GID Reform Advocates

Issues of Psychiatric Diagnosis for Gender Nonconforming Youth
-- Kelley Winters, Ph.D.

DSM-IV-TR: Gender Identity Disorder in Children, 302.6
Section: Sexual and Gender Identity Disorders
SubSection: Gender Identity Disorders

Diagnostic Criteria (APA 2000, p. 581)

A. 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 preferences for playmates of the other sex

B. 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.

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.

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

"Gender Identity Disorder" (GID) is a diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association (APA, 1994). The DSM is regarded as the medical and social definition of mental disorder throughout North America and strongly influences the *The International Statistical Classification of Diseases and Related Health Problems* (ICD) published by the World Health Organization. GID currently includes a broad array of gender variant adults and children who may or may not be transsexual and may or may not be distressed or impaired. GID literally implies a *"disordered"* gender identity.

Thirty-four years after the American Psychiatric Association (APA) voted to delete homosexuality as a mental disorder, the diagnostic categories of "gender identity disorder" and "transvestic fetishism" in the *Diagnostic and Statistical Manual of Mental Disorders* continue to raise questions of consistency, validity, and fairness. Recent revisions of the DSM have made

false, negative stereotypes of gender variant people and at the same time fail to legitimize the medical necessity of sex reassignment surgeries (SRS) and procedures for transsexual women and men who urgently need them. The result is that a widening segment of gender non-conforming youth and adults are potentially subject to diagnosis of psychosexual disorder, stigma and loss of civil liberty.

Overinclusive Diagnosis.

The diagnostic criteria for Gender Identity Disorder of Children were significantly broadened in the DSM-IV (1994, p. 537), to the concern of civil rights advocates. GID of Children is clearly not limited to ego-dystonic youth, that is, children unhappy or distressed with their bodies or assigned sex roles. High functioning children may be presumed to meet criteria A and B on the basis of cultural nonconformity alone, if they exhibit 4 of the 5 characteristics of criterion A and any of those listed for criterion B. Thus, a child may be diagnosed with gender identity disorder without ever having stated any desire to be the other sex. Most puzzling, the DSM-IV-TR admits that:

> Only a very small number of children with Gender Identity Disorder with continue to have symptoms that meet criteria for Gender Identity Disorder in adolescence or adulthood (p. 579).

This calls into question the therapeutic purpose of GID of Children. Overbroad diagnosis contributes to the stigma and undeserved shame that gender nonconforming youth must endure. Parents accepting of their gender nonconforming children live in fear of persecution by courts, school officials and government agencies who infer a broad interpretation of GID of Children and seek punitive treatment remedies.

The "Prehomosexual" Agenda.

Author Phyllis Burke (1996) describes cases of children as young as age three institutionalized or treated with a diagnosis of gender identity disorder for widely varying gender nonconformity. She presents evidence of increasing use of GID for children suspected of being "prehomosexual," and not necessarily transsexual. Diagnosis and treatment is often at the insistence of non-accepting parents with the intent of changing a perceived homosexual orientation. Burke quotes Kenneth Zucker, of the GID subcommittee, that parents bring children to gender clinics for the most part "because they don't want their kid to be gay" (p. 100).

Zucker and Bradley (1995, p. 53) noted that "homosexuality is the most common postpubertal psychosexual outcome for children [with GID]." They defended the treatment of gender nonconforming children on three points: reduction of social ostracism, treatment of underlying psychopathology, and prevention of GID in adulthood (pp. 266-7). The first appears to shift the blame for the distress of discrimination from its inflictors to its victims. The second presumes theories of psychodynamic etiology which lack evidence in nonclinical populations (Wilson, 1997). With respect to the third, the authors conceded that,

> there are simply no formal empirical studies demonstrating that therapeutic intervention

> (Zucker and Bradley 1995, p. 270).

This misuse of Gender Identity Disorder for children and youth was condemned by the National Gay and Lesbian Task Force and the San Francisco Human Rights Commission (1996) :

> 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 based on GID.

Far from promoting consistency in diagnosis and treatment, ambiguous and conflicting language in the DSM-IV and TR has created much confusion and controversy. Interpretation of the Gender Identity Disorder of Children may range from a narrow definition of objective distress to an overinclusive loophole to the 1973 American Psychiatric Association decision to declassify homosexuality as a mental disorder.

Disparate Standards for Boys and Girls.

Boys are inexplicably held to a much stricter standard of conformity than girls in their choice of clothing and activities. A simple preference for cross-dressing or simulating female attire meets the diagnostic criterion for boys but not for girls, who must insist on wearing only male clothing to merit diagnosis. References to "stereotypical " or "normative" clothing, toys and activities of the other sex are imprecise in an American culture where much children's clothing is unisex and appropriate sex role is the subject of political debate. This disparity serves to enforce a stricter standard of conformity for boys than girls. Its dual standard not only reflects the social privilege of males in American culture, but promotes it. One implication is that biological boys who emulate girls or women, with their lower social status, are presumed irrational and mentally disordered, while biological girls who emulate boys or men are less so.

Pathologization of Ordinary Behaviors.

In the diagnostic criteria and supporting text of Gender Identity Disorder for Children, behaviors that would be ordinary or even exemplary for gender conforming girls and boys are presented as symptomatic of mental disorder for gender nonconforming children. For boys, these include playing with Barbie dolls, homemaking and nurturing role play, and aversion to cars, trucks, competive sports and "rough and tumble" play. For girls, pathology is implied by playing Batman or Superman, competitive contact sports, "rough and tumble" play, and aversion to dolls or wearing dresses (APA 1994, p. 576). It is unclear whether the intent of the DSM is to reflect such dated, narrow and sexist gender stereotypes or to enforce them. More puzzling is criterion A, which lists a "strong preference for playmates of the other sex" as symptomatic and seems to equate mental health with sexual discrimination.

The vision of GID Reform

It is time for the medical professions to affirm that difference is not disease, nonconformity is not pathology, and uniqueness is not illness

It is time for culturally competent psychiatric policies that recognize the legitimacy of cross-gender identity and yet distinguish gender dysphoria (distress with one's physical sex characteristics or assigned social sex role) as a serious condition, treatable with medical procedures.

It is time for diagnostic criteria that serve a clear therapeutic purpose, are appropriately inclusive, and define disorder on the basis of distress or impairment and not upon social nonconformity.

It is time for medical policies, which above all do no harm to those they are intended to help.

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About the Author

Kelley Winters, Ph.D., formerly under pen-name Katherine Wilson, is a writer on issues of transgender medical policy, founder of GID Reform Advocates (www.gidreform.org) and an Advisory Board Member for the Matthew Shepard Foundation. She has presented papers on the psychiatric classification of gender diversity at the annual conventions of the American

Psychology. Her most recent work appears in *Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM), A Reevaluation* , edited by Dan Karasic and Jack Drescher (2005).

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Please send comments and suggestions to kelley@gidreform.org