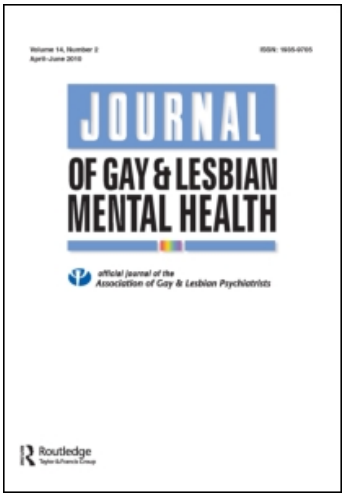

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INTRODUCTION

Gender Variance: An Ongoing Challenge to Medico-Psychiatric Nosology

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An array of gender variant behaviors and identities among youth has been identified in many historical periods and diverse cultures around the globe. The *cinaedos* in Ancient Rome have been well documented: groups of young men who performed female-typical activities such as dancing and playing music and performed receptive sexual intercourse (Richlin, 1993). In the New World, Spanish explorers since the 16th century described a widespread institution among the natives of the "berdache": biological males who dressed and behaved as women, some even marrying masculine men. There is historical documentation throughout the Americas of parents gendering certain boys as girls and to a lesser extent of girls as boys (Trexler, 1995). More recent ethnography describes the continued presence of such cross-gendered people among North American natives (Roscoe, 1991), and in the 1990s gay and lesbian Native Americans adopted the term "two-spirit" people to describe the phenomenon.

Neurologist William Hammond (1828–1900), former surgeon general of the U.S. Army, described with amazement and some revulsion the "mujerados" or "bote" he had observed in 1851 as a U.S. Army medical officer in a Pueblo village in New Mexico. According to Hammond, these young men had been feminized through repeated masturbation. Their genitals had atrophied and they possessed enlarged breasts; furthermore, they dressed and behaved fully as women. He concluded that this was a form of "mental alienation" due to "sexual impotence" (Hammond, 1882). Hammond's medical ethnography was written just as European and American doctors were "discovering" a new disorder they struggled to classify. Physicians variously labeled it "contrary sexual sensation," "psychosexual hermaphroditism," or "sexual inversion" (Rosario, 2002).

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Hannoverian lawyer Karl Heinrich Ulrichs (1825–1895) labeled himself and other man-loving men as "Urnings." In his writings from the mid-1860s he elaborated a complex biological theory of the innate nature of Urnings, relying especially on his own developmental history of effeminacy. He recalled wearing girls' clothes as a child and insisting that he wanted to be a girl. "This outwardly recognizable female essence I call the female habitus of the Urning," he wrote. "The Urning shows as a child a quite unmistakable partiality for girlish activities, for interaction with girls, for playing with girls' playthings, namely also with dolls" (cited in Kennedy, 1988, p. 31). He proposed that Urnings constituted a "third sex" with a "female soul confined in a male body" (*anima muliebris virili corpore inclusa*). Although his formulation has an uncanny similarity to the current nosology of Gender Identity Disorder in Children (GIDC), his theories would be subsumed into the emerging medical diagnosis of "sexual inversion"—one of a growing number of "sexual perversions" documented in the late 19th century (Rosario, 1997). The first medical use of this term was in Italian (*inversione del l'istinto sessuale*) in 1878 by the forensic doctor Arrigo Tamassia (1848–1917). Tamassia astutely pointed out that his own term was "too vague" since it conflated two different phenomena: (1) psychological gender crossing and (2) the preference "to satisfy [one's] sexual instinct with individuals of the same sex" (Tamassia, 1878, p. 99).

Whether "savages" in the New World or "perverts" in modern cities, all these manifestations of crossed gender and contrary sexual behavior were collapsed into the emerging neuropsychiatric diagnosis of "sexual inversion." The term became synonymous with "homosexual" (coined in 1869) and was still the term Sigmund Freud used in his *Three Essays on the Theory of Sexuality* (1905). Magnus Hirschfeld, a homosexual sexologist and civil rights advocate, did much to split "inversion" into a variety of component elements and terms: transvestitism, intersex, and transsexualism (although his connotations of these terms were not exactly those we ascribe to them today). His dominant model of sex and sexuality was that humans exist on a continuum between the poles of the ideal female and the ideal male, in between are diverse manifestations of sexual intermediates (*sexuelle Zwischenstufen*) (Steakley, 1997). His model was not one of pathology but of the hereditary diversity of sexual behavior driven by gendered variations of the central nervous system (Hirschfeld, 1914). He was also the first doctor, as far as we know, to refer extreme sexual intermediate men for hormonal and surgical treatment to feminize them (Abraham, 1931).

Although these genital transformation (*Genitalumwandlung*) surgeries were being done since the interwar period (including in the United States by UCLA urologist Elmer Belt), it was not until Christine Jorgensen received worldwide notoriety in 1952 that transsexualism became widely known (probably even to medical professionals) (Hamburger, Stürup, & Dahl-Iverson, 1953). Jorgensen's history of lifelong cross-sexed feeling and

unhappiness about her natal sexed body were similar to Ulrichs's sexual subjectivity, but by the 1950s—a century later—hormones and surgery were available to do something about it. Jorgensen's childhood history of cross-gendered behavior and interests, along with gender dysphoria, became the template for the new diagnosis of transsexualism. The media at the time, swooning from the scientific hubris of the Atomic Age, were mesmerized by the idea of a "sex change" (Meyerowitz, 2002).

At that historical point, transsexualism and homosexuality seemed like distinct phoenomena, and Jorgensen herself denied having had homosexual encounters and (like most Americans in the 1950s) had felt homosexuality was immoral (Jorgensen 1967, p. 38). As gender clinics in academic medical centers began to proliferate in the 1950s and 1960s, medical experts, particularly psychiatrists, became the gatekeepers of "sex change" treatment, charged with the triage of supposedly authentic transsexuals from repressed, confused, or psychotic homosexuals and transvestites. The first *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (which hewed to analytic principles) classified homosexuality as a "sexual deviation" under the rubric of "sociopathic personality disturbance" (APA, 1952, p. 38). Historian Ronald Bayer (1981) has documented both the scientific evidence and the political pressure that led to the tumultuous removal of "homosexuality" from the DSM-II in 1973. In its place appeared "Sexual Orientation Disturbance" and later "Ego-Dystonic Homosexuality" in DSM-III (1980) before homosexuality entirely vanished as a disorder in DSM-III-R (1987).

Transsexuality, being a newer medical phenomenon, did not appear in the psychiatric nosology until DSM-III (1980) where it was represented by the diagnoses of Gender Identity Disorder of Childhood (GIDC) and Transsexualism (Bryant, 2006). Richard Green, a pioneer in studying transsexualism, was instrumental in the introduction of GIDC into the DSM and discusses this process in this issue. In DSM-IV (1994) the two diagnoses would be consolidated under the term GID with distinct criteria for children versus adolescents and adults (Zucker & Spitzer, 2005). This certainly suggests continuity between GIDC and adult GID or transsexualism. However, Green's prospective study of gender-variant boys (1987) followed into adolescence and young adulthood found that 75% of those who could be reassessed had developed a gay or bisexual orientation, and only one was primarily transsexual. Subsequent studies of girls and boys have continued to find that the majority of gender-variant children grow up to have a homosexual or bisexual orientation rather than identify as transsexual (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). The persistence of gender dysphoria and the wish to transition sex, however, is higher in these more recent studies than in Green's study (1987).

The Victorian conundrum about the nature of sexual inversion once again confounds our understanding of GIDC. Is it continuous with adult transsexualism or is it primarily a predictor of adult homosexuality; that is,

is childhood gender atypicality a matter of sexual orientation or of gender identity? Are the two really so easy to tease apart? Furthermore, is GIDC a disorder, and does it need to be treated? What should be the goals of treatment? Is gender variance a single phenomenon or a variety of states? The implications are significant: the essentialist position would have it that there is a distinct phenotype of transsexualism (presumably with a biological, perhaps genetic, etiology) to be treated medically with cross-sex hormones and surgeries. Under this view, Hijra in India, Katoey in Thailand, and two-spirit Native Americans are all "really" transsexuals who would benefit from sex reassignment surgery. Alternatively, a cultural contructivist model would argue that even if there were common biological roots to gender diversity, the multitude of historical and cultural manifestations of gender variance are their own entities and no common label or treatment is indicated.

The phenomenology, nosology, and even the very name and pathological status of gender variance have been particularly heated topics recently because of revisions in the DSM with the planned publication of the DSM-5 in 2013. While all the sexual disorders have long been controversial, debate about GIDC has been particularly fiery. As Jack Drescher (2010), a member of the Work Group on Sexual and Gender Identity Disorders, summarizes, lesbian, gay, bisexual, and transgender (LGBT) activists criticized the Work Group and the APA more broadly of pathologizing transgender people. Some activists erroneously claimed that GIDC was a Trojan horse aimed at repathologizing homosexuality. Furthermore, therapies aimed at coaxing gender dysphoric children to accept their natal sex were likened by these advocates to "reparative therapy" of homosexuality. While some transgender activists argued for the complete elimination of GID and GIDC from the DSM, others feared that expunging GID would allow insurers to drop coverage of transgender medical care and instead view it as an elective or cosmetic. The articles by individual members of the Work Group point out that these researchers thoughtfully grappled with the scientific, political, and sociological ramifications of having GID in a psychiatric nosology (Cohen-Kettenis & Pfäfflin, 2010; Drescher, 2010; Meyer-Bahlburg, 2010; Zucker, 2010). The Working Group's proposed revision of the very term GID to "Gender Incongruence" was partly to mitigate the social stigma of a psychiatric "disorder" as well as to more accurately portray a psychological phenomenon that benefits from identification and therapy: a lasting, "marked incongruence between one's experienced/expressed gender and assigned gender" (APA, 2010). Readers should review the "Rationale" section of the GIDC draft revision as well as the aforementioned articles to appreciate the reasons for retaining a diagnosis as well as the changes in criteria according to newly accumulated psychometric data.

The articles in this volume tackle these vexing uncertainties about the nature of childhood gender variance utilizing a wide range of scientific and psychotherapeutic methods. They also examine a variety of national

and ethnic contexts. They demonstrate the many faces of gender variance as well as different approaches to understanding its origins, nature, and treatment—indeed, even questioning whether treatment is necessary. As noted above, Richard Green's essay provides a personal historical note on his involvement in the formulation of the diagnosis of Gender Identity Disorder of Childhood for the DSM.

Paul Vasey has long studied the *fa'afafine* of Samoa and the Pacific Islands. The *fa'afafine* are natal boys who exhibit an alternative gender. It would be facile to classify them as "gay" or "transgender," but they do not quite fit into these Western categories of sexual/gender identity. Vasey and Bartlett (2007) found that *fa'afafine* did not experience emotional distress about their gender or being *fa'afafine*. In their article here, Doug P. VanderLaan, Laura M. Gothreau, Nancy H. Bartlett, and Paul L. Vasey examine this phenomenon from the framework of evolutionary psychology comparing nonclinical populations of Samoan and Canadian feminine males.

Italian researchers Davide Dèttore, Jiska Ristori, and Silvia Casale administrated the "Gender Identity Interview" to preschool and kindergarten children in Florence. Such basic research is notably lacking in Italy. Their article provides an initial snapshot of gender dysphoria and, more broadly, gendered attitudes among young children in Italy. Their research relies on the psychometric foundations of Kenneth Zucker and Susan Bradley in Toronto. In this volume, Kenneth J. Zucker, Susan J. Bradley, Allison Owen-Anderson, Devita Singh, Ray Blanchard, and Jerald Bain report on a longitudinal study of adolescents with GID. The present article reports on demographic and psychological factors that predict which individuals are approved for puberty-blocking hormonal therapy.

Diane Ehrensaft, a clinical psychologist specializing in the treatment of gender-variant children, presents here a detailed case study of her treatment of a Mexican-American boy. Her nondirective treatment approach allows the child to work through issues of gender behavior and identity, even as Ehrensaft examines their interrelations with the child's parental dynamics and ethnic/socioeconomic roots.

Edgardo Menvielle directs the Gender/Sexuality Development Program of Children's National Medical Center in Washington, D.C., which takes an affirmative approach to working with gender-variant children. In this volume, Menvielle and Darryl B. Hill present results of parent surveys of families participating in their in-person and on-line support groups.

Iran would seem to represent the other end of the spectrum in terms of cultural acceptance of gender variance and same-sex attraction. Yet Tehran has an active academic gender clinic. Masoud Ahmadzad-Asl, Amir-Hossein Jalali, Kaveh Alavi, Morteza Naserbakht, Mojgan Taban, Khadijeh Mohseninia-Omrani, and Mehrdad Eftekhar present their initial results on the epidemiology of GID and transsexualism in Iran, including subjects' reports on their gendered feelings in childhood.

These articles only scratch the surface of the great diversity in gender variance around the world and the still relatively young status of research in this field. The *Journal of Gay & Lesbian Mental Health* hopes to continue presenting cutting-edge research on the intersections of gender identity and sexuality to elucidate the phenomenology of gender variance in order to better aid gender variant individuals and their families.

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