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

preferable because it correctly emphasizes that the deviation (para) is in that to which the individual is attracted (philia).

The imagery in a Paraphilia, such as simulated bondage, may be playful and harmless and acted out with a mutually consenting partner. More likely it is not reciprocated by the partner, who consequently feels erotically excluded or superfluous to some degree. In more extreme form, paraphiliac imagery is acted out with a nonconsenting partner, and is noxious and injurious to the partner (as in severe Sexual Sadism) or to the self (as in Sexual Masochism).

Since paraphiliac imagery is necessary for erotic arousal, it must be included in masturbatory or coital fantasies, if not actually acted out alone or with a partner and supporting cast or paraphernalia. In the absence of paraphiliac imagery there is no relief from nonerotic tension, and sexual excitement or orgasm is not attained.

The imagery in a paraphiliac fantasy or the object of sexual excitement in a Paraphilia is frequently the stimulus for sexual excitement in individuals without a Psychosexual Disorder. For example, women's undergarments and imagery of sexual coercion are sexually exciting for many men; they are paraphiliac only when they become necessary for sexual excitement.

The Paraphilias included here are, by and large, conditions that traditionally have been specifically identified by previous classifications. Some of them are extremely rare; others are relatively common. Because some of these disorders are associated with nonconsenting partners, they are of legal and social significance. Individuals with these disorders tend not to regard themselves as ill, and usually come to the attention of mental health professionals only when their behavior has brought them into conflict with society.

The specific Paraphilias described here are: (1) Fetishism, (2) Transvestism, (3) Zoophilia, (4) Pedophilia, (5) Exhibitionism, (6) Voyeurism, (7) Sexual Masochism, and (8) Sexual Sadism. Finally, there is a residual category, Atypical Paraphilia, for noting the many other Paraphilias that exist but that have not been sufficiently described to date to warrant inclusion as specific categories.

Paraphilias may be multiple or may coexist with other mental disorders, such as Schizophrenia or various Personality Disorders. In such cases multiple diagnoses should be made.

Associated features. Frequently these individuals assert that the behavior causes them no distress and that their only problem is the reaction of others to their behavior. Others admit to guilt, shame, and depression at having to engage in an unusual sexual activity that is socially unacceptable. There is often impairment in the capacity for reciprocal affectionate sexual activity, and psychosexual dysfunctions are common. Personality disturbances, particularly emotional immaturity, are also frequent.

Impairment. Social and sexual relationships may suffer if others, such as a spouse (many of these individuals are married), become aware of the unusual sexual behavior. In addition, if the individual engages in sexual activity with a partner who refuses to cooperate in the unusual behavior, such as fetishistic or sadistic behavior, sexual excitement may be inhibited and the relationship may

suffer. In rare instances the unusual behavior may become the major activity in the individual's life, such as the collection of fetishes or voyeuristic acts.

Complications. In Zoophilia physical harm may result from sexual activity with animals. In Sexual Masochism, the individual may inflict serious physical damage on himself or herself. Paraphilias involving another person, particularly Voyeurism, Exhibitionism, and Pedophilia, often lead to arrest and incarceration. Sexual offenses against children constitute a significant proportion of all reported criminal sex acts. Individuals with Exhibitionism make up about one-third of all apprehended sex offenders.

Predisposing factors. With the exception of Transvestism (see p. 269), predisposing factors are unknown.

Prevalence. The disorders are apparently rare.

Sex ratio. Virtually all reported cases have been in males, with the exception of Sexual Sadism and Sexual Masochism, which, however, occur far more commonly in males. Although no cases of Voyeurism in women have been reported in the literature, some clinicians claim to know of such cases.

Familial pattern. No information.

302.81 Fetishism

The essential feature is the use of nonliving objects (fetishes) as a repeatedly preferred or exclusive method of achieving sexual excitement. The diagnosis is not made when the fetishes are limited to articles of female clothing used in cross-dressing, as in Transvestism, or when the object is sexually stimulating because it has been designed for that purpose, e.g., a vibrator.

Sexual activity may involve the fetish alone, such as masturbation into a shoe, or the fetish may be integrated into sexual activities with a human partner. In the latter situation the fetish is required or strongly preferred for sexual excitement, and in its absence there may be erectile failure in males.

Fetishes tend to be articles of clothing, such as female undergarments, shoes, and boots, or, more rarely, parts of the human body, such as hair or nails. The fetish is often associated with someone with whom the individual was intimately involved during childhood, most often a caretaker.

Age at onset. Usually the disorder begins by adolescence, although the fetish may have been endowed with special significance earlier, in childhood. Once established, the disorder tends to be chronic.

Differential diagnosis. Nonpathological sexual experimentation can involve sexual arousal by nonhuman objects, but this stimulus for sexual excitement is neither persistently preferred nor required.

In **Transvestism** the sexual arousal is limited to articles of female clothing used in cross-dressing. Although Transvestism could be considered fetishistic cross-dressing, the additional diagnosis of Fetishism should not be made.

Diagnostic criteria for Fetishism

A. The use of nonliving objects (fetishes) is a repeatedly preferred or exclusive method of achieving sexual excitement.

B. The fetishes are not limited to articles of female clothing used in cross-dressing (Transvestism) or to objects designed to be used for the purpose of sexual stimulation (e.g., vibrator).

302.30 Transvestism

The essential feature is recurrent and persistent cross-dressing by a heterosexual male that during at least the initial phase of the illness is for the purpose of sexual excitement. Interference with the cross-dressing results in intense frustration. This diagnosis is not made in those rare instances in which the disturbance has evolved into Transsexualism.

Transvestic phenomena range from occasional solitary wearing of female clothes to extensive involvement in a transvestic subculture. Usually more than one article of women's clothing is involved, and the man may dress entirely as a woman. The degree to which the cross-dressed individual appears as a woman varies, depending on mannerisms, body habitus, and cross-dressing skill. When not cross-dressed, he is usually unremarkably masculine. Although the basic preference is heterosexual, rarely has the individual had sexual experience with several women, and occasional homosexual acts may occur.

Age at onset and course. Cross-dressing typically begins in childhood or early adolescence. In some cases the cross-dressing is not done in public until adulthood. The initial experience may involve partial or total cross-dressing; when it is partial, it often progresses to total. A favored article of clothing may become erotic in itself and may habitually be used first in masturbation, and later in intercourse. In some individuals sexual arousal by the clothing tends to disappear, although the cross-dressing continues as an antidote to anxiety. Cross-dressing, although intermittent in the beginning, often becomes more frequent, and may become habitual. A small number of individuals with Transvestism, as the years pass, want to dress and live permanently as women, and the disorder may evolve into Transsexualism.

Predisposing factors. According to the folklore of individuals with this condition, a "petticoat punishment," the punishment of humiliating a boy by dressing him in the clothes of a girl, is common in the history of individuals who later develop this disorder.

Differential diagnosis. In **Transsexualism** there is a persistent wish to be rid of one's own genitals and to live as a member of the other sex, and there is never any sexual excitement with cross-dressing. The individual with Transvestism considers himself to be basically male, whereas the anatomically male Transsexual has a female sexual identity. In those rare instances when Transvestism evolves into Transsexualism, the diagnosis of Transvestism is changed to Transsexualism.

Cross-dressing for the relief of tension or gender discomfort may be done without directly causing sexual excitement. This should not be diagnosed as Transvestism; the diagnosis of Atypical Gender Identity Disorder should be considered. In **male homosexuality** there may be occasional cross-dressing to attract another male or to masquerade in theatrical fashion as a woman. However, the act of cross-dressing does not cause sexual arousal. In **female impersonators,** unless Transvestism is also present, the act of cross-dressing does not cause sexual arousal, and interference with the cross-dressing does not result in intense frustration.

Fetishism is not diagnosed when sexual arousal by nonhuman objects is limited to articles of female clothing used in cross-dressing.

Diagnostic criteria for Transvestism

A. Recurrent and persistent cross-dressing by a heterosexual male.

B. Use of cross-dressing for the purpose of sexual excitement, at least initially in the course of the disorder.

C. Intense frustration when the cross-dressing is interfered with.

D. Does not meet the criteria for Transsexualism.

302.10 Zoophilia

The essential feature is the use of animals as a repeatedly preferred or exclusive method of achieving sexual excitement. The animal may be the object of intercourse or may be trained to sexually excite the human partner by licking or rubbing. Usually the preferred animal is one with which the individual had contact during childhood, such as a household pet or farm animal. The animal is preferred no matter what other forms of sexual outlet are available.

Age at onset. No information.

Course. Initially in the course of the disorder there may also be sexual arousal by humans. As time progresses, however, the animal becomes the most powerful sexual stimulus. This usually occurs by early adulthood and the course then becomes chronic.

Differential diagnosis. Nonpathological sexual activity with animals may occur because of the unavailability of suitable human partners or as a form of sexual experimentation. In such instances the use of animals is not the consistently preferred method of achieving sexual excitement.

Diagnostic criteria for Zoophilia

The act or fantasy of engaging in sexual activity with animals is a repeatedly preferred or exclusive method of achieving sexual excitement.

307.50 Eating Disorder Not Otherwise Specified

Disorders of eating that do not meet the criteria for a specific Eating Disorder.

Examples:

(1) a person of average weight who does not have binge eating episodes, but frequently engages in self-induced vomiting for fear of gaining weight
(2) all of the features of Anorexia Nervosa in a female except absence of menses
(3) all of the features of Bulimia Nervosa except the frequency of binge eating episodes

GENDER IDENTITY DISORDERS

The essential feature of the disorders included in this subclass is an incongruence between assigned sex (i.e., the sex that is recorded on the birth certificate) 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 to indicate to others or to oneself the degree to which one is male or female.

Some forms of gender identity disturbance are on a continuum, whereas others may be discrete. When gender identity disturbance is mild, the person is aware that he is a male or that she is a female, but discomfort and a sense of inappropriateness about the assigned sex are experienced. When severe, as in Transsexualism, the person not only is uncomfortable with the assigned sex but has the sense of belonging to the opposite sex.

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 of the latter would be a person who perceives himself or herself as being sexually unattractive yet experiences himself or herself unambiguously as a man or a woman in accordance with his or her assigned sex.

Although people who first present clinically with gender identity problems may be of any age, in the vast majority of cases the onset of the disorder can be traced back to childhood. In rare cases, however, an adult will present clinically for the first time with a gender identity problem and report that the first signs of the disturbance were in adult life.

302.60 Gender Identity Disorder of Childhood

The essential features of this disorder are persistent and intense distress in a child about his or her assigned sex and the desire to be, or insistence that he or she is, of the other sex. (This disorder is not merely a child's nonconformity to stereotypic 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.) In addition, in a girl there is either persistent marked aversion to normative feminine clothing and insistence on wearing stereotypic masculine clothing, or persistent repudiation of her female anatomic characteristics. In a boy, there is either preoccupation with female stereotypic activities, or persistent repudiation of his male anatomic characteristics. This diagnosis is not given after the onset of puberty.

Girls with this disorder regularly have male companions and an avid interest in sports and rough-and-tumble play; they show no interest in dolls or playing "house" (unless they play the father or another male role). More rarely, a girl with this disorder refuses to urinate in a sitting position, claims that she has, or will grow, a penis, does not

want to grow breasts or menstruate, or asserts that she will grow up to become a man (not merely in role).

Boys with this disorder usually are preoccupied with female stereotypic 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 typically does not cause sexual excitement, as in Transvestic Fetishism.) They often have a compelling desire to participate in the games and pastimes of girls. Female dolls are often their favorite toy, and girls are regularly their preferred playmates. When playing "house," the role of a female is typically adopted. Rough-and-tumble play or sports are generally avoided. Gestures and actions are often judged against a cultural stereotype of femininity, and the boy is usually subjected to male peer group teasing and rejection, whereas the same rarely occurs among girls until adolescence. Boys with this disorder may assert that they will grow up to become women (not merely in role). 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 assigned sex. Most children with this disorder deny being disturbed by it, except that 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 social withdrawal, separation anxiety, or depression.

Age at onset and course. The majority of the boys with this disorder begin to develop it before their fourth birthday. 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. Studies indicate that from one-third to two-thirds or more of boys with the disorder develop a homosexual orientation during adolescence.

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

Whereas most adult people with Transsexualism report having had a gender identity problem during childhood, prospective studies of children with Gender Identity Disorder of Childhood indicate that very few develop Transsexualism in adolescence or adulthood.

Complications. In a small number of cases, the disorder becomes continuous with Transsexualism or Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type.

Impairment. Positive 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 associated psychopathology and the reaction of peers and family to the person's behavior.

Prevalence. The disorder is apparently uncommon.

Sex ratio. In clinic samples there are many more boys with this disorder than girls. The sex ratio in the general population is unknown.

Familial pattern. No information.

Predisposing factors. Studies indicate that characteristics of the child, the parents, or of other social agents, such as parental substitutes and siblings, may be predisposing factors for the development of the disorder. In boys, the characteristics may include "feminine" physical features, an aversion to rough-and-tumble play, separation anxiety, and a history of early hospitalization. The relevant characteristics of parents and other influential people in the child's environment may include weak reinforcement of normative gender-role behavior, absence or unavailability of a father, and encouragement of extreme physical and psychological closeness with her son by a mother. In girls, a strong interest in rough-and-tumble play on the part of the child and weak reinforcement of normative gender-role behavior by the parents may contribute to the development of the disorder.

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 of Childhood; when they are present, the physical disorder should be noted on Axis III.

Diagnostic criteria for 302.60 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

(continued)

Diagnostic criteria for 302.60 Gender Identity Disorder of Childhood continued

(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.

302.50 Transsexualism

The essential features of this disorder are a persistent discomfort and sense of inappropriateness about one's assigned sex in a person who has reached puberty. In addition, there is 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. Therefore, the diagnosis is not made if the disturbance is limited to brief periods of stress. Invariably there is the wish to live as a member of the other sex. In the rare cases in which physical intersexuality or a genetic abnormality is present, such a condition should be noted on Axis III.

People with this disorder usually complain that they are uncomfortable wearing the clothes of their assigned sex and therefore dress in clothes of the other sex. Often they engage in activities that in our culture tend to be associated with the other sex. These people often find their genitals repugnant, which may lead to persistent requests for sex reassignment by hormonal and surgical means.

To varying degrees, the behavior, dress, and mannerisms become those of the other sex. With cross-dressing and hormonal treatment (and for males, electrolysis), some males and some females with the disorder will appear relatively indistinguishable from members of the other sex. However, even after sex reassignment, many people still have some physical features of their originally assigned sex that the alert observer can recognize.

Cross-culturally, the Hijra of India and the corresponding group in Burma may have conditions that, according to this manual, would be diagnosed as male-to-female Transsexualism. The Hijra, however, traditionally undergo castration, not hormonal and surgical feminization (creation of a vagina).

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

Course. Without treatment, the course of the disorder is chronic, but cases with apparently spontaneous remission do occur. The long-term outcome of combined psychiatric, hormonal, and surgical sex-reassignment treatment is not well known. Many people function better for years after such treatment, but a number of cases in which re-reassignment has been desired have also been reported.

People 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 a more stable course, with or without treatment.

Age at onset. People who develop Transsexualism almost invariably report having had a gender identity problem in childhood. Some assert that they were secretly aware of their gender problem, but that it was not evident to their family and friends. Although onset of the full syndrome is most often in late adolescence or early adult life, in some cases the disorder has 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. It seems usually to develop within the context of a disturbed relationship with one or both parents. Some cases of Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type, evolve into Transsexualism.

Prevalence. The estimated prevalence is one per 30,000 for males and one per 100,000 for females.

Sex ratio. Males seek help at clinics specializing in the treatment of this disorder more commonly than do females. The ratio varies from as high as 8:1 to as low as 1:1.

Familial pattern. No information.

Differential diagnosis. Some people with 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 a diagnosis of **Gender Identity Disorder Not Otherwise Specified** 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 a person 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 person *feels like* a member of the other sex rather than truly believes that he or she *is* a member of the other sex. In very rare cases, however, Schizophrenia and Transsexualism may coexist.

In both **Transvestic Fetishism** and **Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type**, there may be cross-dressing. But unless these disorders evolve into Transsexualism, there is no wish to be rid of one's own genitals.

Types. The disorder is subdivided according to the history of sexual orientation, as asexual, homosexual (toward same sex), heterosexual (toward opposite sex), or unspecified. In the first, "asexual," the person reports never having had strong sexual feelings. Often there is an additional history of little or no sexual activity or pleasure derived from the genitals. In the second group, "homosexual," a predominantly homosexual arousal pattern preceding the onset of the Transsexualism is acknowledged, although often such people deny that the orientation is homosexual because of their conviction that they are "really" of the other sex. In the third group, "heterosexual," the person claims to have had a heterosexual orientation.

Diagnostic criteria for 302.50 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.**

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

The essential features of this disorder are a persistent or recurrent discomfort and sense of inappropriateness about one's assigned sex, and persistent or recurrent cross-dressing in the role of the other sex, either in fantasy or in actuality, in a person who has reached puberty. This disorder differs from Transvestic Fetishism in that the cross-dressing is not for the purpose of sexual excitement; it differs from Transsexualism in that there is 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.

Some people with this disorder once had Transvestic Fetishism, but no longer experience sexual arousal with cross-dressing. Other people with this disorder are homosexuals who cross-dress. This disorder is common among female impersonators.

Cross-dressing phenomena range from occasional solitary wearing of female clothes to extensive feminine identification in males and masculine identification in females, and involvement in a transvestic subculture. More than one article of clothing of the other sex is involved, and the person may dress entirely as a member of the opposite sex. The degree to which the cross-dressed person appears as a member of the other sex varies, depending on mannerisms, body habitus, and cross-dressing skill. When not cross-dressed, the person usually appears as an unremarkable member of his or her assigned sex.

Associated features. Anxiety and depression are common, but are often attenuated when the person is cross-dressing.

Age at onset and course. Age at onset and course are variable. In most cases, before puberty there was a history of some or all of the features of Gender Identity Disorder of Childhood. However, by definition, GIDAANT is diagnosed only once puberty has been reached. The initial experience may involve partial or total cross-dressing; when it is partial, it often progresses to total. Cross-dressing, although intermittent in the beginning, often becomes more frequent, and may become habitual. A small number of people with GIDAANT, as the years pass, want to dress and live permanently as the other sex, and the disorder may evolve into Transsexualism.

Impairment. Unless there is another diagnosis in addition to GIDAANT, the impairment is generally restricted to conflicts with family members and other people regarding the cross-dressing.

Complications. The major complication is Transsexualism.

Predisposing factors. As noted above, both Gender Identity Disorder of Childhood and Transvestic Fetishism sometimes evolve into GIDAANT.

Prevalence. Although its prevalence is unknown, the disorder is probably more common than Transsexualism.

Sex ratio. The disorder is more common in males.

Familial pattern. No information.

Differential diagnosis. In **Transvestic Fetishism**, the cross-dressing is for the purpose of sexual excitement. In **Transsexualism**, there is a persistent (for more than two years) wish to get rid of one's primary and secondary sex characteristics and acquire the sex characteristics of the other sex. In those rare instances in which a person with GIDAANT develops Transsexualism, the diagnosis of GIDAANT is changed accordingly.

Subtypes. The disorder is subdivided according to the history of sexual orientation, as asexual, homosexual (toward same sex), heterosexual (toward opposite sex), or unspecified. In the first, "asexual," the person reports never having had strong sexual feelings. Often there is an additional history of little or no sexual activity or pleasure derived from the genitals. In the second group, "homosexual," a predominantly homosexual arousal pattern preceding the onset of the GIDAANT is acknowledged. In the third group, "heterosexual," the person claims to have had a heterosexual orientation.

Diagnostic criteria for 302.85 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.**

302.85 Gender Identity Disorder Not Otherwise Specified

Disorders in gender identity that are not classifiable as a specific Gender Identity Disorder.

Examples:

(1) children with persistent cross-dressing without the other criteria for Gender Identity Disorder of Childhood
(2) adults with transient, stress-related cross-dressing behavior
(3) adults with the clinical features of Transsexualism of less than two years' duration
(4) people who have a persistent preoccupation with castration or peotomy without a desire to acquire the sex characteristics of the other sex

TIC DISORDERS

Tics are the essential feature of the three disorders in this subclass: Tourette's Disorder, Chronic Motor or Vocal Tic Disorder, and Transient Tic Disorder. There is evidence from genetic and other studies that Tourette's Disorder and Chronic Motor or Vocal Tic Disorder represent different symptomatic expressions of the same underlying disorder. However, they are included in this manual as separate disorders because they generally involve different degrees of impairment (the former being more disabling) and they have different treatment implications.

A tic is an involuntary, sudden, rapid, recurrent, nonrhythmic, stereotyped, motor movement or vocalization. It is experienced as irresistible, but can be suppressed for varying lengths of time. All forms of tics are often exacerbated by stress and usually are markedly diminished during sleep. They may become attenuated during some absorbing activities, such as reading or sewing.

Both *motor* and *vocal tics* may be classified as either *simple* or *complex*, although the boundaries are not well defined. Common *simple motor tics* are eye-blinking, neck-jerking, shoulder-shrugging, and facial grimacing. Common *simple vocal tics* are coughing, throat-clearing, grunting, sniffing, snorting, and barking. Common *complex motor tics* are facial gestures, grooming behaviors, hitting or biting self, jumping, touching, stamping, and smelling an object. Common *complex vocal tics* are repeating words or phrases out of context, coprolalia (use of socially unacceptable words, frequently obscene), palilalia (repeating one's own sounds or words), and echolalia (repeating the last-heard sound, word, or phrase of another person, or a last-heard sound). Other complex tics include echokinesis (imitation of the movements of someone who is being observed).

Associated features. Discomfort in social situations, shame, self-consciousness, and depressed mood are common, especially with Tourette's Disorder.

Predisposing factors. A controversy exists as to whether or not the onset of some cases of Tic Disorders is precipitated by exposure to phenothiazines, head trauma, or the administration of central nervous system stimulants. It is estimated that in one-third of cases of Tourette's Disorder, the severity of the tics is exacerbated by administration of central nervous system stimulants, which may be a dose-related phenomenon.

Impairment. Social, academic, and occupational functioning may be impaired because of rejection by others or anxiety about having tics in social situations. In addition, in severe cases of Tourette's Disorder, the tics themselves may interfere with daily activities, such as reading or writing. Although most people with Tourette's Disorder do not have marked impairment, in general the impairment is more severe than in Chronic Motor or Vocal Tic Disorder. Impairment in Transient Tic Disorder rarely is marked.

302.82 Voyeurism

The paraphiliac focus of Voyeurism involves the act of observing unsuspecting individuals, usually strangers, who are naked, in the process of disrobing, or engaging in sexual activity. The act of looking ("peeping") is for the purpose of achieving sexual excitement, and generally no sexual activity with the observed person is sought. Orgasm, usually produced by masturbation, may occur during the voyeuristic activity or later in response to the memory of what the person has witnessed. Often these individuals have the fantasy of having a sexual experience with the observed person, but in reality this rarely occurs. In its severe form, peeping constitutes the exclusive form of sexual activity. The onset of voyeuristic behavior is usually before age 15 years. The course tends to be chronic.

■ Diagnostic criteria for 302.82 Voyeurism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

302.9 Paraphilia Not Otherwise Specified

This category is included for coding Paraphilias that do not meet the criteria for any of the specific categories. Examples include, but are not limited to, telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine).

Gender Identity Disorders

Gender Identity Disorder

Diagnostic Features

There are two components of Gender Identity Disorder, both of which must be present to make the diagnosis. There must be evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex

(Criterion A). This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex (Criterion B). The diagnosis is not made if the individual has a concurrent physical intersex condition (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia) (Criterion C). To make the diagnosis, there must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion D).

In boys, the cross-gender identification is manifested by a marked preoccupation with traditionally feminine activities. They may have a preference for dressing in girls' or women's clothes or may improvise such items from available materials when genuine articles are unavailable. Towels, aprons, and scarves are often used to represent long hair or skirts. There is a strong attraction for the stereotypical games and pastimes of girls. They particularly enjoy playing house, drawing pictures of beautiful girls and princesses, and watching television or videos of their favorite female characters. Stereotypical female-type dolls, such as Barbie, are often their favorite toys, and girls are their preferred playmates. When playing "house," these boys role-play female figures, most commonly "mother roles," and often are quite preoccupied with female fantasy figures. They avoid rough-and-tumble play and competitive sports and have little interest in cars and trucks or other nonaggressive but stereotypical boy's toys. They may express a wish to be a girl and assert that they will grow up to be a woman. They may insist on sitting to urinate and pretend not to have a penis by pushing it in between their legs. More rarely, boys with Gender Identity Disorder may state that they find their penis or testes disgusting, that they want to remove them, or that they have, or wish to have, a vagina.

Girls with Gender Identity Disorder display intense negative reactions to parental expectations or attempts to have them wear dresses or other feminine attire. Some may refuse to attend school or social events where such clothes may be required. They prefer boy's clothing and short hair, are often misidentified by strangers as boys, and may ask to be called by a boy's name. Their fantasy heroes are most often powerful male figures, such as Batman or Superman. These girls prefer boys as playmates, with whom they share interests in contact sports, rough-and-tumble play, and traditional boyhood games. They show little interest in dolls or any form of feminine dress up or role-play activity. A girl with this disorder may occasionally refuse to urinate in a sitting position. She may claim that she has or will grow a penis and may not want to grow breasts or to menstruate. She may assert that she will grow up to be a man. Such girls typically reveal marked cross-gender identification in role-play, dreams, and fantasies.

Adults with Gender Identity Disorder are preoccupied with their wish to live as a member of the other sex. This preoccupation may be manifested as an intense desire to adopt the social role of the other sex or to acquire the physical appearance of the other sex through hormonal or surgical manipulation. Adults with this disorder are uncomfortable being regarded by others as, or functioning in society as, a member of their designated sex. To varying degrees, they adopt the behavior, dress, and mannerisms of the other sex. In private, these individuals may spend much time cross-dressed and working on the appearance of being the other sex. Many attempt to pass in public as the other sex. With cross-dressing and hormonal treatment (and for males, electrolysis), many individuals with this disorder may pass convincingly as the other sex. The sexual activity of these individuals with same-sex partners is generally constrained by the preference that their partners neither see nor touch their genitals. For some males who

present later in life, (often following marriage), sexual activity with a woman is accompanied by the fantasy of being lesbian lovers or that his partner is a man and he is a woman.

In adolescents, the clinical features may resemble either those of children or those of adults, depending on the individual's developmental level, and the criteria should be applied accordingly. In a younger adolescent, it may be more difficult to arrive at an accurate diagnosis because of the adolescent's guardedness. This may be increased if the adolescent feels ambivalent about cross-gender identification or feels that it is unacceptable to the family. The adolescent may be referred because the parents or teachers are concerned about social isolation or peer teasing and rejection. In such circumstances, the diagnosis should be reserved for those adolescents who appear quite cross-gender identified in their dress and who engage in behaviors that suggest significant cross-gender identification (e.g., shaving legs in males). Clarifying the diagnosis in children and adolescents may require monitoring over an extended period of time.

Distress or disability in individuals with Gender Identity Disorder is manifested differently across the life cycle. In young children, distress is manifested by the stated unhappiness about their assigned sex. Preoccupation with cross-gender wishes often interferes with ordinary activities. In older children, failure to develop age-appropriate same-sex peer relationships and skills often leads to isolation and distress, and some children may refuse to attend school because of teasing or pressure to dress in attire stereotypical of their assigned sex. In adolescents and adults, preoccupation with cross-gender wishes often interferes with ordinary activities. Relationship difficulties are common and functioning at school or at work may be impaired.

Specifiers

For sexually mature individuals, the following specifiers may be noted based on the individual's sexual orientation: **Sexually Attracted to Males, Sexually Attracted to Females, Sexually Attracted to Both,** and **Sexually Attracted to Neither.** Males with Gender Identity Disorder include substantial proportions with all four specifiers. Virtually all females with Gender Identity Disorder will receive the same specifier—Sexually Attracted to Females—although there are exceptional cases involving females who are Sexually Attracted to Males.

Recording Procedures

The assigned diagnostic code depends on the individual's current age: if the disorder occurs in childhood, the code 302.6 is used; for an adolescent or adult, 302.85 is used.

Associated Features and Disorders

Associated descriptive features and mental disorders. Many individuals with Gender Identity Disorder become socially isolated. Isolation and ostracism contribute to low self-esteem and may lead to school aversion or dropping out of school. Peer ostracism and teasing are especially common sequelae for boys with the disorder. Boys with Gender Identity Disorder often show marked feminine mannerisms and speech patterns.

The disturbance can be so pervasive that the mental lives of some individuals revolve only around those activities that lessen gender distress. They are often preoccupied with appearance, especially early in the transition to living in the opposite sex role. Relationships with one or both parents also may be seriously impaired. Some males with Gender Identity Disorder resort to self-treatment with hormones and may very rarely perform their own castration or penectomy. Especially in urban centers, some males with the disorder may engage in prostitution, which places them at high risk for human immunodeficiency virus (HIV) infection. Suicide attempts and Substance-Related Disorders are commonly associated.

Children with Gender Identity Disorder may manifest coexisting Separation Anxiety Disorder, Generalized Anxiety Disorder, and symptoms of depression. Adolescents are particularly at risk for depression and suicidal ideation and suicide attempts. In adults, anxiety and depressive symptoms may be present. Some adult males have a history of Transvestic Fetishism as well as other Paraphilias. Associated Personality Disorders are more common among males than among females being evaluated at adult gender clinics.

Associated laboratory findings. There is no diagnostic test specific for Gender Identity Disorder. In the presence of a normal physical examination, karyotyping for sex chromosomes and sex hormone assays are usually not indicated. Psychological testing may reveal cross-gender identification or behavior patterns.

Associated physical examination findings and general medical conditions. Individuals with Gender Identity Disorder have normal genitalia (in contrast to the ambiguous genitalia or hypogonadism found in physical intersex conditions). Adolescent and adult males with Gender Identity Disorder may show breast enlargement resulting from hormone ingestion, hair denuding from temporary or permanent epilation, and other physical changes as a result of procedures such as rhinoplasty or thyroid cartilage shaving (surgical reduction of the Adam's apple). Distorted breasts or breast rashes may be seen in females who wear breast binders. Postsurgical complications in genetic females include prominent chest wall scars, and in genetic males, vaginal strictures, rectovaginal fistulas, urethral stenoses, and misdirected urinary streams. Adult females with Gender Identity Disorder may have a higher than expected likelihood of polycystic ovarian disease.

Specific Age and Gender Features

Females with Gender Identity Disorders generally experience less ostracism because of cross-gender interests and may suffer less from peer rejection, at least until adolescence. In child clinic samples, there are approximately five boys for each girl referred with this disorder. In adult clinic samples, men outnumber women by about two or three times. In children, the referral bias toward males may partly reflect the greater stigma that cross-gender behavior carries for boys than for girls.

Prevalence

There are no recent epidemiological studies to provide data on prevalence of Gender Identity Disorder. Data from smaller countries in Europe with access to total population statistics and referrals suggest that roughly 1 per 30,000 adult males and 1 per 100,000 adult females seek sex-reassignment surgery.

Course

For clinically referred children, onset of cross-gender interests and activities is usually between ages 2 and 4 years, and some parents report that their child has always had cross-gender interests. Only a very small number of children with Gender Identity Disorder will continue to have symptoms that meet criteria for Gender Identity Disorder in later adolescence or adulthood. Typically, children are referred around the time of school entry because of parental concern that what they regarded as a "phase" does not appear to be passing. Most children with Gender Identity Disorder display less overt cross-gender behaviors with time, parental intervention, or response from peers. By late adolescence or adulthood, about three-quarters of boys who had a childhood history of Gender Identity Disorder report a homosexual or bisexual orientation, but without concurrent Gender Identity Disorder. Most of the remainder report a heterosexual orientation, also without concurrent Gender Identity Disorder. The corresponding percentages for sexual orientation in girls are not known. Some adolescents may develop a clearer cross-gender identification and request sex-reassignment surgery or may continue in a chronic course of gender confusion or dysphoria.

In adult males, there are two different courses for the development of Gender Identity Disorder. The first is a continuation of Gender Identity Disorder that had an onset in childhood or early adolescence. These individuals typically present in late adolescence or adulthood. In the other course, the more overt signs of cross-gender identification appear later and more gradually, with a clinical presentation in early to mid-adulthood usually following, but sometimes concurrent with, Transvestic Fetishism. The later-onset group may be more fluctuating in the degree of cross-gender identification, more ambivalent about sex-reassignment surgery, more likely to be sexually attracted to women, and less likely to be satisfied after sex-reassignment surgery. Males with Gender Identity Disorder who are sexually attracted to males tend to present in adolescence or early adulthood with a lifelong history of gender dysphoria. In contrast, those who are sexually attracted to females, to both males and females, or to neither sex tend to present later and typically have a history of Transvestic Fetishism. If Gender Identity Disorder is present in adulthood, it tends to have a chronic course, but spontaneous remission has been reported.

Differential Diagnosis

Gender Identity Disorder can be distinguished from simple **nonconformity to stereotypical sex role behavior** by the extent and pervasiveness of the cross-gender wishes, interests, and activities. This disorder is not meant to describe a child's nonconformity to stereotypic sex-role behavior as, for example, in "tomboyishness" in girls or "sissyish" behavior in boys. Rather, it represents a profound disturbance of the individual's sense of identity with regard to maleness or femaleness. Behavior in children that merely does not fit the cultural stereotype of masculinity or femininity should not be given the diagnosis unless the full syndrome is present, including marked distress or impairment.

Transvestic Fetishism occurs in heterosexual (or bisexual) men for whom the cross-dressing behavior is for the purpose of sexual excitement. Aside from cross-dressing, most individuals with Transvestic Fetishism do not have a history of childhood cross-gender behaviors. Males with a presentation that meets full criteria for Gender Identity Disorder as well as Transvestic Fetishism should be given both diagnoses. If gender dysphoria is present in an individual with Transvestic Fetishism but full criteria

for Gender Identity Disorder are not met, the specifier With Gender Dysphoria can be used.

The category **Gender Identity Disorder Not Otherwise Specified** can be used for individuals who have a gender identity problem with a **concurrent congenital intersex condition** (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia).

In **Schizophrenia,** there may rarely be delusions of belonging to the other sex. Insistence by a person with a Gender Identity Disorder that he or she is of the other sex is not considered a delusion, because what is invariably meant is that the person feels like a member of the other sex rather than truly believes that he or she is a member of the other sex. In very rare cases, however, Schizophrenia and severe Gender Identity Disorder may coexist.

Diagnostic criteria for Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

In children, the disturbance is manifested by four (or more) of the following:

(1) repeatedly stated desire to be, or insistence that he or she is, the other sex
(2) in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
(3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
(4) intense desire to participate in the stereotypical games and pastimes of the other sex
(5) strong preference for playmates of the other sex

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

In children, the disturbance is 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 toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

(continued)

☐ **Diagnostic criteria for Gender Identity Disorder** (*continued*)

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Code based on current age:

302.6 Gender Identity Disorder in Children
302.85 Gender Identity Disorder in Adolescents or Adults

Specify if (for sexually mature individuals):

Sexually Attracted to Males
Sexually Attracted to Females
Sexually Attracted to Both
Sexually Attracted to Neither

302.6 Gender Identity Disorder Not Otherwise Specified

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

1. Intersex conditions (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia) and accompanying gender dysphoria
2. Transient, stress-related cross-dressing behavior
3. Persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex

302.9 Sexual Disorder Not Otherwise Specified

This category is included for coding a sexual disturbance that does not meet the criteria for any specific Sexual Disorder and is neither a Sexual Dysfunction nor a Paraphilia. Examples include

1. Marked feelings of inadequacy concerning sexual performance or other traits related to self-imposed standards of masculinity or femininity
2. Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used
3. Persistent and marked distress about sexual orientation

Gender Dysphoria

In this chapter, there is one overarching diagnosis of gender dysphoria, with separate developmentally appropriate criteria sets for children and for adolescents and adults. The area of sex and gender is highly controversial and has led to a proliferation of terms whose meanings vary over time and within and between disciplines. An additional source of confusion is that in English "sex" connotes both male/female and sexuality. This chapter employs constructs and terms as they are widely used by clinicians from various disciplines with specialization in this area. In this chapter, *sex* and *sexual* refer to the biological indicators of male and female (understood in the context of reproductive capacity), such as in sex chromosomes, gonads, sex hormones, and nonambiguous internal and external genitalia. Disorders of sex development denote conditions of inborn somatic deviations of the reproductive tract from the norm and/or discrepancies among the biological indicators of male and female. *Cross-sex* hormone treatment denotes the use of feminizing hormones in an individual assigned male at birth based on traditional biological indicators or the use of masculinizing hormones in an individual assigned female at birth.

The need to introduce the term *gender* arose with the realization that for individuals with conflicting or ambiguous biological indicators of sex (i.e., "intersex"), the lived role in society and/or the identification as male or female could not be uniformly associated with or predicted from the biological indicators and, later, that some individuals develop an identity as female or male at variance with their uniform set of classical biological indicators. Thus, *gender* is used to denote the public (and usually legally recognized) lived role as boy or girl, man or woman, but, in contrast to certain social constructionist theories, biological factors are seen as contributing, in interaction with social and psychological factors, to gender development. *Gender assignment* refers to the initial assignment as male or female. This occurs usually at birth and, thereby, yields the "natal gender." *Gender-atypical* refers to somatic features or behaviors that are not typical (in a statistical sense) of individuals with the same assigned gender in a given society and historical era; for behavior, *gender-nonconforming* is an alternative descriptive term. *Gender reassignment* denotes an official (and usually legal) change of gender. *Gender identity* is a category of social identity and refers to an individual's identification as male, female, or, occasionally, some category other than male or female. *Gender dysphoria* as a general descriptive term refers to an individual's affective/cognitive discontent with the assigned gender but is more specifically defined when used as a diagnostic category. *Transgender* refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender. *Transsexual* denotes an individual who seeks, or has undergone, a social transition from male to female or female to male, which in many, but not all, cases also involves a somatic transition by cross-sex hormone treatment and genital surgery (*sex reassignment surgery*).

Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se.

Gender Dysphoria

Diagnostic Criteria

Gender Dysphoria in Children 302.6 (F64.2)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

Gender Dysphoria in Adolescents and Adults 302.85 (F64.0)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

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).
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).
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).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

Specify if:

Posttransition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen—namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

Specifiers

The posttransition specifier may be used in the context of continuing treatment procedures that serve to support the new gender assignment.

Diagnostic Features

Individuals with gender dysphoria have a marked incongruence between the gender they have been assigned to (usually at birth, referred to as *natal gender*) and their experienced/expressed gender. This discrepancy is the core component of the diagnosis. There must also be evidence of distress about this incongruence. Experienced gender may include alternative gender identities beyond binary stereotypes. Consequently, the distress is not limited to a desire to simply be of the other gender, but may include a desire to be of an alternative gender, provided that it differs from the individual's assigned gender.

Gender dysphoria manifests itself differently in different age groups. Prepubertal natal girls with gender dysphoria may express the wish to be a boy, assert they are a boy, or assert they will grow up to be a man. They prefer boys' clothing and hairstyles, are often perceived by strangers as boys, and may ask to be called by a boy's name. Usually, they display intense negative reactions to parental attempts to have them wear dresses or other feminine attire. Some may refuse to attend school or social events where such clothes are required. These girls may demonstrate marked cross-gender identification in role-playing, dreams, and fantasies. Contact sports, rough-and-tumble play, traditional boyhood games, and boys as playmates are most often preferred. They show little interest in stereotypically feminine toys (e.g., dolls) or activities (e.g., feminine dress-up or role-play). Occasionally, they refuse to urinate in a sitting position. Some natal girls may express a desire to have a penis or claim to have a penis or that they will grow one when older. They may also state that they do not want to develop breasts or menstruate.

Prepubertal natal boys with gender dysphoria may express the wish to be a girl or assert they are a girl or that they will grow up to be a woman. They have a preference for dressing in girls' or women's clothes or may improvise clothing from available materials (e.g., using towels, aprons, and scarves for long hair or skirts). These children may role-play female figures (e.g., playing "mother") and often are intensely interested in female fantasy figures. Traditional feminine activities, stereotypical games, and pastimes (e.g., "playing house"; drawing feminine pictures; watching television or videos of favorite female characters) are most often preferred. Stereotypical female-type dolls (e.g., Barbie) are often favorite toys, and girls are their preferred playmates. They avoid rough-and-tumble play and competitive sports and have little interest in stereotypically masculine toys (e.g., cars, trucks). Some may pretend not to have a penis and insist on sitting to urinate. More

rarely, they may state that they find their penis or testes disgusting, that they wish them removed, or that they have, or wish to have, a vagina.

In young adolescents with gender dysphoria, clinical features may resemble those of children or adults with the condition, depending on developmental level. As secondary sex characteristics of young adolescents are not yet fully developed, these individuals may not state dislike of them, but they are concerned about imminent physical changes.

In adults with gender dysphoria, the discrepancy between experienced gender and physical sex characteristics is often, but not always, accompanied by a desire to be rid of primary and/or secondary sex characteristics and/or a strong desire to acquire some primary and/or secondary sex characteristics of the other gender. To varying degrees, adults with gender dysphoria may adopt the behavior, clothing, and mannerisms of the experienced gender. They feel uncomfortable being regarded by others, or functioning in society, as members of their assigned gender. Some adults may have a strong desire to be of a different gender and treated as such, and they may have an inner certainty to feel and respond as the experienced gender without seeking medical treatment to alter body characteristics. They may find other ways to resolve the incongruence between experienced/expressed and assigned gender by partially living in the desired role or by adopting a gender role neither conventionally male nor conventionally female.

Associated Features Supporting Diagnosis

When visible signs of puberty develop, natal boys may shave their legs at the first signs of hair growth. They sometimes bind their genitals to make erections less visible. Girls may bind their breasts, walk with a stoop, or use loose sweaters to make breasts less visible. Increasingly, adolescents request, or may obtain without medical prescription and supervision, hormonal suppressors ("blockers") of gonadal steroids (e.g., gonadotropin-releasing hormone [GnRH] analog, spironolactone). Clinically referred adolescents often want hormone treatment and many also wish for gender reassignment surgery. Adolescents living in an accepting environment may openly express the desire to be and be treated as the experienced gender and dress partly or completely as the experienced gender, have a hairstyle typical of the experienced gender, preferentially seek friendships with peers of the other gender, and/or adopt a new first name consistent with the experienced gender. Older adolescents, when sexually active, usually do not show or allow partners to touch their sexual organs. For adults with an aversion toward their genitals, sexual activity is constrained by the preference that their genitals not be seen or touched by their partners. Some adults may seek hormone treatment (sometimes without medical prescription and supervision) and gender reassignment surgery. Others are satisfied with either hormone treatment or surgery alone.

Adolescents and adults with gender dysphoria before gender reassignment are at increased risk for suicidal ideation, suicide attempts, and suicides. After gender reassignment, adjustment may vary, and suicide risk may persist.

Prevalence

For natal adult males, prevalence ranges from 0.005% to 0.014%, and for natal females, from 0.002% to 0.003%. Since not all adults seeking hormone treatment and surgical reassignment attend specialty clinics, these rates are likely modest underestimates. Sex differences in rate of referrals to specialty clinics vary by age group. In children, sex ratios of natal boys to girls range from 2:1 to 4.5:1. In adolescents, the sex ratio is close to parity; in adults, the sex ratio favors natal males, with ratios ranging from 1:1 to 6.1:1. In two countries, the sex ratio appears to favor natal females (Japan: 2.2:1; Poland: 3.4:1).

Development and Course

Because expression of gender dysphoria varies with age, there are separate criteria sets for children versus adolescents and adults. Criteria for children are defined in a more con-

crete, behavioral manner than those for adolescents and adults. Many of the core criteria draw on well-documented behavioral gender differences between typically developing boys and girls. Young children are less likely than older children, adolescents, and adults to express extreme and persistent anatomic dysphoria. In adolescents and adults, incongruence between experienced gender and somatic sex is a central feature of the diagnosis. Factors related to distress and impairment also vary with age. A very young child may show signs of distress (e.g., intense crying) only when parents tell the child that he or she is "really" not a member of the other gender but only "desires" to be. Distress may not be manifest in social environments supportive of the child's desire to live in the role of the other gender and may emerge only if the desire is interfered with. In adolescents and adults, distress may manifest because of strong incongruence between experienced gender and somatic sex. Such distress may, however, be mitigated by supportive environments and knowledge that biomedical treatments exist to reduce incongruence. Impairment (e.g., school refusal, development of depression, anxiety, and substance abuse) may be a consequence of gender dysphoria.

Gender dysphoria without a disorder of sex development. For clinic-referred children, onset of cross-gender behaviors is usually between ages 2 and 4 years. This corresponds to the developmental time period in which most typically developing children begin expressing gendered behaviors and interests. For some preschool-age children, both pervasive cross-gender behaviors and the expressed desire to be the other gender may be present, or, more rarely, labeling oneself as a member of the other gender may occur. In some cases, the expressed desire to be the other gender appears later, usually at entry into elementary school. A small minority of children express discomfort with their sexual anatomy or will state the desire to have a sexual anatomy corresponding to the experienced gender ("anatomic dysphoria"). Expressions of anatomic dysphoria become more common as children with gender dysphoria approach and anticipate puberty.

Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary. In natal males, persistence has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%. Persistence of gender dysphoria is modestly correlated with dimensional measures of severity ascertained at the time of a childhood baseline assessment. In one sample of natal males, lower socioeconomic background was also modestly correlated with persistence. It is unclear if particular therapeutic approaches to gender dysphoria in children are related to rates of long-term persistence. Extant follow-up samples consisted of children receiving no formal therapeutic intervention or receiving therapeutic interventions of various types, ranging from active efforts to reduce gender dysphoria to a more neutral, "watchful waiting" approach. It is unclear if children "encouraged" or supported to live socially in the desired gender will show higher rates of persistence, since such children have not yet been followed longitudinally in a systematic manner. For both natal male and female children showing persistence, almost all are sexually attracted to individuals of their natal sex. For natal male children whose gender dysphoria does not persist, the majority are *androphilic* (sexually attracted to males) and often self-identify as gay or homosexual (ranging from 63% to 100%). In natal female children whose gender dysphoria does not persist, the percentage who are *gynephilic* (sexually attracted to females) and self-identify as lesbian is lower (ranging from 32% to 50%).

In both adolescent and adult natal males, there are two broad trajectories for development of gender dysphoria: early onset and late onset. *Early-onset gender dysphoria* starts in childhood and continues into adolescence and adulthood; or, there is an intermittent period in which the gender dysphoria desists and these individuals self-identify as gay or homosexual, followed by recurrence of gender dysphoria. *Late-onset gender dysphoria* occurs around puberty or much later in life. Some of these individuals report having had a desire to be of the other gender in childhood that was not expressed verbally to others. Others do not recall any signs of childhood gender dysphoria. For adolescent males with late-onset gender dysphoria, parents often report surprise because they did not see signs of gender

dysphoria during childhood. Expressions of anatomic dysphoria are more common and salient in adolescents and adults once secondary sex characteristics have developed.

Adolescent and adult natal males with early-onset gender dysphoria are almost always sexually attracted to men (androphilic). Adolescents and adults with late-onset gender dysphoria frequently engage in transvestic behavior with sexual excitement. The majority of these individuals are gynephilic or sexually attracted to other posttransition natal males with late-onset gender dysphoria. A substantial percentage of adult males with late-onset gender dysphoria cohabit with or are married to natal females. After gender transition, many self-identify as lesbian. Among adult natal males with gender dysphoria, the early-onset group seeks out clinical care for hormone treatment and reassignment surgery at an earlier age than does the late-onset group. The late-onset group may have more fluctuations in the degree of gender dysphoria and be more ambivalent about and less likely satisfied after gender reassignment surgery.

In both adolescent and adult natal females, the most common course is the early-onset form of gender dysphoria. The late-onset form is much less common in natal females compared with natal males. As in natal males with gender dysphoria, there may have been a period in which the gender dysphoria desisted and these individuals self-identified as lesbian; however, with recurrence of gender dysphoria, clinical consultation is sought, often with the desire for hormone treatment and reassignment surgery. Parents of natal adolescent females with the late-onset form also report surprise, as no signs of childhood gender dysphoria were evident. Expressions of anatomic dysphoria are much more common and salient in adolescents and adults than in children.

Adolescent and adult natal females with early-onset gender dysphoria are almost always gynephilic. Adolescents and adults with the late-onset form of gender dysphoria are usually androphilic and after gender transition self-identify as gay men. Natal females with the late-onset form do not have co-occurring transvestic behavior with sexual excitement.

Gender dysphoria in association with a disorder of sex development. Most individuals with a disorder of sex development who develop gender dysphoria have already come to medical attention at an early age. For many, starting at birth, issues of gender assignment were raised by physicians and parents. Moreover, as infertility is quite common for this group, physicians are more willing to perform cross-sex hormone treatments and genital surgery before adulthood.

Disorders of sex development in general are frequently associated with gender-atypical behavior starting in early childhood. However, in the majority of cases, this does not lead to gender dysphoria. As individuals with a disorder of sex development become aware of their medical history and condition, many experience uncertainty about their gender, as opposed to developing a firm conviction that they are another gender. However, most do not progress to gender transition. Gender dysphoria and gender transition may vary considerably as a function of a disorder of sex development, its severity, and assigned gender.

Risk and Prognostic Factors

Temperamental. For individuals with gender dysphoria without a disorder of sex development, atypical gender behavior among individuals with early-onset gender dysphoria develops in early preschool age, and it is possible that a high degree of atypicality makes the development of gender dysphoria and its persistence into adolescence and adulthood more likely.

Environmental. Among individuals with gender dysphoria without a disorder of sex development, males with gender dysphoria (in both childhood and adolescence) more commonly have older brothers than do males without the condition. Additional predisposing

factors under consideration, especially in individuals with late-onset gender dysphoria (adolescence, adulthood), include habitual fetishistic transvestism developing into autogynephilia (i.e., sexual arousal associated with the thought or image of oneself as a woman) and other forms of more general social, psychological, or developmental problems.

Genetic and physiological. For individuals with gender dysphoria without a disorder of sex development, some genetic contribution is suggested by evidence for (weak) familiality of transsexualism among nontwin siblings, increased concordance for transsexualism in monozygotic compared with dizygotic same-sex twins, and some degree of heritability of gender dysphoria. As to endocrine findings, no endogenous systemic abnormalities in sex-hormone levels have been found in 46,XY individuals, whereas there appear to be increased androgen levels (in the range found in hirsute women but far below normal male levels) in 46,XX individuals. Overall, current evidence is insufficient to label gender dysphoria without a disorder of sex development as a form of intersexuality limited to the central nervous system.

In gender dysphoria associated with a disorder of sex development, the likelihood of later gender dysphoria is increased if prenatal production and utilization (via receptor sensitivity) of androgens are grossly atypical relative to what is usually seen in individuals with the same assigned gender. Examples include 46,XY individuals with a history of normal male prenatal hormone milieu but inborn nonhormonal genital defects (as in cloacal bladder exstrophy or penile agenesis) and who have been assigned to the female gender. The likelihood of gender dysphoria is further enhanced by additional, prolonged, highly gender-atypical postnatal androgen exposure with somatic virilization as may occur in female-raised and noncastrated 46,XY individuals with 5-alpha reductase-2 deficiency or 17-beta-hydroxysteroid dehydrogenase-3 deficiency or in female-raised 46,XX individuals with classical congenital adrenal hyperplasia with prolonged periods of non-adherence to glucocorticoid replacement therapy. However, the prenatal androgen milieu is more closely related to gendered behavior than to gender identity. Many individuals with disorders of sex development and markedly gender-atypical behavior do not develop gender dysphoria. Thus, gender-atypical behavior by itself should not be interpreted as an indicator of current or future gender dysphoria. There appears to be a higher rate of gender dysphoria and patient-initiated gender change from assigned female to male than from assigned male to female in 46,XY individuals with a disorder of sex development.

Culture-Related Diagnostic Issues

Individuals with gender dysphoria have been reported across many countries and cultures. The equivalent of gender dysphoria has also been reported in individuals living in cultures with institutionalized gender categories other than male or female. It is unclear whether with these individuals the diagnostic criteria for gender dysphoria would be met.

Diagnostic Markers

Individuals with a somatic disorder of sex development show some correlation of final gender identity outcome with the degree of prenatal androgen production and utilization. However, the correlation is not robust enough for the biological factor, where ascertainable, to replace a detailed and comprehensive diagnostic interview evaluation for gender dysphoria.

Functional Consequences of Gender Dysphoria

Preoccupation with cross-gender wishes may develop at all ages after the first 2–3 years of childhood and often interfere with daily activities. In older children, failure to develop age-typical same-sex peer relationships and skills may lead to isolation from peer groups and to distress. Some children may refuse to attend school because of teasing and harass-

ment or pressure to dress in attire associated with their assigned sex. Also in adolescents and adults, preoccupation with cross-gender wishes often interferes with daily activities. Relationship difficulties, including sexual relationship problems, are common, and functioning at school or at work may be impaired. Gender dysphoria, along with atypical gender expression, is associated with high levels of stigmatization, discrimination, and victimization, leading to negative self-concept, increased rates of mental disorder comorbidity, school dropout, and economic marginalization, including unemployment, with attendant social and mental health risks, especially in individuals from resource-poor family backgrounds. In addition, these individuals' access to health services and mental health services may be impeded by structural barriers, such as institutional discomfort or inexperience in working with this patient population.

Differential Diagnosis

Nonconformity to gender roles. Gender dysphoria should be distinguished from simple nonconformity to stereotypical gender role behavior by the strong desire to be of another gender than the assigned one and by the extent and pervasiveness of gender-variant activities and interests. The diagnosis is not meant to merely describe nonconformity to stereotypical gender role behavior (e.g., "tomboyism" in girls, "girly-boy" behavior in boys, occasional cross-dressing in adult men). Given the increased openness of atypical gender expressions by individuals across the entire range of the transgender spectrum, it is important that the clinical diagnosis be limited to those individuals whose distress and impairment meet the specified criteria.

Transvestic disorder. Transvestic disorder occurs in heterosexual (or bisexual) adolescent and adult males (rarely in females) for whom cross-dressing behavior generates sexual excitement and causes distress and/or impairment without drawing their primary gender into question. It is occasionally accompanied by gender dysphoria. An individual with transvestic disorder who also has clinically significant gender dysphoria can be given both diagnoses. In many cases of late-onset gender dysphoria in gynephilic natal males, transvestic behavior with sexual excitement is a precursor.

Body dysmorphic disorder. An individual with body dysmorphic disorder focuses on the alteration or removal of a specific body part because it is perceived as abnormally formed, not because it represents a repudiated assigned gender. When an individual's presentation meets criteria for both gender dysphoria and body dysmorphic disorder, both diagnoses can be given. Individuals wishing to have a healthy limb amputated (termed by some *body integrity identity disorder*) because it makes them feel more "complete" usually do not wish to change gender, but rather desire to live as an amputee or a disabled person.

Schizophrenia and other psychotic disorders. In schizophrenia, there may rarely be delusions of belonging to some other gender. In the absence of psychotic symptoms, insistence by an individual with gender dysphoria that he or she is of some other gender is not considered a delusion. Schizophrenia (or other psychotic disorders) and gender dysphoria may co-occur.

Other clinical presentations. Some individuals with an emasculinization desire who develop an alternative, nonmale/nonfemale gender identity do have a presentation that meets criteria for gender dysphoria. However, some males seek castration and/or penectomy for aesthetic reasons or to remove psychological effects of androgens without changing male identity; in these cases, the criteria for gender dysphoria are not met.

Comorbidity

Clinically referred children with gender dysphoria show elevated levels of emotional and behavioral problems—most commonly, anxiety, disruptive and impulse-control, and de-

pressive disorders. In prepubertal children, increasing age is associated with having more behavioral or emotional problems; this is related to the increasing non-acceptance of gender-variant behavior by others. In older children, gender-variant behavior often leads to peer ostracism, which may lead to more behavioral problems. The prevalence of mental health problems differs among cultures; these differences may also be related to differences in attitudes toward gender variance in children. However, also in some non-Western cultures, anxiety has been found to be relatively common in individuals with gender dysphoria, even in cultures with accepting attitudes toward gender-variant behavior. Autism spectrum disorder is more prevalent in clinically referred children with gender dysphoria than in the general population. Clinically referred adolescents with gender dysphoria appear to have comorbid mental disorders, with anxiety and depressive disorders being the most common. As in children, autism spectrum disorder is more prevalent in clinically referred adolescents with gender dysphoria than in the general population. Clinically referred adults with gender dysphoria may have coexisting mental health problems, most commonly anxiety and depressive disorders.

Other Specified Gender Dysphoria

302.6 (F64.8)

This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The other specified gender dysphoria category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for gender dysphoria. This is done by recording "other specified gender dysphoria" followed by the specific reason (e.g., "brief gender dysphoria").

An example of a presentation that can be specified using the "other specified" designation is the following:

The current disturbance meets symptom criteria for gender dysphoria, but the duration is less than 6 months.

Unspecified Gender Dysphoria

302.6 (F64.9)

This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The unspecified gender dysphoria category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for gender dysphoria, and includes presentations in which there is insufficient information to make a more specific diagnosis.