

Was the Gender Identity Disorder of Childhood Diagnosis Introduced into DSM-III as a Backdoor Maneuver to Replace Homosexuality? A Historical Note

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Over the years, the DSM diagnosis of gender identity disorder (and its predecessors gender identity disorder of childhood [GIDC] and transsexualism) has attracted controversy as a mental disorder, for its diagnostic criteria, as a target of therapeutic intervention, and for its relationship to a homosexual sexual orientation. Another point of controversy is the claim that the diagnosis of GIDC was introduced into the DSM-III in 1980 as a kind of “backdoor maneuver” to replace homosexuality, which was deleted from the DSM-II in 1973. In this article, we challenge this historical interpretation and provide an alternative account of how the GIDC diagnosis (and transsexualism) became part of psychiatric nosology in the DSM-III. We argue that GIDC was included as a psychiatric diagnosis because it met the generally accepted criteria used by the framers of DSM-III for inclusion (for example, clinical utility, acceptability to clinicians of various theoretical persuasions, and an empirical database to propose explicit diagnostic criteria that could be tested for reliability and validity). In this respect, the entry of GIDC into the psychiatric nomenclature was guided by the reliance on “expert consensus” (research clinicians)—the same mechanism that led to the introduction of many new psychiatric diagnoses, including those for which systematic field trials were not available when the DSM-III was published.

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In the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980), there appeared for the first time two psychiatric diagnoses pertaining to gender dysphoria in children, adolescents, and adults: gender identity disorder of childhood (GIDC) and transsexualism (the latter was to be used for adolescents and adults). In the DSM-III-R (APA, 1987), a third diagnosis was added: gender identity disorder of adolescence and adulthood, nontranssexual type. In DSM-IV (APA, 1994, 2000), this last diagnosis was eliminated (“sunsetting”), and the diagnoses of GIDC and transsexualism were collapsed into one overarching diagnosis, gender identity disorder (GID), with different criteria sets for children versus adolescents and adults (cf. Pincus, Frances, Davis, First, & Widiger, 1992, p. 114).

Over the years, the diagnosis of GID (and its predecessors GIDC and transsexualism) has attracted controversy as a mental disorder, for its diagnostic criteria, as a target of therapeutic intervention, and for its relationship to a homosexual sexual orientation (see, for example, Bartlett, Vasey, & Bukowski, 2000; Bem, 1993; Ehrensaft, 2001; Feder, 1997; Isay, 1997; McCarthy, 2003; Menvielle, 1998; Minter, 1999; Moore, 2002; Richardson, 1996, 1999; Rosenberg, 2002). Although these issues are by no means resolved, they have been debated and discussed in detail elsewhere (see, for example, Bradley & Zucker, 1998, 2003; Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Green, 1987; Meyer-Bahlburg, 1999, 2002; Zucker, 1999a, 1999b, 2003a; Zucker & Bradley, 1995). As the American Psychiatric Association moves toward the planning of DSM-V (Kupfer, First, & Regier, 2002), it is likely that all of these matters will be subject to even more intense scrutiny and debate.

In this article, we examine one point of controversy: the claim that the diagnosis of GIDC was introduced into the DSM-III as a kind of “backdoor maneuver” to replace homosexuality, which was deleted from the DSM-II (APA, 1968) in 1973 (for a review, see Bayer, 1981; Bayer & Spitzer, 1982; Spitzer, 1981). Our aim is to challenge this historical interpretation and to provide an alternative account of how the GIDC diagnosis (and transsexualism) became part of psychiatric nosology in the DSM-III.

Even before the publication of DSM-III, critics objected to the treatment of children who displayed marked cross-gender behavior, arguing that there was nothing inherently wrong, disadvantageous, or maladaptive about a child who displayed such behavior as opposed to traditionally gender-typical behavior. Indeed, such critics charged that treatments designed to modify marked cross-gender behavior in children were, wittingly or not, perpetuating traditional gender stereotypes about what was “appropriate” gender-related behavior for a boy or a girl (Norczyk, Baer, Etzel, & LeBlanc, 1977; Winkler, 1977). Post-DSM-III, this line of criticism has continued (e.g., Corbett, 1996, 1998; Haldeman, 2000; Menvielle & Tuerk, 2002; Neisen, 1992; Pickstone-Taylor, 2003).

In the 1970s, with the publication of descriptive, etiological, and treatment studies on children whose behavior was consistent with the later DSM-III diagnostic criteria for GIDC, other critics claimed that there was little evidence that persistent and pervasive patterns of cross-gender behavior were associated with a person's later sexual orientation (e.g., Serbin, 1980). At the time, this was an important issue because some clinicians (definitely not all) who treated cross-gender-identified children cited prevention of later homosexuality as one of their explicit goals (e.g., Rekers, 1977).

The assertion that there is no empirical evidence regarding the relationship between patterns of childhood sex-typed behavior and sexual orientation has now been proven to be incorrect. Bailey and Zucker's (1995) meta-analysis on the relation between childhood sex-typed behavior and sexual orientation in adults, as assessed by retrospective studies, showed clearly that the two variables had a substantial association. On average, gay men and lesbians recalled more cross-gender behavior than their same-sex heterosexual counterparts, with a mean effect size, using Cohen's *d*, of 1.31 and 0.96 for heterosexual versus homosexual men and heterosexual versus homosexual women, respectively. To our knowledge, no retrospective study published since the Bailey and Zucker meta-analysis has contradicted these findings (Zucker, Mitchell, Bradley, Tkachuk, & Allin, 2004).

Moreover, Green's (1987) prospective follow-up study showed that a large majority of his feminine boys developed a later bisexual or homosexual sexual orientation, compared with virtually none of his control group boys. Other studies showed a high rate of a homosexual sexual orientation in pervasively feminine boys (Money & Russo, 1979; Zuger, 1984), and there is now some indication that a homosexual sexual orientation is overrepresented in girls who show pervasive masculine behavior during childhood (Cohen-Kettenis, 2001; Zucker, 2004). There also is clearer evidence now that a minority of children with GID show a persistence of it into adolescence and young adulthood, culminating in the request for both hormonal and surgical sex-reassignment, with a co-occurring homosexual sexual orientation (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Zucker, 2003b). There also is some evidence that a minority of GID children develop a heterosexual sexual orientation, without co-occurring GID. Taken together, then, there appear to be a range of developmental outcomes for children with GID, although the data to date suggest that a homosexual sexual orientation without co-occurring GID is the most common.

Given the connection between GID in childhood and a later homosexual sexual orientation, a number of critics have claimed that the GIDC diagnosis was included in the DSM-III as an indirect method of preventing the development of a later homosexual sexual orientation. Sedgwick (1991), in a

critique of books by Friedman (1988) and Green (1987), appeared to hint at a link:

The same DSM-III that . . . was the first that did not contain an entry for “homosexuality,” was also the first that *did* contain a new diagnosis . . . Gender Identity Disorder of Childhood. . . . While the decision to remove “homosexuality” from DSM-III was a highly polemicized and public one, accomplished only under intense pressure from gay activists . . . the addition to DSM-III of “Gender Identity Disorder of Childhood” appears to have attracted virtually no outside attention. (p. 20)

Bem (1993) acknowledged the influence of clinical work on adult transsexuals in leading to the introduction of both GIDC and transsexualism into the DSM-III (a point on which we concur; see below) but made a stronger connection than Sedgwick:

Ironically, this first official pathologizing of gender identity disorders appeared in the same DSM in which, for the first time in psychiatric history, there was no official pathologizing of homosexuality. Perhaps this was no coincidence. Perhaps the psychiatric establishment still believed so completely in the pathology of gender nonconformity that if the politics of the times would not allow it to express that belief through homosexuality, then it would express it where and how it could. (pp. 106–107)

Nine years later, Bem’s views were summarized by Wilson, Griffin, and Wren (2002) as follows:

Bem (1993) suggested, more politically, that it [i.e., the introduction of GID for children and adolescents] may have occurred in response to the removal of homosexuality from the same edition; a decision that occurred in the context of affirmative gay and lesbian politics. (p. 339)

Morgan (2000) appeared to endorse the GID-homosexuality connection more directly:

In 1973 . . . the American Psychiatric Association . . . voted to delete homosexuality as a mental disorder from the . . . [DSM-II]. . . . Seven years later, with the 1980 publication of the [DSM-III], a new mental disorder appeared which some say . . . filled the vacancy left by the declassification of homosexuality. This new mental disorder was designated Gender Identity Disorder. (p. 1)

Moore (2002) was even more blunt: “the GID diagnosis . . . is an attempt to prevent adult homosexuality via psychiatric intervention with children” (p. 1).

Most recently, McCarthy (2003) asserted the following:

In 1973, the American Psychological [sic] Association voted to eliminate homosexuality from the [DSM]. Not coincidentally, the catch-all diagnosis of “Gender Dysphoria Syndrome” (GDS)¹ was introduced that year; GDS encompassed cross-dressers, transsexuals, homosexuals, and others, and it was not by chance that these disparate identities were seen as one and the same. The construction of GDS allowed clinicians to continue to pathologize gay people. . . . Since homosexuality is no longer considered pathological, GID is now used as a diagnosis for gay and lesbian adolescents who are viewed as in need of treatment, which includes hospitalization and medication. (pp. 35–36)

In this article we argue that, for three reasons, this historical interpretation of the introduction of the GIDC diagnosis is inaccurate.

First, in the DSM-III, there was no need for any kind of veiled backdoor diagnosis, because it contained the diagnosis of ego-dystonic homosexuality. The inclusion of this diagnosis in the DSM-III represented a compromise among the various clinicians and scientists who had argued in favor of delisting homosexuality from the DSM-II (Bayer & Spitzer, 1982; Spitzer, 1981).

Second, ego-dystonic homosexuality was delisted from the DSM-III-R, because it was argued that “empirical data [did] not support the diagnosis, that it [was] inappropriate to label culturally induced homophobia as a mental disorder, that the diagnosis was rarely used clinically, and that few articles in the scientific literature [used] the concept” (Krajeski, 1996, p. 26; see also Cohler & Galatzer-Levy, 2000, pp. 290–294; Marmor, 1980). Nonetheless, it should be noted that in DSM-III-R, DSM-IV, and DSM-IV-TR (APA, 2000) there remains the residual diagnosis of sexual disorder not otherwise specified, and one example is that of a person who experiences “marked distress about his or her sexual orientation.” Again, there is no need for a backdoor diagnosis to replace homosexuality as it appeared in the DSM-II.

Third, several clinicians and scientists who argued in favor of delisting homosexuality from the DSM-II (e.g., Green, 1972; Friedman, 1988; Stoller, 1973) were members of the DSM-III subcommittee on psychosexual disorders that recommended the inclusion of the GIDC diagnosis in DSM-III. To our knowledge, no one has ever interviewed any of these individuals to see if they had either a conscious or unconscious intent to use the GIDC diagnosis as a replacement for the diagnosis of homosexuality. Given these members’ advocacy for deleting homosexuality as a diagnosis, it is difficult to understand why the claim has been made that there was some insidious

¹DSM certainly did not introduce the “catch-all diagnosis” of gender dysphoria syndrome in 1973. The term was coined by Fisk (1973), a surgeon. McCarthy (2003), however, did not credit Fisk, and it is unclear from the passage if she believed that it had been adopted for use in DSM-II.

effort to introduce the GIDC diagnosis into the DSM-III as some kind of veiled effort to prevent homosexuality (or to treat it in its immature form). Indeed, the second author (RLS), who chaired all of the DSM-III Advisory Committees, can recall no instance in which the members of the psychosexual disorders subcommittee discussed inclusion of the GIDC diagnosis for this reason.

Of course, this is not to say that some clinicians offer treatment for children with GID, in part, to prevent homosexuality or that some parents request treatment, in part, for the same reason. There is clear evidence that this is sometimes the case (see, for example, Pleak, 1999; Zucker & Bradley, 1995, pp. 267–269; see also de Ahumada, 2003; Nicolosi & Nicolosi, 2002), so, in this respect, we are in agreement with the critics. But, as has been argued elsewhere (Zucker, 1999a; Zucker & Bradley, 1995), this is a separate matter unrelated to the decision-making process that led the framers of DSM-III to recognize GIDC as a psychiatric disorder in its own right.

If GIDC was not introduced into the DSM-III for the reason claimed by the critics, it is a legitimate question to ask on what basis the diagnosis was recommended for inclusion in the manual. The conceptual framework that guided DSM-III, including delineation of the definition of mental disorder, has been described in detail elsewhere (Spitzer & Endicott, 1978). For the purpose of this discussion, however, it is sufficient to rely on text material from the DSM-III (APA, 1980, pp. 1–12) regarding various parameters that were considered in the inclusion of specific diagnostic categories. Among others, these included clinical utility, acceptability to clinicians of various theoretical persuasions, reliability, and validity. In DSM-III, it is noted that there were 14 advisory committees that considered various domains of psychiatric difficulties, one of which was psychosexual disorders.

As noted by Spitzer (1991) and Davis et al. (1998), DSM-III continued the DSM-I (APA, 1952) and DSM-II tradition in its reliance on “expert consensus.” In contrast to the two prior editions, however, DSM-III (as well as DSM-III-R and DSM-IV) placed much greater emphasis on the establishment of explicit diagnostic criteria (what some have termed a “neo-Kraepelian” paradigm), which would increase the likelihood of establishing a putative disorder’s reliability and validity (Spitzer, 1991; Widiger, Frances, Pincus, & Davis, 1990; Widiger, Frances, Pincus, Davis, & First, 1991). Clearly, this was one of the more novel, if not radical, departures from the two previous editions, which lacked explicit diagnostic criteria (see Horwitz, 2002, pp. 66–82). Thus, one can examine in Appendix F in DSM-III the results of field trials that provided data on interrater reliability for some of the diagnoses that appeared in the manual. Inspection of this appendix, however, indicates that no field trials were conducted for the diagnoses of GIDC or transsexualism. Of course, not all of the diagnoses (a total of 265, according to Pincus et al. [1992]), including the new ones, that appeared in the DSM-III were subjected to field trials. Indeed, it was explicitly noted in the DSM-III that “for most of

the categories the diagnostic criteria are based on clinical judgment, and have not yet been fully validated by data about such important correlates as clinical course, outcome, family history, and treatment response” (APA, 1980, p. 8). The greatest time was clearly devoted to field trials for high-prevalence disorders. If the introduction of GIDC and transsexualism into the DSM-III was not justified on the basis of formal field trials, what other considerations were relied on?

During the 1960s, North American psychiatry had begun to take a look at the phenomenon of transsexualism in adults (see, for example, Green & Money, 1969; Stoller, 1968). It became apparent that psychiatrists and other mental-health professionals had become increasingly aware of the phenomenon, that is, of adult patients reporting substantial distress about their gender identity and seeking treatment for it, typically hormonal and surgical sex-reassignment. Indeed, there were enough observed cases that it was possible in the 1960s to establish the first university- and hospital-based gender identity clinics for adults (Meyerowitz, 2002; Pauly & Edgerton, 1986). Many clinicians and researchers were writing about transsexualism, and by 1980, there was a large enough database to support its uniqueness as a clinical entity and a great deal of empirical research that examined its phenomenology, natural history, psychologic and biologic correlates, and so forth. Thus, by the time DSM-III was in its planning phase in the mid-1970s, there were sufficient clinical data available to describe the phenomenon, to propose diagnostic criteria, and so on. At the same time, there also was an emerging clinical and research literature on children who expressed the desire to be of the opposite sex, leading to a similar situation, that is, there was a clear description of the phenomenology, development of diagnostic criteria, and so on (e.g., Green, 1974; Stoller, 1968, 1975). Although research on both GIDC and transsexualism likely lagged behind other psychiatric phenomena with much higher prevalence rates, expert consensus clearly concluded that there was sufficient indication of clinical usefulness and acceptability for these two disorders to be considered for the DSM-III. In this respect, the reliance on expert consensus regarding parameters that justified inclusion was probably not much different from the many other DSM diagnoses, such as borderline personality disorder or narcissistic personality disorder, that had not been subjected to more systematic field trials.

Although it is well-recognized that GID has a very low prevalence in the general population (Cohen-Kettenis & Pfäfflin, 2003), the past 25 years since DSM-III has seen a fair amount of both basic and applied research on the phenomenon (for reviews, see Cohen-Kettenis & Gooren, 1999; Cohen-Kettenis & Pfäfflin, 2003; Zucker, 2002, in press; Zucker & Bradley, 1995). It is unlikely that such research would have been possible without its recognition in the DSM as a clinical phenomenon worthy of such attention. As the American Psychiatric Association develops its plans for DSM-V (Kupfer et al., 2002), it is clear that some critics will argue for the removal of GID

as a psychiatric disorder (e.g., Isay, 1997). Others will argue for its retention, with a continued critical examination of the diagnostic criteria that relies on empirical evidence for modification (Zucker, 2003c). As this debate evolves, we hope that this article has provided an adequate historical analysis that challenges revisionist arguments about the putative origin of the inclusion of the GIDC diagnosis in the DSM-III. Inaccurate claims about the origins of the GIDC diagnosis are not helpful to constructive debate and dialogue.

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