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Interim Report of the DSM-IV Subcommittee on Gender Identity Disorders

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This article summarizes the discussions and recommendations of the DSM-IV Subcommittee on Gender Identity Disorders, a subcommittee of the Child Psychiatry Work Group, regarding diagnostic issues. The issues reviewed include placement in the nomenclature, the concept of a spectrum of gender dysphoria rather than discrete levels of symptomatology, criticisms of current diagnostic criteria, subtyping by sexual orientation, and proposed changes in diagnostic criteria for the current DSM-III-R diagnoses of Gender Identity Disorder of Childhood, Transsexualism, and Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type.

KEY WORDS: DSM; diagnosis; gender identity disorder; transsexualism; transvestic fetishism.

The views expressed in this article are those of the authors and do not represent the official positions of the DSM-IV Task Force of the American Psychiatric Association.

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INTRODUCTION

Concern about adequate diagnosis of individuals with gender identity disorders developed as such patients began presenting themselves, in the early 1960s, requesting sex reassignment surgery (SRS). Earlier work naturally focused on formulating diagnostic criteria permitting clinicians to make safe judgments about who should and should not have surgery. The DSM-III-R (American Psychiatric Association, 1987) clearly reflects this tradition in that it divides disorders into Transsexualism and Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type.

As clinicians were exposed to a broad range of children, adolescents, and adults with gender identity disorders, it became apparent that patients vary greatly with regard to the severity, constancy, and natural history of their gender dysphoria. For example, only a small minority of cross-gender-identified children followed prospectively go on to develop transsexualism (e.g., Green, 1987); in contrast, a much larger percentage of cross-gender-identified persons who present in adolescence will remain gender dysphoric or eventually receive a diagnosis of transsexualism (e.g., McCauley and Ehrhardt, 1984). It is also clear from referrals to adult gender identity clinics that differences between individuals who proceed towards SRS and those who do not may be more quantitative than qualitative.

Members of the Subcommittee on Gender Identity Disorders, a subcommittee of the Child Psychiatry Work Group for DSM-IV (see Shaffer *et al.,* 1989), began meeting in March 1989. The initial task of this committee was to examine category and criterion issues. Recommendations for change are to be based on a review of the literature or on analysis of data sets or, where neither exist, on the grounds that widely accepted clinical experience would clearly support such change. The remainder of this article summarizes the issues so far addressed by the subcommittee; its purpose is to stimulate discussion and to solicit feedback from members of the sexological community.

PLACEMENT IN THE NOMENCLATURE

A basic issue considered by the subcommittee, but one that was not in its jurisdiction to alter, was the diagnostic category in which gender identity disorders should be placed. In DSM-III (American Psychiatric Association, 1980), Transsexualism and Gender Identity Disorder of Childhood were placed under the larger category entitled *Psychosexual Disorders.* In DSM-III-R, the category *Psychosexual Disorders* was eliminated, with many of the former diagnoses placed under a new category termed *Sexual Dis-*

Table I. DSM-III-R Diagnostic Criteria for Gender Identity Disorder of Childhood

For females

A. Persistent and intense distress about being a girl, and a stated desire to be a boy (not merely a desire for any perceived cultural advantages from being a boy), or insistence that she is a boy.
B. Either (1) or (2):
   (1) persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing, e.g., boys' underwear and other accessories
   (2) persistent repudiation of female anatomic structures, as evidenced by at least one of the following:
      (a) an assertion that she has, or will grow, a penis
      (b) rejection of urinating in a sitting position
      (c) assertion that she does not want to grow breasts or menstruate
C. The girl has not yet reached puberty.

For males

A. Persistent and intense distress about being a boy and an intense desire to be a girl or, more rarely, insistence that he is a girl.
B. Either (1) or (2):
   (1) preoccupation with female stereotypical activities, as shown by a preference for either cross-dressing or simulating female attire, or by an intense desire to participate in the games and pastimes of girls and rejection of male stereotypical toys, games, and activities
   (2) persistent repudiation of male anatomic structures, as indicated by at least one of the following repeated assertions:
      (a) that he will grow up to become a woman (not merely in role)
      (b) that his penis or testes are disgusting or will disappear
      (c) that it would be better not to have a penis or testes
C. The boy has not yet reached puberty.

orders. Transsexualism and Gender Identity Disorder of Childhood were placed under the larger category entitled *Disorders Usually First Evident in Infancy, Childhood, or Adolescence.*

The subcommittee recognized some advantages for the DSM-III-R placement, in that such an arrangement forced more attention to and recognition of gender identity disorders on the part of child and adolescent clinicians. On the other hand, adult clinicians felt that such placement was inappropriate for transsexualism, particularly given that behavioral precursors of some cases of adult transsexualism are not evident in childhood. On balance, the subcommittee agreed that a distinct diagnostic category, Gender Identity Disorders, should be created in DSM-IV. Such a category would have the same status as, for example, Anxiety Disorders and Mood Disorders, in which there may be childhood precursors, if not identical symptoms, to what is observed in adults (see Shaffer *et al.,* 1989).

Table II. DSM-III-R Diagnostic Criteria for Transsexualism

A.	Persistent discomfort and sense of inappropriateness about one's assigned sex.
B.	Persistent preoccupation for at least two years with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex.
C.	The person has reached puberty.

Specify history of sexual orientation: asexual, homosexual, heterosexual, or unspecified

SPECIFIC CATEGORY AND CRITERION ISSUES

Gender Identity Disorder of Childhood

The Subcommittee has identified two substantive concerns about the present criteria: (i) differences in the criteria for boys and girls and (ii) the distinctness of the criterion pertaining to the wish to be of the opposite sex.

Diagnostic Criteria for Boys and Girls

In DSM-III-R, a girl is required not only to have "persistent and intense distress" about being a girl but also to have a "stated desire" to be a boy. Boys must also have a "persistent and intense distress" about being a boy, but only need to have an "intense desire" to be a girl. In other words, girls must state their desire to be a boy, whereas boys need not verbalize such wishes. Moreover, for boys, the desire must be "intense," whereas for girls no specification regarding intensity is made with regard to the verbalized wish to be a boy (Table I).

The subcommittee has taken the position that the reasons for these distinctions are not clear. It was felt that whatever criterion was adopted regarding the verbalized wish to be of the opposite sex should be the same for boys and girls. The subcommittee also felt that the *desire* to be of the opposite sex would be difficult to infer independently of other aspects of the criteria as they stood in DSM-III-R.

Another issue involving girls concerns the statement in Point A that the desire to be a boy is not due to "perceived cultural advantages from being a boy." The subcommittee took the position that it was inappropriate to place such an exclusion rule in the criteria themselves, as there may be many reasons why a child adopts a cross-gender identity, and that these issues should be dealt with in the text (for further discussion of these points, see Zucker, 1991).

Table III. DSM-III-R Diagnostic Criteria for Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT)

A.	Persistent or recurrent discomfort and sense of inappropriateness about one's assigned sex.
B.	Persistent or recurrent cross-dressing in the role of the other sex, either in fantasy or actuality, but not for the purpose of sexual excitement (as in Transvestic Fetishism).
C.	No persistent preoccupation (for at least two years) with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex (as in Transsexualism).
D.	The person has reached puberty.

Specify history of sexual orientation: asexual, homosexual, heterosexual, or unspecified

Should the Desire to be of the Opposite Sex Be a Distinct Criterion?

Clinical experience suggests that children may manifest significant cross-gender identification without verbalizing the wish to be of the opposite sex. This appears particularly true of children over the age of 6 or 7, perhaps because of the social opprobrium that ensues (Zucker, 1991). Currently, the subcommittee is analyzing data sets from Green's (1987) study and from the data base of the Child and Adolescent Gender Identity Clinic at the Clarke Institute of Psychiatry to examine the similarities and differences between children referred for gender identity concerns who do and do not verbalize the wish to be of the opposite sex.

It was the recommendation of the subcommittee that the explicit wish to be of the opposite sex be combined with other behavioral markers of gender identity disorder into one criterion. This would eliminate the pivotal role that the verbalized wish to change sex plays in the DSM-III-R criteria.

Transsexualism and Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT)

The DSM-III-R diagnostic criteria for Transsexualism and GIDAANT are presented in Tables II and III. These categories are similar except that Transsexualism appears designed for gender-dysphoric individuals who have decided upon surgical sex reassignment as the solution to their inner distress (Levine, 1989). The desire to uncouple the clinical diagnosis of gender dysphoria from criteria for approving patients for SRS was one factor in the subcommittee's recommendation that these categories be merged under the

single heading of Gender Identity Disorder. The subcommittee was also influenced by the perception of many clinicians that there are no distinct boundaries between gender dysphorics who request sex reassignment surgery and those whose cross-gender wishes are of lesser intensity or constancy (Benjamin, 1966; Fisk, 1973; Freund *et al.,* 1982; Person and Ovesey, 1974a, 1974b). Specific issues addressed within this broad category have included (i) the present exclusion of fetishistic cross-dressers, (ii) subtypes of gender-dysphoric adults, and (iii) the diagnostic classification of physical intersexes.

Exclusion of Fetishistic Cross-Dressers from the Present Transsexual and GIDAANT Categories

In DSM-III-R, any individual who reported that he was currently gender dysphoric and currently aroused by cross-dressing would necessarily be diagnosed as Gender Identity Disorder Not Otherwise Specified (GIDNOS). The GIDNOS label is the only one applicable because gender dysphoria precludes the diagnosis of Transvestic Fetishism, whereas fetishistic arousal precludes the diagnoses of Transsexualism and GIDAANT. This diagnostic rule is discordant with both clinical experience and the available research literature, which suggests that about half of even the most strongly gender-dysphoric nonhomosexual men acknowledge that they still become sexually aroused or masturbate at least occasionally when cross-dressing (Blanchard and Clemmensen, 1988). Because of the excessive number of cases currently classified as GIDNOS, our subcommittee and the Sexual Disorders Work Group (Wise, 1989) agreed that the current arrangement was unsatisfactory.

The Sexual Disorders Work Group proposed to subtype Transvestic Fetishists with and without gender dysphoria (Wise, 1989). Our subcommittee found that proposal problematic because many such individuals appear to lose the fetishistic arousal as the gender dysphoria develops (Benjamin, 1966; Buhrich and Beaumont, 1981; Buhrich and McConaghy, 1977; Person and Ovesey, 1978; Wise and Meyer, 1980). Subtyping transvestic fetishists according to the presence of gender dysphoria could then require changing the diagnosis from transvestic fetishism to gender identity disorder in those individuals whose fetishistic arousal has diminished. This would appear to be unduly cumbersome.

The Subcommittee on Gender Identity Disorders recommends that fetishistic arousal should *not* be an exclusion criterion for Gender Identity Disorder. Individuals who currently experience erotic arousal in association with cross-dressing as well as gender dysphoria would receive two diagnoses: Gender Identity Disorder and Transvestic Fetishism.

Subtypes of Gender Identity Disorder

After reviewing Blanchard's (1985, 1988, 1989a, 1989b) analyses of the various subtypes presenting at the (adult) Gender Identity Clinic of the Clarke Institute of Psychiatry in Toronto, the subcommittee agreed that there are two common routes leading to a gender identity disorder in adolescence or adulthood. The first group of cases progresses from Gender Identity Disorder of Childhood and are sexually oriented toward members of their own biological sex; the second appears to progress from Transvestic Fetishism over time to a full-blown gender identity disorder. The latter group may have had, or may still have, erotic attraction to members of the opposite biological sex; mixed within this group are others who might be described as bisexual or asexual.

The subcommittee debated the utility of subtyping, various methods of subtyping, and the diagnostic labels to apply to subtypes. There was consensus that it is important for clinical management as well as research purposes to note gender dysphorics' sexual preferences (e.g., Blanchard *et al.,* 1989). With regard to method of subtyping, the subcommittee felt that, notwithstanding the above-mentioned evidence that there may be only two fundamentally different types of gender identity disorder, it was better to anchor subtyping at the descriptive level and to distinguish four different subtypes.

A great deal of discussion was devoted to the question of subtype labels. Many patients object to being labeled "homosexual" or "heterosexual," and many professionals appear confused about the reference point (the patient's anatomic sex or subjective gender identity) in applying such terminology (Pauly, 1990). The subcommittee's recommendations were intended to make the principles of subtyping clear to professionals and the language inoffensive to the patients themselves. The recommended system of subtyping is as follows: (i) sexually attracted to males, (ii) sexually attracted to females, (iii) sexually attracted to both, (iv) sexually attracted to neither, and (v) unspecified.

The subcommittee further agreed that, because the rationale for subtyping is not entirely clear to those not working in this area, explanation of the need for this will be provided in the text.

Intersexuality and Gender Dysphoria

The subcommittee debated whether individuals who appear to be cross-gender-identified and have a history of ambiguous genitalia or some significant chromosomal anomaly should be given a psychiatric diagnosis. The subcommittee was not unanimous in recommending a

Table IV. Proposed DSM-IV Diagnostic Criteria for Gender Identity Disorder[a]

A. A profound and persistent cross-gender identification.
   In *children,* as manifested by at least 4 of the following:
   1. *repeatedly* stated desire to be, or insistence that he or she is, the opposite sex
   2. in girls, insistence on wearing stereotypical masculine clothing; in boys, preference for cross-dressing or simulating female attire
   3. *strong and persistent preferences for cross-sex roles in fantasy play or persistent fantasies of being the opposite sex*
   4. intense desire to participate in the games and pastimes of the *opposite* sex
   5. *strong preference for playmates of the opposite sex*

   In *adolescents and adults,* as manifested by symptoms such as *a stated desire to be the opposite sex, frequent passing as the opposite sex, desire to live as or be treated as the opposite sex, or the conviction that one has the typical feelings and reactions of the opposite sex.*

B. Persistent discomfort with one's assigned sex or sense of inappropriateness in *that gender role.*
   In *children,* manifested by any of the following:
   In boys, assertion that his penis or testes are disgusting or will disappear, or assertion that it would be better not to have a penis, or *aversion towards rough and tumble play* and rejection of male stereotypical toys, games, and activities
   In girls, rejection of urinating in a sitting position or assertion that she does not want to grow breasts or menstruate, assertion that she has or will grow a penis, or persistent marked aversion towards normative feminine clothing
   In *adolescents and adults,* manifested by symptoms such as preoccupation with getting rid of one's primary and secondary sex characteristics (e.g., *request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the opposite sex*) or belief that one was born the wrong sex
   For sexually mature individuals, specify history of sexual attraction: towards males, females, both, neither, unspecified

[a]Italicized sections are new.

solution. Concern was expressed that, although there may be etiologic and phenomenological differences, the evidence is not yet strong enough to suggest that such disorders differ from gender identity disorders in physically normal individuals. Thus it was recommended that we continue to use the present classification scheme, that is, to give a psychiatric diagnosis of gender identity disorder but to include, as is present practice, the physical anomaly on Axis III. It was suggested that there is a need for further research in this area to clarify whether the factors thought to be relevant in the development of gender identity disorders in physically normal individuals are essentially the same as those in individuals with clear-cut physical or biochemical abnormalities.

Gender Identity Disorder Not Otherwise Specified (GIDNOS)

This category, as presently described, includes disorders that differ both qualitatively and quantitatively from the major disorders in this sec-

tion. There is a need for description in the text of the use of this category. For example, the subcommittee discussed the proper diagnosis of boys who cross-dress but who do not otherwise exhibit evidence of a gender disorder. These boys may develop into heterosexual transvestic fetishists, but mature patterns of sexual behavior at the time of diagnosis are lacking. They present clinically as early as age 3 to 4 but most typically in early adolescence. Various options were discussed for ways of categorizing them, none of which seemed suitable. The possibilities of using a V code, of including them among the anxiety disorders, or of using GIDNOS were raised. GIDNOS, with text clarification, may be the simplest way of diagnostically capturing this group of children and adolescents.

PROPOSED DIAGNOSTIC CRITERIA

As a result of the extensive discussions within the Child Psychiatry Work Group and presentations at the American Academy of Child Psychiatry and consultation with advisors, the subcommittee decided to develop one set of criteria for gender identity disorder (Table IV). The subcommittee felt that a statement of the essential, common elements of gender identity disorder could be applied to patients at different phases of the life cycle, i.e., childhood, adolescence, and adulthood, thus obviating the necessity of arbitrary age-related delineations (e.g., puberty). The criteria have been separated for children and adults to reflect developmental differences.

For children, it can be seen that a repeatedly stated desire to be of the opposite sex is now one of five behavioral signs, of which, it is proposed, four must be present for this criterion to be met. Conceptually, this criterion is intended to reflect the child's marked cross-gender identification. At present, the empirical basis for a cutoff of four signs or symptoms is debatable, although this was the consensus of the subcommittee. The subcommittee is currently analyzing available data bases to evaluate further the legitimacy of this recommendation.

It can also be seen in Table IV that the proposed Point B criterion is intended to reflect the child's severe discomfort with characteristics of his or her own gender, including expressions of anatomic dysphoria and the intense rejection of certain normative behavioral attributes.

It should be noted that polythetic criteria are not employed for adults. The specific symptoms listed are intended only as examples.

TEXT ISSUES

In the next phase of the subcommittee's work, a review of the text will be undertaken, with suggestions for revisions of its separate headings: associated features, age of onset and course, complications, impairment, prevalence, sex ratio, familial pattern, predisposing factors, and differential diagnosis. Investigators possessing data bases of potential relevance to these various topics are urged to contact the Chair of the Subcommittee, if they feel that they can offer empirical findings that would support revisions of the text.

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REFERENCES

American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders,* 3rd ed. APA, Washington, DC.

American Psychiatric Association. (1987). *Diagnostic and Statistical Manual of Mental Disorders,* 3rd ed., rev., APA, Washington, DC.

Benjamin, H. (1966). *The Transsexual Phenomenon,* Julian Press, New York.

Blanchard, R. (1985). Typology of male-to-female transsexualism. *Arch. Sex. Behav.* 14: 247-261.

Blanchard, R. (1988). Nonhomosexual gender dysphoria. *J. Sex Res.* 24: 188-193.

Blanchard, R. (1989a). The classification and labeling of nonhomosexual gender dysphorias. *Arch. Sex. Behav.* 18: 315-334.

Blanchard, R. (1989b). The concept of autogynephilia and the typology of male gender dysphoria. *J. Nerv. Ment. Dis.* 177: 616-623.

Blanchard, R., and Clemmensen, L. H. (1988). A test of the DSM-III-R's implicit assumption that fetishistic arousal and gender dysphoria are mutually exclusive. *J. Sex Res.* 25: 426-432.

Blanchard, R., Steiner, B. W., Clemmensen, L. H., and Dickey, R. (1989). Prediction of regrets in postoperative transsexuals. *Can. J. Psychiat.* 34: 43-45.

Buhrich, N., and Beaumont, T. (1981). Comparison of transvestism in Australia and America. *Arch. Sex. Behav.* 10: 269-279.

Buhrich, N., and McConaghy, N. (1977). The clinical syndromes of femmiphilic transvestism. *Arch. Sex. Behav.* 6: 397-412.

Fisk, N. (1973). Gender dysphoria syndrome (the how, what, and why of a disease). In Laub, D. R., and Gandy, P. (eds.), *Proceedings of the Second Inderdisciplinary Symposium on Gender Dysphoria Syndrome,* Stanford University Press, Stanford, CA, pp. 7-14.

Freund, K., Steiner, B. W., and Chan, S. (1982). Two types of cross-gender identity. *Arch. Sex. Behav.* 11: 49-63.

Green, R. (1987). *The "Sissy Boy Syndrome" and the Development of Homosexuality,* Yale University Press, New Haven, CT.

Levine, S. B. (1989). Gender identity disorders of childhood, adolescence, and adulthood. In Kaplan, H. I. and Sadock, B. J. (eds.), *Comprehensive Textbook of Psychiatry,* Vol. 1, 5th ed., Williams and Wilkins, Baltimore, pp. 1061-1069.

McCauley, E., and Ehrhardt, A. A. (1984). Follow-up of females with gender identity disorder. *J. Nerv. Ment. Dis.* 172: 353-358.

Pauly, I. B. (1990). Gender identity disorders: Evaluation and treatment. *J. Sex Educ. Ther.* 16: 2-24.

Person, E., and Ovesey, L. (1974a). The transsexual syndrome in males. I: Primary transsexualism. *Am. J. Psychother.* 28: 4-20.

Person, E., and Ovesey, L. (1974b). The transsexual syndrome in males. II: Secondary transsexualism. *Am. J. Psychother.* 28: 174-193.

Person, E., and Ovesey, L. (1978). Transvestism: New perspectives. *J. Am. Acad. Psychoanal.* 6: 301-323.

Shaffer, D., Campbell, M., Cantwell, D., Bradley, S., Carlson, G., Cohen, D., Denckla, M., Frances, A., Garfinkel, B., Klein, R., Pincus, H., Spitzer, R. L., Volkmar, F., and Widiger, T. (1989). Child and adolescent psychiatric disorders in DSM-IV: Issues facing the work group. *J. Am. Acad. Child Adolescent Psychiat.* 28: 830-835.

Wise, T. N. (1989). *Transvestitic fetishism.* Unpublished manuscript, DSM-IV Work Group on Sexual Disorders.

Wise, T. N., and Meyer, J. K. (1980). The border area between transvestism and gender dysphoria: Transvestitic applicants for sex reassignment. *Arch. Sex. Behav.* 9: 327-342.

Zucker, K. J. (1991). Gender identity disorder. In Hooper, S. R., Hynd, G. W., and Mattison, R. E. (eds.), *Child Psychopathology: Diagnostic Criteria and Clinical Assessment,* Erlbaum, Hillsdale, NJ, pp. 305-342.