

The Medicalization of Gender and Sexual Deviance:

Social Values and Psychiatric Diagnosis

Megan R. Yost

Dickinson College

Tara E. Smith

Elizabethtown College

Abstract

Over the past century, our attitudes about and treatments for mental illness have changed dramatically. This is particularly evident in the case of disorders involving gender and sexual variation, as these disorders involve an individual who differs from the norm in a way that society finds objectionable. If individuals experience rejection by society for their differences in the realm of gender or sexuality, do we consider their distress to be symptomatic of illness, or is their distress a sign of an intolerant society? In this chapter, we examine the history of the psychiatric community's diagnoses of homosexuality and gender identity disorder. Psychiatric diagnoses are written by physicians whose understanding of illness is shaped not just by scientific research but also by societal opinion. Psychiatric diagnoses both guide *and* reflect societal understanding of difference, and the history of the American Psychiatric Association's treatment of homosexuality and gender identity disorder illustrates this give-and-take between societal opinion and medical practice.

Samantha is a 22-year-old woman who is seeking treatment because she's "having trouble with family" and has been "feeling so low for a long time." Though she is initially reluctant to discuss what preceded her "feeling low," Samantha states that she recently moved out of the apartment she shared with her female lover, and returned home to live with her mother and brother. She feels grief over the loss of her relationship, but also pressured by her family to confirm their impression that the relationship was a meaningless infatuation. Samantha thinks she may be attracted to other women in the future, but isn't sure and is worried her mom might disown her. She reports that on multiple occasions she has stayed in bed for days because she is overwhelmingly tired and, "just can't deal with anything, especially my mother." She feels sad most of the time, and cannot muster interest in any of the things that she used to enjoy doing,

Quinn is a six-year-old boy for whom his parents seek treatment because "he wants to be a girl." Quinn's parents have tried to encourage friendships with boys, but he dislikes rough, active play and prefers to play house and Barbies. He is very interested in jewelry and female apparel, and, though his parents actively discourage this behavior, he likes to pretend a towel is a skirt or a T-shirt is a dress. Upon interview, Quinn states that he wishes "a fairy could change him into a girl" and that what he likes about being a girl is wearing dresses and long hair. His development has otherwise been similar to other boys his age (he learned to crawl, walk, and talk at expected ages), and he appears of average intellect.

(Adapted from Spitzer, Gibbon, Skodol, Williams, & First, 1989)

Do you think Samantha and Quinn are psychologically healthy? Why or why not? What type of treatment, if any, do you believe they each need? What might Samantha's life be like in 10 years if she does receive treatment? If she doesn't? What about Quinn? Consider why you answered these questions the way that you did. Did your own personal experience or the experiences of one of your friends influence your opinion? What about something you read in a novel or saw in a movie? Or your own moral or religious beliefs regarding sexuality and gender?

Up until the early-1970s, Samantha would likely have been diagnosed with what were then considered two mental disorders: depression and homosexuality. Today, Quinn would be diagnosed with gender identity disorder. In this chapter, we explore the politics of these diagnoses, focusing on the ways that societal norms and values have influenced the psychiatric community's beliefs about gender and sexuality.

Psychiatrists and other mental health professionals define mental disorders as dysfunctional patterns of thoughts, emotions, or behaviors that are atypical (rare in comparison to others in one's culture), disturbing (judged to be unacceptable according to the standards of one's culture), maladaptive (potentially or actually harmful to oneself; causing feelings of distress or impairing one's ability to function), and unjustifiable (again, as judged by others) (Spitzer, 1997). All aspects of this definition are socially contingent, depending upon the judgment of others in one's society. As such, each and every

diagnosis given by psychiatrists is based on a social comparison with other, apparently “normal,” people and is dependent on societal beliefs about normality. Because societal values shift over time, so too do diagnostic categories. For example, in the 1800’s, William Acton, a prominent physician, considered it atypical, disturbing, and maladaptive for women to have orgasms during sexual encounters, and women who did experience orgasms were thought to have a disorder (Wakefield, 1997). In the mid 1900s, Masters and Johnson, biological sex researchers, considered it atypical, disturbing, and maladaptive for women *not* to have orgasms, and there is now a psychiatric diagnosis for orgasm disorders (Wakefield). Unlike physical disorders, whose diagnosis usually involves clear symptoms and obvious outcomes, the diagnosis of mental disorders has depended upon more subjective experiences of personal distress, the perceptions of family and significant others, and social values and norms.

To aid in the diagnosis of mental disorders, the national organization for psychiatrists, the American Psychiatric Association (APA), developed a classification of mental disorders called the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), first published in 1952. At the time, the US government was interested in gathering statistics about the prevalence of various psychiatric disorders, and a widely-accepted classification scheme was needed in order to define types of mental disorders. According to the APA, “The purpose of DSM-IV is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about study, and treat people with various mental disorders.” (1994, pp. xxvii). Mental disorders listed in the DSM represent the current psychiatric standards of mental health and the classification of mental illness.

One area in which the influence of social norms is strikingly apparent is in the DSM diagnoses for sexual and gender identity disorders. Sexual deviance and gender deviance are especially controversial, and their expression has evoked strong and negative reactions in observers. For example, the murderers of Matthew Shepard, a young gay man killed in Wyoming in 1998, claimed that they were driven into a psychotic rage when Matthew made sexual advances. Similarly, Gwen Araujo, a transgender teenager, was brutally killed in 2002 when friends at a party discovered she was biologically male. In both of these cases, the perpetrators reportedly felt such rage when confronted with differing sexual or gender expression that they were driven to kill. Although the “gay panic” defense (in which a perpetrator seeks a charge of manslaughter rather than murder, by claiming temporary insanity was brought on by learning

about the victim's homosexuality or transgender identity) is now illegal in California and Wyoming, and faces challenges in many other states, these examples still illustrate the intense and negative emotional response that many people have when confronted with people who do not conform to mainstream ideas about sex and gender.

Perhaps due to this societal discomfort regarding sexual and gender deviance, psychiatric diagnoses involving sex and gender have a history of being inextricably tied to social values, more so than other diagnoses (e.g., depression, anxiety, schizophrenia). Although few people disagree that the inability to get out of bed in the morning accompanied by prolonged and deep feelings of sadness are symptoms of a problem, many people disagree that people like Samantha are psychologically disordered due to their same-sex attractions, or that people like Quinn are psychologically disordered due to their cross-gender identifications.

In this chapter, we examine two psychiatric disorders that have clearly been influenced by societal values: homosexuality and gender identity disorder of childhood. Homosexuality, manifested by sexual attraction, fantasy, or behavior toward a person of the same sex, was considered a mental disorder in the U.S. until 1973 when it was removed from DSM-II. Conversely, gender identity disorder of childhood (children acting as or identifying with the other sex) was first included in DSM-III in 1980. In addition, these two "disorders" are theoretically related, in that gender non-conformity is associated with homosexuality in both the research and clinical literature (Bradley & Zucker, 1997; Green, 1987) and in popular opinion (Deaux & Lewis, 1984; Kite & Deaux, 1987; Martin, 1990; McCreary, 1994; Taylor, 1983). Despite their similarities, the inclusion of these "mental disorders" in the DSM has been fiercely debated as societal views around sexual orientation and gender have changed over time. We will trace the history of psychiatry's views of homosexuality and examine the ongoing controversy over the relatively new diagnosis of gender identity disorder. Through a discussion of these two so-called disorders, we hope to illustrate the ways in which societal values, psychological research, and psychiatric diagnoses influence one another in the conceptualization of mental health and illness.

Homosexuality as a Psychiatric Disorder

The medical establishment, specifically psychiatry, became involved in issues of homosexuality relatively recently. Up until the late 1800s, homosexuality was not conceptualized as a sexual identity,

but rather simply referred to the sexual practice of same-sex sexual behavior. Homosexual behavior was considered a religious issue, involving an unnatural and immoral act condemned by God. These religious beliefs were apparent in legal customs: early American settlers imposed stiff penalties for deviant sexual practices (including homosexuality) that could range from public shaming to corporal punishment or even death (Katz, 1976). Interestingly, it was not until the late 1800s and early 1900s that homosexuality began to be conceptualized as an identity; this shift in thinking about a homosexual person rather than a homosexual activity laid the groundwork for the later claims that homosexuality was a mental illness.

By the early 1900's, psychiatrists argued that homosexual behavior was not a religious issue, but rather a medical one. Although some early psychoanalysts believed homosexuality was an alternate form of sexual expression (both Sigmund Freud (1905/1953) and Havelock Ellis (1901) expressed tolerant and even supportive views of homosexuality and bisexuality), the majority believed that homosexuality was pathological. These psychoanalysts theorized that heterosexuality was the only natural sexual orientation and that homosexuality represented a disease or dysfunction. Krafft-Ebing, for example, argued that homosexuality was a degenerative sickness evident from birth (1906), and Lombroso believed that homosexuals represented a primitive stage of human evolution (1968). Similar theorizing on the psychopathology of homosexuality continued among psychoanalysts and psychiatrists through the middle of the 20th century (for examples, see Rado, 1949, and Socarides, 1968).

Importantly, these psychoanalytical theories, although highly influential in society at the time, were not developed from scientific research; rather, they were based on psychoanalysts' own observations of their patients. In other words, homosexual men and women who sought out psychiatric treatment or therapy served as the basis for psychiatric theories that homosexuality itself was a mental illness. This practice, although quite common and accepted at the time, is of questionable validity because the theories of homosexuality that were proposed failed to take into account the many gay men and lesbians that did *not* seek out psychiatric care. Without accurately sampling from the entire population, the theories could not be valid because they systematically excluded vast numbers of gay men and lesbians. Despite the lack of scientific evidence or research support, but with the backing of conventional wisdom born out of the moral climate and psychoanalytic, clinical "evidence" of the time, by the 1950s the psychiatric community treated homosexuality as a mental disorder that could be cured

through behavioral modification, electroshock therapy, hospitalization, hormone therapy, and aversive conditioning.

Not surprisingly, with a backdrop of religious and psychiatric condemnation of homosexuality, the social climate for lesbians and gay men through the 1950s was oppressive. Homosexual sexual activities were against the law, as had been the case since the time settlers colonized America. The military and the US government (led by Joseph McCarthy) engaged in witch hunts to uncover secret homosexuals and dishonorably discharge or fire them from any high-level positions. President Dwight D. Eisenhower signed an executive order in 1953 that banned all gays and lesbians from jobs in the federal government; this led to the firing or resignation of 7,500 federal workers (Faderman, Retter, & Ramírez, 2006). Police raids of gay bars and clubs were common, with gay, lesbian, and transgender patrons routinely harassed and abused by police. Religious beliefs about the primacy of heterosexuality and the immorality of homosexuality, and now also psychiatric and medical theories claiming that homosexuality was a disease, dominated US culture.

It was during this climate of anti-homosexual sentiment that the American Psychiatric Association first published their Diagnostic and Statistical Manual of Mental Disorders in order to create a common nomenclature of psychiatric diagnoses and to promote communication among clinicians. The diagnostic categories that appeared in the first edition of DSM (1952) were based on psychodynamic models which, as discussed above, had little empirical research support and instead came from clinician's own patients. In the first edition, homosexuality was listed as a sexual deviation under the broader category of sociopathic personality disturbance. To receive this diagnosis, an individual simply had to display homosexual behaviors. The diagnostic criteria reads, "Individuals to be placed in this category are ill primarily in terms of society and of conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals...The diagnosis will specify the type of the pathologic behavior, such as homosexuality, transvestism, pedophilia, fetishism, and sexual sadism (including rape, sexual assault, mutilation)." (pp. 38-39). The striking aspect of this criteria is that any homosexual, even if otherwise fully functioning and socially well-adjusted, would nonetheless receive a diagnosis of a mental disorder. In other words, the criterion discussed at the beginning of this chapter, maladaptive and causing distress or impairment, did not exist.

The late 1940s and 1950s were a period of remarkable growth of empirical research on sexuality and homosexuality. One of the most famous sex researchers, Alfred Kinsey, published results of the first large-scale survey of male sexual behavior in 1948 (Kinsey, Pomeroy, & Martin) and the first survey of female sexual behavior in 1953 (Kinsey, Pomeroy, Martin, & Gebhard). Through interviews with roughly 18,000 people, Kinsey discovered that homosexuality was much more prevalent than previously thought. Further, Kinsey radically demonstrated that sexual orientation should not be conceptualized as a dichotomy (heterosexual/homosexual); rather, he showed that sexual orientation exists on a continuum, ranging from exclusively heterosexual (score of 0) to exclusively homosexual (score of 6), but with a great number of people falling somewhere in-between (scores 1 – 5). By showing that homosexuality occurred somewhat frequently in men and women (anywhere from 3-10% of the population), and by showing that human sexuality could not be thought of in terms of sharp divides between heterosexuals and homosexuals, Kinsey encouraged greater tolerance around sexual orientation.

Other social scientists were simultaneously conducting research that suggested that homosexuality was not a mental illness. Ford and Beach (1951), in an anthropological analysis, found that homosexuality was considered socially acceptable for at least some people in 64% of 76 societies studied. The first study to explicitly compare heterosexuals and homosexuals on measures of psychological health and illness was published by Evelyn Hooker in 1957. In this groundbreaking research, Hooker gathered a sample of heterosexual and homosexual men from the community (meaning that they were not seeking psychiatric care). Hooker administered a set of tests that measure psychological distress and mental functioning. Then, a panel of psychiatrists were asked to score these tests, *without knowing whether the men were heterosexual or homosexual*. Hooker found that there was no difference between the men in terms of their psychological adjustment – about 2/3 of each sample was rated in the highest category of psychological functioning. When Hooker asked the psychiatrists to try to determine which men were heterosexual and which were homosexual (based on their responses to these tests), they could not reliably do so. Hooker concluded that homosexuality is not a psychiatric disorder nor is it reliably associated with any other psychiatric disorder.

Unfortunately, the psychiatric community largely ignored these advances in research when revising the DSM, and continued to define disorders based on clinician's psychiatric clients with a focus

on psychoanalytical theory. In 1968, the second edition of the DSM was published with revised classification categories and the addition of roughly 80 new diagnoses, still with the goal of promoting communication among clinicians. One important modification was an increased attention to the mental health of children and adolescents, which accounted for many of the new diagnoses. Further modifications involved the recategorization of existing diagnoses: sexual deviations, the broad category which still contained homosexuality, were no longer considered personality disturbances and were instead labeled as non-psychotic mental disorders. The new diagnostic criteria read, "This category is for individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances as in necrophilia, pedophilia, sexual sadism, and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them." (p. 44). This criteria continued to allow a psychiatrist to diagnose a gay man with the mental disorder of homosexuality even if he was otherwise fully functioning and content with his sexual orientation.

Just a year after DSM-II was published, a pivotal event in the gay liberation movement occurred. On June 27th, 1969, police officers began a routine raid of the Stonewall Inn, a gay bar in New York City. On this night, however, the gay and transsexual patrons at Stonewall fought back, rioting throughout the night to protest the unfair treatment by police. Many today regard the Stonewall riot as the beginning of the gay rights movement; historian John D'Emilio explains, "Gay liberation transformed homosexuality from a stigma that one kept carefully hidden into an identity that signified membership in a community organizing for freedom." (1983, p. 247). Gay liberation groups such as the Mattachine Society (predominantly gay men), the Daughters of Bilitis (lesbian women), and the Gay Liberation Front sprang up all over the country.

A primary focus of the activism of these groups was the depathologization of homosexuality. Protesters picketed the APA annual conferences, disrupted panel presentations, and arranged sit-ins to force the APA to allow homosexuals to present their views of homosexuality as a normal sexual variant. Finally, at the 1972 APA conference, a panel including homosexual laypersons and psychiatrists was arranged entitled, "Gay, proud, and healthy," and the following year a panel entitled, "Should homosexuality be in the APA nomenclature?" attracted a thousand participants (Bayer, 1987).

The direct result of this political activism was APA's decision to reconsider the diagnosis of homosexuality as a psychiatric disorder. In 1973, the APA began to radically reformulate the DSM, shifting away from a classification system based on psychoanalytic theory and moving toward more research-based diagnoses. This shift in diagnostic criteria coincided with similar shifts in the discipline of psychology at the time, as psychoanalysis and introspection were replaced in the 1960s and 1970s with the empirical study of observable behavior¹ (Myers, 2004). The discipline of medicine was also changing at this time, as advances in pharmacology and greater reliance on scientific rigor characterized the field (Menninger & Meniah, 2000). These changes in both psychology and medicine/psychiatry created a culture in which research was more highly valued. Furthermore, many psychiatrists now believed that the diagnosis of a mental disorder was only appropriate when an individual experiences distress or impairment. Robert Spitzer, a psychiatrist revising DSM-II, noted that homosexuality was one of the only mental disorders listed that did not inherently cause distress or impair a person's social functioning. Spitzer argued that the manual should no longer list homosexuality as a mental disorder in and of itself, but rather a new diagnosis of "sexual orientation disturbance" should be added in order to help those individuals whose "sexual interests are directed primarily toward people of the same sex and who are either disturbed by, in conflict with, or wish to change their sexual orientation." (1973, p. 1). This new diagnosis was a positive step in that it recognized the possibility of a psychologically healthy gay or lesbian individual, but still continued to pathologize homosexuality by perpetuating the idea that a gay or lesbian individual could or should be disturbed by this facet of themselves and may wish to change.

Psychological research around this time continued to find support for the notion that homosexuality is not associated with psychological distress. Various reviews of published articles comparing heterosexual and homosexual samples on a wide range of tests of psychological functioning found that both groups consistently score within the normal range, with few if any differences of clinical significance (Gonsiorek, 1982; Hart, Roback, Tittler, Weitz, Walston & McKee, 1978; Riess, 1980).

In response to this body of research and the great social pressure from gay liberation groups and now openly gay psychiatrists, the Board of Trustees of the APA voted to remove homosexuality from the DSM. After fierce debate among the members of APA, 10,000 psychiatrists voted on the issue; 58%

¹ Notable scholars pioneering this shift include B.F Skinner (1953, 1969), Albert Bandura (1965, 1977), and Konrad Lorenz (1965, 1970).

were in favor of the removal of homosexuality and 37% were opposed (Bayer, 1987). Opponents feared that the APA would appear to be bowing to social pressure from gay rights activists, and also worried that the removal would hinder their ability to help this “mentally disordered” group. However, with majority support, homosexuality was removed from the 6th printing of DSM-II, and DSM-III was published in 1980 without a diagnosis for homosexuality. As a compromise between gay rights activists and more conservative psychiatrists, this DSM contained a new diagnosis for “ego-dystonic homosexuality” (what Spitzer had previously termed sexual orientation disturbance). The diagnostic criteria read, “The essential features are: a desire to acquire or increase heterosexual arousal so that heterosexual relationships can be initiated or maintained and a sustained pattern of overt homosexual arousal that the individual explicitly complains is unwanted and a source of distress...Unless there are complications, such as depression, anxiety or problems with alcohol, there is generally no or only mild impairment in social functioning” (p. 30). This was one of the most controversial diagnoses in DSM-III because it continued to suggest that homosexuality was a mental disorder and it continued to diagnose despite lack of social impairment. Even if “homosexuality” no longer remained in the DSM, this new diagnosis continued to allow psychiatrists to diagnose a particular type of homosexuality, and to treat homosexuals in an attempt to make them heterosexual.

Opponents to this diagnosis, most notably an APA committee on Gay, Lesbian, and Bisexual Issues, argued that it is normal for homosexual individuals to go through a phase in which they are unhappy with their sexual orientation, primarily because gay men and lesbians experience high levels of social prejudice and stigma. It is inappropriate, the committee argued, for this normal reaction to societal prejudice to be labeled a psychiatric disorder. Furthermore, the president of the Association for Gay and Lesbian Psychiatrists, Robert Cabaj, stressed that continued inclusion of this diagnosis encouraged socially repressive policies in the larger society (Bayer, 1987). In 1987, with the publication of the revised manual, DSM-III-R, ego-dystonic homosexuality was removed.

Advances in the biological sciences during the 1980s and 1990s allowed researchers to begin to question the origin of sexual orientation, with a new focus on potential physiological and genetic influences on sexuality. Hormone studies found that excess androgens (masculinizing hormones) in developing female fetuses yield higher than expected rates of lesbianism and bisexuality as compared

with fetuses whose androgens are within normal limits (Dittman, Kappes, & Kappes, 1992; Money, Schwartz, & Lewis, 1984; Zucker et al., 1992). High levels of fetal androgens are associated with left-handedness, and indeed, lesbian women are more likely to be left-handed than are heterosexual women (McCormick, Witelston, & Kingstone, 1990). High levels of androgens are also associated with better spatial skills, and comparison studies of boys and men found that homosexual men and more “feminine” acting boys (who are potentially likely to identify as homosexual in adulthood (Bailey, 2003)) perform more poorly on tests of spatial skills than do heterosexual or “masculine” acting boys (Finegan, & Doering, 1982; McCormick et al., 1990; Sanders & Rossfield, 1986). Further biological research has considered genetic causes of sexual orientation. Through studies of twins, one of whom identifies as homosexual or bisexual, researchers have found evidence for the genetic heritability of sexual orientation in both male (Bailey, Willerman, & Parks, 1991; Bailey & Pillard, 1991; Eckert, Bouchard, Bohlen, & Heston, 1996) and female (Bailey & Benishay, 1993; Bailey, Pillard, Neale, & Agyei, 1993; Pillard, 1990) siblings. This literature suggests that sexual orientation is at least partially influenced by biological factors.

Scientists have yet to conclusively demonstrate the cause of sexual orientation, and this research is on-going, with new data coming from functional magnetic resonance imaging (f-MRI) scans of the brain, more complex genetic mapping technologies, and more in-depth analysis of life trajectories of heterosexual, bisexual, and homosexual individuals. Determination of a clear biological cause or a clear social/environmental cause of sexual orientation would have important social ramifications (such as stronger arguments for anti-discrimination legislation in the case of the former, and stronger arguments for the possibility of changing one’s sexual orientation in the case of the latter). However, it is not clear what the impact on psychiatric diagnoses would be; the current version of the DSM includes diagnostic categories for both mental disorders that have no demonstrated biological cause (such as the personality disorders and the sexual paraphilias) and disorders that have strong evidence of a biological or genetic cause (such as schizophrenia, depression, and bipolar disorders). For the psychiatric community, the cause of the disorder is less important than the distress felt by the individual (Spitzer, 1997).

One last vestige of the pathologization of homosexuality in the field of psychiatry remains today. DSM-III-R (1987) and DSM-IV (1994) both contain a catch-all category labeled “Sexual disorder not

otherwise specified.” The criteria reads, “Sexual disorders that are not classifiable in any of the previous categories... Examples: persistent and marked distress about one’s sexual orientation.” (p. 296). Of all the prior iterations, this diagnosis is the least damning to gays and lesbians, because it is written in sexual orientation-neutral language (homosexual, bisexual and even heterosexual individuals may all experience such distress and qualify for this diagnosis). As revisions begin for DSM-V (anticipated in 2011), this too may fall away.

Undoubtedly, the implications of the APA’s decision on this diagnosis will be debated by activists concerned with the rights of LGB individuals; however, another decision revealed in the DSM-V will likely be the subject of much more controversy. While sexual minority individuals have gradually been gaining rights in the United States, the lack of rights afforded the transgender community has increasingly come into societal consciousness. In the fall of 2007, this discrepancy between mainstream acceptance of LGB activism and transgender activism became clear as Congress considered the Employment Non-Discrimination Act (ENDA). Passage of the original version of this act (H.R. 2015) would have made it a federal crime for employers to discriminate on the basis of real or perceived sexual orientation *and* gender identity. In a decision protested by many LGBT activists groups, the sponsors of this bill decided to champion an alternative bill that addressed only sexual orientation and not gender identity (H.R. 3685). Co-sponsor, and openly gay U.S. representative, Barney Frank (D, MA) noted that a trans-inclusive bill would almost certainly fail while the sexual orientation only bill has a much better chance of passing in both the House of Representative and in the Senate (Frank, 2007). As this controversy indicates, societal acceptance of gender variation lags behind acceptance of homosexuality. Perhaps the most hotly anticipated decision in the DSM-V is the APA’s stance on Gender Identity Disorder. The topic of whether gender variation should be considered pathological (being a mental disorder) for adults who identify as transgender or transsexual is highly controversial (see Winters, 2007). For this chapter, we will focus only on the diagnosis of children and draw parallels between the APA’s past and present stance on variations of sexuality and gender.

Gender Identity Disorder as a Psychiatric Disorder

Gender Identity Disorder (GID) was introduced with the publication of DSM-III (APA) in 1980 following 20 years of clinical research on gender-variant behavior in children (Zucker, 1990). It is notable

that the DSM-III was also the first edition to not include homosexuality. There are two key components of GID that must be met for diagnosis: a strong and persistent cross-gender identification, and persistent discomfort about one's genetic sex (APA, 1994). Additionally, the individual must also be experiencing clinically significant distress or impairment due to their condition. This diagnosis encompasses cases involving children, adolescents, and adults; however, we will focus on Gender Identity Disorder of Childhood (GIDC). Perhaps surprisingly, there is not a strong relationship between GIDC and adult gender identity disorder. As noted in the DSM-TR, "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" (1994, p. 579). In adults and late adolescents, the two criteria from the DSM can be met by a stated desire to be the other sex and preoccupation with physically changing their bodies to appear as the other sex. In children, however, the criteria are based primarily upon observation and parent report of the child's behavior rather than on statements by the child. Both criteria necessary for the diagnosis of GIDC may be met by observation of the child's gender variance without the child voicing his or her interest in becoming the other sex (Minter, 1999). Nor does the child have to verbalize distress to meet criteria; in fact, a child's statement that he or she wishes to be the other sex is considered evidence of distress! Indeed, the DSM-III (APA, 1980) noted that "most children with this disorder deny being disturbed by it (GIDC), except that it brings them in to conflict with the expectations of their family or peers" (p. 72). The weak relationship between GIDC and GID of adulthood and the seeming subjectivity of this diagnosis—children *could* be diagnosed without expressing distress over their gender variant behavior and without ever stating a desire to be the other sex—represent the cornerstones of the argument to remove this diagnosis from future editions of the DSM (see gidreform.org).

The relationship between childhood gender variance and adult homosexuality is widely acknowledged by researchers and clinicians who work with children with GIDC or adult gay men and lesbians (Bradley & Zucker, 1997; Green, 1987). Due to the strength of this link, many activists and scholars have argued that the inclusion of GIDC was merely a backdoor method of continuing to pathologize homosexuality (Burke, 1996; Sedgewick, 1990). The timing of the introduction of GIDC, the parallels between the two "conditions," and the conceptual goals of treatment make such assertions understandable. In both cases, patients can be diagnosed regardless of their contentedness with their

sexuality or gender variance (Richardson, 1999). Treatment for both conditions was / is to bring the individual in line with societal expectations. These diagnoses, past and present, suggest that if one's gender or sexuality does not conform to society's expectations, it is the individual who must change, not society. A member of the subcommittee charged with writing the criteria for Gender Identity Disorder for the most recent version of DSM-IV (APA, 1994) remarked on this similarity, and concluded that the rationale used for the diagnosis of GIDC as a mental disorder is virtually identical to that used to justify the disorder of homosexuality. For that reason, he believes GIDC may eventually go the way of homosexuality and be removed from the DSM (Meyer-Bahlburg, 1993).

History of GIDC

The earliest studies of gender variant children were conducted in the 1960s and focused almost exclusively on "feminine" boys (e.g., Green, 1968; Green & Money, 1960; Stoller, 1968; Zuger, 1966). Though systematic longitudinal data were not available at that time, the consensus emerging from these researchers was that "feminine" boys were at risk of becoming homosexuals (still considered a disorder at this time), transvestites, or transsexuals (Bryant, 2006). Some explanations for boys' "feminine" behavior mirrored classic explanation for the development of male homosexuality, "too much mother made possible by too little father," (Stoller, 1968, p. 264), but there was no definitive conclusion about the origins of these boys' behaviors. The lack of a clear explanation for this phenomenon did not, however, diminish attempts to treat "feminine" boys. The objective of all clinical research was to "fix" these boys by making them more masculine and less feminine (Bryant, 2006).

In the 1970s, UCLA became a hub for the study of boyhood femininity. Richard Green, the leading researcher of children's gender variance, began a 15-year longitudinal study to understand the long-term effects of boyhood femininity (Green, 1987). Psychologist George Rekers began to explore what has become the most criticized aspect of psychology's treatment of gender variant children: behavior modification (Bryant, 2006). These techniques, historically used in therapeutic interventions to treat homosexuality, involve the punishment of unacceptable behavior (feminine behavior) and the reinforcement of desired behavior (masculine behavior, in this case). With the use of these techniques, boys were trained to change their behaviors to meet societal expectations of boys' behavior (see Rekers, 1979; Rekers, 1982).

Rekers' work drew criticism from other researchers who foreshadowed many of the current critiques levied at the diagnosis of GIDC (Bryant, 2006). Some noted that the boys' gender-variant behavior itself should not be viewed as the problem, and that the fault lay with society's constrictive views of gender (e.g., Nordyke, Baer, Etzel, & LeBlanc, 1977; Rorvik, 1975). Other scholars questioned whether steering boys to behave in narrowly-defined masculine ways would lead to the most positive outcomes (Winkler, 1977). The research on "feminine" boys also drew the attention of activists; the Coalition against the Dehumanization of Children protested the UCLA child gender program, an event that drew coverage from *Rolling Stone* (Rorvik, 1975 as cited by Bryant, 2006).

In the mid 1970s, Robert Spitzer, lead editor of DSM-III, asked Richard Green to write the initial criteria for GIDC (Bryant, 2006). Despite scant research on "masculine" girls, his initial version of the criteria was sex-neutral with parallel standards held for boys and girls to be diagnosed with GIDC. In response to critiques from feminist mental health professionals questioning whether young girls might take on "masculine" characteristics because of men's greater status and power in society, the diagnosis was ultimately changed to require that girls demonstrate more extreme gender variation than boys.

The publication of the long-awaited results of Green's longitudinal study could not add to the conversation about girls' gender variance; however, *The "Sissy Boy Syndrome" and the Development of Homosexuality* (1987), clarified researchers' understanding of likely outcomes for GIDC boys. As the title suggests, most of the "feminine" boys grew up to be gay or bisexual men. Of the original 66 boys, 44 were available for the final assessment in adulthood; 75% of these men reported predominantly homosexual / bisexual fantasy (Green, 1987). Green flippantly summarized the connection between boyhood "femininity" and adult homosexuality with his televised statement "Barbies at five. Sleeps with men at twenty-five." (1995, as cited in Wilson, 1998). Other researchers have also provided evidence for a strong relationship between early gender variant behavior and homosexual or bisexual adulthood (Bailey & Zucker, 1995). Retrospective data from self-identified gay men and lesbians converge with these findings and show that a much higher percentage of lesbians and gay men recall a history of gender variant behavior than a matched heterosexual control group (Bradley & Zucker, 1997). Thus, while the editors of DSM-III strongly disavow any intention of including GIDC to pathologize precursors of homosexuality (Zucker & Spitzer, 2005), homosexuality was still classified as a mental illness while the

foundational work on GIDC was conducted. As the probability of a homosexual adulthood was initially used to justify the importance of research on gender variant children, the two diagnoses are inextricably tied.

Movement to Remove GIDC

As transgender visibility and activism has increased over the past two decades, so has opposition to the diagnosis of Gender Identity Disorder, particularly GIDC. Though research strongly indicates that gender variance in childhood is much more likely to predict a homosexual or bisexual rather than a transgender identification in adulthood, most individuals identifying as transgendered (not fully identifying with one's genetic sex) report that their feelings of identification with the other sex date back to a very young age (Devor, 1997). Thus, trans and gay rights activist groups have both rallied around the movement to reform GIDC. The 1990s were a "coming out" period for trans individuals—a time of emerging activism for the nascent community. During this time, trans activist groups such as Transsexual Menace and Transgender Nation were joined by the National Gay and Lesbian Task Force (NGLTF) in protesting the diagnosis by demonstrating at meetings of the annual convention of the APA and picketing their national offices in Washington, DC (Lobel, 1996).

Though the NGLTF voiced strong concern that the diagnosis of GID pathologized gender variance, their stance on GID was supportive of reform rather than removal of the diagnosis from the DSM (Lobel, 1996). Regarding GIDC, they state "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." (Lobel, 1996). Drawing on the statement by the NGLTF, the Gender Public Advocacy Coalition passed a resolution in 1997 denouncing the diagnosis and calling for its reform. As part of this resolution they resolved that "no one -- gay, lesbian, bisexual, transgender, intersexed, or straight -- should have to accept being pathologized as mentally ill in order to attain wholeness, completeness and civil equality" (Wilchins, 1997).

Mental health professionals have echoed the theme of activist critique, and have shifted the focus away from children's behaviors to societal understanding and acceptance of gender expression. Psychoanalyst Ken Corbett (1998) purported that feminine identifications for "prehomosexual" boys are not indicative of the desire to be a girl (even if that is the stated desire); rather, they represent the boys'

shame over their failure to conform to traditional masculinity. He quotes a gay male patient who aptly illustrates this point by commenting “I never believed I was a girl, but I had trouble believing I was a boy. You have only two options, after all. So how do you decide?” (p. 353). Corbett’s position and his patient’s statement point to the strict dichotomization of gender presumed by the criteria for GIDC. Within the diagnosis itself, the social construction of gender is made visible by differing criteria for girls and boys. To meet one of the GIDC criteria, girls must “insist on wearing only stereotypical masculine clothing,” while boys need only show a “preference for cross-dressing or simulating female attire” (DSM-IV, 1994, p.532). This language clearly shows that to be “normal,” boys and men must adhere to a more narrow range of behaviors than girls and women. Some psychologists take issue with the idea that gender roles are so clearly dichotomized: “It seems increasingly difficult in modern Western culture to classify such a wide range of behaviors into neatly distinct forms” (Hill, Rozanski, Carfagnini, & Willoughby, 2005, p. 11).

Because it is typically parents’ concern that brings a gender variant child into contact with mental health professionals (Hill, et al., 2005; Pleak, 1999; Zucker & Bradley, 1995), other reform-minded mental health professionals focus on familial and interpersonal relationships in their treatment of GIDC. If a child’s parents have highly stereotypical views of gender, they may find any gender deviance troubling, resulting in strained family relationships. Alternative approaches to treatment focus on the education of parents and caregivers rather than changing children to meet stereotyped views of gender, and improved family relationships are evidence that parent education is a crucial step in bettering the lives of gender variant children (Children’s National Medical Center, 2003). Edgardo Menvielle and Catherine Tuerk run a support group for parents which helps them learn to deal with their children’s gender variance in a positive and supportive way (Crawford, 2003). These strategies represent a dramatic shift in the conceptualization and treatment of GIDC. James deJesus, coordinator for a community outreach program, discusses difficulties in his family relationships due to his gender variance while shifting the location of distress in GID from an internal pathology to a social prejudice: “I would have felt better about myself if as a child I could have felt free to play with dolls or play house with my sisters instead of being forced to take judo lessons and spar with my brothers. The question still haunts me, ‘Why wasn’t it okay just being the way I was?’” (Crawford, 2003, p. 40).

Revisiting Samantha and Quinn

Read back over the vignettes at the beginning of this chapter. After having read this chapter, what is your opinion now about the psychological health of Samantha and Quinn? How do you think Samantha could best be helped by a psychologist or psychiatrist? How could her family be helped? How could Quinn and his family be helped by a psychologist or psychiatrist? What needs to change for Samantha and Quinn, if anything, to help relieve the distress that they (or their family) feel?

We hope that your answers to these questions are informed by the notion, developed throughout this chapter, that the current sociohistorical context influences one's understanding of sexual and gender variation, and determines the extent to which that variation is pathologized. In the end, perhaps much of the distress experienced by Samantha and Quinn derives from the mismatch between their sexuality or gender identity, respectively, and societal norms or family expectations, not from an internal psychiatric problem.

Conclusions

"If being unusual, even undesirable, sufficed to define a psychiatric disorder, our classification system would be little more than a club wielded to enforce conventional notions of how humans should behave" (Richardson, 1999, p. 44).

This quote from psychiatrist Justin Richardson, in reference to GIDC, illustrates the need for mental health professionals to push past their personal views to consider what ought to constitute grounds for psychiatric disorders. Richardson's call to mental health professionals to interrogate their own biases must be heeded, particularly surrounding diagnostic categories involving gender and sexual deviance where biases and prejudice are so prevalent.

The question of what constitutes "normal" sexuality or gender cannot be answered in isolation. As the history of the "illnesses" homosexuality and gender identity disorder illustrate, sexual and gendered behavior are inextricably embedded in their cultural context; psychiatric science is not immune from cultural influence. The removal of homosexuality from the DSM was not a result of new evidence about the relationship between same-sex sexuality and mental health, but a response to a period of social change in which gay men, lesbians, and bisexuals chose to become visible and demand that their relationships be recognized. As psychiatrists voted to maintain or reject the disordered status of homosexuality, some votes were certainly cast based on moral grounds rather than on the scientific evidence. Gender identity disorder of childhood continues to be classified as a mental illness, but if its

treatment by the psychiatric community continues to parallel the path of homosexuality, that may soon change (Meyer-Bahlburg, 1993).

As noted in the introduction, current psychiatric standards hold that in order for a set of behaviors to be considered a disorder, it must be considered atypical, disturbing (judged to be unacceptable), maladaptive (causing distress or impairment), and unjustifiable. Most importantly, the distress or impairment must be *inherent* to the illness. Undoubtedly, most gay men and lesbians have experienced some distress due to their sexual orientation—they are a minority group in a world that affords heterosexuals privileges that are denied to lesbians, gay men, and bisexuals. Additionally, they are more likely to be bullied as children and be victims of hate crimes (Savin-Williams, 1994). If lesbians and gay men are content with their sexual orientation (as recent studies suggest; Gonsiorek, 1996) but feel distress due to societal prejudice, then distress is not inherent to their sexual orientation. The location of distress is similarly central to the controversy over GIDC. Gender-variant youth unquestionably suffer because of their gender variance. Indeed, transgender teens experience bullying by their peers to a far greater degree than any other group of teens, and are also thought to be more at risk for suicide attempts than any other group (Wilchins & Taylor, 2007). These children and adolescents are clearly penalized for their gender variance, and feel distress at the hands of an intolerant society. Whether this distress is inherent to GIDC will be debated as the DSM-V is compiled.

If the inclusion of GIDC in the DSM-V comes to a vote, voters will likely again rely heavily on their beliefs about the *morality* of gender variance just as they voted on the morality of sexual variance in the 1970's. These beliefs are shaped by ongoing experience in a society with views on gender and sexuality that are in flux. Just as the lesbian, gay, and bisexual community became more organized and politically active in the 1970s, so did the transgender community in the 1990s. Individuals from both groups found a sense of belonging and were emboldened to collectively fight for rights they had not been afforded. Over the past decade, gender-variant individuals have become much more visible to mainstream society. Gender-variant children have been featured on Oprah, gender-variant college students have been the focus of a reality series, (*Transgeneration*, 2005), and an Oscar has been awarded to a portrayal of a genetic female who lived as a man (Hillary Swank for her role in *Boys Don't Cry*). The body of voting psychiatrists today likely has a very different view of gender variance than they had 10 years ago.

This is not simply an academic debate. Diagnostic categories such as homosexuality and gender identity disorder are not only important to those in the psychiatric or psychological community; the existence of these diagnostic categories has serious implications for the lives of gay, lesbian, bisexual, and gender-variant individuals. At a societal level, the existence of these disorders can be used to justify continued social prejudices and discrimination. For example, the exclusion of these individuals from social institutions (such as marriage, various jobs, political office) would be socially acceptable and validated. At an interpersonal level, romantic relationships may be more difficult if those involved feel that they themselves and their partners are mentally disordered. Other relationships may also suffer; for example, parents may blame themselves for their child's different gender or sexual expression, leading to strained parent-child relationships. Finally, at an individual level, gay, lesbian, bisexual, and gender-variant individuals who are having emotional or psychological difficulties (such as depression or anxiety) might choose not to receive therapeutic help out of fear of being labeled mentally ill because of their gender or sexual expression. Such individuals might never receive the help that they need because of distrust for the mental health industry.

Departures from societal norms, particularly those involving gender or sexuality, have historically not been viewed kindly by the field of psychiatry or the general public, but this history demonstrates that political activism can enact change in society as well as in the medical establishment's diagnostic categories. The relations between scientific research, public sentiment, and psychiatric diagnosis are complex, and the eventual removal of homosexuality as a psychiatric diagnosis demonstrates that the field of psychiatry can adapt to changes in the broader cultural understandings of sexuality. However, it remains to be seen whether the psychiatric community will adapt to similar changes in cultural understandings of gendered behavior, and remove gender identity disorder from the DSM as well. Such openness to change does not imply indecisiveness or lack of scientific rigor, but rather recognizes the socially-situated nature of mental illness and mental health.

References

- American Psychiatric Association. (1952). *Diagnostic and Statistical Manual of Mental Disorders*. Washington, DC: Author.
- American Psychiatric Association. (1968). *Diagnostic and Statistical Manual of Mental Disorders* (2nd ed.). Washington, DC: Author.
- American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association. (1987). *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., Revised). Washington, DC: Author.
- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC: Author.
- Bailey, J.M. (2003). Biological perspectives on sexual orientation. In L.D. Garnets & D.C. Kimmel (Eds.), *Psychological perspectives on lesbian, gay, and bisexual experiences*. (pp. 50-85). New York: Columbia University Press.
- Bailey, J.M., & Benishay, D. (1993). Familial aggregation of female sexual orientation. *American Journal of Psychiatry*, *150*, 272-277.
- Bailey, J.M., & Pillard, R.C. (1991). A genetic study of male sexual orientation. *Archives of General Psychiatry*, *48*, 1089-1096.
- Bailey, J.M., Pillard, R.C., Neale, M.C., & Agyei, Y. (1993). Heritable factors influence female sexual orientation. *Archives of General Psychiatry*, *50*, 217-223.
- Bailey, J.M., Willerman, L., & Parks, C. (1991). A test of the maternal stress hypothesis of human male homosexuality. *Archives of Sexual Behavior*, *20*, 277-293.
- Bailey, J.M., & Zucker, K.J. (1995). Childhood sex-typed behavior and sexual orientation: A conceptual analysis and quantitative review. *Developmental Psychology. Special Issue: Sexual orientation and human development*, *31*, 43-55.
- Bandura, A. (1965). Influence of models' reinforcement contingencies on the acquisition of imitative response. *Journal of Personality and Social Psychology*, *1*, 589-595.
- Bandura, A. (1977). *Social learning theory*. New York: General Learning Press.

- Bayer, R. (1987). *Homosexuality and American psychiatry: The politics of diagnosis* (2nd Ed.). Princeton, NJ: Princeton University Press.
- Bradley, S. J., & Zucker, K. J. (1997). Gender identity disorder: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 872-880.
- Bryant, K. (2006). Making gender identity disorder of childhood: Historical lessons for contemporary debates. *Sexuality Research & Social Policy*, 3, 23-39.
- Burke, P. (1996). *Gender Shock: Exploding the myths of male and female*. New York, NY: Anchor Books.
- Corbett, K. (1998). Cross-gendered identifications and homosexual boyhood: Toward a more complex theory of gender. *American Journal of Orthopsychiatry*, 69, 352-360.
- Children's National Medical Center. (2003). *If you are concerned about your child's gender behavior: A guide for parents*. Washington, DC: Author.
- Deaux, K., & Lewis, L.L. (1984). Structure of gender stereotypes: Interrelationships among components and gender label. *Journal of Personality and Social Psychology*, 46, 991-1004.
- D'Emilio, J. (1983). *Sexual politics, sexual communities: The making of a homosexual minority in the United States*. Chicago: University of Chicago Press.
- 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.
- Eckert, E.D., Bouchard, T.J., Bohlen, J., & Heston, L.L. (1986). Homosexuality in monozygotic twins reared apart. *British Journal of Psychiatry*, 148, 421-425.
- Ellis, H. (1901). *Studies in the psychology of sex: Volume 2: Sexual inversion*. Philadelphia: F.A. Davis.
- Faderman, L., Retter, Y., & Ramírez, H.R. (2006). *Great events from history: Gay, lesbian, bisexual, transgender events*. Pasadena, CA: Salem Press.
- Finegan, J.K., Zucker, K.J., Bradley, S.J., Doering, R.W. (1982). Patterns of intellectual functioning and spatial ability in boys with gender identity disorder. *Canadian Journal of Psychiatry*, 27, 135-139
- Ford, C.S., & Beach, F.A. (1951). *Patterns of sexual behavior*. New York: Harper & Brothers.
- Frank, B. (2007, September 27). *Statement of Barney Frank on ENDA*. Retrieved November 11, 2007, from <http://www.house.gov/frank/ENDASeptember2007.html>

- Freud, S. (1953). Three essays on the theory of sexuality. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud*. (Vol. 7, pp. 123-246). London: Hogarth Press. (Original work published 1905).
- Gonsiorek, J.C. (1996). Mental health and sexual orientation. In R.C. Savin-Williams & K.M. Cohen (Eds.), *The lives of lesbians, gays, and bisexuals*. Fort Worth: Harcourt Brace.
- Gonsiorek, J.C. (1982). Results of psychological testing on homosexual populations. *American Behavioral Scientist*, 25 (4), 385-396.
- Green, R. & Money, J. (1960). Incongruous gender role: Nongenital manifestations in prepubertal boys. *Journal of Nervous Disorders*, 131, 160-168.
- Green, R. (1968). Childhood cross-gender identification. *Journal of Nervous and Mental Disease*, 147, 500-509.
- Green, R. (1987). *The "Sissy Boy Syndrome" and the development of homosexuality*. New Haven: Yale University Press.
- Hart, M., Roback, H., Tittler, B., Weitz, L., Walston, B., & McKee, E. (1978). Psychological adjustment of nonpatient homosexuals: Critical review of the research literature. *Journal of Clinical Psychiatry*, 39(7), 604-608.
- Hill, D. B., Rozanski, C., Carfagnini, J., & Willoughby, B. (2005). Gender identity disorders in childhood and adolescence: A critical inquiry. *Journal of Psychology and Human Sexuality*, 17, 7-33.
- Hooker, E. (1957). The adjustment of the male overt homosexual. *Journal of Projective Techniques*, 21, 18-31.
- Katz, J. N. (1976). *Gay American history: Lesbians and gay men in the USA*. New York: Thomas Y. Crowell Company.
- Kinsey, A.C., Pomeroy, W.B., & Martin, C.E. (1948). *Sexual behavior in the human male*. Philadelphia: W.B. Saunders.
- Kinsey, A.C., Pomeroy, W.B., Martin, C.E., & Gebhard, P.H. (1953). *Sexual behavior in the human female*. Philadelphia: W.B. Saunders.
- Kite, M.E., & Deaux, K. (1987). Gender belief systems: Homosexuality and the implicit inversion theory. *Psychology of Women Quarterly*, 11, 83-96.

- Krafft-Ebing, (1906). *Psychopathia sexualis*. New York: Rebman Company.
- Lobel, K. (1996). *NGLTF statement on gender identity disorder and transgender people*. Washington D.C.: National Gay and Lesbian Task Force.
- Lombroso, C. (1968). *Crime: Its causes and remedies*. Montclair: Patterson Smith.
- Lorenz, K. (1965). *Evolution and modification of behavior*. Chicago: University of Chicago Press.
- Lorenz, K. (1970). *Studies in animal and human behaviour*. Oxford, England: Harvard U. Press.
- Martin, C.L. (1990). Attitudes and expectations about children with nontraditional and traditional gender roles. *Sex Roles*, 22, 151-165.
- McCormick, C.M., Witelson, S.F., & Kingstone, E. (1990). Left-handedness in homosexual men and women: Neuroendocrine implications. *Psychoneuroendocrinology*, 15, 69-76.
- McCreary, D. R. (1994). The male role and avoiding femininity. *Sex Roles*, 31, 517-531.
- Menninger, M.D., & Nemiah, J.C. (Eds.). (2000). *American psychiatry after World War II (1944-1994)*. Washington, D.C., American Psychiatric Press.
- Menvielle, E.J., & Tuerk, C. (2002). A support group for parents of gender-nonconforming boys. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41, 1010-1013.
- Meyer-Bahlburg, H. (1993). Psychiatrists set to approve DSM-III. *Journal of the American Medical Association*, 270, 13-15.
- Minter, S. (1999). Diagnosis and treatment of gender identity disorder in childhood. In M. Rottnek (Ed.) *Sissies and Tomboys: Gender nonconformity and homosexual childhood* (pp. 9-33). New York: New York University Press.
- Money, J., Schwartz, M., & Lewis, V. G. (1984). Adult erotosexual status and fetal hormonal masculinization and demasculinization. *Psychoneuroendocrinology*, 9, 405-514.
- Myers, D.G. (2004). *Psychology*. New York: Worth Publishers.
- Nordyke, N. S., Baer, D. M., Etzel, B. C., & LeBlanc, J. M. (1977). Implications of the stereotyping and modification of sex role. *Journal of Applied Behavior Analysis*, 10, 553-557.
- Pillard, R. C. (1990). The Kinsey Scale: Is it familial? In E. P. McWhirter, S. A. Sanders, & J. M. Reinisch (Eds.), *Homosexuality / Heterosexuality: Concepts of sexual orientation* (pp. 88-100). New York: Oxford University Press.

- Pleak, R. R. (1999). Ethical issues in diagnosing and treating gender-dysphoric children and adolescents. In M. Rottnek (Ed.) *Sissies and tomboys: Gender nonconformity and homosexual childhood* (pp. 34-51). New York: New York University Press.
- Rado, S. (1949). An adaptational view of sexual behavior. In P.H. Hoch & J. Zubin (Eds.), *Psychosexual development in health and disease* (pp. 159-189). New York: Grune and Stratton.
- Rekers, G. A. (1979). Sex-role behavior change: Intrasubject studies of boyhood gender disturbance. *Journal of Psychology*, 103, 255-269.
- Rekers, G. A. (1982). *Growing up straight: What every family should know about homosexuality*. Chicago: Moody Press.
- Richardson, J. (1999). Response: Finding the disorder in gender identity disorder. *Harvard Review of Psychiatry*, 7, 43-50.
- Riess, B.F. (1980). Psychological tests in homosexuality. In J.Marmor (Ed.), *Homosexual behavior: A modern reappraisal* (pp. 296-311). New York: Basic Books.
- Rorvik, D. M. (1975, October 9). The gender enforcers: Seeing to it that boys will be boys. *Rolling Stone*, 53, 67, 86-88.
- Sanders, G. & Ross-Field, L. (1986). Sexual orientation and visuo-spatial ability. *Brain and Cognition*, 5, 280-290.
- Savin-Williams, R. (1994). Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: Associations with school problems, running away, substance abuse, prostitution, and suicide. *Journal of Consulting and Clinical Psychology*, 62, 261-269.
- Sedgwick, E. K. (1990). How to bring your kids up gay. *Social Text*, 29, 18-27.
- Skinner, B.F. (1953). *Science and human behavior*. New York: Macmillan.
- Skinner, B.F. (1969). *Contingencies of reinforcement: A theoretical analysis*. New York: Appleton-Century-Crofts.
- Socarides, C. (1968). *The overt homosexual*. New York: Grune and Stratton.
- Spitzer, R.L. (1973). *Homosexuality and sexual orientation disturbance: Proposed change in DSM-II*, 6th printing, page 44: *Position statement (retired)*. APA Document Reference No. 730008, Washington, DC: American Psychiatric Association.

- Spitzer, R.L. (1997). Brief comments from a psychiatric nosologist weary from his own attempts to define mental disorder: Why Ossorio's definition muddles and Wakefield's "harmful dysfunction" illuminates the issues. *Clinical Psychology Science and Practice*, 4, 259-266.
- Spitzer, R.L., Gibbon, M., Skodol, A.E., Williams, J.B.W., & First, M.B. (1989). *DSM-III-R diagnostic and statistical manual of mental disorders (revised edition) case book*. Washington, D.C.:American Psychiatric Press, Inc.
- Stoller, R. J. (1968). *Sex and gender: On the development of masculinity and femininity*. New York, NY: Science House.
- Taylor, A. (1983). Conceptions of masculinity and femininity as a basis for stereotypes of male and female homosexuals. *Journal of Homosexuality*, 9, 37-53.
- Wakefield, J.C. (1997). Normal inability versus pathological disability: Why Ossorio's definition of mental disorder is not sufficient. *Clinical Psychology Science and Practice*, 4, 249-258.
- Wilchins, R.A. (1997). *Read my lips: Sexual subversion and the end of gender*. Ithaca, NY: Firebrand Books.
- Wilchins, R.A., & Taylor, T. (2007). *50 under 30: Masculinity and the war on America's youth: A human rights report*. Washington, DC: Gender Public Advocacy Coalition.
- Wilson, K.K. (1998). The disparate classification of gender and sexual orientation in American psychiatry. Retrieved November 10, 2007, from <http://gidreform.org/kwapa98.html>
- Winkler, R. C. (1977). What types of sex-role behavior should behavior modifiers promote? *Journal of Applied Behavior Analysis*, 10, 549-552.
- Winters, K. (2007). *GID Reform Advocates: Because our identities are not disordered*. Retrieved November 11, 2007, from <http://gidreform.org>
- Zucker, K. J. (1990). Gender identity disorders in children: Clinical descriptions and natural history. In R. Blanchard & B. Steiner (Eds.) *Clinical Management of Gender Identity Disorders in Children and Adults*, (pp. 1-23). Washington, DC: American Psychiatric Press.
- Zucker, K. J., & Bradley, S.J., Oliver, G., Hood, J.E., Blake, J., & Fleming, S. (1992). Psychosexual assessment of women with congenital adrenal hyperplasia: Preliminary analyses. Paper presented at Annual Meeting, International Academy of Sex Research, Prague, Czechoslovakia.

Zucker, K. J., & Spitzer, R.L. (2005). Was the Gender Identity Disorder of Childhood diagnosis introduced into DSM-III as a backdoor maneuver to replace homosexuality? A historical note. *Journal of Sex and Marital Therapy*, 31, 31-42.

Zuger, B. (1966). Effeminate behavior in boys present from early childhood. I. The clinical syndrome and follow-up studies. *Journal of Pediatrics*, 69, 1098-1107.