1B-GID.rtf

GENDER IDENTITY DISORDER

==========

GENDER IDENTITY DISORDER: DSMIV DEFINITION

Diagnostic and Statistical Manual of Mental Disorders, IV revised. American Psychological Association. (1994). p.533-536

The following are direct quotations from the source:
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 clothes
3) strong and persistent preferences for cross-sex roles in male-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, frequently 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-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...

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

[Boys] 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... [Boys] 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. [The boys] 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 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... 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.

Gender Identity Disorder can be distinguished from simple **nonconformity to stereotypical sex role behavior** by the extent and pervasiveness of cross-gender wishes, interests, and activities. This disorder is not meant to describe a child's nonconformity to stereotypical 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.

==========

TREATMENT OF GENDER IDENTITY PROBLEMS IN CHILDREN

Zucker, K., Bradley, S. (1995) *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents.* NY: Guilford.

The following are direct quotations from the source:
CROSS-DRESSING: ... In many boys, cross-dressing has an obligatory quality (e.g., insistence on cross-dressing outside the home) and is not restricted to play situations. A common precipitant for referral is extensive cross-dressing by a boy in preschool or kindergarten. The driven quality of the cross-dressing is sometimes manifested by the boy's need to sleep in female clothing or by his agitation when female clothing is unavailable. Some parents report that when their son comes home from school, he manifests a frantic need to change into women's clothing. Even among parents who have a generally ambivalent or supportive reaction to their sons' cross-gender identification, there is an emerging unease with the chronic display of cross-dressing and by school age such parents have usually attempted to set limits on the behavior. By late childhood, the interest in cross-dressing may be transformed into a preoccupation with the appearance of female movie stars or other popular figures.(p.15)

PEER RELATIONS: ... There is usually a strong avoidance of boys as playmates. Some of the boys worry a great deal about bodily injury that they anticipate will occur during rough-and-tumble play. They appear to have trouble distinguishing between rough-and-tumble play and intent to hurt.(p. 19)
MANNERISMS AND VOICE: ... "He at times becomes very effeminate in his mannerisms and his voice, particularly when he's under stress... he's under stress typically because he's either shy or ... reacting to something, he gets very effeminate... It's short-lived... but it's a, it's a very effeminate reaction."(p.21)
ANATOMIC DYSPHORIA: ... "When my penis goes up, I get mad and angry. I hate it when it goes up. I want to shoot it off with a gun. I want to get rid of it. I want to shoot myself and die."(p.21)
DIFFERENTIAL DIAGNOSIS: ... Clinical experience also suggests that this type **[fetish use of underwear and nylons rather than outerwear]** of cross-dressing is associated with self-soothing or reduction of anxiety. **[**

... the clinician who accepts the notion that there is a spectrum of cross-gender identification ... Clinical experience suggests that boys who fall into this 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 (1988) coined the term *juvenile unmasculinity* 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."(p.50)
CASE EXAMPLE: ... Jeremiah's mother had a great deal of ambivalence regarding men and masculinity and that it was probably very difficult for her to tolerate any signs of masculinity in Jeremiah.(p.90)
CONCLUSIONS: ... Boys with GID have been shown to have largely insecure attachments to their mothers;" however, they also found, "ample clinical evidence that boys with gender identity disorder have greater emotional closeness with their mothers than with their fathers." (p. 229)
A CLINICAL FORMULATION... we feel that parental tolerance of cross-gender behavior at the time of its emergence is instrumental in allowing the behavior to develop...What is unique in the situation with children who develop a gender identity disorder is the co-occurrance of a multitude of factors at a sensitive period in the child's development -- that is, most typically in the first few years of life, the period of gender identity formation and consolation. there must be a sufficient numbers of factors to induce a state of inner insecurity in the child, such that he or she requires a defensive solution to deal with anxiety. This must occur in a context in which the child perceives that the opposite-sex role provides a sense of safety or security.(p.259)
SUMMARY OF MODEL FOR BOYS: ... The boy, who is highly sensitive to maternal signals, perceives the mother's feelings of depression and anger. Because of his own insecurity, he is all the more threatened by his mother's anger or hostility, which he perceives as directed at him. His worry about the loss of his mother intensifies his conflict over his own anger, resulting in high levels of arousal or anxiety. The father's own difficulty with affect regulation and inner sense of inadequacy usually produces withdrawal rather than approach.

The parents have difficulty resolving the conflicts they experience in their own marital relations, and fail to provide support to each other. This produces an intensified sense of conflict and hostility.

In this situation, the boy becomes increasingly unsure about his own self-value because of the mother's withdrawal or anger and the father's failure to intercede. This anxiety and insecurity intensify, as does his anger.(p.262)

PARENTAL ENCOURAGEMENT OF CROSS GENDER BEHAVIOR: ... we were unable to identify in any case reports a clinician who felt that the parents unequivocally encouraged a masculine identity in their sons."(p.277)

IN THE BEST INTERESTS OF THE CHILD: THERAPEUTIC OPTIMISM OR NIHILISM: ... In our clinical experience, we have found no compelling reason not to offer treatment to a child with gender identity disorder. We have reviewed the evidence on the impact of marked cross-gender indentification on the child's psychosocial functioning, documented the nature of the associated psychopathology, and summarized what is known about the familial psychopathology. **We found that many of the youngsters we have evaluated are very troubled, as are their families.**

...In general we concur with those (e.g. Green 1972; Newman 1976; Stoller, 1978) who believe that the earlier treatment begins, the better. (p.281)

It has been our experience that a sizable number of children and their families can achieve a great deal of change. In these cases, the gender identity disorder resolves fully, and nothing in the children's behavior or fantasy suggest that gender identity issues remain problematic.... All things considered, however, we take the position that in such cases a clinicians should be optimistic, not nihilistic, about the possibility of helping the children to become more secure in their gender identity.(p.282)

==========

REVIEW OF LITERATURE ON GID

Bradley, S., Zucker, K. (1997) Gender Identity Disorder: A Review of the Past 10 Years. *Journal of the American Academy of Child and Adolescent Psychiatry.* 34, 7: 872 - 880

The following are direct quotations from the source:

TERMINOLOGY: ...In most children, there is an increase in sex-stereotypic gender role behavior, accompanied by highly sex-stereotypic ideas about gender roles, by the ages of 4 to 5 years. A gradual shift to a more flexible understanding of gender role behavior occurs throughout the latency years, but most children continue to display a preference for gender-typical activities and to exclude or reject children that deviate significantly from the norm.... (p. 872)

ASSOCIATED PSYCHOPATHOLOGY:... Coates and Person (1985) reported that 60% of 25 boys with GID met criteria for separation anxiety disorder. ... on a larger sample of gender-referred boys (N = 115). Boys who met the complete criteria for GID showed more traits of separation anxiety, as judged by maternal responses to a standardized interview schedule, than did boys who did not meet the complete diagnostic criteria, a finding consistent with the

predominance of internalizing psychopathology on the CBCL [Child Behavior Check List]. (p. 874)

Parental psychopathology has been observed consistently in our sample ... For example, mothers of boys with GID have higher rates of depression and borderline personality disorder than normal control mothers, (Marantz 1991) have higher rates of other psychiatric disorders, (Wolfe 1990) and report more psychopathology on symptom checklist and meet criteria for more psychiatric diagnosis on a structured diagnostic interview than do mothers of normal controls... (p.875)

A THEORETICAL MODEL: ... Once the child has begun to engage in significant cross-gender behavior, especially if that occurs when the child's gender identity has not yet consolidated, the child may evolve a cross-gender identified self which serves an important defensive function and which may be difficult to relinquish, especially if the factors which contributed to its development have not changed.(p.878)

CONCLUSION:... Empirical work over the past 10 years has documented the presence of associated psychopatholgy in both child and parents.**..** Despite political pressures that come largely from outside the domain of child psychiatry, it is important that efforts continue to explore the best ways to assist individuals with GID to resolve their acute sense of unhappiness and to develop the skills to live with comfort in their families and amidst their peers.(p.879)

==========

LETTER TO EDITOR CHALLENGING BRADLEY AND ZUCKER ARTICLE

Menvielle, E.(1998) Gender identity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry.* 37, 3: 243 -244.

The following are direct quotations from the source:

LETTER TO THE EDITOR IN RESPONSE TO BRADLEY AND ZUCKER ARTICLE: ...The authors lead us to believe that there is no question about the pathological nature of GID. This is not so. Although the authors concluded that there was no good correspondence between childhood GID and adult homosexual orientation, they presented compelling evidence to the contrary. A 75% homosexual outcome makes GID an unusually strong predictor. Furthermore, the remaining 25% figure may be inflated: the subjects were followed into young adulthood, not long enough to conclude that they would identify themselves as heterosexual in the long term. Although many gay adults do not recall a history of GID, most GID children grow up to be gay. This means that there is a strong correspondence between GID behaviors and adult homosexuality, wherein GID children may largely represent a subset of the homosexual population and rarely a precursor of transsexuality. The ethical implication of whether childhood GID is a psychiatric disorder versus a manifestation of normal homosexual orientation are vital because labeling prehomosexual children as disordered would be incorrect.

There is no way to predict what adult sexual/gender orientation an individual child with GID will have. The existing evidence suggest that psychotherapy will not affect the outcome. Children are ostensibly treated to become more comfortable with their biological gender;

however, most treatments reviewed are oriented toward decreasing the cross gender behaviors turning parents into 'gender cops.' There is no doubt that these behaviors generate discomfort in others...

A fair analysis of the powerful role of prejudice and bias on the mental health of these children and families should not be left out. Above all, we need not take the appropriateness of this diagnostic category for granted as important questions about the significance of these behaviors are still far from resolved. (p.243)

==========

BRADLEY AND ZUCKER'S RESPONSE

Bradley, S., Zucker, K. (1998) Drs. Bradley and Zucker reply. *Journal of the American Academy of Child and Adolescent Psychiatry.* 37, 3: 244 - 245.

The following are direct quotations from the source:

In our view, there are several compelling reasons why GID should be considered a psychiatric disorder... clinic referred children with GID express significant distress and unhappiness about their status as boys or as girls -- the majority of such children express this distress *directly* by frequently stating that they want to change their sex and that they do not like themselves as boys or girls.

Most clinicians attempt to enable the child to feel more comfortable about being a boy or a girl... helping children adapt in a way that allows them to function optimally and without the preoccupation that they would be happier if only they changed sex.

Dr. Menvielle suggests that the cross gender behaviors that constitute the GID diagnosis are not, for the most part, a "problem" for the child. We disagree. Not only do these children encounter substantial social ostracism because of their marked cross-gender behavior and have, on average, more peer relationship problems than their siblings, it should also be recognized that these youngsters rely on these behaviors to regulate affect, a defensive strategy that interferes with the development of other more adaptive strategies.

The issue of which behaviors endanger the child versus which meet only with social disapproval is a false dichotomy. The constellation of cross-gender behaviors that signify GID comprises a gestalt that allows the child to continue to believe that he or she would be 'better off' as the opposite sex. This 'fantasy solution' provides relief but at a cost. Persisting with these behaviors, with no interference or reaction from others, often results in a fixed fantasy that the child can exist in a secure world only in the opposite gender.

In many families, the parents have *not* reacted to the child's cross-gender behavior to any extent and the child has received minimal social disapproval from others. Despite this, children with GID still manifest a variety of other comorbid difficulties, such as separation anxiety, depression, and behavior problems. Furthermore, it is hard to dismiss the high levels of psychopathology in the parents of some of these children as simply reactive to the child's gender identity difficulties.(p.244)

Our experience is that such suffering diminishes radically, and self esteem improves

when the parent are able to value the child and to support and to encourage same-sex behavior. Although children with GID seldom become robustly stereotypic in their same-sex interests, they can usually find children of their own gender with whom they can relate comfortably, which facilitates a same-sex identification. Dr. Menvielle is naive in his assumption that these children would be happy if they were simply allowed to 'grow up' pursing their cross-gender behavior and interests, including the desire to change sex. They are unhappy children who are using these behaviors defensively to deal with their distress."

... those children who have had good therapy when young accomplish a comfortable sense of self in their biological sex and the parents, therefore do not need to go through this process.

Clearly, simple measures such as joining teams and clubs are insufficient in a disorder as complicated as this. They can, however, serve as adjunctive aspects of the therapeutic intervention process and provide opportunities for a child to establish new relationships in a supportive environment. (p.245)

==========

STUDY OF PRISONERS

Holemon, R., Winokur, G. (196*) Effeminate homosexuality: A disease of childhood. *** 48 - 56.

The following are direct quotations from the source:

ABSTRACT: In a systematic study of 40 homosexuals and 25 non-homosexual controls data indicated that effeminate homosexual exhibited effeminacy before puberty. Homosexual behavior was only a secondary maifestation. (p.48)

EFFEMINACY AND HOMOSEXUALITY: ...Ten fathers in the homosexual category were unknown. There was more psychopathology in the siblings of the homosexuals than in the controls. (P.54)

SUMMARY: Patients in a psychiatric facility for a prison population were studied: Effeminate homosexuals, non-effeminate homosexual and non-homosexual controls. (p.55)

The effeminate homosexuals reported more effeminate social behavior as children than either the non-effeminate homosexuals or controls. This report seemed reliable in that the effeminate homosexuals reported homosexual episodes as occurring at an earlier age than the non-effeminate homosexuals. Also the effeminate homosexuals reported more sexual activity both in and out of prison than the non-effeminate homosexual. It appears then that the aberration is effeminacy with homosexual lustful behavior being a secondary manifestation. Effeminate homosexuality is then a disease of childhood. (p.56)

==========

TREATMENT OF GID

Rekers, G., Lovaas, O., Low, B. (1974) Behavioral treatment of deviant sex role behaviors in a male child. *Journal of Applied Behavioral Analysis.* 7: 134 - 151.

The following are direct quotations from the source:

When we first saw him, the extent of his feminine identification was so profound (his mannerisms, gestures, fantasies, flirtations, etc., as shown in his "swishing" around the home and the clinic, fully dressed as a woman with a long dress, wig, nail polish, high screechy voice, slatternly, seductive eyes) that it suggested irreversible neurological and biochemical determinants. After 26 months follow-up, he looked and acted like any other boy. People who viewed the video taped recordings of him before and after treatment talk of him as "two different boys."

==========

TREATMENT FOR PARENTS

Newman, L. (1976) Treatment for the parents of feminine boys. *American Journal of Psychiatry.* 133, 6: 683 - 687.

The following are direct quotations from the source:

ABSTRACT: Because extreme boyhood femininity is often a precursor of adult transsexualism, transvestism, and homosexuality, the author recommends early intervention for boys who meet specific behavioral criteria of gender disturbance. It is necessary to involve the parents in such treatment and to deal with the resistances they may have to recognize and working on the problem as well as problems within the marital relationship that may affect the child's behavior. These boys are remarkably responsive to treatment given between the ages of 5 and 12, becoming more masculine in behavior and more comfortable with their identity as males.

INTRODUCTION: ... Lebovitz (1972) found that of 16 adult males who had been considered feminine in childhood, 3 were transsexuals, 2 were homosexuals, and 1 was a transvestite.

RESPONSIVENESS TO EARLY INTERVENTION: Feminine boys, unlike men with postpubertal gender identity disorders seem remarkably responsive to treatment. ...Teasing and social rejection by male peers decreases and is replaced by acceptance. During the initial 12 -- 24 months of treatment, **these patients begin to enjoy being accepted as boys, and their acceptance is a strong, continuing reinforcer**. Improvement has been achieved with a variety of different approaches, including daily psychoanalytic play therapy, behavioral therapies, and individual therapy for the child combined with counseling for the parents, either individually or in groups.

Some of the boys treated in childhood have now become adolescents and remain masculine. None are reported to have reverted to cross-dressing...

Acceptance by the same-sex in childhood replaces ostracism with a happier existence. They no longer need to withdraw into the feminine fantasy world and are capable of giving up this world voluntarily.

It seems evident that the treatment of choice for gender identity disorders is primary

prevention in childhood. No matter how dramatic the femininity of a prepubertal child may be, the evidence indicates that his gender orientation has not yet crystallized. These patterns are not fixed by the third year of life.

FAMILY PATHOLOGY: ... It is not unusual for parents to shield, tolerate, and rationalize the boy's cross-dressing for years. Mothers generally fear losing the son's companionship as he becomes more masculine and therefore reluctant to begin a treatment program. The fathers generally resent and avoid their feminine sons.

Both parents tend to find rationalizations for avoiding professional help. The most common are: 1) the problem is being exaggerated and is actually much milder than the person who has pressured the parents to seek help believes it to be, 2) it will go away with time, 3) evaluation or treatment might in some way damage the child's sensitive nature or paradoxically make matters worse boy "making the child think about it more," and 4) the feminine son is "destined" to become homosexual (or other very feminine male) regardless of any intervention, so why bother?

In the rare case in which there is no covert parental resistance, therapeutic change may occur with extraordinary speed.(Green 1972)

The therapist has to bring into the open and fight the nihilism of the parent (usually the father) who feels that his son is already a homosexual or worse and wants nothing to do with him.

THE TREATMENT PHASE: ... Mothers may feel that because the son has so little else (no boy friends, girl friends whose parents dislike him, ostracism at school), it would be cruel to deprive him of his feminine activities. They may covertly supply him with feminine play materials after treatment starts because they do not want him to be sad.

CASE REPORT: The boy felt that his father hated him... The mother secretly hated what she then thought masculinity was -- a mixture of brutality, sexual license, and boorishness. These had been qualities of her own hated father, and she felt they were also characteristics of her husband. .. She discouraged any signs of assertiveness or aggressiveness in her son and often expressed to him her hatred for the "nasty" boys in the neighborhood.

After 15 months of treatment the boy, who had become much less effeminate in his mannerism, and had drawn away from his mother, seemed to regress... When confronted with this, the mother admitted in her session that she had given [her high heeled] shoes to her son because "I was all through with them anyway and he always used to admire them so..." With help , she was able to see that her behavior had been an effort to sabotage the treatment.

THE POSTTREATMENT PHASE: ... Pride in being a boy appears for the first time along with increased aggressiveness toward the mother, breaking their symbiotic tie.

ETHICS OF TREATMENT FOR FEMININE BOYS: ... The preference for feminine behaviors seems to be based upon a deficit in learning masculine behaviors from an appropriate model... Experiences of being ostracized and ridiculed may play a more important role than has been recognized in the total abandonment of the male role at a later time. ..Treatment should not be directed not at turning the feminine boy into an athlete or suppressing his aesthetic yearnings, but rather at developing his pride in being male.

==========

GENDER IDENTITY PROBLEMS

Green, R. (1974) *Sexual Identity Conflict in Children and Adults.* Baltimore: Penguin.

The following are direct quotations from the source:

FEMININE BOYS: PARENTAL DESCRIPTIONS: ..."He loves *The Wizard of Oz*. ... he usually plays Dorothy or the Wicked Witch... he'll try to find a pair of my shoes that are like Dorothy's shoes -- you know her magic shoes." (p.154)

These parents report that their son, at age two and a half, began showing an intense preoccupation with one item of women's attire -- the classic fetish -- high-heeled shoes. (p. 158)

... When asked to draw a person normally girls draw females and boy draw males, however when "feminine" boys were asked to "a person the majority of the feminine boys drew a female. In addition, when they were asked to draw a picture of themselves, the feminine boys drew a girl. (p.162)

"I didn't want it to be too rough. If I saw that he was going to be hurt--now this was before he was five years old--he went out once and the other boys, his own age, were going to push him down the concrete steps--and I stopped them, stopped him from getting pushed. And I think I did more of that than I needed to do."

"Competitive sports are frightening to him. Yet I've seen him out there with a big rubber ball like a basketball socking it against the garage door and then catching it on his own. When there's no other person involved, the fear is eliminated, but when the other person's involved, the unsureness -- whether they'll hurt him -- comes through."(p.165)

FEMININE BOYS: HOW THEY GET THAT WAY

The following factors have been found in association with the emergence of boyhood femininity...

---

1. Parental indifference to feminine behavior in a boy during his first years.
2. Parental encouragement of feminine behavior in a boy during his first years
3. Repeated cross-dressing of a young boy by a female.
4. Maternal overprotection of a son and inhibition of boyish or rough and tumble play during his first years
5. Excessive maternal attention and physical contact resulting in lack of separation and individuation of a boy from his mother.
6. Absence of an older male as an identity model during a boy's first years or paternal rejection of a young boy.
7. Physical beauty of a boy that influences adults to treat him in a feminine manner.
8. Lack of male playmates during a boy's first years of socialization.
9. Maternal dominance of a family in which the father is relatively powerless.
10. Castration fear (p.212)

"... he was a year and a half and these two little girls took him and they dressed him up completely from a wig all the way down to shoes. And he started to play with dolls them.

Everybody thought *it was cute. Everyone laughed*."(p.217)

"he was a very delicate baby. He didn't belong out there with the other boys! He belonged inside with *me*. I didn't want him to get dirty. I wanted him to be clean all the time. and I used to make him little shirts with little panties. Of course I made my other sons that, but with him it was *special* because I wanted *a girl* so bad, and he had the features of a girl."(p.219)

==========

Green, R., Roberts, C., Williams, Goodman, M., Mixon, A. (1987) Specific cross-gender behavior in boyhood and later homosexual orientation. *British Journal of Psychiatry.* 151: 84 -85.

The following are direct quotations from the source:

ABSTRACT: Data from a group of males aged 12 to 23, who as children exhibited extensive cross-gender behaviour, was analyzed. In boyhood they frequently played with dress-up dolls, role-played as females, dressed in girls' clothes, stated the wish to be girls, primarily had girls as friends, and avoided rough-and-tumble play. The majority of the group evolved a bisexual or homosexual orientation; two types of behaviour, boyhood doll play and female role-playing, were found to be associated with later homosexual orientation. The findings suggest developmental associations between specific types of boyhood cross-gender behavior and the objects of later sexual arousal. (p.84)

==========

GID BOYS

Bates, J., Skilbeck, W., Smith, K, Bentley, P. (1974) Gender role abnormalities in boys: An analysis of clinical rates. *Journal of Abnormal child Psychology.* 2, 1: 1 - 17.

The following are direct quotations from the source:

ABSTRACT: ... Children judged as noneffeminate or mildly effeminate were less effeminate ($p < .001$), came from more stereotypically normal families ($p < .05$), and tend to be less overprotected ($p < .10$) than highly effeminate children. Effeminate children between ages 5 and 7 tended to be more effeminate ($p < .10$) and less overprotected ($p < .10$) than effeminate children between ages 8 and 10. (p.1)

SUBJECTS: The subjects of the study were 29 boys, 5 -- 13 years old, evaluated and treated for gender role abnormality. (p.3)

GENDER ROLE ABNORMALITIES: ...Edward A., a 5-year-old boy who had been adopted shortly after birth. Edward showed a very strong interest in dressing in his mother's clothes and female costumes at nursery school. He took a feminine role in games, seldom played with boys, and had no interest in masculine games. Even for such a young child his gestures and speech inflections were often effeminate, particularly when excited. This pattern, present from at least age 3, seemed partially to stem from his play with a very dominant 7-year-old neighborhood girl who encouraged Edward in his effeminate ways. (p.7)

Barry B., an 11-year-old child adopted at birth, who was relatively high on family normalcy. The family had always been intact, but Barry's father often worked late. The parental power was evenly divided in this family, and neither was unusually masculine in his or her behavior. Barry, although highly effeminate, was well-liked by most of his peers. His good nature and enthusiasm, and possibly the more liberal behavior standards of his upper middle class neighborhood, helped him avoid the rejection confronting other equally effeminate boys. (p.7)
Frederick, C., age 7... a clinging, fearful boy who was somewhat clumsy and compulsively clean, was not permitted to roam the neighborhood because of his mother's constant fear that he might be injured by the rough neighborhood boys. His mother also protected him against any anger from his large, imposing father who slept days and worked nights. Since she saw her son as helpless to achieve things by himself, she continued to bathe him herself, and even required that he change clothes with her in the women's locker room at the public swimming pool. Roughness, noise, and physical risk were not allowed. (p.7,10)
Owen D., aged 10... was an isolated, rejected child without male friends. At times, he was permitted to play feminine games with his younger sister's friends, but even they often excluded him. He tended to be passive, was unenthusiastic about nearly everything (including activities laboriously devised to interest him), and responded very little to social rewards and punishments from any source. This turned-off style had long ago extinguished his father's interest in him, which was only partially rekindled during therapy. Parental conflict resulted from Owen's mother being a strict disciplinarian and his father being more permissive. Owen was closest to his mother, while Owen's sister, a girl whose masculine interests and skills put Owen to shame, was closest to her father.(p.10)
DISCUSSION: ...Children who were judged to have a significant degree of gender role problem showed a cluster of effeminate features... to a greater degree in early childhood than middle childhood. It would probably be unjustified to conclude that this reduction in overt effeminacy in middle childhood represents a meaningful change in gender identification. As others have noted, social pressures on effeminate children can lead to overt acquiescence in gender behavior while effeminate preferences are forced "underground" only to appear later in life. (p.13)

... comparisons do suggest that the referrals were seen rather uniformly as being unable to deal successfully in interpersonal situations. In support of this interpretation, 19 of our referrals were judged to be more reinforcing; 23 were judged to be more rejected by peers than normal, while only 1 was seen as more popular. Such lack of social attractiveness would leave these children unable to enter peer reinforcement systems in which spontaneous correction of inappropriate behavior, both gender related and nongender related, might be brought about. As might be expected, this situation seemed to be associated in high and low gender-problem boys alike with more general dysfunction in development. For example, 20 of our referrals were judged to be less happy than most children, and only 1 was judged to be more happy; 15 were seen as independent than normal, and only 4 as more independent; and 18 were seen as immature overall for their ages, and only 3 as more mature...

It seems likely that it is the combination of effeminacy, fearfulness, social aversiveness; and immaturity that together constitute sufficient conditions for parents, schools, and others to seek clinical intervention for effeminacy. Boys can be seen as passive, harm-avoidant, immature, and socially unresponsive without necessarily being seen as having significant gender

disturbance. In addition, even within the group of boys considered to have a gender disturbance there can be come family characteristics such as the mother not accepting masculinity**...**(p.14)

==========

ROUGH-AND-TUMBLE PLAY .

Friedman, R. Stern, L. (1980a) Juvenile aggressivity and sissiness in homosexual and heterosexual males. *Journal of the American Academy of Psychoanalysis*. 8,3: 427 - 440

The following are direct quotations from the source:
INTRODUCTION: ... We were impressed that so many nonpatient homosexual men reported by Saghir and Robins did not describe an aversion to rough-and-tumble activities. We felt that it would be important to replicate the existence of a significant subgroup of homosexual men who experienced a "normal" or average amount of same-sexed peer aggressivity during juvenile years. Obviously, if such a group does exist, then theories about the importance of aversion to male peer aggressivity in the etiology of homosexuality would be weakened.(p.428)

We hypothesized that at least one-third of a group of masculine, socially well-adjusted homosexual men would describe normal participation in rough-and-tumble activities during these developmental periods. We further speculated that these developmental periods. We further speculated that these individuals should be similar to heterosexual boys in terms of interests, peer relationships, and overall behavior.
METHODS: The sample consisted of two groups 17 men each. One group was exclusively homosexual, the other, exclusively heterosexual. ...

Subjects were excluded if they manifested effeminacy, childhood histories of more than incidental cross-dressing, sexual desire for females, history of sexual activity with females... Subjects were excluded if, during the past year, they demonstrated affective disorders, drug abuse, depression, excessive and problem drinking, anxiety-phobic neurosis, antisocial personality, psychophysiolgical reactions, venereal disease, or suicide attempts.(p.429)
DESCRIPTION OF SAMPLE: ... No subjected related that he had ever had venereal disease nor had any subject ever made a suicide attempt.(p.431)
RESULTS: AGGRESSIVITY AND ROUGH-AND-TUMBLE PLAY IN HOMOSEXUALS AND HETEROSEXUALS: No Experience with Aggression (with Resultant Adverse Social Consequences).
Homosexuals: Thirteen of the 17 homosexual subjects (76%) reported chronic, persistent terror of fighting with other boys during the juvenile and early adolescent period. The intensity of this fear approximated a panic reaction. **To the best of their recall, these boys *never* responded to challenge from a male peer with counter-challenge, threat, or attack. the pervasive dread of male-male peer aggression was a powerful organizing force in their minds**. Anticipatory anxiety resulted in phobic responses to social activities; the fantasy that fighting *might* occur led to avoidance of wide variety of social interactions, especially rough-and-tumble activities (defined in our investigation as body-contact sports such as football and soccer).

These subjects reported that painful loss of self-esteem and loneliness resulted from their

extreme aversion to juvenile peer aggressive interactions. All but one (12 of 13) were chronically hungry for closeness with other boys. Unable to overcome their dread of potential aggression in order to win respect and acceptance, these boys were labeled "sissies" by peers. These 12 subjects related that they had the lowest possible peer status during juvenile and early adolescent years. Alternately ostracized and scapegoated, they were the targets of continual humiliation.(p.432)

All of these boys denied effeminacy. Only three formed compensatory close relationships with girls and enjoyed girl-like activities such as doll play and hopscotch. The rest simply remained chronically isolated and fantasized friendship with other boys...

All 13 youngsters had markedly negative feelings about their bodies. In ten cases, subjects described them as soft and flabby (in six cases, to their consternation) as being "like a girl's." ... Another boy had poor vision and, as a result, "hated his body." In all cases, the body was perceived as being easily damaged. All subjects expressed a strong fear of physical injury were they to engage in contact sports.(p.433)

Heterosexuals: Only two heterosexual boys (12%) reported a response to real or fantasized male peer-peer aggression similar in quality, chroncity, and consequence to that occurring in the prehomosexual males.

SOME EXPERIENCE WITH AGGRESSION

Homosexuals: No prehomosexual youngster had *any* degree of experience with fighting or rough-and-tumble during the juvenile years. None engaged in even the modest juvenile sex-typed interactions described by the least aggressive heterosexual youngster.

Heterosexuals: Thirteen subjects related that they engaged in male-male peer aggression to some degree during their juvenile and adolescent period. All of these boys occasionally initiated attack, all responded to challenge with counter challenge... Despite varying degrees of timidity, all engaged in some fighting and made no heroic efforts to avoid it. Mastery of the anxiety resulting from fear of defeat and injury itself was an important source of self-esteem during their juvenile years in all cases.

NO EXPERIENCES WITH AGGRESSION (BUT NO ADVERSE SOCIAL CONSEQUENCES) The remaining cases consist of four prehomosexuals and four preheterosexuals. these individuals all denied extreme fear of fighting with resultant social phobic reactions. These eight subjects maintained that they did not fight during the juvenile and early adolescent years because fighting was no part of their peer culture... These boys had adequate peer status.(p.434)

DISCUSSION: ... Our homosexual subjects were not conflict-ridden about their sexual preferences, absence of major present psychopathology, and, unlike individuals in less selective studies, had no past histories of arrests, venereal disease, or suicide attempts.... Our findings suggest that at least for some boys, 'sissiness; refers more to negative feelings about one's place in the world of males than to recognition that one belongs to the world of females... the sissies in our study were not hopscotch-playing, girl-like boys. Rather, they were boys who, to their shame, were unable to develop behaviors that would make them acceptable to male peers. (p. 435)

We favor the hypothesis that the wish to be sexually close to males arose in a setting where there were intense longings for general closeness with male peers at a critical period of

development. The erotic desire appeared to repair in fantasy feelings of deprivation resulting from inadequate positive social input. It is important to note that all the sissies lost their sissy labels by mid-to late adolescence, but by this time, their sexual orientation appeared to have been fixed.

Although we were well aware that prehomosexual youngsters tend to avoid aggressive activities, we were astonished at the universality of this finding in our study, and at its age specificity. Many prehomosexual youngster developed skills at aggressive behavior during later years. In our study not a single youngster had what must be termed positive aggressive input during juvenile years.(p.436)

We emphasize that male-male aggressive competency during the juvenile years is conceptualized by us with respect to homosexual development as being an extinguishing fact, not a cause.

... we conceptualize a durable father-son relationship as being a preventive agent with respect to homosexual development.(Friedman 1980b) (p.437)

Successful attainment of a minimal degree of aggressivity increases the likelihood that a boy will obtain social supports with peers that further his development of masculine autonomy.

Two heterosexual sissies manifested attributes of the prehomosexuals sissies. .. in one case the answer lies in the dynamics of the subject's family: the mother persistently and energetically pushed her son toward heterosexuality. The remaining preheterosexual sissy had a psychobiography that follows the classic patterns outlined by the Bieber group as predisposing toward homosexuality. This suggests to us that occasionally heterosexuality may develop in boys irrespective of psychosocial influences that should lead to homosexuality. (p.438)

==========

GID IN BOYS

Zuger, B., Taylor, P. (1969) Effeminate behavior present in boys from early childhood: II Comparison with similar symptoms in non-effeminate boys. *Pediatrics.* 44, 3: 375 - 380.

The following are direct quotations from the source:

ABSTRACT: Data on the frequencies of certain feminine-type symptoms in two groups of boys, numbering 84 and 95 each, were obtained from their parents. These frequencies were much lower than those in a comparable group of 26 effeminate boys. The individuals of the non-effeminate group who did show possible symptoms generally had fewer of them than did the individual effeminate boys. A shorter duration and other characteristics of the symptoms usually differentiated the non-effeminate from the effeminate boys.(p.375)

COMPARISON WITH EFFEMINATE GROUP: ... In the non-effeminate boys, the manifestation of a possible effeminate trait was usually singular, e.g. putting on high heels as a possible manifestation of feminine dressing. In the effeminate boys such manifestations were almost always multiple, e.g., feminine dressing would include wearing many items of women's dress, with perhaps placing something on the head to simulate women's hair , or even wearing a

sweater over the shoulders like a woman. (p.378)
DURATION OF FEMININE ACTIVITY: ... In the case of the boys considered effeminate, the manifestation of symptoms was continuous, if allowed, and even if forbidden would come out in furtive ways. The symptoms underwent various metamorphoses (feminine dressing, for instance, into interest in clothes, male and female) some disappearing by 9 to 10 years of age (e.g. doll playing); others, like aversion to boys' games and feminine-type gesturing continued into adolescence.
DISCUSSION: The belief is widely held that feminine-type interests in very young boys are common and are eventually outgrown. Several of the parents of the effeminate children we have been following had consulted their pediatricians specifically for their boys' effeminate behavior and were told to "forget it." Such behavior obviously deserves the pediatrician's attention so that he may differentiate what may be a passing manifestation from a more malignant kind. (p.379)

==========

FAMILIAL FACTORS

(It should be noted that the author makes claims in his conclusions which are not supported by the data he presents.)

Zuger, B. (1970) The role of familial factors in persistent effeminate behavior in boys. *American Journal of Psychiatry.* 126, 8: 1167 - 1170.

The following are direct quotations from the source:
ABSTRACT: The author describes a study of the familial environment of 25 young effeminate boys. In most cases the parents' relationship with each other and the sons was good. The boy's closeness to their mothers and distance from their fathers appeared to reflect their interests from the beginning. There were no statistically significant differences between this and a similar group of non effeminate boys.
INTRODUCTION: ... Twenty-five boys with persistent effeminate behavior and 84 noneffeminate boys were studied. They were consecutive admissions to the Greenwich Hospital children's psychiatric clinic and the author's private practice. (p.1151)
FINDINGS: ... The parental marital situation was fair to good in 14 (58 percent of the effeminate boys and 44 (58 percent) of the non effeminate boys. Poor or broken marriages amounted to 24 and 20 percent, respectively for the effeminate group compared to 20 and 27 percent for the noneffeminate group.(p.1152)
PARENTAL ATTITUDES TOWARD EFFEMINATE BEHAVIOR: Among the parents of the 25 effeminate boys only six of the mothers and two of the fathers had strong negative reactions to the effeminate behavior from the very beginning. The remaining parents were either unaware of the problem, confused about it, or tolerant of it. Four of the families had consulted their pediatricians regarding their sons' behavior and had been advised to ignore it. Some parents expressed the fear that they would be frustrating their children if they forbade their practices.
CHILD'S PARENTAL PREFERENCE: ... In 21 of the 22 cases for which data were available, the [effeminate] boy was considered closer to the mother, and in only one to the father.
... The closeness of the effeminate and noneffeminate boys to their mothers was different

qualitatively. The noneffeminate boy solicited his mother's attention and sympathy in regard to his own concerns and occupations; the effeminate boy aligned himself with those of his mother -- her domestic duties, her dress, appearance, etc.

On the other hand, the effeminate boy had no interest in the activities of his father. This gradually led to separation from him. (p.1169)

DISCUSSION: ... The findings in this study indicate that parental relationships and attitudes in families of effeminate boys are not very different from those in families of noneffeminate boys. It would appear, then, that these relationships and attitudes are not a significant factor in the origin and development of persistent effeminate behavior. It appears instead that the origin and development of such behavior is inherent in the boys themselves. (p.1170)

==========

EFFEMINATE BEHAVIOR IN BOYS

(It should be noted that the final conclusion is not demonstrated by the material presented)

Zuger, B. (1984) Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disorders* 172, 2: 90 - 97.

The following are direct quotations from the source:

ABSTRACT: This is a long term follow-up of 55 boys with early effeminate behavior. It was possible to determine the outcome in sexual orientation in 38 of the boys, which included homosexuality or variants of it in 35 (63.6 per cent) of the total of 55 and heterosexuality in three (5.5 percent). In 10 boys the outcome was uncertain, and seven were lost to follow-up. .. the conclusion is ventured that all male homosexuality begins with early effeminate behavior.

SUBJECTS AND METHODS: ... Reasons for referral varied : effeminate behavior primarily --33 patients; effeminate behavior and beginning homosexuality (older boys) -- 6 patients, effeminate behavior or homosexuality plus behavior problems - three patients; behavior problems primarily plus effeminacy -- three patients; behavior problems primarily -- 10 patients. (p.70)

Police discovered another boy at age 13 paying other boys to have sex with him; he said he had known he was homosexual since age 9, and was later a confirmed homosexual.(p.71)

ONSET OF EFFEMINATE BEHAVIOR:.. questioning of some of the effeminate boys as to onset produced such answers as "always," "all the time," "feeling different all my life," "never interested in boys' things." One boy at about 2 years of age, insisted on being dressed in girl's clothes before he would go to nursery school. Similarly, another boy less than 4 years of age would not leave the house unless in dress and makeup like a girl.

COMMON EARLY SYMPTOMS: ... These boys were also excessively aware of their mothers' dress and would often comment about it. (p.92)

The high frequency with which these boys were described as "loners" was probably the resultant factor of other behavioral characteristics, such as disinterest in boys' games and sports, preference for playing with girls at their games, and their tendency to be "bossy" with whomever they played. Their inadequacy at boys' games was often explained by their mothers as due to

clumsiness. Dislike of gym class and athletics generally was present in almost all the boys and became manifest very early. As they grew older, it because more intense; to be excused from attending gym class was often the initial reason in older boys for seeing a psychiatrist. (p.93)
DISCUSSION: ... How did the three boys who ended up heterosexual differ from those who became homosexuals?... The first showed no interest at all in boys' games and sports. He had become very religious and was attending an orthodox religious school where sports aroused little interest and no encouragement. There was no gym at the school.(p.95)

Retrospective studies have their own problems ... One of the boys was referred for effeminate behavior at 11 years of age... When seen at 31 years of age, and after he had disclosed that he was a homosexual, he remembered none of the earlier symptoms except that he had been lonely.
CONCLUSION: Taken together, prospective and retrospective studies point unmistakably to the high incidence of adult homosexuality as the final outcome in male children manifesting early effeminate behavior. ... Effeminate behavior parallels corresponding behavior of noneffeminate boys in time of appearance, its widespread and varied expression, its acceptance as natural to the organism, and its strong resistance to change. This would argue against an external imposition. It would appear most likely that the basic organization for effeminate behavior is present at birth in the same sense as the potential for walking or talking. These considerations and its omnipresence in homosexuality as gathered from prospective and retrospective studies would warrant the proposition that all male homosexuality begins with early effeminate behavior, that it is congenital, though whether it is genetic or incidental to an event in fetal life remains to be determined. (p.96)

==========

EFFEMINACY IN BOYS

Zuger, B. (1988) Is early effeminate behavior in boys early homosexuality? *Comprehensive Psychiatry.* 29, 5: 509 - 519.

The following are direct quotations from the source:
INTRODUCTION: In a previous report the proposition was advanced that homosexuality in boys begins with early effeminate (cross-gender) behavior and that it is congenital, though whether it is also genetic was left open.

Looking at early effeminate behavior as part of the growth pattern of homosexual boys gives understanding to the "prehomosexual" years and adds continuity to its natural history. (p. 509)
COURSE OF EARLY SIGNS: ... By about 3 years of age, 21 of the 57 mothers, and by 6 years of age, 49 of them, knew that their boys' behavior was atypical. (p.510)
DISCUSSION: Bieber et al reached a conclusion similar to Kinsey's that homosexuality was a matter of nurture and not nature, but that it was a pathologic condition and not a biologic variant.

But the answer to the question when homosexuality begins has been available all along -- from the effeminate boy himself. From the very beginning, however differently he might have

been saying it, the effeminate boy has been delivering the same message: "I am a girl, not a boy." This he did verbally and behaviorally probably at the earliest time he could express it, and objectively for the observer to apprehend it, if he or she would.

Essentially, the effeminate boy's development mirrored that of a girl. He wanted to dress and appear like a girl...

The formulation of Bieber et al. has been widely accepted, at times even by the principals themselves -- the homosexual son and one or the other of his parents.
CONCLUSION: Early effeminate behavior in boys and later homosexuality constitutes a developmental sequences which is consistent with each other.(p.517)

==========

LONGITUDINAL STUDY OF GID BOYS

Money, J., Russo, A. (1979) Homosexual outcome of discordant gender activity role in childhood: Longitudinal follow-up. *Journal of Pediatric Psychology.* 4, 1: 29 -49.

The following are direct quotations from the source:
ABSTRACT: ...Nine of 11 boys with prepubertal discordance of gender identity/role have been maintained in follow-up until young adulthood. All are known to be homosexual or predominately so. None is known to be either a transvestite or transsexual, though one formerly began the real-life test for transsexualism and quit after 6 weeks....There was a consensus in adulthood that the nonjudgmentalism of those responsible for their follow-up over the years had had a strongly positive therapeutic effect on the boys' personal development. (p.28)
ETIOLOGY: ... In some cases, the relationship between the parents was blatantly pathological, in others not. When the parents were caught in a pathological relationship, the nature of the pathology was not consistent among families...(p.37)
DAGNOSIS: ... In the present era of equal rights for both sexes and of the destereotyping of occupational, recreational, and legal sex roles, one may be called upon to justify the legitimacy of labeling a boy's behavior as girlish and then classifying it as pathological. In the present group of cases, it was not simply girlish or androgenous behavior that brought the boys to medical attention. Rather it was the pervasive discordance between the sex of the genitalia and the sex of the mind, so pervasive that each boy had developed a conviction that he should change into a girl, and that he should be able do so by somehow or other losing his penis, for example, by praying to God to perform the miracle of having it wither and drop off...

At the time they were first seen, these boys were unable to expand their repertory of behavior to encompass that which in our society is stereotypically coded as male as well as that which is coded female. They had no option of moving back and forth between both sets of stereotypes, which is the true mark of sexual liberation and of behavioral androgyny. They were trapped in one of the two stereotypes, the one in which they were victimized as freakish, and in which they suffered too much at the hands of a disapproving society. (p.38)

==========

LONGITUDINAL STUDY

Green, R. (1985) Gender identity in childhood and later sexual orientation: Follow-up of 78 males. *American Journal of Psychiatry.* 142, 3: 339 - 441.

The following are direct quotations from the source:

ABSTRACT: Two groups of males were evaluated on parameters of gender identity, initially in boyhood and later in adolescence or young adulthood. One group was composed of 66 clinically referred boys whose behaviors were consistent with the diagnosis of gender identity disorder of childhood. The other group consisted of 56 volunteers selected on the basis of demographic matching. Two-thirds of each group were reevaluated for sexual orientation; 30 of the 44 who previously had shown extensive cross-gender behavior and none of the 34 in the comparison group were bisexually or homosexually orientated. (p.339)

DISCUSSION: This longitudinal study of two groups of boys demonstrates that the association between extensive cross-gender behavior in boyhood and homosexual behavior in adulthood, suggested by previous retrospective reports, can be validated by a prospective study of clinically or family-referred boys with behaviors consistent with the gender identity disorder of childhood. However, not all boys with extensive cross-gender behavior evolved as bisexual or homosexual men. No boys in the comparison group evolved as bisexual or homosexual...(p.340)

==========

PREVENTION OF HOMOSEXUALITY

Brown, D. (1963). *Homosexuality and Family Dynamics.* Paper presented at the Annual Air Force Clinical Psychology Meeting, Jan. 10. *Bulletin of the Menninger Clinic*. 27: 227 - 232.

The following are direct quotations from the source:

In summary, then it would seem that the family pattern involving a combination of a dominating, overly intimate mother *plus* a detached, hostile or weak father is beyond doubt related to the development of male homosexuality...It is surprising there has not been greater recognition of this relationship among the various disciplines that are concerned with children. A problem that arises in this connection is how to inform and educate teachers and parents relative to the decisive influence of the family in determining the course and outcome of the child's psychosexual development. There would seem no justification for waiting another 25 or 30 years to bring this information to the attention of those who deal with children. And there is no excuse for professional workers in the behavioral sciences to continue avoiding their responsibility to disseminate this knowledge and understanding as widely as possible. (p.232)