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GENDER DISORDERS IN CHILDHOOD
A Formulation

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How does one become a transsexual? Although current data do not provide the definitive answer to this question, we can clearly gather some understanding from the study of gender disorders in children. Outcome studies are now confirming the link between early cross-sex behaviors and later gender identity disorders (Green, 1979; Money & Russo, 1979; Zuger, 1978; see Zucker, Chapter 4 in this volume for a review of follow-up studies). Follow-up data also appear to show a degree of variability in outcomes that would suggest more flexibility in these disorders than had originally been supposed. Reports, although few in number, documenting changes in gender identity (Barlow, Reynolds, & Agras, 1973; Davenport & Harrison, 1977; Kronberg, Tyano, Apter, & Wijsenbeek, 1981) and our own clinical experience in following children and adolescents with these disorders have led us to believe that the critical factors relevant in the development and maintenance of these disorders are psychological and social.

What then of the elusive biological factor posited by many authors as the ultimate explanation in these disorders (Baker & Stoller, 1968; Zuger, 1970; see Hoenig, Chapter 3 in this volume)? It is my belief that biological or constitutional factors are important in inducing a vulnerability that then allows the psychosocial factors within the family to exert their effect. To propose a biological factor of greater specificity for the onset of gender disorders appears unnecessary, as the work of Money and the Hampsons (1955) clearly demonstrates the

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overriding importance of psychological factors in the development of gender identity. Despite issues raised by anomalous findings (Imperato-McGinley, Peterson, Gautier, & Sturla, 1979), these early studies stressing the primacy of sex of assignment and rearing remain convincing. This point of view does not preclude the possibility that biological factors (e.g., hypothalamo-pituitary differences) may influence one's vulnerability to gender disorders. However, in those individuals most likely to display alterations in brain development from abnormalities in the prenatal hormonal milieu, for example, the adrenogenital-syndrome girls, very few display abnormalities in their gender identity (despite behavioral differences) when reared as girls (Ehrhardt & Baker, 1974).

Despite earlier beliefs that there might be qualitative differences between individuals who go on to a transsexual outcome versus those who manifest a fluctuant or intermittent desire for sex change surgery or those who manifest their gender identity disturbance only in some cross-sex behaviors and homosexuality in adulthood, few truly significant differences have emerged. Instead, we appear to be dealing with a spectrum of disorders with those who appear at the transsexual end manifesting more persistent and severe patterns of behavior likely stabilized in this direction because of a lack of interference by significant others. Although some authors (e.g., Stoller, 1968) have suggested a qualitative difference in that boyhood transsexuals manifest a cross-sex gender identity significantly different from others who may only be confused about their gender identity, in our clinical sample of children with gender identity disorders seen over the last 8 years, we have found this an unsatisfactory way of classifying children with gender disorders. The extent to which a child may manifest less confusion (i.e., be more cross-sex identified) is probably the result of lack of intrusion into the belief or defensive system that the cross-sex behaviors play. In our experience, however, the same familial factors appear to operate in the more severe cases of gender disorder as well as in the less severe. The differences appear to be quantitative and to reflect varying degrees of vulnerability in the affected children as well as differences in the severity and extent of the family pathology. It is my thesis, then, that the transsexual syndrome arises from an earlier history of childhood gender identity disorder as do other less extreme disorders of gender identity that are manifest in adulthood. As well, I believe these same earlier disorders influence later sexual orientation.

Our experience in assessing and treating children with gender identity disorders began with the opening of the Child and Adolescent Gender Identity Clinic at the Clarke Institute of Psychiatry in 1976. Since that time, a total of 64 children (55 male, 9 female) and 70 adolescents (59 male, 11 female) have been referred for assessment of gender symptomatology. All of the younger children presented with cross-sex behaviors and/or wishes. Although cross-sex wishes were less frequently a reason for referral in the late latency children or young adolescents, they continued to present some cross-sex behaviors and interests and

were often referred primarily because of teasing or social ostracism at school. Approximately 30% of the adolescents presented with a stated desire to have sex change surgery. About 20% of the male adolescents were brought because of varying degrees of transvestitic behavior. The rest of the adolescents were seen because of individual or parental concern with respect to homosexual behavior.

Children referred for assessment of gender disturbance were seen for psychiatric assessment that encompassed both individual interviews and a family assessment. In addition, the younger children received an extensive battery of psychological testing, tapping cognitive, adaptive, and gender-related functioning. Some of these findings have been reported elsewhere (Bradley, Doering, Zucker, Finegan, & Gonda, 1980; Finegan, Zucker, Bradley, & Doering, 1982; Zucker, Doering, Bradley, & Finegan, 1982). These children are currently being followed up on a yearly basis and will receive a more in-depth assessment as they move into adolescence. The willingness of the families to bring their children back on a yearly basis for reassessment has provided us with the opportunity to observe the changes that can occur with a variety of interventions over a period of time. Although these observations remain uncontrolled, we have had a unique opportunity to observe fluctuations in gender-related behaviors that appear related to such changes as family stresses and change of therapist. Obviously, the weight that can be given to our conclusions from this way of observing is somewhat limited, but it provides the ground for further, more rigorous study.

General Observations

Although it is possible to group gender-referred children according to whether or not they meet DSM-III criteria for gender identity disorder of childhood (e.g., Zucker, Finegan, Doering, & Bradley, 1984), this does not erase the clinical impression that the distinctions between these two groups are essentially quantitative rather than qualitative. In general, these children display an excessive interest in activities considered more appropriate for the opposite sex, prefer opposite sex peers as playmates, may disavow their own physical/genital attributes, and may express the wish to be or the belief that they are the opposite sex. Differences between the adolescent and child population appear to reflect developmental differences as opposed to qualitative differences. Older children and young adolescents seldom reveal cross-sex wishes despite earlier histories suggestive of extreme cross-gender orientation. It is our opinion that this reflects familial and social pressures as well as changing cognitions in the child that force a move away from earlier magical or wishful thinking. Adolescents manifesting *transvestitic* behavior, however, appear qualitatively different (see the later discussion).

Although most gender disorders appear to originate very early in childhood,

most children are referred for assessment around school age either because of teacher pressure or parental realization that the child is not "outgrowing" the cross-sex behaviors. Early history may reveal self-soothing with soft objects including contact with maternal clothing, silky fabrics, and furs. Parents who are keen observers may report a gradual progression from interest in maternal or women's clothing to other activities considered stereotypically suited for the opposite sex. If not particularly discouraged, these behaviors tend to continue on either a sporadic or relatively continuous basis until the youngster meets the usual social sanctions encountered in the school situation. Boys manifesting cross-sex behavior tend to be excluded from their peer group because of their behavior and interests and are usually seen as gravitating toward the female peer group. Girls, on the other hand, experience less peer ostracism in manifesting cross-sex behavior (Fagot, 1977). With or without treatment, there is a tendency with age for at least some of the cross-sex behaviors to diminish (Green, 1975; Zuger, 1978). Nevertheless, the follow-up studies to date indicate a rather high incidence of homosexual orientation with maturity (see Zucker, Chapter 4 in this volume). A rather small proportion of the gender-referred population appears to become more fixed in their belief that a change of their anatomical sex is the only way to achieve a sense of comfort within themselves (a congruence between their inner and outer selves).

The adolescents referred for *transvestitic* behaviors (wearing of women's undergarments or occasional total cross-dressing, often accompanied by erotic arousal) have not typically manifested the early history of extreme cross-sex interest and behavior. They also appear to manifest a *somewhat* more secure sense of gender identity. Most transvestitic adolescents express interest in heterosexual relations. However, a few transvestitic individuals present a more mixed picture with greater gender confusion and more extreme cross-dressing.

The Child

Those authors looking at the personality structure of individuals with gender pathology (e.g. Bradley *et al.*, 1980; Lothstein, 1979; Meyer, 1980; Person & Ovesey, 1974a, 1974b, 1978) appear to agree that they display a vulnerability that allows social forces to impinge on the child, thereby producing pathology. The nature of this vulnerability has variously been described as *borderline* or *narcissistic* personality organization. Because of semantic difficulties in the use of these terms and lack of agreement about the existence of such personality disorders in children, we tend to view these children as sensitive individuals with poor anxiety tolerance. In our clinic population, there is an apparently increased family history (over 50%) of affective illness, including alcoholism (as obtained

from the parent report). Whether the vulnerability described previously is a manifestation of an affective diathesis or related to *in utero* influences (hormonal imbalance) is something about which we can only speculate. However, Herrenkohl (1982), in a recent review of studies related to the development of an anxiety prone personality, discusses ways in which stress during pregnancy may lead to a hormonal imbalance that appears related to behavioral changes in offspring. In a study by Yalom, Green, and Fisk (1973), boys born to diabetic mothers treated with diethylstilbestrol (DES) and synthetic progestin during pregnancy displayed less aggression, less assertion, and less athletic skills compared to controls. Although there are difficulties in transposing the effects of either animal studies or the study of boys of DES-exposed mothers to gender-disturbed children, the results are still suggestive of ways in which the observed vulnerability may arise.

Green's (1974) earlier observation about marked physical attractiveness in some gender-disordered boys has certainly been observed in a small proportion of subjects. These boys tend to present as slim and winsome and, at least at the time of assessment, could pass or be viewed as girls if cross-dressed.

It has also been our observation that some of these children have been extremely difficult for their parents to manage as infants. In these situations, the behavioral difficulty creates a frustrating interaction between parent and child, which appears to lead, in the child's mind, to a lack of certainty about parental affection.

Many of the children presenting with gender disturbance have been seen as experiencing considerable stress within their families, either due to parental fighting or, in some circumstances, as due to a single traumatic episode. The stress is frequently expressed in play, interview, or dramatic material of a highly aggressive nature in which the threat to the child's sense of self is obvious (Pruett & Dahl, 1982).

The adolescent who presents with *transvestitic* symptoms, on the other hand, is seldom identified as having feminine characteristics. He does, however, manifest a similar personality structure to that described for other gender-disordered individuals.

The Parents

The most consistent finding is that when the cross-sex behaviors were first manifest, they were not particularly discouraged by the parenting figures and, in fact, in some cases were encouraged (Bradley *et al.*, 1980; Green, 1974). This appears to reflect, in part, a somewhat permissive style of parenting, which, in the extreme, may be important in reinforcing the child's belief in the omnipo-

tence of thoughts. On the other hand, *transvestitic* behaviors, usually carried out privately, were seldom observed by the parents. Parental reaction on discovery was usually quite negative.

Mothers

Mothers of Gender-Disturbed Boys. Mothers of these boys were described by Stoller (1975) as having a phallic envy and a degree of cross-gender identification themselves. This has been our observation in some instances as well. However, even in our most extreme cases of cross-gender identity disorder we have had difficulty finding these characteristics consistently. In some instances, the mothers have openly acknowledged their wish for a child of the opposite sex but in others this wish has not been apparent. During the first 2 to 3 years of the child's development, many mothers have had prolonged periods of depression that were often related to marital dissatisfaction and/or the father's frequent absence from the home. In some instances, there has been actual physical withdrawal/separation because of maternal sickness. Some mothers of gender-disturbed boys have evinced open hostility to males, and in interview they provided ample evidence that they viewed males as inadequate. In some families, these mothers have been viewed by their gender-disturbed sons as very powerful and threatening. Obviously, there has been no "universal" mother of children with a gender identity disorder.

Mothers of Gender-Disturbed Girls. All of these mothers have been conflicted about their own adequacy and are frequently seen by their masculine daughters as weak and unable to protect themselves (Bradley, 1980).

Mothers of Transvestitic Boys. In our sample, these mothers have been outstanding in the degree to which they overtly reject their children, usually after a period of some closeness. In several of our cases, the mothers have left the family. These mothers, as well, frequently have manifested problems with depression that are often related to a chronically dissatisfying marriage.

Fathers

Fathers of Gender-Disturbed Boys. A sense of withdrawal is probably the most consistent observation of these men (Bradley *et al.*, 1980; Green, 1974). Most tended to have a closer relationship with their own mothers than with their fathers. Generally, these fathers are psychologically unavailable, if not also physically absent from the home during the early years of their son's development, but they also have difficulty relating to sons who do not readily reach out to

them. Much of their absence from the family is work related but also appears to be an avoidance of intimacy and an attempt to shore up their own competency through overwork.

Fathers of Gender-Disturbed Girls. These men are sometimes described as reinforcing their daughters masculine interests (Bradley, 1980; Green, 1974). They are sometimes violent and are often seen by their masculine daughters as powerful in contrast to their inadequate and sometimes physically threatened wives. They may express views about the general inadequacy of women.

Fathers of Transvestitic Boys. These men are poorly described in the literature. In our sample, there were no particularly striking features in the fathers we interviewed, although one father had a history of transvestitic behavior himself.

Siblings

In several of our less typical cases of boyhood gender disturbance, older, dominant, hostile female siblings appear to have been active in encouraging their younger brothers' cross-sex interests.

Theoretical Formulation

Although the preceding observations are uncontrolled in the sense that we have not evaluated these variables against control families, I have been struck by the way in which the absence of certain characteristic parts of the pattern produces a lesser degree of disturbance. For example, boys whose fathers have been more involved manifest less extreme symptomatology generally. Because I am wary of such dangers as overpsychologizing but am also mindful of the need to provide a conceptual framework within which to understand gender pathology, I would like to suggest the following formulation, first of gender identity development and then of its connection with later sexual orientation.

The Gender-Disturbed Boy

The vulnerable child, as defined here, suffers an increased sensitivity and poor anxiety tolerance. His sensitivity may make him aware of parental affects and tensions that other children ignore. The boy's poor anxiety tolerance may lead to, or accompany, a sense of affective flooding that may be triggered in any affect-laden situation (a not uncommon occurrence in these families). Consolidation of a sense of self is difficult because disorganization of thinking frequently accompanies affective flooding.

This vulnerable individual encounters a family system in which the mother has difficulty providing the positive emotional support needed to achieve a comfortable sense of self-value. This may occur for many reasons. The mother may have wished for a girl to recapitulate a longed-for relationship with her own mother. Alternatively, she may have hostile feelings toward this child, her husband, or men generally that the child senses. In some situations, the mother's intense frustration at having to deal with a difficult or unsatisfying child may be perceived by the child as rejection. Similarly, the mother's intense frustration with an absent husband may induce a sense of blameworthiness in the child.

The child reacts to his mother's withdrawal or hostility with the sense that there is something wrong with himself. His father, because of absence or perhaps some sense of his own inadequacy, is unable to provide the sense of valuing that would counterbalance the child's developing sense of confusion or devaluation of self. The child, experiencing a sense of uncertainty about his self-worth, looks to ways to enhance himself with his parents. Early testing with cross-sex behavior may be seen as a way of looking for parental recognition, especially if there is any sense of increased valuing of females by significant others. There may be a further anxiety-relieving function in the donning of women's clothing because of early contact with maternal clothing (in this way fulfilling a transitional object role). Other dynamic factors may reinforce the child's belief that being female would be better; for example, value systems that equate males with aggression and aggression as bad. Oedipal factors may also play a role. The parents' response, which may be encouragement or lack of discouragement, produces confusion about what the parents really value. This, then, leads to a failure to establish a stable gender identity and is part of the ongoing weak self-value that the child experiences.

As the gender-confused child moves on into midchildhood, his innate tendency to withdraw from rough-and-tumble play and his effeminate mannerisms lead to difficulty establishing himself in a male peer group. This social ostracism initially produces greater involvement with female peers and then ultimately a sense of social isolation as the child is also abandoned by his female playmates in late childhood. A result of this social isolation is a lack of positive peer feedback that normally helps consolidate a boy's identity as a male group member (a likely component of gender identity). Further, this isolated individual is now the butt of constant name-calling; for example, he may be called "fag," "fairy," and "queer." This must undermine any efforts at moving to consolidate a relaxed or comfortable sense of self.

Many factors may modify this pattern. In some situations, a father may become concerned and increase his involvement with his son. Interaction with same-sex peers may be supported by integration into a boys' group. Both parents may respond to concern about later homosexuality by changing their previous patterns of behavior. Many of these events may occur without outside interven-

tion but they are also obviously encouraged by therapeutic intervention. Also, the child himself may decide to overcome effeminate mannerisms, and he can be helped to do so in therapy. Although events such as these may help consolidate a more secure sense of gender identity, many of these children move on into adolescence feeling uncertain about themselves. My understanding of what makes them likely to move on to a later homosexual orientation will be explained later.

Throughout the preschool and latency years, cross-dressing may fluctuate, and it appears often at times of stress to provide anxiety relief. Similarly, threats to one's self-value may lead to increased needs to cross-dress.

For those gender-disturbed boys who have received little discouragement of their cross-sex behavior or who have maintained a significant undisturbed fantasy of themselves as females, the cross-sex identity may have become the most significant or valued part of themselves. For these individuals, moving toward passing as a female and ultimately to the request for sex change surgery seems most likely. Although at times cross-dressing has served as an anxiety relief function, it now also provides a sense of completeness or wholeness that is especially essential for the adolescent coping with the broader issues of identity.

The Gender-Disturbed Girl

With the gender-disturbed girl, the factors are similar, but they obviously operate in the reverse. The same sensitivity and poor anxiety tolerance create a vulnerability to a family situation in which the mother is seen as inadequate and weak. This perception may arise because of maternal depression (Stoller, 1972), but it also seems to occur in the context of family conflict in which the mother appears threatened by a violent or intimidating husband. The daughter's temperamental tendency to a rather high activity level appears to support an identification with the more powerful or competent parent. The mother, perhaps because of her depression or other preoccupations, fails to provide a positive validation of her daughter's femaleness (often related to her own belief that females are powerless and therefore less valued) and so fails to counteract the anxiety-provoked identification with the aggressor.

Sexual Object Choice

As we ascend the evolutionary scale, biological mechanisms underlying behavior have tended to be balanced if not in some instances overridden by psychological or cognitive factors. Thus, it becomes very difficult to understand human behavior either by comparison with animal models or simply through a knowledge of biology. Nowhere is this more true than in the area of sexual

functioning. Even in our life span, the advent of effective methods of birth control has allowed the "pleasure of sex" to override its reproductive function. This notion of sex as essentially pleasurable and highly valued has so permeated our society that late-latency children and adolescents are strongly conditioned to think of various aspects of life in sexual terms. This, I would suggest, creates more pressure not only for earlier sexual activity but also for foreclosure of identity with respect to sexual preference. At the same time, it allows for greater cognitive and psychological influence in the area of sexual attraction. Cognitive theorists working in other domains have recently been stressing the critical role of cognitive processes in the individual's response to a situation. I believe this internal dialogue, including labeling of feelings, is very relevant to the understanding of sexual object choice because it forms the intermediary stage between a variety of affects and drives and how they are expressed in behavior—in this instance, sexual behavior.

I believe that the basic principles that lead to sexual object choice occur out of a basic attraction for the opposite sex as well as an attraction that we all experience for others who are more like ourselves than less like ourselves. This attraction and involvement with others like ourselves provides a feedback that reinforces one's identity as a member of that group. The early evidence of this behavior is readily seen in the phenomenon of young children gravitating toward other young children quite unknown to them. Further evidence comes from studies indicating that marriage partners have fairly marked similarities (see Cook, 1981). Duyckaerts (1964) provides a similar view. An important feature is how the individual defines these feelings of attraction to same-sex individuals, that is, as sexual or "identificatory." For sensitive people, these feelings may appear very intense and, if defined as sexual, may lead to a self-definition or questioning of oneself as homosexual.

For most adolescents, seeing oneself as sexually active with another partner generates some anxiety. Given reasonable anxiety tolerance, adequate self-esteem (including comfort with one's gender identity), and peer support, most adolescents are able to deal with this anxiety and move into a heterosexual role. That this is not accomplished easily for most individuals is suggested by Schofield's finding that "a fifth of young adults expressed anxiety over their sexual performance and a half had a sex problem of one kind or another" (cited in Rutter, 1980). The gender-disordered child moving into adolescence is a sensitive individual with reduced anxiety tolerance, a rather weak sense of himself or herself, and a degree of gender insecurity. These factors may make it very difficult for this individual to contemplate heterosexual involvement. Even if efforts are made to achieve a heterosexual relationship, these may be made almost impossible because of a disabling level of anxiety. The choice of a same-sex partner may reduce that anxiety and may also coincide with that individual's need to reinforce his or her self-value through identification with another biolog-

ically similar but stronger individual. Other dynamic factors may also reinforce same-sex object choice, for example, fear of, or hostility toward, the opposite-sex parent. Once begun, however, sexual activity in itself is reinforcing because of the pleasure involved and the self-validation, both from other partners and from a group. This produces, I believe, a homosexual identity and becomes sufficiently reinforced so that efforts to change it may, in fact, produce more anxiety. Because of the reinforcement value of the pleasure involved, there may be little motivation to change. This theory would be consistent with the literature that states that it is very difficult to change homosexual orientation after extensive homosexual experience (Langevin, 1983).

For those individuals with somewhat weak self-esteem and less gender confusion, heterosexual relationships may develop. And if the feedback from these experiences is positive, they may experience sufficient consolidation of their self-value to allow them to function adequately. However, a dissatisfying heterosexual relationship may provoke increasing uncertainty about one's self-esteem and, to the extent that this is linked with questions about one's gender identity, may force the individual to exploration of homosexual relationships. This is seen, not infrequently, when a homosexual relationship follows a dissatisfying or unsuccessful marriage and with it an underlying assumption that the person was "latently" gay. Obviously, in those situations where the feedback from the homosexual relationship is self-validating, the person may then declare himself or herself as gay. Again, however, lack of positive feedback in the homosexual relationship may lead to further shifts and self-labeling as bisexual.

In the adolescent *transvestite*, maternal rejection of a sensitive and vulnerable boy seems important in the development of these behaviors. These adolescents, faced with intense but intolerable affects (usually anger at maternal rejection), appear to resort to cross-dressing as a self-soothing behavior (the transitional object function) that is often accompanied by masturbation (also self-soothing). One may speculate that their difficulty with anxiety tolerance makes anger at the mother more frightening. The use of maternal garments may act as a fantasized protector against fear of loss of the mother at these times. The connection with masturbation may become almost that of a conditioned association. Although these individuals are heterosexually oriented, their anxiety in social-sexual situations may be sufficient for them to require anxiety-reducing mechanisms—previously connected with sexual activity. This is the reason for the transvestitic behavior.

Discussion

What this formulation implies is that, at least for many "homosexual" adolescents, object choice may be less fixed than is sometimes believed. This

position is supported by Bell, Weinberg, and Hammersmith's (1981) finding that many homosexual adults did experience heterosexual attractions and arousal during childhood and adolescence. In addition, although many were involved in heterosexual activity, they did not find these activities pleasurable. Although these authors interpret this lack of satisfaction as due to a more innate interest in same-sex individuals, it is also possible to interpret their data as the early negative reinforcement for further heterosexual activities. One further interesting observation is that, in one of the few cases of conversion from homosexual to heterosexual object choice, the patient (a male) made this change in the context of a very supportive, apparently highly validating relationship with a female (Latimer, 1977).

Treatment recommendations that flow from this formulation would be focused on understanding and controlling the individual's anxiety, perhaps involving desensitization/conditioning techniques as well as promoting self-validation in the gender role. In addition, intervention with parents of gender-disturbed children should involve advice regarding discouragement of gender inappropriate behaviors and encouragement of same-sex activities and peer involvement. Additional efforts may have to be directed at exploring current parental conflicts or attitudinal biases that may contribute to, or maintain, the child's sense of insecurity. With the gender-disturbed early adolescent, efforts to diminish cross-sex mannerisms and social-skill training to allow better integration with same-sex peers seems critical.

For many adolescents and their families, the key issue is whether one can or should change what appears to be a developing homosexual orientation. The preceding formulation would suggest that efforts to promote heterosexual functioning should focus on those individuals who have not yet had extensive homosexual experiences. Obviously, much effort is needed by both the therapist and adolescent to clarify a sexual orientation that allows the individual to function comfortably. For many gender-disordered adolescents, support in adapting to a homosexual orientation, life-style and community living will be the most appropriate therapeutic direction. For those individuals who prefer to work toward a heterosexual orientation, the therapist should probably feel comfortable in discouraging homosexual experience unless it is clear that a comfortable level of heterosexual experience cannot be achieved. The same would apply with respect to use of transvestitic garments; that is, they should be discouraged while the individual is attempting to clarify whether he can deal with the anxiety of sexual functioning without resorting to such anxiety-relieving materials.

Future Needs

Obviously, there is a need for prospective studies of healthy (nonpsychiatric) latency-aged and adolescent children followed up into adulthood. Given a suffi-

ciently large sample, with the freedom to interview these young people with respect to sexual attractions and experiences, we might begin to understand the relevance of the preceding speculations.

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