

## **302.85**

# **Gender Identity Disorder in Adolescents or Adults**

### **Proposed Revision**

Gender Incongruence (in Adolescents or Adults) [1]

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

1. a marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics) [13, 16]

2. a strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics) [17]

3. a strong desire for the primary and/or secondary sex characteristics of the other gender

4. a strong desire to be of the other gender (or some alternative gender different from one's assigned gender)

5. a strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)

6. a strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

### Subtypes

With a disorder of sex development

Without a disorder of sex development

[14, 15, 16, 19]

### **Rationale**

For the adult criteria, we propose, on a preliminary basis, the requirement of only 2 indicators. This is based on a preliminary secondary data analysis of 154 adolescent and adults patients with GID compared to 684 controls (Deogracias et al., 2007; Singh et al., 2010). From a 27-item dimensional measure of gender dysphoria, the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults (GIDYQ), we extracted five items that correspond to the proposed A2-A6 indicators (we could not extract a corresponding item for A1). Each item was rated on a 5-point response scale, ranging from Never to Always, with the past 12 months as the time frame. For the current analysis, we coded a symptom as present if the participant endorsed one of the two most extreme response options (frequently or always) and as absent if the participant endorsed one of the

three other options (never, rarely, sometimes). This yielded a true positive rate of 94.2% and a false positive rate of 0.7%. Because the wording of the items on the GIDYQ is not identical to the wording of the proposed indicators, further validation work will be required during field trials.

#### 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, 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.

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, 2009a, 2009b). 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).

16. Although the DSM-IV diagnosis of GID encompasses more than transsexualism, it is still often used as an equivalent to transsexualism (Sohn & Bosinski, 2007). For instance, a man can meet the two core criteria if he only believes he has the typical feelings of a woman and does not feel at ease with the male gender role. The same holds for a woman who just frequently passes as a man (e.g., in terms of first name, clothing, and/or haircut) and does not feel comfortable living as a conventional woman. Someone having a GID diagnosis based on these subcriteria clearly differs from a person who identifies completely with the other gender, can only relax when permanently living in the other gender role, has a strong aversion against the sex characteristics of his/her body, and wants to adjust his/her body as much as technically possible in the direction of the desired sex. Those who are distressed by having problems with just one of the two criteria (e.g., feeling uncomfortable living as a conventional man or woman) will have a GIDNOS diagnosis. This is highly confusing for clinicians. It perpetuates the search for the "true transsexual" only, in order to identify the right candidates for hormone and surgical treatment instead of facilitating clinicians to assess the type and severity of any type of GI and offer appropriate treatment. Furthermore, in the DSM-IV, gender identity and gender role were described as a dichotomy (either male or female) rather than a multi-category concept or spectrum (Bockting, 2008; Bornstein, 1994; Ekins & King, 2006; Lev, 2007; Røn, 2002). The current formulation makes more explicit that a conceptualization of GI acknowledging the wide variation of conditions will make it less

likely that only one type of treatment is connected to the diagnosis. Taking the above regarding the avoidance of male-female dichotomies into account, in the new formulation, the focus is on the discrepancy between experienced/expressed gender (which can be either male, female, in-between or otherwise) and assigned gender (in most societies male or female) rather than cross-gender identification and same-gender aversion (Cohen-Kettenis & Pfäfflin, 2009).

17. In referring to secondary sex characteristics, anticipation of the development of secondary sex characteristics has been added for young adolescents. Adolescents increasingly show up at gender identity clinics requesting gender reassignment, before the first signs of puberty are visible (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker & Cohen-Kettenis, 2008).

18. In contemporary clinical practice, sexual orientation per se plays only a minor role in treatment protocols or decisions. Also, changes as to the preferred gender of sex partner occur during or after treatment (DeCuypere, Janes, & Rubens, 2005; Lawrence, 2005; Schroder & Carroll, 1999). It can be difficult to assess sexual orientation in individuals with a GI diagnosis, as they preoperatively might give incorrect information in order to be approved for hormonal and surgical treatment (Lawrence, 1999). Because sexual orientation subtyping is of interest to researchers in the field, it is recommended that reference to it be addressed in the text, but not as a specifier. It should also be assessed as a dimensional construct.

19. The subworkgroup has had extensive discussion about the placement of GI in the nomenclature for DSM-V, as the meta-structure of the entire manual is under review. The subworkgroup questions the rationale for the current DSM-IV chapter Sexual and Gender Identity Disorders, which contains three major classes of diagnoses: sexual dysfunctions, paraphilias, and gender identity disorders (see Meyer-Bahlburg, 2009a). Various alternative options to the current placement are under consideration.

## References

Bockting, W. O. (2008). Psychotherapy and the real-life experience: From gender dichotomy to gender diversity. *Sexologies*, 17, 211-224.

Bornstein, K. (1994). *Gender outlaw: On men, women and the rest of us*. London: Routledge.

Bradley, S. J., Blanchard, R., Coates, S., Green, R., Levine, S. B., Meyer-Bahlburg, H. F. L., et al. (1991). Interim report of the DSM-IV subcommittee on gender identity disorders. *Archives of Sexual Behavior*, 20, 333-343.

Cohen-Kettenis, P. T. (2005). Gender change in 46,XY persons with 5 $\alpha$ -reductase-2-deficiency and 17 $\beta$ -hydroxysteroid dehydrogenase-3 deficiency. *Archives of Sexual Behavior*, 34, 399-410.

Cohen-Kettenis, P. T., & Pfäfflin, F. (2009). The DSM diagnostic criteria for adolescents and adults. *Archives of Sexual Behavior*, doi: 10.1007/s10508-009-9562-y.

Cohen-Kettenis, P. T., & van Goozen, S. H. M. (1997). Sex reassignment of adolescent transsexuals: A follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 263-271.

De Cuypere, G., Janes, C., & Rubens, R. (1995). Psychosocial functioning of transsexuals in Belgium. *Acta Psychiatrica Scandinavica*, 91, 180-184.

Delemarre-van de Waal, H. A., & Cohen-Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology*, 155(Suppl. 1), S131-S137.

Deogracias, J. J., Johnson, L. L., Meyer-Bahlburg, H. F. L., Kessler, S. J., Schober, J. M., & Zucker, K. J. (2007). The Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults. *Journal of Sex Research*, 44, 370-379.

Dessens, A. B., Slijper, F. M. E., & Drop, S. L. S. (2005). Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. *Archives of Sexual Behavior*, 34, 389-397.

Ekins, R., & King, D. (2006). *The transgender phenomenon*. London, CA: Sage.

Green, R. (1987). *The "sissy-boy syndrome" and the development of homosexuality*. New Haven, CT: Yale University Press.

Johnson, L. L., Bradley, S. J., Birkenfeld-Adams, A. S., Radzins Kuksis, M. A., Maing, D. M., & Zucker, K. J. (2004). A parent-report Gender Identity Questionnaire for Children. *Archives of Sexual Behavior*, 33, 105-116.

Lawrence, A. A. (1999). [Letter to the Editor]. *Archives of Sexual Behavior*, 28, 581-583.

Lawrence, A. A. (2005). Sexuality before and after male-to-female sex reassignment surgery. *Archives of Sexual Behavior* 34, 147-166.

Lev, A. I. (2007). Transgender communities: Developing identity through connection. In K. J. Bieschke, R. M. Perez, & K. A. Debord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients*(2nd ed., pp. 147-175). Washington, DC: American Psychological Association.

Mazur, T. (2005). Gender dysphoria and gender change in androgen insensitivity or micropenis. *Archives of Sexual Behavior*, 34, 411-421.

Meyer-Bahlburg, H. F. L. (1994). Intersexuality and the diagnosis of gender identity disorder. *Archives of Sexual Behavior*, 23, 21-40

Meyer-Bahlburg, H. F. L. (2005). Gender identity outcome in female-raised 46,XY persons with penile agenesis, cloacal exstrophy of the bladder, or penile ablation. *Archives of Sexual Behavior*, 34, 423-438.

Meyer-Bahlburg, H. F. L. (2009a). From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Archives of Sexual Behavior*, doi: 10.1007/s10508-009-9532-4.

Meyer-Bahlburg, H. F. L. (2009b). Variants of gender differentiation in somatic disorders of sex development: Recommendations for Version 7 of the World Professional Association for Transgendered Health's Standards of Care. *International Journal of Transgenderism*, 11, 226-237.

Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, H., Macri, M., et al. (2009). Psychiatric impact of gender-related abuse across the life course of male to female transgender persons. *Journal of Sex Research*, doi: 10.1080/00224-490903062258.

Røn K. (2002). 'Either/or' and 'both/neither': Discursive tensions in transgender politics. *Signs*, 27, 501-522.

Schroder, M., & Carroll, R. (1999). Sexological outcomes of gender reassignment surgery. *Journal of Sex Education and Therapy*, 24, 137-146.

Singh, D., Deogracias J. J., Johnson, L. L., Bradley, S. J., Kibblewhite, S. J., Owen-Anderson, A., et al. (2010). The Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults: Further validity evidence. *Journal of Sex Research*, 47, 49-58.

Sohn, M., & Bosinski, H. A. G. (2007). Gender identity disorders: Diagnostic and surgical aspects. *Journal of Sexual Medicine*, 4, 1193-1208.

Vance, S., Cohen-Kettenis, P.T., Drescher, J., Meyer-Bahlburg, H. F. L., Pfäfflin, F., & Zucker, K. J. (in press). Transgender advocacy groups' opinions on the current DSM gender identity disorder diagnosis: Results from an international survey. *International Journal of Transgenderism*.

Winters, K. (2005). Gender dissonance: Diagnostic reform of gender identity disorder for adults. *Journal of Psychology and Human Sexuality*, 17, 71-89.

Winters, K. (2008). *Gender madness in American psychiatry: Essays from the struggle for dignity*. Dillon, CO: GID Reform Advocates.

Zucker, K. J. (1992). Gender identity disorder. In S. R. Hooper, G. W. Hynd, & R. E. Mattison (Eds.), *Child psychopathology: Diagnostic criteria and clinical assessment* (pp. 305-342). Hillsdale, NJ: Erlbaum.

Zucker, K. J. (2006). Gender identity disorder. In D. A. Wolfe & E. J. Mash (Eds.), *Behavioral and emotional disorders in adolescents: Nature, assessment, and treatment* (pp. 535-562). New York: Guilford Press.

Zucker, K. J. (2009). The DSM diagnostic criteria for gender identity disorder in children. *Archives of Sexual Behavior*, doi: 10.1007/s10508-009-9540-4.

Zucker, K. J., & Cohen-Kettenis, P. T. (2008). Gender identity disorder in children and adolescents. In D. L. Rowland & L. Incrocci (Eds.), *Handbook of sexual and gender identity disorders* (pp. 376-422). New York: Wiley & Sons.

Zucker, K. J., Green, R., Bradley, S. J., Williams, K., Rebach, H. M., & Hood, J. E. (1998). Gender identity disorder of childhood: Diagnostic issues. In T. A. Widiger, A. J. Frances, H. A. Pincus, R. Ross, M. B. First, W. Davis, & M. Kline (Eds.), *DSM-IV sourcebook* (Vol. 4, pp. 503-512). Washington, DC: American Psychiatric Association.

## **Severity**

For Adolescents and Adults

Please complete the following questions: [Note to Task Force—these first 4 questions are preliminary; the corresponding dimensional questions for the categorical diagnosis are on the next page]

1. My current legal sex or gender (e.g., as listed under "sex" on my passport or driver's license, also called "assigned" gender) is:

- a. Female
- b. Male
- c. Other (describe): \_\_\_\_\_

2. My confidence that I really am what my legal "sex" states (namely, a girl/woman or boy/man) is:

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

3. The way that I experience and express my true gender compared to my legal sex or gender is:

- a. Not at all different
- b. Mildly different
- c. Moderately different
- d. Strongly different
- e. Very Strongly different

4. I am distressed by feeling different from my legal sex or gender:

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

Note to the Task Force: Definitions will be provided for primary and secondary sex characteristics and "assigned sex" and "assigned gender." Questions A1-A6 are the dimensional metrics for the corresponding categorical criteria.

For Questions 1-8, please circle the letter next to the statement that applies to you the best.

A1. Over the past 6 months, how intense was your discomfort because your primary and/or secondary sex characteristics do not match your gender identity?

- 1. None
- 2. Mild
- 3. Moderate
- 4. Strong
- 5. Very Strong

A2. Over the past 6 months, how intense was your desire to be rid of your primary and/or secondary sex characteristics because they do not match your gender identity?

1. None
2. Mild
3. Moderate
4. Strong
5. Very Strong

A3. Over the past 6 months, how intense was your desire for the primary and/or secondary sex characteristics of the other gender?

1. None
2. Mild
3. Moderate
4. Strong
5. Very Strong

A4. Over the past 6 months, how intense was your desire to be of the other gender (or some gender different from your assigned gender)?

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

A5. Over the past 6 months, how intense was your desire to be treated as the other gender (or some gender different from your assigned gender)?

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

A6. Over the past 6 months, how intense was your conviction that you have the typical feelings and reactions of the other gender (or some gender different from your assigned gender)?

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

7. Over the past 6 months, how would you describe your sexual attraction to other people?

- a. Sexually attracted to males
- b. Sexually attracted to females
- c. Sexually attracted to both males and females
- d. Sexually attracted to neither males or females
- e. Other (please describe): \_\_\_\_\_

8. How old were you when you first had the strong desire to be, or to live in the gender role, of the other gender (or some gender different from your assigned gender)?

- a. Age 5 years or younger

- b. Between 6 and 9 years
- c. Between 10 and 12 years
- d. Between 13 and 17 years
- e. Age 18 years or older