Childhood Gender Disturbance: Diagnostic Issues

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This paper critically evaluates three diagnostic models developed for use with gender-disturbed children: the DSM-III diagnosis of gender identity disorder of childhood, Rosen et al.'s (1977) distinction between "cross-gender identification" and "gender behavior disturbance," and Stoller's diagnosis of male childhood transsexualism. Particular attention is paid to developmental variables affecting diagnostic decisions. In addition, current evidence for the reliability and validity of the three diagnostic models is presented.


It is now recognized that adult transsexuals, some homosexuals, and some transvestites manifest atypical patterns of gender identity and role in childhood. This awareness has resulted in an increased interest in studying children with gender identity problems in their own right. As is the case with any psychiatric disorder, diagnostic precision is an important prerequisite in formulating etiological models and in making treatment decisions. In the past few years, three major diagnostic proposals have been developed for use with gender-disturbed children. The purpose of the present paper is to critically review and analyze these three diagnostic formulations.

Diagnostic Models

DSM-III: Gender Identity Disorder of Childhood

The third edition of DSM (American Psychiatric Association, 1980) includes, for the first time, a psychosexual disorder designated for children. Gender Identity Disorder of Childhood can be used to diagnose either boys or girls, though the criteria differ somewhat for the two sexes. While the criteria show general promise in correctly identifying these children, there appear to be some problems with them as they currently stand, especially for girls. Nevertheless, the inclusion of such a diagnostic category represents an achievement in its own right and reflects the culmination of a number of years of steady work with a group of children previously given little attention.

Table 1 outlines the diagnostic criteria for gender identity disorder in boys. In our experience, these criteria accurately reflect what one will observe in clinical assessment. In order to meet the criterion for Point A, one should note that the boy can either state the wish to be a girl, or actually insist that he is a girl. From an assessment point of view, we have found this option to be a helpful one. Our experience has been that the vast majority of cross-gender identified boys, when seen clinically, seem to know they are boys though they wish they were girls. This clinical impression has been confirmed in our research sample of 20 gender-problem boys (mean age, 7.4 years) where none answered the question "Are you a boy or a girl?" and its negation incorrectly (Zucker et al., 1980b). When taking a developmental history, however, our experience has been that some of these boys claimed they were girls when younger.

The criteria for Point B are met if the boy shows evidence of "anatomic dysphoria" and/or a strong preference for culturally stereotypic feminine activities. In assessment, evidence for the presence of characteristics in the latter category are more consistently obtained: these include cross-dressing, cross-gender toy preference, emulation of female super-heroes, effeminate mannerisms, and preference for female playmates (see, for example, Green, 1971, 1974; Stoller, 1968, 1975a). At the same time, interest in culturally stereotypic masculine activities is low, or nonexistent. Evidence of anatomic dysphoria, though less consistently present, can be found in a sufficient number of cases such that its inclusion as a separate criterion appears warranted. Although gender-disturbed boys typically do not deny that they have male genitalia (Stoller, 1968 (Ch. 8); Stoller and Newman, 1971), they do attempt to hide their penis by squeezing it against their inner thighs, and then pretend that they have a vagina. Though not specifically noted in the DSM-III description, one of the most common indices of anatomic dysphoria in gender-disturbed boys is their preference to sit when urinating (e.g., Stoller, 1968 (Ch. 8)).
TABLE 1

**DSM-III Diagnostic Criteria for Gender Identity Disorder of Childhood (Boys)**

<table>
<thead>
<tr>
<th>A. Strongly and persistently stated desire to be a girl, or insistence that he is a girl</th>
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<td>B. Either (1) or (2):</td>
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<td>(1) Persistent repudiation of male anatomic structures, as manifested by at least one of the following repeated assertions:</td>
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<tr>
<td>(a) That he will grow up to become a woman (not merely in role)</td>
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<tr>
<td>(b) That his penis or testes are disgusting or will disappear</td>
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<tr>
<td>(c) That it would be better not to have a penis or testes</td>
</tr>
<tr>
<td>(2) Preoccuption 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</td>
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<tr>
<td>C. Onset of the disturbance before puberty</td>
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Table 2 outlines the diagnostic criteria for gender identity disorder in girls. As may be seen, the criterion for Point A parallels the criterion in Point A for boys. However, the criterion for Point B diverges sharply from the requirement for boys. First, evidence for anatomic dysphoria does not include feelings of aversion for one's sexual anatomy, as is the case for boys. The only evidence considered valid are statements that deny the reality, or future reality, of the girl's anatomic status or biological capabilities. Second, a criterion comparable to the boy's preoccupation with female stereotypical activities has not been included for girls.

In our experience, we have found that the criteria for Point B force the clinician to avoid making a positive diagnosis of gender identity disorder, even though the clinical evidence suggests the presence of disturbance. In our small sample of five cross-gender identified girls (median age, 5.9 years), all showed evidence of anatomic dysphoria (e.g., wanting a penis, standing to urinate, verbalizing negative feelings regarding their sexual anatomy) but only one child (3.2 years) actually met the diagnostic criterion for Point B. For a period of 8 months prior to assessment, this child claimed that she had a penis and would grow a beard when older. It is our opinion, therefore, that it is unrealistic to expect older girls to literally deny the nature of their female anatomy, though their disappointment regarding it can be documented in much the same way as the gender-disturbed boy's misgivings regarding his male anatomy can be. In short, it is the persistent negative feeling state regarding anatomic sex which we believe is as salient for gender-disturbed girls as it is for gender-disturbed boys.

Point B also does not allow one to evaluate the gender-disturbed girl's preference for culturally stereotypic masculine activity and behavior, although this preference is quite extreme (e.g., Rekers and Mead, 1980). Coupled with this preference is an avoidance of feminine activity, including an aversion toward the wearing of feminine clothing.

The rationale for the omission of a criterion dealing with gender role behavior can be understood, in part, by the greater latitude our culture affords to such behavior in girls. That is, normal girls are more likely to engage in at least some kinds of cross-gender behavior than are boys, a pattern which is more likely to be accepted by significant adults as well (e.g., Brown, 1956; Feinman, 1974). Thus, by excluding a criterion dealing with cross-gender behavior, one avoids the potential problem of diagnosing a gender disturbance incorrectly ("false positives"). This decision has some merit in light of the recent work of Green and his associates (Williams et al., 1979) with a nonclinical sample (N = 45) of prepubertal girls identified as "tomboys." Their preliminary findings revealed gender role behavior patterns that appear similar to the patterns one would see in a gender-disturbed girl.

Although these findings suggest caution in assessing the clinical significance of such behavior, it should be pointed out that extreme and persistent cross-gender behavior in childhood has been found to be associated with adult female transsexualism and homosexuality (e.g., Ehrhardt et al., 1979; Saghir and Robins, 1971, 1973), a pattern which is similar to the association found with adult male transsexualism and homosexuality (e.g., Freund et al., 1977; Whitam, 1977).

Given these complex findings, an important diagnostic question is whether or not a nonclinical sample, such as the one studied by Williams et al. (1979), would meet the DSM-III criteria for the diagnosis of gender identity disorder. Unfortunately, it is not possible to answer this question definitively on the basis of their published data. For example, Williams et al. reported that 39% of the girls in their sample "frequently" expressed cross-sex wishes and an additional 42% did so "once in a while." Thus, it appears...
that only those girls who frequently expressed cross-
sex wishes would meet the criterion for Point A. How-
ever, the meaning of these cross-sex wishes is not
entirely clear, since Green (1980) reports else-
where that these girls are “generally content being
female” (emphasis in original). In addition, Williams
et al. (1979) do not report data relevant to the criterion
for Point B, so its applicability to their sample is
uncertain.

Inclusion of a criterion dealing with a “preoc-
cupation with masculine stereotypical activities”
would probably result in a number of “tomboys” meet-
ing it. But given the ambiguity surrounding the mean-
ing of their cross-sex wishes, it is not very likely that
the majority of tomboys would meet the criterion for
Point A. Hence, the diagnosis of a gender disturbance
would probably be ruled out.

In conclusion, it would appear that the more con-
servative DSM-III diagnostic criteria for girls deserves
reconsideration. Clinically, the presenting features of
a gender disturbance in childhood are quite similar for
the two sexes. In the case of girls, therefore, it is
suggested that the criteria for Point B be modified
such that the “persistent repudiation of female anat-
omic structures” can be assessed through the girl’s
feelings and attitudes toward them as well as through
denial and that a criterion dealing with extreme and
persistent cross-gender role behavior be included as
well.

Given our overall satisfaction with the DSM-III
criteria for diagnosing gender identity disorder in chil-
dren, we attempted a systematic study of its reliability.
Two raters independently read the psychiatric histo-
ries in the charts of the first 30 cases (25 boys, 5 girls)
referred to our gender identity clinic (Bradley et al.,
1978). One rater was personally familiar with all of the
cases whereas the second rater knew the cases only
from reading the child’s chart. After searching the
history for information regarding specific cross-gender
behaviors (see Bradley et al., 1980), each rater made
da decision as to the presence or absence of each
criterion for the DSM-III diagnosis of gender identity
disorder. However, Point B was not considered for
girls because of our disagreement with the criteria. For
the 30 cases, the presence or absence of Point A was
agreed upon in 29 cases (17 present, 12 absent). For
the 25 cases where a decision was made for Point B,
agreement was unanimous. These preliminary findings
clearly suggest that this particular DSM-III disorder
of childhood can be reliably diagnosed.

As is known, establishment of reliability is only a
precondition for demonstrating the validity of a par-
ticular diagnosis. To provide evidence for the validity
of a diagnosis, a variety of procedures need to be
carried out. One such procedure is known as discrim-
inanat validity, where between group differences are
demonstrated on variables assumed to be unique to
one of the groups.

In the case of gender-problem children, between
group discriminant validity has been demonstrated in
a number of previous investigations (e.g., Green et al.,
1972; Rekers and Yates, 1976; Skilbeck et al., 1975;
Zuger and Taylor, 1969) though none of these studies
employed the not yet available DSM-III criteria in
describing their gender-problem probands. However,
our own preliminary research has demonstrated good
between group discriminant validity on a number of
behaviors assumed unique to gender-problem children
when DSM-III criteria were used (Bradley et al., 1980;
Zucker et al., 1980a; Zucker et al., 1982). Zucker et al.
(1981b) also found that gender-referred children who
met DSM-III criteria were more extreme in their
cross-gender behavior than gender-referred children
who did not meet DSM-III criteria, as judged by
behavioral tests and parent questionnaires. Taken to-
gether, these findings provide preliminary evidence for
the validity of the DSM-III diagnosis of gender iden-
tity disorder of childhood.

Cross-Gender Identification vs. Gender Behavior
Disturbance

This second diagnostic formulation was developed
by Rosen et al. (1977) for use with boys evaluated for
problems in their gender identity development. On the
basis of clinical experience, Rosen et al. proposed that
two syndromes—“cross-gender identification” and
“gender behavior disturbance”—can be identified
within the “relatively rare population of male child
gender disturbances.” Theoretically, the distinction
between the two syndromes was based on the idea
that one’s gender identity (sense of maleness or fe-
maleness) need not be correlated with one’s preference
for same-sex or cross-sex gender role behavior (e.g.,

In developing this diagnostic formulation, Rosen et
al. suggested that three characteristics of gender-prob-
lem boys are useful in making the differential diagno-
sis. First, they suggest that a “boy’s preference for a
feminine identity” differentiates the two syndromes.
That is, only the cross-gender identified boy will make
verbal statements about wanting to be a girl or a
mother. Second, they claim that the cross-gender iden-
tified boy is more likely to engage in extreme and
persistent cross-dressing than will the boy with gender
behavior disturbance. And third, they suggest that the
cross-gender identified boy is more likely to have an
extremely close and dependent relationship with his
mother than will the boy with “simple” gender behav-
or disturbance.

If these syndromes are, in fact, distinct then one
would expect to find no consistent correlation between the presence of cross-gender identification and gender behavior disturbance in individual children. To test this hypothesis, Bentler et al. (1979) quantified their assessment of the severity of these two syndromes using 5-point rating scales in a sample of 38 gender-referred children.

A rating for cross-gender identification was made independently by two clinicians. One based his rating on a complex "psychodynamic assessment" procedure involving the child and his parents and a variety of psychological tests administered to the child. The other clinician based his rating on "behavioral assessment" procedures which included observations of the child playing with sex-typed toys and in a second play situation where the occurrence of cross-sex-typed mannerisms was recorded. In addition, information from the child's parents and teacher was also used. The mean rating of the two clinicians comprised the child's final score for cross-gender identification.

These two clinicians used the same data base for rating gender behavior disturbance while a third clinician made this rating on the basis of a "psychometric assessment" procedure in which the parents completed two questionnaires concerning the child's sex-role behavior. The mean rating of the three clinicians comprised the child's final score for gender behavior disturbance (see Bentler et al. (1979) pp. 271-275 for the exact details of their procedure).

The correlation between the two syndromes was 0.71. On the basis of this finding, Bentler et al. (1979) concluded that the two syndromes "were not entirely synonymous" and, as a result, there was "a basis of differentiation of these concepts in individual cases." Until more precise data are available, however, it is open to debate whether a correlation of this magnitude will have any value in distinguishing the two syndromes in clinical practice.

One problem in evaluating the merits of Rosen et al.'s proposal is their failure to document whether the three distinguishing characteristics of these two "syndromes" do, in fact, differentiate the cross-gender identified boy from the boy with simple gender behavior disturbance. For example, do boys who verbalize cross-sex wishes actually engage in more cross-dressing than boys who do not verbalize such wishes? Another area of interest would be whether or not a child "high" on both cross-gender identification and gender behavior disturbance will be more difficult to treat and have a poorer prognosis (e.g., transsexualism) than, say, a child "low" on cross-gender identification but "high" on gender behavior disturbance. These would be important questions to answer since the authors themselves argue that "the prognosis and treatment of the two syndromes [should] not be the same" (Rosen et al., 1977). Unfortunately, this kind of information is not yet available.

While the clinical utility of Rosen et al.'s (1977) diagnostic model remains an open question, it is important to determine whether or not the two syndromes can be reliably assessed. Bentler et al. (1979) provided some data which addressed this question. As noted earlier, three different assessment procedures—psychodynamic, behavioral, and psychometric—were independently employed to arrive at the overall mean rating of gender behavior disturbance while the psychodynamic and behavioral assessment procedures were used to produce the overall mean rating of cross-gender identification. For gender behavior disturbance, there was good reliability between the psychodynamic and behavioral assessment procedures ($r = 0.69$); however, these two procedures did not correlate highly with the psychometric procedure ($rs = 0.25$ and 0.23, respectively). For cross-gender identification disturbance, the psychodynamic and behavioral assessment ratings yielded a correlation of 0.59. Thus, Bentler et al. (1979) demonstrated that their ratings of the two syndromes have some reliability across different types of data sources.

Within each type of procedure, however, Bentler et al. provided no test of inter-rater reliability. This is unfortunate since it is unclear how the data were used to make the ratings for the two syndromes. In the behavioral assessment procedure, for example, data were collected on dozens of specific questions posed to the child's parents and on a number of observations of the child in controlled settings. Whether or not two independent raters, with this huge corpus of information, would make a reliable rating is questionable. In effect, it appears that across these different assessment procedures (particularly the psychodynamic and behavioral), the raters were probably utilizing some kind of qualitative judgment in making their final rating, and it was this qualitative impression which produced the reasonable interassessment reliability. This interpretation probably best explains their finding of poor reliability with the psychometric procedure, since it utilized a much more limited and specific data base in arriving at a rating for gender behavior disturbance.

In order for the diagnostic proposal of Rosen et al. (1977) to be used meaningfully by other clinicians, it is crucial that the criteria used in making the final ratings on the two syndromes be outlined with a greater degree of specificity.

What are the differences and similarities between the DSM-III diagnosis of gender identity disorder and the diagnostic formulation proposed by Rosen et al. (1977)? The DSM-III diagnosis clearly does not consider cross-gender identification and gender behavior disturbance to be distinct syndromes; rather, both
features are required to make the diagnosis of gender identity disorder of childhood. Conversely, Rosen et al.'s (1977) proposal appears to divide the DSM-III diagnosis into two components: (1) a child who meets the criterion only for Point B-2 would be considered to have a gender behavior disturbance whereas (2) a child who meets the criterion for both points A and B would be considered to have a cross-gender identification disturbance. It is not entirely clear if Rosen et al. would consider a child who meets the criterion only for Point A to have a cross-gender identification disturbance since they do not specify whether or not cross-gender identity statements alone are sufficient for making this diagnosis.

**Male Childhood Transsexualism**

Stoller’s (e.g., 1968, 1975a) contributions to the understanding of gender identity development are well-known. One aspect of his work has focussed on diagnostic issues and it is in this area that the subsequent analysis will concern itself.

Stoller (1977) argues that a “proper diagnosis” can be made only when one has information regarding three variables: a syndrome, underlying dynamics, and etiology. In applying this approach to the differential diagnosis of “male childhood transsexualism,” however, it appears that Stoller relies primarily on information relevant to the syndrome and the underlying dynamics, so only these features of his procedure will be examined in detail.

Stoller (1977 (p. 26)); see also Stoller (1975b (Ch. 10)) defines a syndrome as “a constellation of signs and symptoms common to a group and apparent to an observer.” In the case of the transsexual boy, these signs and symptoms essentially include all of the cross-gender characteristics noted earlier in this paper. However, in Stoller’s view, the key “symptom” which differentiates the transsexual boy from other boys who engage in feminine behavior is the “fixed belief that one is a member of the opposite sex” (Stoller, 1968 (p. 92)). As Stoller notes, “these boys do not only wish at times that they were girls . . . [but also] maintain . . . they are . . . females” (1968 (p. 97)). Thus in the absence of this criterion, Stoller would not make the diagnosis of male childhood transsexualism.

Stoller (e.g., 1974, 1975a) has argued that male child transsexualism is the product of a unique set of family dynamics. From a diagnostic perspective, it would seem that information regarding such dynamics would be irrelevant if male childhood transsexualism is, in fact, a distinct syndrome. However, Stoller has pointed out that one will occasionally see a boy with features suggestive of childhood transsexualism but who, in fact, is not “really” transsexual (Stoller, 1975a (Ch. 16)). In these cases, Stoller uses information regarding family dynamics to make the differential diagnosis of male childhood transsexualism. That is, if the specific familial dynamics are not operative, then the child is not truly transsexual, even if the child’s behavioral characteristics suggest otherwise. Thus, in Stoller’s diagnostic model, one must validate the diagnosis of male childhood transsexualism through the assessment of family dynamics, dynamics one would not find in the families of boys who are feminine, but not transsexual.

In evaluating the merits of Stoller’s diagnostic formulation, there appear to be at least two major problems. First, Stoller himself is inconsistent. If the defining feature of the transsexual syndrome is the boy’s insistence (belief) that he is a girl, a careful reading of Stoller’s writings shows that he does not always make the distinction between “wishing” and “believing.” For example, in summarizing his clinical data on three transsexual boys, Stoller (1968) says “this condition is called childhood transsexualism because its most obvious manifestation is the boy’s feeling that he is a girl” (p. 93, emphasis added). Is there not a difference between feeling that one is a girl and believing it? The same confusion between feeling and believing can be found in a number of other papers written by Stoller (e.g., 1975a (Chs. 2 and 5), 1978; Stoller and Newman, 1971). Until this ambiguity is clarified, one cannot be certain whether or not the key diagnostic criterion is, in fact, the child’s “fixed belief that [he] is a member of the opposite sex.”

The other problem with Stoller’s criterion is a developmental one. Regardless of whether or not Stoller truly intends to make the distinction between feeling and believing, it would still be a developmentally limited one. That is, it is highly doubtful that a child will fail to come to know what sex he is, even in the most unusual of environments.

Though there appear to be some problems in defining what truly constitutes the syndrome of male childhood transsexualism, one can still utilize family dynamic factors in deciding whether or not a particular case conforms to the type of transsexualism Stoller describes in young boys. This would be important given his suggestion that feminine boys who do not come from families where such dynamics are operative will be relatively easier to treat (see Stoller, 1975a (Ch. 16)). However, until additional clinical and research studies on such boys and their families become available, this hypothesis will remain untested.

Compared to DSM-III, it appears that Stoller is describing a more delimited condition. With respect to Point A, Stoller would consider the “desire” to be a girl insufficient to make a positive diagnosis of male...
childhood transsexualism—only the “insistence that one is a girl” would be deemed acceptable. As to Point B, it appears that only the statement “that he will grow up to become a woman” differentiates the transsexual boy from other feminine boys. Preoccupation with female stereotypes, while characteristic of the transsexual boy, also characterizes other feminine boys, so it would not be helpful in making the differential diagnosis. One final difference between Stoller’s model and the DSM-III criteria is his consideration of family dynamics which, in DSM-III, would be noted as a psychosocial stressor (Axis IV) under the heading “family factors.” Due to the multiaxial nature of DSM-III, however, this factor would not be considered a part of the formal criteria for the diagnosis of the syndrome per se.

In comparison with Rosen et al.’s (1977) proposal, it appears that similar distinctions would be required. For example, Stoller would distinguish between the wish “to be” the opposite sex from the belief that one “is” a member of the opposite sex in order to find Rosen et al.’s diagnosis of cross-gender identification akin to his diagnosis of male childhood transsexualism. As was the case with part of Point B in DSM-III, the characteristics of the boy with gender behavior disturbance would not be sufficient in their own right in making the diagnosis of boyhood transsexualism.

**General Developmental Issues in Diagnosis**

The prospective study of the association between marked cross-gender behavior in childhood and adult psychosexuality is just beginning. The few available studies have reported that the majority of children developed a homosexual orientation in adolescence or early adulthood (Green, 1979; Money and Russo, 1979; Zuger, 1978). To what extent this particular outcome was influenced by professional contact, either for research or various kinds of therapy, is unknown.

Surprisingly, there is little information on the developmental course of gender disturbance within childhood itself. Do the presenting features remain stable, lessen, or increase in intensity as the child grows older? Are older children less or more likely to meet the criteria for a gender disturbance than younger children? If there are changes in the course of development, what implication does this have for diagnosis?

There is both cross-sectional and longitudinal evidence that at least some cross-gender behaviors lessen in intensity as a function of age. In our own study of gender-referred children, two diagnostically defined subgroups have been contrasted: children who met DSM-III criteria for the diagnosis of gender identity disorder (N = 18) vs. children who did not (N = 12). The children who met DSM-III criteria were significantly younger than those who did not (mean, 6.8 vs. 9.3 years, p < 0.02). As noted earlier, validation of this subgroup distinction was documented by a variety of behavioral tests and parent questionnaires (see Zucker et al. (1981b) for details). Although a few of the non-DSM-III children may have been genuine examples of “false positives,” other children clearly had a history which would have warranted a positive diagnosis of gender disturbance, but at the time of assessment the diagnosis could not be given. Thus, there appear to be age-related factors which affect the expression of the kinds of behaviors required to make the diagnosis of gender identity disorder.

These cross-sectional data are consistent with longitudinal data reported on a clinical basis by both Green (1975) and Zuger (1978). For example, Zuger noted “a kind of ‘decay’ or burning out of... symptoms, completely in some, partially in others, and not at all in a few” (p. 368). Because Zuger’s cases were seen clinically, at least to some extent, it is unclear whether the purported changes reflect the impact of therapeutic intervention or the disorder’s “natural history.” However, Green (1975) has observed that “feminine boys who have not entered into any formal treatment program, but who have merely undergone a diagnostic-research evaluation have also shown comparable behavioral change on follow-up two to three years later” (p. 342, emphasis in original).

While our research has given some support to the idea that there are age-related changes in overt symptomatology, we have also found evidence for stability in the cross-gender behavior of gender-disturbed children over a one-year time frame (Zucker et al., 1981a). In this study, the child’s behavior at the initial assessment, rather than treatment variables, was the best predictor of behavior at the 1-year follow-up. This finding suggests, therefore, that future research will have to consider more precisely when and what changes occur in the course of the gender-disturbed child’s development.

In conclusion, there appears to be some evidence supporting the idea that there are age-related changes in the expression of cross-gender behavior in gender-disturbed children. The diagnostic dilemma, therefore, is to determine whether or not these changes reflect an authentic shift in the child’s gender identity development or simply reductions in the phenotypic visibility of the same underlying disturbance (cf. Bentler, 1976). If the latter is the case, then one would need to develop alternative criteria in order to accurately assess the presence of a gender disturbance in late childhood.

At present, the exact nature of what these criteria might be is unclear, though there are some hints in the literature, at least for boys. These include lack of
interest in group activities involving same-sex peers, social isolation and/or ostracism, continued effeminacy, and occupational interests stereotypically associated with homosexuals (see Whitam & Dizon, 1979). However, these characteristics probably do not differentiate the prehomosexual boy from the pretranssexual boy so their value in assessing the child’s satisfaction with his maleness, or “core gender identity” (Stoller, 1964, 1968 (ch. 5)), is limited. Only additional clinical and research studies will answer these kinds of diagnostic issues.

References

American Psychiatric Association (1980), Diagnostic and Statistical Manual of Mental Disorders, Ed. 3. Washington D.C.


