DOCUMENT RESUME

ED 142 316 PS 009 426

AUTHOR DeFillipis, Nick
TITLE [Cross-Gender Identity in Childhood.]
PUB DATE Feb 77
NOTE 20p.; Paper presented at "Toward the Competent Parent: An Interdisciplinary Conference on Parenting" (Atlanta, Georgia, February 21-22, 1977)

EDRS PRICE MF-$0.83 HC-$1.67 Plus Postage.
DESCRIPTORS Early Childhood Education; Environmental Influences; Ethics; *Identification (Psychological); Literature Reviews; Males; Parent Influence; Personality Development; *Preschool Children; *Psychopathology; *Sex Role; *Sexuality; Therapy
IDENTIFIERS *Cross Gender Behavior; *Transsexuals

ABSTRACT

This paper discusses causes and symptoms of transsexual identity in young children, especially boys. Presented are defining characteristics and possible causal factors of cross-gender behavior based on the work of Richard Green and others. Research thus far has been unable to strongly implicate either biological or psychological etiological factors, although there is some evidence which points to parenting and environmental variables as causal factors. Treatment programs, which entail family consultations and individual counseling with the child, and the ethics of early intervention with children who show cross-sexual tendencies are discussed. (Author/SB)

CROSS-GENDER IDENTITY IN CHILDHOOD
(Title Supplied)

Nick DeFillipis, Ph.D.

ABSTRACT

It is recognized that adult transsexuals and homosexuals have rather high rates of serious psychological problems. Since many male transsexuals had childhood histories of effeminate behavior, it seems that cross gender behavior in children deserves serious study. Richard Green and John Money have conducted several studies in the area of cross-gender behavior in childhood and regard it as a recognizable psychiatric syndrome. Research thus far has been unable to strongly implicate either biological or psychological etiological factors, although there is some evidence which points to parenting and environmental variables as causal factors. Treatment programs, which entail family consultations and individual counseling with the child have reported some success in alleviating the adjustment problems of these children.

TABLE I

DEFINING CHARACTERISTICS

1. Cross-gender clothing preferences.
2. Actual or imagined use of cosmetics.
3. Aversion to rough and tumble boy games and sports, coupled with preferences for girl playmates, playthings and activities.
4. Takes famale role in play or fantasy and exhibits marked involvement in fantasy or play acting.
5. Feminine mannerisms.
6. Feminine speech content and voice inflection.
7. Verbal statements to the effect the child prefers the female role, wants to be a girl or hopes to become a woman.

TABLE II

POSSIBLE CAUSAL FACTORS OF CROSS-GENDER BEHAVIOR

1. Parental indifference to feminine behavior in a boy during his first years.
2. Parental encouragement of feminine behavior in a boy during his first years.
3. Repeated cross-dressing of a young boy by a female.
4. Maternal over-protection.
5. Excessive maternal attention and physical contact.
6. Abscence of an older male as an identity model or paternal rejection.
7. Physical beauty of a boy.
8. Lack of male playmates during boys first years of socialization.
9. Maternal dominance of a family.
10. Castration fear.

This paper is on cross-gender behavior in children and is a summary of some research findings I've come across in my attempts to get a better understanding of a problem which I and other therapist occasionally encounter.

I'd like to begin with a definition. Rather than trying to define the concepts of masculinity and feminity, I choose to accept the position of Richard Green of the State University of New York at Stony Brook and John Money of Johns Hopkins, two prominent researchers in this area. Their contention is that masculinity and feminity represent two ends of a distribution, and they refer to this distribution as gender identity. Gender identity, then, refers to the self-awareness of one's role as either a man or a woman and is apparent in everything a person does to indicate that he or she is male or female.

The important point here is that we are not considering masculinity or feminity as unitary concepts, but rather as characteristics which a person may have varying amounts of. Also, gender identity includes a wide range of behaviors, besides sexual preferences.

Before discussing gender identity problems in children, I believe it will be helpful to consider what we now know about these problems in adults.

An adult transsexual, as the term is used in psychiatry, is a person with a strong desire to belong to the opposite sex, who attempts to take on the characteristics of the

opposite sex, and who attempts to be accepted as a member of the opposite sex. The transsexual also has a persistent feeling that attraction to members of the same sex is not homosexual orientation. Although the transsexual may dress like a member of the opposite sex, he does not get sexual gratification from this and, therefore, is not a transvestite. Another important ovservation concerning transsexualism is that most are anatomically and physiologically normal.

Although there are no systematic epidemiological studies, the most recent estimate in the literature was that there are about 10,000 transsexuals in the U.S.. It is also clear that there are many more male than female transsexuals.

The evidence we have concerning the social and psychological adjustments of this group of people is quite grim. Besides living typically as social outcasts, transsexuals very often have had long histories of being ostracized and cruelly teased children. They live in constant fear of being discovered and rarely escape all the guilt which their lifestyles, so opposed to cultural norms, engenders.

It is small wonder that the incidence of psychological disturbance is quite high among transsexuals, and it has been noted that about two-thirds of male transsexuals suffer depressive reactions and about 20% of male transsexuals make suicide attempts.

Another serious problem among adult transsexuals is auto-castration. It is generally believed the only form of successful treatment of adult transsexualism is sexual re-

assignment through surgical and hormonal treatment. This form of treatment, however, has become available in the U. S. only in the last ten years and is still quite difficult for most transsexuals to obtain. Thus, there have been reports of as many as 18% of male transsexuals who attempt to castrate themselves.

Although the data on adult transsexualism is interesting and disconcerning, of particular relevance for our discussion of gender identity problems in childhood is the finding that most adult transsexuals report that their cross-gender behaviors began in early childhood. Several researchers have consistently reported that about two-thirds of adult transsexuals reported feeling that they belonged to the opposite sex prior to the age of 5. This suggests, then, that cross-gender identity, normal and abnormal, occurs at a very early age, and that cross-gender identity in childhood may be the first step in the road to adult transsexualism.

For this reason, there has been an attempt to conceptualize a childhood syndrome of cross-gender identity with the hope that if these children can be identified early, then the problems associated with leading an adult life as a transsexual can be avoided.

Before I present the syndrome as it is known in psychiatry, I'd like to point out that most of the attention on childhood cross-gender identity has been focused on boys. The reason for this is that although there are more tomboys in childhood

than effeminate boys, there are markedly less female than male adult transsexuals. It appears, then, that being a tomboy has less implications for adult gender identity than being an effeminate boy.

If you would please refer to the first page of the handout, I'd like to go over the defining characteristics of a syndrome of childhood cross-gender identity which has been reported in the psychiatric literature. (See Table I)

Please note that this syndrome refers only to males who are anatomically normal. This information is taken largely from the work of Richard Green and John Money, and a dissertation by George Rekers.

1) "Cross-gender clothing preferences." This behavior is widely reported and often has its onset at the time the child is first able to dress himself.

2) "Actual or imagined use of cosmetics." This too has a rather early onset and may first occur when a boy has an acute interest in his mother applying her make-up but no interest in his father shaving.

3) "Aversion to boy games and preference for girl play." These boys relate better to girls, and if they do play with a boy, it is typically a younger boy. Their role in play is rarely one of the leader.

4) "Takes female role in fantasy and is quite involved in play acting." It has been hypothesized that this capacity for role playing contributes to the ease in assuming the feminine role.

5) "Feminine mannerisms." It is almost as if the child is a charicature of a female in that his feminine behavior is quite exaggerated.

6) "Feminine speech and voice inflextion." This has been noted by investigators who feel that it occurs primarily when the child is cross-dressing. Rekers however, in his 1972 dissertation, observed the behavior of two boys with the syndrome we are discussing and noted this behavior to be quite consistently displayed at all times.

7) "Verbal preferences for opposite sex." He is, however, aware of his male role.

It is important to note that I'm presenting a syndrome of behavior. So that any one of these behaviors can and does occur rather commonly in normal children. It is, however, rather uncommon for several of these behaviors to occur together in a child who is not regarded as particularly effeminate.

A relevant question to ask now is what happens to children who display the syndrome I've just presented. We know that adult transsexuals generally had histories of effeminate behavior, but this does not mean that most effeminate boys will become adult transsexuals. This question can only be answered through the use of follow-up research methods. Thus, groups of effeminate boys should be observed for several years to determine if they develop into adult transsexuals or if they tend to eventually adopt appropriate sex roles.

The limited evidence we now have from a few reports indicates that the overwhelming majority of feminine boys grow up to be effeminate men, often homosexuals, transvestites, or transsexuals. This is true regardless of treatment efforts.

This now brings us to the question "What causes cross-gender behavior?"

There are several possible biological explanations for cross-genderbehavior, and these have to do with brain damage, chromosal abnormalities, gonadal underdevelopment, and hormonal abberations. To briefly summarize the literature, there is no evidence of any genetic, CNS, or physiological deviation in the great majority of adult transsexuals.

This is not to say that cross-gender identity in adults and children contains no contribution from biological factors. Children are known to differ from birth presumably due to genetic influence in temperamental features such as activity level, aggressivity, and cuddliness, and these features may have some influence on their later socialization. Mothers of very cuddly boys may form very strong ties to them which could lead to the adoption of feminine mannerisms. This, of course, is all speculation.

Also, in support of a biological basis of cross-gender behavior, there is a body of data which suggests that girls who were exposed to large amounts of androgenic (male) hormones before birth are unusually masculine, both physically and psychologically (the adrenogenital syndrome).

In spite of the evidence that there may be prenatal hormonal influences on cross-gender behavior, most researchers in the area agree that environmental and psychological influences in the socialization process are the primary determinants of gender identity.

Perhaps the strongest evidence for this view comes from the work of John Money with hermaphrodites, children born with ambivalent genitals.

Money, reporting on 119 cases of hermaphrodites, noted that in every case the sex of rearing determined the gender identity, given that corrective surgery was performed early, appropriate hormonal treatment was administered, and the child was consistently reared as the assigned sex.

Money's cases of hermaphrodites clearly indicated that genetic, physiological, and anatomical characteristics were secondary to postnatal rearing in the establishment of gender identity.

A case he presented which dramatically supports this view is of a 17 month old boy whose penis was accidentally cauterized during circumcision and was subsequently raised as a girl. The child reportedly adjusted quite well to the sexual reassignment and had no serious psychological problems. So it is possible to reassign sex role even in previously anatomically normal children.

One might then conclude that the cause of cross-gender identity lies in child rearing practices, but the evidence for this conclusion is far less than adequate.

Richard Green in 1974 listed 10 variables which you have on the second page of the handout (See Table II), that he felt were possible causes of cross-gender behavior. Green chose these variables from his own clinical experience and from the writings of others in the area. He then determined the frequency of occurence of these variables in a group of 50 families with pre-adolescent boys who preferred the dress, play, and companionship of girls.

I'd like to go through his findings with you.

1) "Parental indifference to feminine behavior." Most of the parents in Green's sample were forced to seek help for their sons by sources outside their families. They typically ignored the cross-gender behavior of their children and would sometimes refer to it as being cute.

In my own clinical experiences, I've noticed this parental attitude to be present even in rather extreme cases of cross-gender identity.

2) "Parental encouragement of feminine behavior in a boy during his early years." In Green's sample, only 10% of the mothers seemed to be promoting feminine behavior.

3) "Repeated cross dressing." This was observed in only 15% of Green's sample. Another weakly supported causal factor.

4) "Maternal overprotection." Presumably this would inhibit rough and tumble play, but observed in only 15% of Green's sample.

5) "Excessive maternal attention and physical contact." This might result in the lack of individuation of the boy from his mother, and this hypothesis has been suggested by the psychoanalytically oriented researchers. Green did find that 20% of the boys he studied frequently slept with their mothers.

6) "Lack of an older same sex model." This variable has been proposed by several writers in the area. Green found that 20% of the boys in his sample had been abandoned by their fathers early in their lives. He also felt that in many other cases the father, although physically present, was psychologically or emotionally abscent. Several other researchers, however, have not been able to find father abscence to be related to effeminacy in boys.

7) "Physical beauty." Green describes one-third of his children as "pretty boys" and this is thought to lead to the child being treated as feminine.

8) "Lack of male playmates early in life." One-third of Green's sample reported an abscence of male playmates and this variable had been reported by other writers.

9) "Maternal dominance." Supposedly the father is powerless and from what we know of modeling theory, this might lead to the young boy choosing his mother as a model over his father. However, neither Green or others could find a relationship between this variable and effeminacy in boys.

10) "Castration fears" -- held by analytically oriented investigators, but there is little concrete evidence for its existence in feminine boys.

So we are left with precious little information from both biologically and psychologically oriented research into the causes of cross-gender identity. Although prenatal hormonal factors can have an impact on later gender identity, these influences can be almost totally overcome by later environmental experiences, as the studies of hermaphrodites have shown. But, as I've indicated, very little beyond theoretical speculation has turned up in the search for psychological factors leading to cross-gender identity.

Regardless of the knowledge we have of causes, the problem of cross-gender identity in children does exist and the clinician is faced with the problem of attempting to aid worried parents in their efforts to masculinize male children who seem to be expressing a strong preference for a feminine role.

The traditional approach taken by many therapists entails several stages: First, the parents are convinced that the condition is not a passing phase. Secondly, the therapist develops a relationship of trust and affection with the feminine boy to facilitate the therapist's role as masculine model. Third, the therapist then discusses the problems the boy inevitably has in getting along with other children and suggests engaging in masculine activities as a way to better adjust. This stage may also engage the therapist in teaching the child certain skills and/or reducing the child's anxieties about engaging in masculine activities. Fourth, the therapist advised the parents as to how they may be unconsciously fostering sexual

identity conflict in their child. And fifth, the therapist advised the child as to the impossibility of changing his sex.

There have been case reports of children being helped by this technique, but since treatment failures usually do not find their way into print, it is difficult to say what percentage of effeminate boys, treated by this method, would be helped.

More behaviorally oriented programs have been employed in attempting to masculinize effeminate boys. These usually involve attempts to systematically encourage or discourage masculine and feminine behaviors through the use of rewards and punishment. Although such techniques have been found to be effective when employed in clinic settings, there have not been any reports of effects of such treatments generalizing to behavior outside the clinic.

Possibly the single most important factor that has been found to be related to success and may be said to be a prerequisite to successful treatment with these children is related to the first causal factor I presented earlier. This is that the parents must be made aware from the very beginning of the long range implications of extremely effeminated behavior in childhood. This is possibly where some form of intervention can have an important influence. Hopefully, the therapist can give parents an objective opinion of the seriousness of the child's behavior and help them develop methods of encouraging appropriate sex role behavior in their child.

This brings us to an important issue which I have avoided up to now, ethical considerations in researching and treating cross-gender behavior in children.

It is apparent that some extremely effeminate boys will develop into transsexual or homosexual adults, but we do not know what the exact percentages are. So as clinicians, we can only give concerned parents estimates of what the possible consequences of cross-gender behavior in children are. So we, again, can only give parents estimates of the desirable effects of entering into a program. And, perhaps most important, we must address the question of the right of anyone to modify the gender role preferences of anyone else.

To this last point many clinicians and parents have responded with the convincing argument that no matter what your personal view on the ethics of shaping gender identification is, one is confronted by the evidence that people with sex roles opposite to that expected from anatomy face many hardships and personal miseries in our society.

Since a child will have a distinct advantage in our society if he adopts his appropriate sex role, it is to be expected that parents will strive to prevent cross-gender behavior in their children and will enlist the aid of child therapists and researchers in accomplishing this goal.

REFERENCES

Baker, H. Transsexualism: Problems in treatment. American Journal of Psychiatry, 1969, 125, 1412-1418.

Baker, H. & Green, R. Treatment of transsexualism. Current Psychiatric Therapies, 1970, 10, 88-99.

Bakwin, H. A. Deviant gender role behavior in children: Relationships to homosexuality. Pediatrics, 1968, 41, 620-628.

Bandura, A. & Walter, R. H. Social learning and personality development, New York: Holt, Rinehart & Winston, 1963.

Benjamin, H. Nature and management of transsexualism, with a report on thirty-one operated cases. Western Journal of Surgery, 1964, 72, 105-111.

Benjamin, H. The transsexual phenomenon., New York: The Julian Press, 1966.

Benjamin, H. Introduction in R. Green and J. Money (Eds.), Transsexualism and sex reassignment. Baltimore: The Johns Hopkins University Press, 1969.

Bieber, I. Homosexuality., New York: Basic Books, 1962.

Brown, D. Transvestism and sex-role inversion. In A. Ellis and A. Abarbanel (Eds.), Encyclopedia of sexual behavior, New York: Hawthorne, 1961.

Brown, D. G. Masculinity-Feminity development on children. Journal of Consulting Psychology, 1957, 21, 197-202.

Davies, B. M. & Morgenstern, F. S. TEmporal lobe epilepsy and transvestism. Journal of Neurological Neurosurgery and Psychiatry, 1960, 23, 27.

Ehrhardt, A., Epstein, R., & Money, J. Fetal androgens and female gender identity in the early treated adrenogenital syndrome. Johns Hopkins Medical Journal, 1968, 122, 160-167.

Ehrhardt, A., Epstein, R., & Money, J. Influences of androgen and some aspects of sexually dimorphic behavior in women with the late-treated adrenogenital syndrome, 1968, Johns Hopkins Medical Journal, 123, 115-122.

Green, R. Childhood cross-gender identification. Journal of Nervous and Mental Disease, 1968, 147, 500-509.

Green, R. Conclusion. In R. Green & J. Money (Eds.), Transsexualizm and sex reassignment. Baltimore: The Johns Hopkins University Press, 1969.

Green, R. & Money, J. Effeminancy in pre-pubertal boys: Summary of eleven cases and recommendations for case management. Pediatrics, 1961, 27, 286-291.

Green R. & Money, J. Stage-acting, role-taking and effeminate impersonation during boyhood. Archives of General Psychiatry, 1966, 15, 535-538.

Green R. & Money, J. Transsexualism and sex reassignment. Baltimore: The Johns Hopkins University Press, 1969.

Hampson, J. L. Determinants of psychosexual orientation. In F. A. Beach (Ed.) Sex and Behavior., New York: John Wiley and Sons, 1965.

Hunter, L., Logue, V. & McMenemy, W. H. Temporal lobe epilepsy supervening on longstanding transvestism and fetishism. Epilepsia, 1963, 4, 50-65.

Kagan, J. & Moss, H. A. Birth to maturity., New York: Wiley, 1970.

Mischel, W. Sex-typing and socialization. In P. H. Mussen (Ed.) Carmichael's manual of child psychology, 3rd ed., Vol. II, New York: Wiley, 1970.

Money, J. Addendum to: B. Zuger, Gender role determination: A critical review of the evidence from hermaphroditism. Psychosomatic Medicine, 1970, 32, 465-467.

Marmor, J. Homosexuality and sexual orientation disturbances, A. M. Freedman, H. I. Kaplan, & B. J. Sadock (Eds.), Comprehensive textbook of Psychiatry/II, 2nd ed., Vol. II, Baltimore: Williams & Wilkins, 1975.

Myrick, R. D. The counselor-consultant and the effeminate boy., Personnel and Guidance Journal, 1970, 48, 355-361.

Money, J., Hampson, J. & Hampson, J. An examination of some basic sexual concepts: The evidence of human hermaphroditism. Bulliton of Johns Hopkins Hospital, 1955, 97, 301-319.

Money, J. Matched paris of hermaphrodites: Behavioral biology of sexual differentiation from chromosomes to gender identity. Engineering and Science, (California Institute of Technology, Special Issue: Biological Bases of Human Behavior), 1970, 33, 34-39.

Overzier, D. Chromosomally, with rare exception, transvestites and transsexuals conform to the chromosomal constitution of their sex. Deutsche Medizinische Wochenschrift, 1968, 83, 181.

Pauly, I. Male psychosexual inversion: Transsexualism: A review of 100 cases., Archives of General Psychiatry, C965, 13, 172-181.

Rekers, G. Pathological sex-role development in boys: Behavioral therapy and assessment., Unpublished dissertation, UCLA, 1972.

Stoller, R. J. Sex and gender: The development of masculinity and feminity, New York: Science House, 1968 (a).

Stoller, R. J. Psychotherapy of extremely feminine boys. International Journal of Psychiatry, 1970, 9, 278-282.

Walinder, J. Transsexualism: A Study of forty-three cases., Goteburg: Scandinavian University Books, 1967.

Yalom, I., Green, R. & Fisk, N. Pre-natal exposure to female hormones. Effect on psychosexual development in boys. Archives of General Psychiatry, 1973, 28, 554-561.

Zuger, B. Feminine-like behavior in boys present from early childhood., Journal of Pediatrics, 1966, 69, 1098-1107.

Zuger, B. & Taylor, P. Effeminate behavior present in boys from early childhood II: Comparison with similar symptoms in non-effeminate boys. Pediatrics, 1969, 44, 375-380.

Zuger, B. The role of familial factors in persistent effeminate behavior in boys., American Journal of Psychiatry, 1970, 126, 1167-1170.

Zuger, B. Gender role determination: A critical review of the evidence from hermaphroditism., Psychomatic Medicine, 1970, 32, 449-464.