

302.6

Gender Identity Disorder in Children

Proposed Revision

Gender Incongruence (in children) [1]

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least 6* of the following indicators (including A1): [2, 3, 4]

1. a strong desire to be of the other gender or an insistence that he or she is the other gender [5]

2. in boys, a strong preference for cross-dressing or simulating female attire; in girls, a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing [6]

3. a strong preference for cross-gender roles in make-believe or fantasy play [7]

4. a strong preference for the toys, games, or activities typical of the other gender [8]

5. a strong preference for playmates of the other gender [9]

6. in boys, a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; in girls, a strong rejection of typically feminine toys, games, and activities [10]

7. a strong dislike of one's sexual anatomy [11]

8. a strong desire for the primary and/or secondary sex characteristics that match one's experienced gender [12]

[13, 14, 15]

Subtypes

With a disorder of sex development

Without a disorder of sex development

Rationale

*For the child criteria, we propose, on a preliminary basis, the requirement of 6 of the indicators, with A1 as a necessary criterion (for the rationale for A1, see the review by Zucker, 2009). A minimum of 5 other indicators is, at present, based on their similarity to the A and B criteria that currently constitute the remaining diagnostic criteria for GID in children in the DSM-IV. It is, however, conceivable that a lower number of indicators will yield a high rate of true positives and a low rate of false positives, but this will have to be determined from field trial data and, if possible, by use of secondary data sets. Thus, it is important to recognize that the proposed number of indicators is a preliminary recommendation.

End notes

1. It is proposed that the name gender identity disorder (GID) be replaced by "Gender Incongruence" (GI) because the latter is a descriptive term that better reflects the core of the problem: an incongruence between, on the one hand, what identity one experiences and/or expresses and, on the other hand, how one is expected to live based on one's assigned gender (usually at birth) (Meyer-Bahlburg, 2009a; Winters, 2005). In a recent survey that we conducted among consumer organizations for transgendered people (Vance et al., in press), many very clearly indicated their rejection of the GID term because, in their view, it contributes to the stigmatization of their condition.

2. In addition to the proposed name change for the diagnosis (see Endnote 1), there are 6 substantive proposed changes to the DSM-IV descriptive and diagnostic material: (a) we have proposed a change in conceptualization of the defining features by emphasizing the phenomenon of "gender incongruence" in contrast to cross-gender identification per se (Meyer-Bahlburg, 2009a); (b) we have proposed a merging of the A and B clinical indicator criteria in DSM-IV (see Endnotes 10, 13); (c) for the adolescent/adult criteria, we have proposed a more detailed and specific set of polythetic indicators than was the case in DSM-IV (Cohen-Kettenis & Pfäfflin, 2009; Zucker, 2006); (d) for the child criteria, we have proposed that the A1 indicator be necessary (but not sufficient) for the diagnosis of GI (see Endnote 5); (e) we have proposed that the "distress/impairment" criterion not be a prerequisite for the diagnosis of GI (see Endnote 15); and (f) we have proposed that subtyping by sexual attraction (for adolescents/adults) be eliminated (see Endnote 18) but that subtyping by the presence or absence of a co-occurring disorder of sex development (DSD) be introduced (see Endnote 14). As in DSM-IV, we recommend one overarching diagnosis, GI, with separate, developmentally-appropriate criteria sets for children vs. adolescents/adults. The text material will provide updated information on developmental trajectory data for clients who received the GI diagnosis in childhood vs. adolescence or adulthood.

The term "sex" has been replaced by assigned "gender" in order to make the criteria applicable to individuals with a DSD (Meyer-Bahlburg, 2009a, 2009b). During the course of physical sex differentiation, some aspects of biological sex (e.g., 46,XY genes) may be incongruent with other aspects (e.g., the external genitalia); thus, using the term "sex" would be confusing. The change also makes it possible for individuals who have successfully transitioned to "lose" the diagnosis after satisfactory treatment. This resolves the problem that, in the DSM-IV-TR, there was a lack of an "exit clause," meaning that individuals once diagnosed with GID will always be considered to have the diagnosis, regardless of whether they have transitioned and are psychosocially adjusted in the identified gender role (Winters, 2008). The diagnosis will also be applicable to transitioned individuals who have regrets, because they did not feel like the other gender after all. For instance, a natal male living in the female role and having regrets experiences an incongruence between the "newly assigned" female gender and the experienced/expressed (still or again male) gender.

3. It has been recommended by the Workgroup to delete the "perceived cultural advantages" proviso. This was also recommended by the DSM-IV Subcommittee on Gender Identity Disorders (Bradley et al., 1991). There is no reason to "impute" one causal explanation for GI at the expense of others (Zucker, 1992, 2009).

4. The 6 month duration was introduced to make at least a minimal distinction between very transient and persistent GI. The duration criterion was decided upon by clinical consensus. However, there is no clear empirical literature supporting this particular period (e.g., 3 months vs. 6 months or 6 months vs. 12 months). There was, however, consensus among the group that a lower-bound duration of 6 months would be unlikely to yield false positives.

5. The Workgroup recommended that “strong desire” replace “repeatedly stated desire” to capture some children who, in a coercive environment, may not verbalize the desire to be of the other gender. The text will note that the clinician needs to be attentive to the child’s psychosocial environment in considering the presence of this symptom. The diagnosis requires the presence of this symptom and the argument has been made that this will, if anything, make the diagnosis more restrictive and conservative (Zucker, 2009). The pivotal role of the “desire” symptom in making the diagnosis more restrictive is based, in part, on secondary data analysis reported in Zucker (2009) and on another secondary data analysis not reported on in that review. The latter secondary analysis, based on children seen at the gender clinic in Amsterdam, replicated the findings reported on by Zucker (2009).

6. Some small changes in wording is for boys; for girls, the changes in wording a result of combining the A and B criteria from DSM-IV (the Workgroup has recommended the general combining of the A and B criteria) (see also Endnotes 10, 13)

7. Some small changes in wording.

8. Some small changes in wording.

9. No substantive change

10. Moved from Criterion B in order to have one common polythetic criterion set. Wording changes are minor. As noted for adolescents and adults (see Endnote 13), there is evidence for children that the clinical indicators load on one common factor in factor-analytic studies (Green, 1987; Johnson et al., 2004; Zucker et al., 1998).

11. The wording has been simplified to capture the underlying construct. Rejection of one’s own anatomy is separated from the desire for the anatomy of the other gender. Examples will be provided in the text (see also Zucker, 2009).

12. The wording has been simplified to capture the underlying construct . The desire for the anatomy of the other gender is separated from the rejection of one’s own anatomy. Examples will be provided in the text (see also Zucker, 2009).

13. In the DSM-IV, there are two sets of clinical indicators (Criteria A and B). This distinction is not supported by factor analytic studies. The existing studies suggest that the concept of GI is best captured by one underlying dimension (Cohen-Kettenis & van Goozen, 1997; Deogracias et al., 2007; Green, 1987; Johnson et al., 2004; Singh et al., 2010).

14. There is considerable evidence individuals with a DSD experience GI and may wish to change from their assigned gender; the percentage of such individuals who experience GI is syndrome-dependent (Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Mazur, 2005; Meyer-Bahlburg, 1994, 2005, 2009, in press). From a phenomenologic perspective, DSD individuals with GI have both similarities and differences to individuals with GI with no known DSD. Developmental trajectories also have similarities and differences. The presence of a DSD is suggestive of a specific causal mechanism that may not be present in individuals without a diagnosable DSD.

15. It is our recommendation that the GI diagnosis be given on the basis of the A criterion alone and that distress and/or impairment (the D criterion in DSM-IV) be evaluated separately and independently. This definitional issue remains under discussion in the DSM-V Task Force for all psychiatric disorders and may have to be revisited pending the outcome of that discussion. Although there are studies showing that adolescents and adults with the DSM-IV diagnosis of GID function poorly, this type of impairment is by no means a universal finding. In some studies, for example, adolescents or adults with GID were found to generally function psychologically in the non-clinical range (Cohen-Kettenis & Pfäfflin, 2009; Meyer-Bahlburg, 2009a). Moreover, increased psychiatric problems in transsexuals appear to be preceded by increased experiences of stigma (Nuttbrock et al., 2009). Postulating "inherent distress" in case one desires to be rid of body parts that do not fit one's identity is, in the absence of data, also questionable (Meyer-Bahlburg, 2009a).

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Severity

Dimensional Assessment for Gender Identity Disorder (Gender Incongruence)

Questions A1-A8 are the dimensional metrics for the corresponding categorical criteria.

Instructions: Please circle the letter next to the statement that applies to your child the best.

For Male Children (Parent-Report)

A1. Over the past 6 months, how intense was your son's desire to be a girl or insistence he is a girl?

- a. None
- b. Mild
- c. Moderate

- d. Strong
- e. Very Strong

A2. Over the past 6 months, how intense was your son's preference to wear girls' or women's clothing during dress-up play or activities?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Strong

A3. Over the past 6 months, how intense was your son's preference for female roles in fantasy or pretend play?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Strong

A4. Over the past 6 months, how intense was your son's preference for the toys, games, and activities typical of the other gender?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Strong

A5. Over the past 6 months, how intense was your son's preference for playmates of the other gender?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Strong

A6a. Over the past 6 months, how intense was your son's rejection of typically masculine toys, games, and activities?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Strong

A6b. Over the past 6 months, how intense was your son's avoidance of rough-and-tumble play?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Stong

A7. Over the past 6 months, how intense was your son's dislike of his sexual anatomy (e.g., that he dislikes or hates his penis or testes)?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Stong

A8. Over the past 6 months, how intense was your son's desire for the sexual anatomy of a girl (e.g., sits to urinate, pretends to have breasts, would like to have a vagina)?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Stong

For Female Children (Parent-Report)

A1. Over the past 6 months, how intense was your daughter's desire to be a boy or insistence she is a boy?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Stong

A2a. Over the past 6 months, how intense was your daughter's preference for wearing only typical masculine clothing?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Stong

A2b. Over the past 6 months, how intense was your daughter's resistance to the wearing of typical feminine clothing?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Strong

A3. Over the past 6 months, how intense was your daughter's preference for male roles in fantasy or pretend play?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Strong

A4. Over the past 6 months, how intense was your daughter's preference for the toys, games, and activities typical of the other gender?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Strong

A5. Over the past 6 months, how intense was your daughter's preference for playmates of the other gender?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Strong

A6. Over the past 6 months, how intense was your daughter's rejection of typically feminine toys, games, and activities?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Strong

A7. Over the past 6 months, how intense was your daughter's dislike of her sexual anatomy (e.g., dislikes the prospects of breast development or that she has a vagina)?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Strong

A8. Over the past 6 months, how intense was your daughter's desire for the sexual anatomy of a boy (e.g., that she would like to have a penis or to grow one; stands to urinate)?

- a. None
- b. Mild
- c. Moderate
- d. Strong
- e. Very Strong