language is not too clinical.

With the turning of a phrase into poetry, a few words of Dr. Isay blows my dreams into sadness. I never knew that being analytical could have such beautiful simplicity.

I see that gay doctors have created alternatives of dignity while I was dodging the mental health system. I use to wonder why gay people would want to be in a profession that persecutes us. It is because you want to help your own where others would harm them.

The book is quietly progressive. It is a testament to your contributions to the gay rights movement.

A father does not make a child gay by hating the child, but he hates his child because the child is gay. This assumption is the revolutionary and profound accomplishment of gay doctors, and it is what gives your book clarity.

Perhaps in some future edition there will be room for expansion of evolutionary light.

Because as much as I loved the book, it made me feel lonely, outside, left behind. It is the omissions between the words that hover around the edges like a crying child.

I hope these suggestions are not alienating, but I feel that you are safe enough for me to communicate what I wish could be integrated into the shaman's box of healing.

Electroshock is not mentioned in the briefly skimmed section of the history of the psychiatric abuse of queers. The attitudes and treatment received by gay people has actually created mental illness. The mental health system has pushed people across the borderline, and its political oppression of queers is not over.

I would like to have read a study about the effects of some immuno-suppressant psychiatric drugs when mixed with HIV medications.

A warning about the danger of getting tardive dyskenesia is still necessary.

The youth who have escaped their abusive treatment not only have to deal with drugs, violence, homelessness, prostitution, and Aids, but do it while withdrawing from sometimes large and prolonged amounts of psych drugs, with no help.

I hope in some future edition you will be able to describe a healing place for queer psychiatric survivors, young and old, that is run by gay doctors.

The chapter on Native Americans pleased my soul with its inclusionary heart, in contrast to the chapter on transsexuals being ghettoized as the only one about a disorder.

The same false myth that makes transgender polemics so oppressive runs through the book like a river. The myth is that gender identity and sexual orientation are not the same. Sometimes it is. For feminine boys being tortured under G.I.D.C. it is not separate. And primary transsexuals are an extension of being born gay.

If the only choice for us is a straight man's knife, and to be pushed into the closet of hoping that our oppressors, straight men, will love us, how will spiritual illumination ever be retrieved, or true assimilation occur.

If we are not accepted because of the hatred of the feminine in modern gay culture, how will we, part of you, be able to bless your lives, and then rejoice in mental health, when we see what it looks like.

I haven't seen your new book on gay marriage yet, but in the next edition I hope you will encourage gay couples to adopt the most feminine boys and raise them with acceptance and protection. That is my vision of what mental health looks like.

I believe the following transference is not completely unhealthy because queers have to create their own family.

I have, long ago, stopped waiting for my original parents to come for me. And I have ceased to look at PFLAG parents and wish they were mine. The most tender revelation is that only two gay fathers could give the feeling of safety that is like sleeping in heaven.

I am an old child and my beautiful dream is only an illusion, but for some child being born may it be a vision of reality.

Sex and love are not the same, except for gay people's desire to sanctify their union with marriage. It is the ultimate alternative mental health because by its nature it cannot remain exclusionary, and only when it comes will there be a real community of family. And maybe people like me won't have to float in the dreamy pain of alienation forever, but will be adopted as our birth right into a circle of arms.

Sincerely, Camille

March 15, 1999

Camille Moran
[redacted]

Dear Camille,

I am happy to tell you that the PFLAG Transgender Special Outreach Network has decided to change its name to the Transgender Network, and PFLAG T-Net or T-Net for short.

Although this change is effective immediately, they still have 14,000 copies of "Our Trans Children" to sell which indicate that it is published by T-SON. The title is much more prominent and that is how they will refer to it. Also, during the transition, they may occasionally refer to themselves by the current name and "formerly T-SON" where necessary to avoid confusion.

Please let me know if you have any questions or any remaining concerns. I hope that all is going well for you.

Cordially,

Kirsten

Kirsten Kingdon
Executive Director

P.S. Mary Boenke asked me to extend her greetings to you.

cc: Cynthia Newcomer
PFLAG Board of Directors
Mary Boenke

1101 14th Street, NW • Suite 1030 • Washington, D.C. 20005 • (202) 638-4200 • Fax: (202) 638-0243
E-mail: info@pflag.org • Web: http://www.pflag.org