

# Assessment & Diagnosis

## Childhood Gender Identity . . . Disorder? Developmental, Cultural, and Diagnostic Concerns

Eliza A. Dragowski, María R. Scharrón-del Río,  
and Amy L. Sandigorsky

Childhood gender identity development is reviewed in the context of biological, environmental, cultural, and diagnostic factors. With the upcoming 5th revision of the *Diagnostic and Statistical Manual of Mental Disorders*, the authors offer a critical consideration of childhood gender identity disorder, along with proposed diagnostic changes. They argue that meaningful understanding of issues surrounding gender identity is necessary for a conscientious assessment and diagnostic process that does not pathologize human diversity.

Although fundamental to the way most of us experience ourselves and others, gender is rarely contemplated. Left unexplored, however, this complex concept often creates misconceptions and stereotypes, such as the belief that gender and sex are synonymous or that gender assigned at birth indicates a specific preference for toys, interests, clothes, and eventual erotic attraction. The aim of this article is to enhance counselor understanding of childhood gender identity development, to aid in assessment and diagnostic processes surrounding this matter. We review childhood gender identity in the context of developmental and cultural factors before considering the diagnosis of childhood gender identity disorder (GIDC), and we explore proposed changes to the diagnosis in the upcoming fifth revision of the *Diagnostic and Statistical Manual of Mental Disorders*.

### Terms and Definitions

Misconceptions surrounding gender identity often begin with general confabulation of terms used to communicate about the issue. We thus begin this article with a review of terminology, aiming to define and disentangle biological sex, gender, and sexuality.

#### Biological Sex

*Biological sex* relates to one's anatomical and reproductive structures. It is determined by *karyotype* (a specific chromosomal complement, with 46 XY karyotype in typical males and 46 XX karyotype in typical females), *gonads* (testes and ovaries), *external genitalia* (scrotum and penis in typical males; labia and clitoris in typical females), and secondary sex

differentiation at puberty (Pasterski, 2008). Most commonly, it follows a binary model assigned at birth based on the presence of external genitalia (Diamond, 2006). This model does not consider persons with disorders of sex development, whose sex chromosomes and genital structure(s) are considered to be incongruent (Pasterski, 2008).

#### Gender

Jacobs, Thomas, and Lang (1997) used the word *gender* to refer to "cultural rules, ideologies, and expected behaviors for individuals of diverse phenotypes and psychosocial characteristics" (p. 2). *Gender identity* relates to one's subjective sense of congruence with an attributed gender. *Gender role* is a public display of gender identity conveying societal schemes of how boys and girls should behave (Diamond, 2002; Stryker, 2008).

*Transgender* is an umbrella term referring to people who move away from the gender assigned to them at birth, thus violating societal conceptualizations of what it means to be a man or a woman (Stryker, 2008). Included in this category are *transsexuals*, people whose gender identity does not correspond to their physical body (Diamond, 2002). Transsexuals sometimes transform their physical body and often assume gender roles that are congruent with their experienced gender identity. According to Diamond (2002), the term *transsexual* best describes adults, not children who may meet criteria for gender identity disorder (GID). In this article, we interchangeably use the terms *gender-variant* and *gender-nonconforming* to describe children whose gender expression, gender role behavior, and/or gender identity do not conform to the traditional norms.

Eliza A. Dragowski, María R. Scharrón-del Río, and Amy L. Sandigorsky, School of Education, Brooklyn College, City University of New York. Correspondence concerning this article should be addressed to Eliza A. Dragowski, School of Education, Brooklyn College, City University of New York, 2900 Bedford Avenue, Brooklyn, NY 11210 (e-mail: edragowski@brooklyn.cuny.edu).

© 2011 by the American Counseling Association. All rights reserved.

### Sexuality/Sexual Orientation

The terms *sexuality* and *sexual orientation* refer to how and with whom people act on their affectionate, intimate, and erotic desires. In classifying sexuality, people tend to depend on the gender identity of the person to whom their desires are directed. Most commonly, to describe sexual orientation, we use the term *heterosexual/straight* to denote a person attracted to a member of another gender, *homosexual/gay/lesbian* to refer to an individual attracted to the member of the same gender, and *bisexual* to refer to a person attracted to a member of any gender (Diamond, 2002; Stryker, 2008).

### ■ What Does It All Mean?

Our cultural beliefs dictate that there are only two biological sexes corresponding to two genders. Moreover, males are expected to have masculine gender identifications/roles and to be attracted to women. Females, in turn, are expected to have gender identifications/roles of women and to be attracted to men. These two models are thus considered the norm, and any other combination of biological sex, gender, and sexuality is commonly considered unnatural or pathological (Mintz, & O'Neil, 1990; Newman, 2002; Schilt & Westbrook, 2009).

Other combinations are possible, however. A child whose biological sex is that of a typical female can have a gender identity and role of a boy. As an adult, this person may self-identify as transgender or transsexual and live as a man, who, like any other person, can be of any sexual orientation. On the other hand, a biological male can have a gender identity of a boy/man, be attracted to other men, and identify as gay. Contrary to what our society tends to believe, it is not necessary for people who feel attracted to others of the same gender to express any gender nonconformity. Gay men can be comfortable in their male body and exhibit no gender-variant behaviors, just as lesbian women can be comfortable with their sex and gender roles (Diamond, 2002).

The boundaries expand even further when one considers the variety of human experiences represented outside of Western culture, where "wide variations exist in beliefs about the nature of biology and what constitutes sex, and physical difference per se is not always sufficient to produce gender" (Newman, 2002, p. 354). Driven by the belief that the sex/gender may change later in life, the Zuni Nation does not assign the sex to a child at the time of birth. They interpret biology via rituals designed to discover the gender of the infant and thus determine upbringing (Herdt, 1996, cited in Newman, 2002). Many American Indian/First Nation groups recognize persons of a specific biological sex who take on the role and status of the opposite sex. Collectively denominated as *two-spirit* people, they are at times bestowed high social and spiritual status and regarded as a "third gender" (Jacobs et al., 1997).

In Independent Samoa, part of the population consists of *fa'afafine*, most of whom are biological males who are feminine in behavior and sexually attracted to straight men.

In Samoan cultural norms, straight men are those who identify as men and perform masculine gender roles, but whose sexual activity does not have to be limited to women. It is culturally sanctioned for Samoan men to engage in sexual activity with *fa'afafine* or other men, rendering the Western concept of male homosexuality virtually nonapplicable (Vasey & Bartlett, 2007).

### ■ Gender Identity Development

Diversity of experience brings questions about gender identity from the realm of the unexamined to the forefront of our consciousness. How do children know what their gender is and how to behave? Why do some children insist that their gender is not the one assigned to them at birth? Most gender identity theories stand along the nature versus nurture continuum. However, a recent idea gaining prominence is that both innate and acquired aspects of the human experience are inextricably involved in the development of gender identity (Diamond, 2006). We briefly review these paradigms next.

#### Importance of Nature

Gender development is believed to begin at the time of conception and determined by sex chromosomes. All fetuses begin existence with a set of undifferentiated gonads and two sets of ducts, Mullerian and Wolffian. Determining the fate of gonads between Weeks 6 and 12 of gestation is the sex-determining region (SRY) gene present only on the Y chromosome.

In the course of typical male development, the SRY gene prompts development of testes, which then start production of testosterone and Müllerian-inhibiting substance (MIS). This process halts development of Müllerian ducts. At the same time, testosterone stimulates development of Wolffian ducts into a male genital system. Eventually, part of testosterone is converted into dihydrotestosterone (DHT), which triggers development of typical male genitalia. In a process lasting through late gestation, the brain is also masculinized by a metabolite of testosterone called estradiol (Blakemore, Berenbaum, & Liben, 2009; Bostwick & Martin, 2007).

In the absence of the SRY gene, typical female development begins as the undifferentiated gonads develop into ovaries at approximately 3 months of gestation. The Müllerian structures develop into the uterus, fallopian tubes, and upper segment of vagina, while Wolffian ducts fade away. Absence of DHT results in development of typical female genitalia (Blakemore et al., 2009).

Generally, presence of XX chromosomes indicates phenotypic females who develop into girls/women with culturally accepted characteristics. Similarly, chromosomal makeup XY typically produces phenotypic males who mature into boys/men with masculine characteristics seen as culturally appropriate. Development of a minority of individuals, however, is considered gender-variant with respect to gender identification and expression (Diamond, 2006).

According to biological theories, nonconforming gender identity is a result of “abnormal brain sex differentiation with subsequent gender development occurring along predetermined lines and in conflict with the assigned gender role” (Newman, 2002, p. 353). The Gender Identity Research and Education Society (2006) identified three main pathways to “atypical” gender identity development. The first path involves anomalous prenatal hormonal influences, illustrated by studies showing increased incidence of left-handedness among transsexuals (Green & Young, 2001) and finger ratio measurement of transsexual men resembling that of biological women (Kraemer et al., 2009). The second path points to anatomic brain differences. It is supported by postmortem examinations of brains of male-to-female transsexuals, which show a typically female-sized portion of the central subdivision of the bed nucleus of the stria terminalis, a brain area vital in sexual behavior (Zhou, Hofman, Gooren, & Swaab, 1995). The third path to atypical gender identity development is that of genetic influences. This line of inquiry is supported by studies showing heritability of GID among twins, with the highest concordance rates found among monozygotic twins and lesser but still strong concordance among fraternal twins (Diamond & Hawk, 2004, cited in Diamond, 2006). Additionally, Meyer-Bahlburg’s (2010) review of the most recent research indicates presence of various genetic variations that do not cause changes in reproductive anatomical structures but may produce gender-variant identities. It is important to note that most studies validating biological etiology of gender-variant identity are not definitive because they are limited by methodological shortcomings and lack of replication by independent research institutions (Meyer-Bahlburg, 2010).

### Importance of Nurture

Environmental influences on the child’s gender development often begin before birth. Upon finding the biological sex of the child, parents tend to begin making arrangements—purchasing gender-specific clothes, toys, and nursery items—thus assigning gender identity to a child who has not yet been born. After birth, boys and girls elicit specific parental responses: Boys are seen as stronger, whereas girls tend to be considered finer featured and delicate (Karraker, Vogel, & Lake, 1995). Children are treated differently, especially when engaged in behavior resonating gender stereotypes, with parents encouraging sex-typed activities (Fagot & Hagan, 1991; McHale, Crouter, & Whiteman, 2003). Traditional gender behaviors are reinforced with inclusion and praise, whereas “unacceptable” gender behaviors are stigmatized (Girshick, 2008).

Children learn that, at a fundamental level, men and women are different and have a different set of responsibilities in and out of the home (Diamond, 2000). They understand that gender is connected to a whole set of physical and behavioral characteristics and use this framework to communicate with others. By the age of 2, most children show awareness of their own gender, prefer gender-stereotyped toys, and tend to imitate

stereotyped gender behaviors of familiar activities (Campbell, Shirley, & Caygill, 2002; Poulin-Dubois, Serbin, Eichstedt, Sen, & Beissel, 2002; Serbin, Poulin-Dubois, & Eichstedt, 2002). This knowledge is concurrent with preschoolers’ admiration of children who engage in sex-stereotyped behavior and rejection of those children who do not (Davies, 2004).

Theories highlighting the importance of socialization on gender development include but are not limited to the following: (a) psychoanalytic theories, which emphasize early childhood experiences and identifications with parents; (b) learning theories, which underscore the role of reinforcement, punishment, imitation, and modeling in gender development; (c) social constructivism, which emphasizes the social construction of gender against the backdrop of time, place, and social experience of people; and (d) cognitive theories, which focus on children’s knowledge about gender and gender-related behaviors (Blakemore et al., 2009).

Early theories of gender-nonconforming identification explained it in the context of an intrapsychic conflict stemming from environmental instability. Stoller’s (1968, cited in Coates, 1992) blissful symbiosis imprinting theory framed gender-nonconforming identification as resulting from the presence of a bisexual mother, absent father, symbiosis between mother and son, and a special beauty in the boy. Green’s (1974, cited in Coates, 1992) reinforcement theory proposed that femininity in boys was reinforced by the family members and associated with peer rejection, which intensified negative self-feelings and further propelled the boy’s wish to become a girl.

Some current psychological theories propose that both the child’s temperament and a problematic family environment account for childhood gender nonconformity. Zucker and Bradley (2004) hypothesized that gender-nonconforming children are constitutionally anxious and sensitive to parental dynamics, which may include marital discord, conflict about matters of masculinity and femininity, and possible psychopathology. These issues are said to render parents preoccupied and inattentive to the child’s gender-variant behavior. Meyer-Bahlburg (2002) hypothesized that the developmental pathways to boyhood gender nonconformity are likely to involve temperamental inhibition of the child coupled with a variety of psychosocial risks, including (a) strong familial attachment to women who encourage his participation in feminine activities and discourage rough-and-tumble play; (b) insignificant connection with fathers, who may be avoiding the child because of his effeminate behaviors; and (c) gender-variant boys’ avoidance of other boys and their attraction to girl playmates, resulting in rehearsal of typically female behaviors and lack of environment in which to advance male gender roles.

### Integration

Because current knowledge does not provide us with an “empirically grounded detailed theory of the mechanisms and processes of gender identity development” (Meyer-Bahlburg,

2010, p. 472), conclusive scientific statements about determinants of gender-nonconforming identity cannot be made. Gender identity formation is seen from an integrative perspective as a complex biological and psychological process, which is unique for each person and which involves a variety of “genetic, hormonal and environmental factors, acting separately or in combination with each other” (Gender Identity Research and Education Society, 2006, p. 38). According to Diamond’s (2006) biased interaction theory, infants are born with a certain evolutionary heritage, family genetics, and uterine environment influences that bring about a propensity for certain sexual and gender patterns’ expression. However, the patterns eventually expressed depend on the upbringing and societal values. Diamond (2000) noted that transgender children

have to integrate the gender attributions of society and its constructs with feelings of self. I think all do so and match these feelings with some brain template of “similar or different” which is more crucial than penis or clitoris, more central to their sense of being than is a scrotum or vagina, and more important than their familial rearing. The individual comes to identify as a member of one of those groups (boys or girls, men or women) with whom he or she feels more “similar” and less “different.” Fortunately, for most of us, these factors of brain template and the sex-typical biases and inclinations it imparts, are usually in concert with anatomy and cultural construction of gender. When they are not, the mind will usually rule even when in conflict with societal expectations. (p. 51)

## ■ Diagnosis and Its Evaluation

Although there are no definitive theories of transgender development, there is a psychiatric diagnosis describing this phenomenon. According to the fourth text revision edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*, American Psychiatric Association [APA], (2000), GID is a wide diagnostic category, available to diagnose both children and adults. The diagnosis of GIDC is based on four diagnostic features. The first, spelled out in Criterion A, includes “a strong and persistent cross-gender identification” (APA, 2000, p. 581) signifying a desire to be or assertion of being of the other sex. The disturbance is marked by at least four of the following five indicators: (a) repeated insistence or desire to be of the other sex, (b) preference for cross-dressing, (c) strong and continuous affinity for cross-sex roles during play or in fantasy, (d) strong wish to engage in stereotypical play of the other sex, and (e) powerful tendency to play with children of the other sex. The second feature, described in Criterion B, includes “persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex” (APA, 2000, p. 581). It is demonstrated by any of the following indicators: in boys, by disgust with or wish not to have a penis and/or refusal to engage in typically male play; and in girls, by refusal to sit for urination, wish to grow a penis,

negation of eventual acquiring of typically female secondary sex characteristics, or refusal of typical “normative feminine clothing” (APA, 2000, p. 581). According to Criterion C, no concurrent intersex conditions should be present, and, as spelled out in Criterion D, the cross-gender identification must be accompanied by “clinically significant distress or impairment in social, occupational, or other important areas of functioning” (APA, 2000, p. 581).

GIDC is a controversial diagnosis, seen by many as contributing to gender stereotypes and conflating complex matters of gender identity, emotional suffering, and social nonconformity (Lev, 2005). The following critique focuses on debates involving terminology within diagnostic criteria, psychosexual outcomes of gender-variant youth, and status of GIDC as a mental disorder.

### Terminology Within Diagnostic Criteria

The GIDC diagnostic criteria have been criticized not only for their anachronistic language, which overdichotomizes “appropriate” gender roles and behaviors (Hill, Rozanski, Carfagnini, & Willoughby, 2007), but also for the confusing use of terms and concepts. Criterion A, although purporting to scrutinize cross-gender identification, also includes references to cross-sex identifications (“repeatedly stated desire to be or insistence that he or she is, the other sex” [APA, 2000, p. 581]). Similarly, Criterion B appears to confuse sex with gender, as discomfort with one’s biological sex and discomfort with gender roles are ascribed to one category. It is unclear why disgust with one’s genitals is equated with preference for particular toys or attire (Bartlett, Vasey, & Bukowski, 2000).

Another key concern revolves around failure of criteria to sufficiently differentiate between children who violate societal gender norms in the absence of gender dysphoria and children who are uncomfortable with their biological sex *in addition* to unhappiness with the assigned gender roles. Under current diagnostic criteria, it is not necessary for a child to insist that he or she is or desires to be the other sex or to even be uncomfortable with his or her own biological sex to be diagnosed with GIDC (Bartlett et al., 2000). For example, a boy who is content with his assigned gender and sexual body parts, and who, at the same time, prefers to play with girls, wear more feminine attire, act out feminine fantasy figures, and who refuses to play rough or stereotypically boys’ games, can be diagnosed with GIDC, thus increasing the false-positive rate of the diagnosis (Hill et al., 2007).

Studies examining whether a desire to be of the other sex should become a distinct diagnostic criterion are inconclusive, possibly due to frequent co-occurrence but not a complete overlap of cross-sex desires with cross-gender behaviors. According to Bartlett et al. (2000), a child who is uncomfortable with his or her biological sex will likely behave in ways that violate conventional gender norms, but a child engaging in cross-gender behaviors does not automatically wish to be of the other biological sex.

## Psychosexual Outcomes

Related debate concerns the psychosexual outcomes of gender-variant children. Although it is commonly believed that children diagnosed with GIDC grow up to be transsexual adults, such is rarely the case. The most common outcome of childhood gender nonconformity is development of gay/lesbian identity in adolescence or adulthood, without persisting GID. About 30% of children diagnosed with GIDC become heterosexual adults, whereas a very small minority will continue to carry the diagnosis of adult GID (Bartlett et al., 2000; Zucker & Spitzer, 2005). According to Hill et al. (2007), these three disparate psychosexual adult outcomes not only highlight the diagnosis's failure to distinguish between these three phenomenologies but also raise questions about its validity and reliability. This issue is magnified by the fact that since the *DSM-IV-TR* publication, there have been no official studies of reliability of GIDC, demonstrating "a serious deficiency in the literature" (Zucker, 2010, p. 486).

Pathologizing children whose most likely psychosexual outcome is homosexuality also troubles many scholars and activists, who perceive the diagnosis as sanctioning the prevention and treatment of homosexuality under the guise of treating GIDC (Schope & Eliason, 2004). Proponents of the diagnosis disagree with such assessment and assert that (a) gender variance and homosexuality are conceptually different and (b) the diagnosis gives access to treatment aimed at eradicating cross-gender behaviors, thus preventing negative emotional consequences resulting from societal stigma. Moreover, those who support this diagnostic category see early successful treatment as preventing adult GID, thus reducing "the need for the long and difficult process of sex reassignment" (Meyer-Bahlburg, 2002, p. 362).

### Does GIDC Satisfy *DSM* Criteria for a Disorder?

Controversy also surrounds Criterion D, which states that the disorder causes significant distress or impairment in functioning. The *DSM-IV-TR*'s (APA, 2000) definition of mental disorder requires the dysfunction to be within the individual and not based on conflict between the person and society. Thus, to be diagnosed with GIDC, a child's distress has to be intrinsic and not related to social condemnation and rejection (Vasey & Bartlett, 2007).

Our society is generally intolerant of children who do not fit into "typical" gender categories. Boys, who experience a stronger gender role mandate, are especially vulnerable to society's collective disdain when they are gender nonconforming (Wester, McDonough, White, Vogel, & Taylor, 2010). Emotional difficulties associated with GIDC tend to increase with age, suggesting that these problems are related to the additive effect of constant societal censure and ostracism of gender-nonconforming behaviors (Bartlett et al., 2000). Confirming this hypothesis is Zucker and Cohen-Kettenis's (2008) review of behavioral problems in cross-gender-identified children,

showing that childhood gender-nonconforming behavior prominently elicits negative reactions from peers. This issue becomes especially prominent in middle and high schools, where gender-variant youth face harassment and violence even greater than that directed at gender-conforming lesbian, gay, and bisexual youth (Greytak, Kosciw, & Diaz, 2009).

Examining the extent of intrinsic suffering among gender-variant children, Vasey and Bartlett (2007) studied the Samoan *fa'afafine*, who enjoy societal acceptance and tend to see their cross-gender identity and expression as a source of pride rather than distress. The authors concluded that, whereas a small minority of *fa'afafine* were intrinsically distressed about their sexual anatomy, a general lack of such distress rendered the diagnosis with *DSM* in its current form untenable. According to Zucker (2010), although "it remains unclear how distress is to be inferred independently of the clinical indicators" (p. 489) in the diagnostic criteria, "the constructs of distress and impairment require a great deal of further consideration" (p. 490).

## The Future of GIDC

In light of the numerous criticisms, several scholars have called for actions ranging from the dismissal of the GIDC diagnosis to the application of the diagnosis only to those who present with demonstrated pathology (Meyer-Bahlburg, 2010). At the same time, proponents maintain that GIDC has its place in the *DSM* and that "the failure to develop a gender identity that is congruent with biological gender is a dysfunction" (Spitzer, 2005, p. 116).

The DSM-5 Development Sexual and Gender Identity Disorders Work Group (APA, 2010) has proposed several revisions to the GIDC diagnosis. The group recommended a new name—*gender incongruence in children*—seen as less stigmatizing and more representative of the symptomatology. The group also proposed that the distress/impairment criterion be removed, acknowledging that most psychiatric problems in the population stem from an "increased experiences of stigma" (APA, 2010, Rationale, End notes, #15). Other suggested changes include (a) the integration of Criteria A and B into one criterion with at least six of eight indicators necessary for diagnosis (six of the proposed indicators relate to gender role transgressions and two concern anatomical dysphoria); (b) demonstration of "a strong desire to be of the other gender or an insistence that he or she is the other gender" (APA, 2010, Gender Incongruence, A.1.) as necessary for diagnosis; (c) replacement of the term *sex* with *perceived gender* to accommodate persons with disorders of sex development; and (d) a 6-month duration requirement to distinguish between transient and more persistent conditions.

The proposed revisions are drawing attention of the GID reform advocates. In official comments submitted to APA, Winters (2010) praised the less stigmatizing name of the condition, the emphasis on "gender incongruence," and the requirement of gender dysphoria for diagnosis. At

the same time, Winters recommended that several issues be further revised.

Winters (2010) proposed that the diagnosis be clearly made on the basis of dysphoria caused by incongruence between the experienced gender and current physical characteristics/assigned gender role. According to our review of changes proposed by the DSM-5 Development Group, the diagnosis could still be given to children who reject the assigned gender but who do not experience any anatomical dysphoria. Winters also regarded the proposal for removal of the distress/impairment criterion as possibly leading to overdiagnosis of children who do not meet criteria for mental disorder. She proposed that the criterion be kept and that it be based on distress resulting from living in the present gender as opposed to anguish stemming from societal prejudice and discrimination. Furthermore, according to Winters, the term *incongruence* was not effectively defined and was easily confused with social nonconformity. At the same time, Winters assessed the language of diagnostic criteria as anachronistic and pathologizing those who do not conform to "outmoded, sexist, binary gender stereotypes" (Winters, 2010, p. 3). The call to revise the diagnostic language was also previously made by other authors who advocated for this diagnostic category to be written in language reflecting contemporary views of gender rather than views that are based on gender-specific games or clothing (Hill et al., 2007; Martin, 2008).

## Conclusion

Meaningful understanding of gender identity in its developmental and cultural context is paramount in the counseling process whenever determinations about diagnosis and treatment of gender-nonconforming children have to be made. Although in our culture "sexed bodies and gender expressions are severely proscribed, assigned, and delineated" (Lev, 2005, p. 42), decisions about what is gender appropriate depend not only on the geographical location of the individual but also on her or his historical context. After all, most professional women of today would have been considered abnormal 60 years ago. This issue is further complicated by the lack of definitive theories of gender development, prohibiting a definitive declaration about whether gender-nonconforming identity represents a pathological phenomenon (Meyer-Bahlburg, 2010, p. 472).

Psychiatry has a long history of pathologizing human diversity, including race, ethnicity, and sexual orientation (Lev, 2005). Therefore, we must not only be well informed but also especially thoughtful when making decisions about the lives of children who do not adhere to gender norms presently accepted by our society. This stance of awareness, thoughtfulness, and nonpathologizing of diversity that we advocate is imperative in adequately assessing and clinically addressing both the distress inflicted by society and the intrapersonal suffering of children whose gender identity does not match their physical body. While it may be challenging to distinguish between culturally induced and intrinsic suffering, the clinical

and social ramifications of the GIDC diagnosis bring to the forefront the importance of the conscientious and mindful assessment and diagnosis of gender-variant children.

## References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- American Psychiatric Association. (2010). *DSM-5 development: 302.6. Gender identity disorder in children: Proposed revision*. Retrieved from <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=192>
- Bartlett, N., Vasey, P., & Bukowski, W. (2000). Is gender identity disorder in children a mental disorder? *Sex Roles, 43*, 753–785. doi:10.1023/A:1011004431889
- Blakemore, J. E. O., Berenbaum, S. A., & Liben, L. S. (2009). *Gender development*. New York, NY: Psychology Press.
- Bostwick, J., & Martin, K. (2007). A man's brain in an ambiguous body: A case of mistaken gender identity. *American Journal of Psychiatry, 164*, 1499–1505. doi:10.1176/appi.ajp.2007.07040587
- Campbell, A., Shirley, L., & Caygill, L. (2002). Sex-typed preferences in three domains: Do two-year-olds need cognitive variables? *British Journal of Psychology, 93*, 203–217. doi:10.1348/000712602162544
- Coates, S. (1992). The etiology of boyhood gender identity disorder: An integrative model. In D. L. Wolitzky (Ed.), *Interface of psychoanalysis and psychology* (pp. 245–265). Washington, DC: American Psychological Association. doi:10.1037/10118-010
- Davies, D. (2004). *Child development: A practitioner's guide* (2nd ed.). New York, NY: Guilford Press.
- Diamond, M. (2000). Sex and gender: Same or different? *Feminism & Psychology, 10*, 46–54. doi:10.1177/0959353500010001007
- Diamond, M. (2002). Sex and gender are different: Sexual identity and gender identity are different. *Clinical Child Psychology and Psychiatry, 7*, 320–334. doi:10.1177/1359104502007003002
- Diamond, M. (2006). Biased-interaction theory of psychosexual development: "How does one know if one is male or female?" *Sex Roles, 55*, 589–600. doi:10.1007/s11199-006-9115-y
- Fagot, B., & Hagan, R. (1991). Observations of parent reactions to sex-stereotyped behaviors: Age and sex effects. *Child Development, 62*, 617–628. doi:10.2307/1131135
- Gender Identity Research and Education Society. (2006). Atypical gender development: A review. *International Journal of Transgenderism, 9*, 22–44. doi:10.1300/J485v09n01\_04
- Girshick, L. B. (2008). *Transgender voices: Beyond men and women*. Lebanon, NH: University Press of New England.
- Green, R., & Young, R. (2001). Hand preference, sexual preference, and transsexualism. *Archives of Sexual Behavior, 30*, 565–574. doi:10.1023/A:1011908532367
- Greytak, E. A., Kosciw, J. G., & Diaz, E. M. (2009). *Harsh realities: The experiences of transgender youth in our nation's schools*. New York, NY: Gay, Lesbian and Straight Education Network.

- Hill, D. B., Rozanski, C., Carfagnini, J., & Willoughby, B. (2007). Gender identity disorders in childhood and adolescence: A critical inquiry. *International Journal of Sexual Health, 19*, 57–75. doi:10.1300/J514v19n01\_07
- Jacobs, S. E., Thomas, W., & Lang, S. (1997). *Two-spirit people: Native American gender identity, sexuality, and spirituality*. Urbana and Chicago, IL: University of Illinois Press.
- Karraker, K., Vogel, D., & Lake, M. (1995). Parents' gender-stereotyped perceptions of newborns: The eye of the beholder revisited. *Sex Roles, 33*, 687–701. doi:10.1007/BF01547725
- Kraemer, B., Noll, T., Delsignore, A., Milos, G., Schnyder, U., & Hepp, U. (2009). Finger length ratio (2D:4D) in adults with gender identity disorder. *Archives of Sexual Behavior, 38*, 359–363. doi:10.1007/s10508-007-9262-4
- Lev, A. I. (2005). Disordering gender identity: Gender identity disorder in the DSM-IV-TR. *Journal of Psychology & Human Sexuality, 17*, 35–69. doi:10.1300/J056v17n03\_03
- Martin, J. I. (2008). Nosology, etiology, and course of gender identity disorder in children. *Journal of Gay and Lesbian Mental Health, 12*, 81–94. doi:10.1300/J529v12n01\_06
- McHale, S., Crouter, A., & Whiteman, S. (2003). The family contexts of gender development in childhood and adolescence. *Social Development, 12*, 125–148. doi:10.1111/1467-9507.00225
- Meyer-Bahlburg, H. F. L. (2002). Gender identity in young boys: A parent- and peer-based treatment protocol. *Clinical Child Psychology and Psychiatry, 7*, 360–375. doi:10.1177/1359104502007003005
- Meyer-Bahlburg, H. F. L. (2010). From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Archives of Sexual Behavior, 39*, 461–476. doi:10.1007/s10508-009-9532-4
- Mintz, L. B., & O'Neil, J. M. (1990). Gender roles, sex, and the process of psychotherapy: Many questions and few answers. *Journal of Counseling & Development, 68*, 381–387. Retrieved from <http://search.ebscohost.com.ezproxy.brooklyn.cuny.edu:2048/login.aspx?direct=true&db=psyh&AN=1990-17846-001&site=ehost-live>
- Newman, L. K. (2002). Sex, gender and culture: Issues in the definition, assessment and treatment of gender identity disorder. *Clinical Child Psychology and Psychiatry, 7*, 352–359. doi:10.1177/1359104502007003004
- Pasterski, V. (2008). Disorders of sex development and atypical sex differentiation. In D. L. Rowland & L. Incrocci (Eds.), *Handbook of sexual and gender identity disorders* (pp. 354–375). Hoboken, NJ: Wiley.
- Poulin-Dubois, D., Serbin, L., Eichstedt, J., Sen, M., & Beissel, C. (2002). Men don't put on make-up: Toddlers' knowledge of the gender stereotyping of household activities. *Social Development, 11*, 166–181. doi:10.1111/1467-9507.00193
- Schilt, K., & Westbrook, L. (2009). Doing gender, doing heteronormativity: "Gender normals," transgender people, and the social maintenance of heterosexuality. *Gender & Society, 23*, 440–464. doi:10.1177/0891243209340034
- Schope, R., & Eliason, M. (2004). Sissies and tomboys: Gender role behaviors and homophobia. *Journal of Gay & Lesbian Social Services: Issues in Practice, Policy & Research, 16*, 73–97. doi:10.1300/J041v16n02\_05
- Serbin, L., Poulin-Dubois, D., & Eichstedt, J. (2002). Infants' response to gender-inconsistent events. *Infancy, 3*, 531–542. doi:10.1207/S15327078IN0304\_07
- Spitzer, R. L. (2005). Sexual and gender identity disorders: Discussion of questions for DSM-V. *Journal of Psychology & Human Sexuality, 17*, 111–116. doi:10.1300/J056v17n03\_06
- Stryker, S. (2008). *Transgender history*. Berkeley, CA: Seal Press.
- Vasey, P., & Bartlett, N. (2007). What can the Samoan "fa'afafine" teach us about the Western concept of gender identity disorder in childhood? *Perspectives in Biology and Medicine, 50*, 481–490. doi:10.1353/pbm.2007.0056
- Wester, S. R., McDonough, T. A., White, M., Vogel, D. L., & Taylor, L. (2010). Using gender role conflict theory in counseling male-to-female transgender individuals. *Journal of Counseling & Development, 88*, 214–219. Retrieved from <http://aca.metapress.com/link.asp?id=97hh1k6351780200>
- Winters, K. (2010). *Comments on the proposed revision to 302.6 gender identity disorder in children*. Retrieved from <http://www.gidreform.org/201004APAGICHILDkwB.pdf>
- Zhou, J., Hofman, M. A., Gooren, L. J. G., & Swaab, D. F. (1995, November 2). A sex difference in the human brain and its relation to transsexuality. *Nature, 378*, 68–70. doi:10.1038/378068a0
- Zucker, K. J. (2010). The DSM diagnostic criteria for gender identity disorder in children. *Archives of Sexual Behavior, 39*, 477–498. doi:10.1007/s10508-009-9540-4
- Zucker, K. J., & Bradley, S. J. (2004). Gender identity and psychosexual disorders. In M. K. Dulcan (Ed.), *The American Psychiatric Publishing textbook of child and adolescent psychiatry* (3rd ed., pp. 813–835). Arlington, VA: American Psychiatric Publishing, Inc.
- Zucker, K., & Cohen-Kettenis, P. (2008). Gender identity disorder in children and adolescents. In D. L. Rowland & L. Incrocci (Eds.), *Handbook of sexual and gender identity disorders* (pp. 376–422). Hoboken, NJ: Wiley.
- Zucker, K., & Spitzer, R. (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 & Marital Therapy, 31*, 31–42. doi:10.1080/00926230590475251

Copyright of Journal of Counseling & Development is the property of American Counseling Association and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.