

Psychosexual Disorders

The name for this diagnostic class emphasizes that psychological factors are assumed to be of major etiological significance in the development of the disorders listed here. Disorders of sexual functioning that are caused exclusively by organic factors, even though they may have psychological consequences, are not listed in this classification. For example, impotence due to spinal-cord injury is coded on Axis III as a physical disorder, and the psychological reaction to that condition could be coded as an Adjustment Disorder, or some other suitable category, on Axis I.

The Psychosexual Disorders are divided into four groups. The Gender Identity Disorders are characterized by the individual's feelings of discomfort and inappropriateness about his or her anatomic sex and by persistent behaviors generally associated with the other sex. The Paraphilias are characterized by arousal in response to sexual objects or situations that are not part of normative arousal-activity patterns and that in varying degrees may interfere with the capacity for reciprocal affectionate sexual activity. The Psychosexual Dysfunctions are characterized by inhibitions in sexual desire or the psychophysiological changes that characterize the sexual response cycle. Finally, there is a residual class of Other Psychosexual Disorders that has two categories: Ego-dystonic Homosexuality and a final residual category, Psychosexual Disorders Not Elsewhere Classified.

GENDER IDENTITY DISORDERS

The essential feature of the disorders included in this subclass is an incongruence between anatomic sex and gender identity. Gender identity is the sense of knowing to which sex one belongs, that is, the awareness that "I am a male," or "I am a female." Gender identity is the private experience of gender role, and gender role is the public expression of gender identity. Gender role can be defined as everything that one says and does, including sexual arousal, to indicate to others or to the self the degree to which one is male or female.

Disturbance in gender identity is rare, and should not be confused with the far more common phenomena of feelings of inadequacy in fulfilling the expectations associated with one's gender role. An example would be an individual who perceives himself or herself as being sexually unattractive yet experiences himself or herself unambiguously as a man or woman in accordance with his or her anatomic sex.

302.5x Transsexualism

The essential features of this heterogeneous disorder are a persistent sense of discomfort and inappropriateness about one's anatomic sex and a persistent wish

to be rid of one's genitals and to live as a member of the other sex. The diagnosis is made only if the disturbance has been continuous (not limited to periods of stress) for at least two years, is not due to another mental disorder, such as Schizophrenia, and is not associated with physical intersex or genetic abnormality.

Individuals with this disorder usually complain that they are uncomfortable wearing the clothes of their own anatomic sex; frequently this discomfort leads to cross-dressing (dressing in clothes of the other sex). Often they choose to engage in activities that in our culture tend to be associated with the other sex. These individuals often find their genitals repugnant, which may lead to persistent requests for sex reassignment by surgical or hormonal means.

To varying degrees, the behavior, dress, and mannerisms are those of the other sex. With cross-dressing, hormonal treatment, and electrolysis, a few males with the disorder will appear relatively indistinguishable from members of the other sex. However, the anatomic sex of most males and females with the disorder is quite apparent to the alert observer.

Associated features. Generally there is moderate to severe coexisting personality disturbance. Frequently there is considerable anxiety and depression, which the individual may attribute to inability to live in the role of the desired sex.

Course and subtypes. The disorder is subdivided according to the predominant prior sexual history, which is coded in the fifth digit as 1 = asexual, 2 = homosexual (same anatomic sex), 3 = heterosexual (opposite anatomic sex), and 0 = unspecified. In the first, "asexual," the individual reports never having had strong sexual feelings. Often there is the additional history of little or no sexual activity or pleasure derived from the genitals. In the second group, "homosexual," a predominantly homosexual (object choice is same anatomic sex) arousal pattern preceding the onset of the Transsexualism is acknowledged, although often such individuals will deny that the behavior is homosexual because of their conviction that they are "really" of the other sex. In the third group, "heterosexual," the individual claims to have had an active heterosexual life.

Without treatment, the course of all three types is chronic and unremitting. Since surgical sex reassignment is a recent development, the long-term course of the disorder with this treatment is unknown.

Individuals who have female-to-male Transsexualism appear to represent a more homogeneous group than those who have male-to-female Transsexualism in that they are more likely to have a history of homosexuality and to have a more stable course, with or without treatment.

Age at onset. Individuals who develop Transsexualism often evidenced gender identity problems as children. However, some assert that although they were secretly aware of their gender problem, it was not evident to their family and friends. The age at which the full syndrome appears for those with the "asexual" or "homosexual" course is most often in late adolescence or early

adult life. In individuals with the “heterosexual” course, the disorder may have a later onset.

Impairment and complications. Frequently social and occupational functioning are markedly impaired, partly because of associated psychopathology and partly because of problems encountered in attempting to live in the desired gender role. Depression is common, and can lead to suicide attempts. In rare instances males may mutilate their genitals.

Predisposing factors. Extensive, pervasive, childhood femininity in a boy or childhood masculinity in a girl increases the likelihood of Transsexualism. Transsexualism seems always to develop in the context of a disturbed parent-child relationship. Some cases of Transvestism evolve into Transsexualism.

Prevalence. The disorder is apparently rare.

Sex ratio. Males are more common than females among people who seek help at clinics specializing in the treatment of this disorder. The ratio varies from as high as 8:1 to as low as 2:1.

Familial pattern. No information.

Differential diagnosis. In **effeminate homosexuality** the individual displays behaviors characteristic of the opposite sex. However, such individuals have no desire to be of the other anatomic sex. In **physical intersex** the individual may have a disturbance in gender identity. However, the presence of abnormal sexual structures rules out the diagnosis of Transsexualism.

Other individuals with a disturbed gender identity may, in isolated periods of stress, wish to belong to the other sex and to be rid of their own genitals. In such cases the diagnosis Atypical Gender Identity Disorder should be considered, since the diagnosis of Transsexualism is made only when the disturbance has been continuous for at least two years. In **Schizophrenia**, there may be delusions of belonging to the other sex, but this is rare. The insistence by an individual with Transsexualism that he or she is of the other sex is, strictly speaking, not a delusion since what is invariably meant is that the individual *feels like* a member of the other sex rather than a true belief that he or she *is* a member of the other sex.

In both **Transvestism** and **Transsexualism** there may be cross-dressing. However, in Transvestism that has not evolved into Transsexualism there is no wish to be rid of one’s own genitals.

Diagnostic criteria for Transsexualism

- A. Sense of discomfort and inappropriateness about one’s anatomic sex.
- B. Wish to be rid of one’s own genitals and to live as a member of the other sex.
- C. The disturbance has been continuous (not limited to periods of stress) for at least two years.

- D. Absence of physical intersex or genetic abnormality.
- E. Not due to another mental disorder, such as Schizophrenia.

Fifth-digit code numbers and subclassification. The predominant prior sexual history is recorded in the fifth digit as:

- 1 = asexual
- 2 = homosexual (same anatomic sex)
- 3 = heterosexual (other anatomic sex)
- 0 = unspecified

302.60 Gender Identity Disorder of Childhood

The essential features are a persistent feeling of discomfort and inappropriateness in a child about his or her anatomic sex and the desire to be, or insistence that he or she is, of the other sex. In addition, there is a persistent repudiation of the individual's own anatomic attributes. This is not merely the rejection of stereotypical sex role behavior as, for example, in "tomboyishness" in girls or "sissyish" behavior in boys, but rather a profound disturbance of the normal sense of maleness or femaleness.

Girls with this disorder regularly have male peer groups, an avid interest in sports and rough-and-tumble play, and a lack of interest in playing with dolls or playing "house" (unless playing the father or another male role). More rarely, a girl with this disorder claims that she will grow up to become a man (not merely in role), that she is biologically unable to become pregnant, that she will not develop breasts, or that she has, or will grow, a penis.

Boys with this disorder invariably are preoccupied with female stereotypical activities. They may have a preference for dressing in girls' or women's clothes, or may improvise such items from available material when genuine articles are unavailable. (The cross-dressing never causes sexual excitement.) They often have a compelling desire to participate in the games and pastimes of girls. Dolls are often the favorite toy, and girls are regularly the preferred playmates. When playing "house," the role of a female is typically adopted. Rough-and-tumble play or sports are regularly avoided. Gestures and actions are often judged against a standard of cultural stereotype to be feminine, and the boy is invariably subjected to male peer group teasing and rejection, which rarely occurs among girls until adolescence. In rare cases a boy with this disorder claims that his penis or testes are disgusting or will disappear, or that it would be better not to have a penis or testes.

Some children refuse to attend school because of teasing or pressure to dress in attire stereotypical of their sex. Most children with this disorder deny being disturbed by it except as it brings them into conflict with the expectations of their family or peers.

Associated features. Some of these children, particularly girls, show no

other signs of psychopathology. Others may display serious signs of disturbance, such as phobias and persistent nightmares.

Age at onset and course. Three-fourths of the boys who cross-dress begin to do so before their fourth birthday; playing with dolls begins during the same period. Social ostracism increases during the early grades of school, and social conflict is significant at about age seven or eight. During the later grade-school years, grossly feminine behavior may lessen. An as yet undetermined proportion of boys, perhaps one-third to one-half, become aware of a homosexual orientation during adolescence.

For females the age at onset is also early, but most begin to acquiesce to social pressure during late childhood or adolescence and give up an exaggerated insistence on male activities and attire. A minority retain a masculine identification and some of these develop a homosexual arousal pattern.

Complications. In a small number of cases, the disorder becomes continuous with Transsexualism.

Impairment. Peer relations with members of the same sex are absent or difficult to establish. The amount of impairment varies from none to extreme, and is related to the degree of underlying psychopathology and the reaction of peers and family to the individual's behavior.

Prevalence. The disorder is apparently rare.

Sex ratio and familial pattern. No information.

Predisposing factors. Extreme, excessive, and prolonged physical and emotional closeness between the infant and the mother and a relative absence of the father during the earliest years may contribute to the development of this disorder in the male. Females who later develop this disorder have mothers who were apparently unavailable to them at a very early age, either psychologically or physically, because of illness or abandonment; the girl seems to make a compensatory identification with the father, which leads to the adoption of a male gender identity.

Differential diagnosis. Children whose behavior merely does not fit the cultural stereotype of masculinity or femininity should not be given this diagnosis unless the full syndrome is present. **Physical abnormalities of the sex organs** are rarely associated with Gender Identity Disorder; when they are present, the physical disorder should be noted on Axis III.

Diagnostic criteria for Gender Identity Disorder of Childhood

For females:

A. Strongly and persistently stated desire to be a boy, or insistence that she is a boy (not merely a desire for any perceived cultural advantages from being a boy).

B. Persistent repudiation of female anatomic structures, as manifested by at least one of the following repeated assertions:

- (1) that she will grow up to become a man (not merely in role)
- (2) that she is biologically unable to become pregnant
- (3) that she will not develop breasts
- (4) that she has no vagina
- (5) that she has, or will grow, a penis

C. Onset of the disturbance before puberty. (For adults and adolescents, see Atypical Gender Identity Disorder.)

For males:

A. Strongly and persistently stated desire to be a girl, or insistence that he is a girl.

B. Either (1) or (2):

(1) persistent repudiation of male anatomic structures, as manifested 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

(2) preoccupation with female stereotypical activities as manifested by a preference for either cross-dressing or simulating female attire, or by a compelling desire to participate in the games and pastimes of girls

C. Onset of the disturbance before puberty. (For adults and adolescents, see Atypical Gender Identity Disorder.)

302.85 Atypical Gender Identity Disorder

This is a residual category for coding disorders in gender identity that are not classifiable as a specific Gender Identity Disorder.

PARAPHILIAS

The essential feature of disorders in this subclass is that unusual or bizarre imagery or acts are necessary for sexual excitement. Such imagery or acts tend to be insistently and involuntarily repetitive and generally involve either: (1) preference for use of a nonhuman object for sexual arousal, (2) repetitive sexual activity with humans involving real or simulated suffering or humiliation, or (3) repetitive sexual activity with nonconsenting partners. In other classifications these disorders are referred to as Sexual Deviations. The term Paraphilia is