



Making Gender Identity Disorder of Childhood: Historical Lessons for Contemporary Debates

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Abstract: Gender Identity Disorder of Childhood (GIDC)—a psychiatric diagnosis given to gender-variant children—has been controversial since its creation. Critics inside and outside of the mental health professions have called for the removal or revision of GIDC, arguing that it has served to pathologize homosexuality, to enforce normative notions of masculinity and femininity, and to recast a social problem as individual pathology. Drawing on published clinical and research papers, archival materials, and interviews with clinicians, researchers, and advocates, this article analyzes early studies of gender-variant boys from the 1960s and 1970s and describes the process through which the GIDC diagnosis was created. The article examines some of the limitations of current debates over GIDC and points out new trends that hold the most promise for providing support to gender-variant children.

Key words: history of psychiatry; scientific controversy; transsexuality; homosexuality; psychiatric diagnosis

This article examines early research on and treatment of gender-variant boys¹ and the ensuing creation of the psychiatric diagnosis Gender Identity Disorder of Childhood (GIDC). It does so in order to make recommendations relevant to contemporary debates over the GIDC diagnosis and to current policy and practice related to the treatment of gender-variant children. GIDC first appeared as a formal diagnosis in 1980 as part of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders—III* (American Psychiatric Association [APA], 1980). Still a psychiatric diagnosis today,² GIDC is defined as “a strong and persistent cross-gender identification” combined with “evidence of persistent discomfort about one’s assigned sex or the sense of inappropriateness in the gender role of that sex” (APA, 2000, p. 576). Not surprisingly, GIDC and the work associated with it are controversial, with calls

1 Psychiatric and psychological studies and treatment of gender-variant children have focused primarily on boys. For a discussion of the focus on boys in the early period that I primarily discuss in this article, see *Early Work on Gender Variant Boys* below.

from both mental health professionals and lay critics for its reform or elimination (e.g., Bartlett, Vasey, & Bukowski, 2000; Burke, 1996; Butler, 2004; Califia, 1997; Corbett, 1998; Feder, 1997, 1999; Haldeman, 2000; Isay, 1997; Langer & Martin, 2004; Moore, 2002; Morgan, 2001; Pickstone-Taylor, 2003; Richardson, 1996, 1999; Sedgwick, 1993; Wilchins, 1997; Wilson, Griffin, & Wren, 2002).

2 Gender Identity Disorder of Childhood and Transsexualism first appeared in *DSM-III* (APA, 1980) and remained separate diagnoses in *DSM-III-R* (1987). However, in *DSM-IV* (APA, 1994) they were categorized under one overarching diagnosis, Gender Identity Disorder, which included specifications for child, adolescent, and adult variants. For all intents and purposes, the childhood variant of GID is the current version of GIDC and the adult variant of GID is the current version of Transsexualism. The collapsing of these categories and the renaming of Transsexualism as GID has had political fallout, arguably complicating efforts to remove the diagnosis from *DSM*. Throughout the article, I use GIDC to refer to the childhood GID diagnosis. While I could have opted to use GIDC up through 1994, then childhood thereafter, I chose to use GIDC throughout to index the direct lineage of the current diagnosis to the earlier *DSM-III* and *DSM-III-R* diagnoses.

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Critics of the diagnosis and of mental health treatments of gender-variant children argue that GIDC functions to enforce normative notions of masculinity and femininity, to pathologize homosexuality, and to recast a social problem as individual pathology. In the most basic terms, many argue that the diagnosis harms the very children it purports to help.

Within the contemporary critiques of GIDC, there are two broad categories of particular interest for this analysis. Each of these two domains reflects important key concerns of current critiques. First, some critics (e.g., Bartlett et al., 2000; Bem, 1993; Burke, 1996; Haldeman, 2000; Isay, 1997; Moore, 2002; Morgan, 2001; Neisen, 1992; Sedgwick, 1993) have suggested that GIDC functions to pathologize homosexuality by capturing pre-homosexual children in its diagnostic net. Research and treatments of gender-variant boys in the 1960s provided the initial foundation for the creation of GIDC. The hypothesis that these boys would grow up to be homosexual, transvestite, or transsexual adults was a primary legitimating rationale for these studies and treatments. Preventing these possible outcomes was one goal of this early work. Although initially a number of possible outcomes were of interest, the researchers' eventual findings suggested that gender-variant boys would most likely become homosexual men (e.g., Green, 1987; Money & Russo, 1979). The crux of these criticisms stems from the fact that between the time the studies of gender-variant children were begun in the 1950s and 1960s and the time the findings linking them to adult homosexuality were widely reported in the late 1970s and 1980s, the APA removed homosexuality from its list of mental disorders. Critics (e.g., Bem, 1993; Isay; Moore; Morgan; Sedgwick) used GIDC researchers' findings in combination with the APA's delisting of homosexuality to argue that, by practice if not by intent, GIDC continued to pathologize and treat homosexuality.

Critiques of GIDC also fall broadly into a second area that concerns the content of the diagnosis itself (e.g., Bartlett et al., 2000; Burke, 1996; Haldeman, 2000; Langer & Martin, 2004; Richardson, 1999; Wilson et al., 2002). Questioning whether GIDC meets the criteria for mental illness, these critics have examined aspects of the diagnosis—especially the list of diagnostic criteria—for shortcomings and biases. They have argued that GIDC does not meet general criteria for mental illness and have analyzed the specific diagnostic criteria to argue that the diagnosis focuses on behaviors (e.g., cross-dressing) when it should focus on identity (e.g., cross-sex identity statements); that the diagnostic criteria make identity and behavior commensurate; and that the diagnostic net is cast too widely, with, for example, behaviorally deviant

children (but not necessarily cross-gender-identified children) included in the diagnosis.

These arguments, developed since the 1980 formalization of the GIDC diagnosis, have revealed shortcomings of both the diagnosis and the mental health treatments associated with it. However, these critiques have also inadvertently bolstered dominant framings of the so-called problems with gender-variant children—framings initially developed by gender researchers in the 1960s (Green, 1967a, 1968, 1971; Green & Money, 1960, 1961, 1964, 1966; Greenson, 1966; Stoller, 1966, 1967, 1968; Zuger, 1966, 1969). In this article, I turn to the period from 1960 to 1980, during which a small group of gender researchers consolidated a medicopsychological subfield on childhood gender variance and created the GIDC diagnosis. Whereas the process by which GIDC became a psychiatric diagnosis has been seen alternately as the result of scientific progress and expert consensus (Zucker & Spitzer, 2005) or as a conspiracy to keep homosexuality under the purview of psychiatry (Bem, 1993; Burke, 1996; McCarthy, 2003; Moore, 2002; Morgan, 2001; Sedgwick, 1993; Wilson et al., 2002), this review shows instead that it was “the result of negotiations, organizational processes, and conflict” (Bowker & Star, 1999, p. 44) and thus “reveals the multitude of local political and social struggles and compromises that go into the constitution of a ‘universal’ categorization” (p. 47).

A review of this period also exposes some of the limitations of the current critiques of GIDC and associated practices. It illustrates the process through which scientific knowledge about gender-variant children was initially constructed and points to the key constitutive role of debates (Epstein, 1996), both among professionals and between professionals and lay critics, in shaping that knowledge. It shows how critiques have been central in shaping both the diagnosis and the evaluation and treatment practices associated with it, but that these critiques have often been incorporated in ways that jettison their most important critical components. Further, by focusing on adult sexual outcomes (homosexuality), a frame initially developed by the gender researchers themselves, critics have largely missed an opportunity to rethink mental health support for gender-variant children in terms of general psychological health instead of narrow psychosexual outcomes. I conclude by outlining the strengths and weaknesses of current GIDC reform efforts and some of the more promising new directions in mental health practice directed at supporting gender-variant children.

In order to track and evaluate the period from 1960 to 1980, I analyzed a broad range of data from multiple sources. The bulk of this article outlines and analyzes the

period from 1960 to 1980, but I also made use of more recent data in order to mine the historical evidence in terms of its relevance for current debates. In my analysis, I utilized the clinical and research literature on gender-variant children (and later on GIDC) from 1960 to the present; researchers' unpublished papers and correspondence, institutional documents (such as *DSM* committee reports), and community publications (such as fliers, newsletters, and zines) housed in several archives;³ and interviews with GIDC researchers and advocates who have worked to revise or remove the diagnosis. I also drew on my experiences as an observer and participant at professional and advocacy meetings (e.g., the Harry Benjamin International Gender Dysphoria Association meetings, APA meetings, the National Gay and Lesbian Taskforce Creating Change conferences, and the GenderPAC National Conference on Gender) where discussions of GIDC have taken place.

Early Work on Gender-Variant Boys

Increased medicopsychological interest in gender-variant boys during the post–World War II period set in motion the later inclusion of GIDC in *DSM-III* (APA) in 1980. Beginning in the 1960s, researchers and clinicians began producing a small body of psychiatric and psychological literature on feminine boys (Green, 1967a; Green & Money, 1960, 1961, 1964, 1966; Greenson, 1966; Stoller, 1966, 1967, 1968; Zuger, 1966, 1969). These amounted to the first systematic, aggregate-level studies of gender-variant children.

Gender-variant boys were, of course, nothing new. Why, then, did mental health professionals take them up in a new way at this time—as subjects meriting systematic and sustained research and treatment? Whereas gender variance had been of medical and psychological interest since the nineteenth century or earlier, a series of enabling conditions and events came together in the mid–twentieth century to refigure the meanings attached to gender variance in general and to gender-variant boys in particular. Among these factors were White masculinity crises (Feldstein, 2000; Kimmel, 1996), the ascendance of psychological understandings of personal troubles and public issues (Herman, 1995; Lunbeck, 1994), the gender upheavals of the Depression and World War II, the rising visibility of homosexual communities, and the appearance of transsexuality as a new social subjectivity and medicopsychological problem (Meyerowitz, 2002).

³ I collected archival materials at the GLBT Historical Society of Northern California, the Kinsey Institute, University of California, Los Angeles's (UCLA) Special Collections, and the Melvin Sabshin Archives of the APA.

Gender-variant boys thus became a target for medicopsychological interest and intervention.

In fact, studies of gender-variant children during this period overwhelmingly examined gender-variant boys (Green, 1967a; Green & Money, 1960, 1961, 1964, 1966; Green, Newman, & Stoller, 1972; Greenson, 1966; Stoller, 1966, 1967; Zuger, 1966, 1969).⁴ For the most part, early researchers said little or nothing about their exclusive focus on boys. In fact, they often slid easily from their data on gender-variant boys to discussions of gender-variant children. In an extended exception to this tendency, Green (1968) discussed both the lower rate of what he termed adult female transsexuals (now more typically referred to as female-to-male transsexuals, or FtMs) and the lower (nearly nonexistent) rate of masculine female-bodied children referred to him. For adults, he explained this as a function of broader tolerance for adult female masculinity than for adult male femininity and also, in the case of adult transsexuals, as a result of lower levels of sophisticated surgical interventions available at the time to FtMs, especially concerning the construction of a phallus. For children, he asserted that tomboys were valued in ways that sissies were not, noting that tomboyism was generally understood as a normal developmental phase. In other words, Green tacitly acknowledged the kinds of cultural values and beliefs that undergirded at least the impetus for seeking out treatment for some gender-variant children (boys) and rarely others (girls). While Green acknowledged that tomboys were better tolerated than sissies, they did not escape completely from his diagnostic gaze. Green went on to warn that whereas many girls do in fact grow out of their tomboy phase (for Green [1968], this meant that previous tomboy behavior “does not exclude dating and romance” [p. 503] in adolescence), other tomboys may grow up to be lesbians or transsexuals and must therefore be detected and treated.

Research, treatment, and formal diagnostic criteria for gender-variant children, then, have historically focused more on boys than on girls. Critics (e.g., Feder, 1999; Sedgwick, 1993) have noted that the disproportionate focus on boys was driven by cultural anxieties and reflected a general valuation of masculinity (even to a limited degree in girls) and devaluation of femininity (especially in boys).⁵

⁴ For the most significant exceptions to the trend of exclusively studying boys during this period, see Stoller, 1968, chapter 17, and Stoller, 1975, chapter 18.

⁵ For an alternative interpretation of tolerance vis-à-vis tomboys, see Halberstam (1999). Partially drawing on medicopsychological literatures such as those being analyzed here, she argued that the putative acceptance of tomboys is in large part a myth.

Additionally, specific conditions within the mental health professions made gender-variant boys more obvious and enticing objects of study. Most important among these was the new and controversial professional problem of what to do about transsexual adults, understood at the time as almost exclusively male-to-female transsexuals.

In the wake of the early 1950s media uproar surrounding male-to-female transsexual Christine Jorgensen, ideas about transsexuality and sex change became part of the cultural landscape in ever increasing sectors of society. More people, mostly genetic males but also a few genetic females, began contacting medical experts to request the sex change procedures they had heard about. Surgical and other body-altering procedures were available, but in very small numbers and performed by very few practitioners. Many more professionals advocated curing the mind instead of the body. During the 1960s, most medical professionals in the United States, especially psychoanalysts and psychologists, opposed sex change procedures and argued instead that a psychotherapeutic cure was the appropriate course of action (Meyerowitz, 2002; for studies from this period examining medical and mental health professionals' attitudes toward treating transsexuals, see Green, 1967b; Green, Stoller, & McAndrew, 1968). Others, such as endocrinologist Harry Benjamin (1954), argued that transsexualism had an as yet undetermined somatic basis; therefore, changing the body to suit the mind was the proper intervention and the most humane way of alleviating patient pain. Thus, transsexuality created a great deal of controversy among medical and mental health professionals (see Meyerowitz 2002, especially chapter 3). What to do about it was hotly contested. While solving this professional problem animated deep intraprofessional divides, it also directed researchers toward a new population—feminine boys. Studying and treating this group promised to potentially solve the problem of adult transsexuality through preventing its development in the first place.

To understand and explain the phenomenon of boyhood femininity, researchers drew on new ideas about gender identity developed in 1950s research on intersex infants (Money, Hampson, & Hampson, 1955a, 1955b, 1956, 1957). They also found resources in the form of emerging institutional infrastructure (i.e., university-affiliated gender identity clinics) and government funding for research on the topic. Thus, with a problem before them and the theoretical tools and institutional resources to address it, researchers turned to a patient population that promised the solution, gender-variant boys.

Throughout the 1960s, a few researchers and clinicians working in private practice or in university centers

(notably at Johns Hopkins and University of California, Los Angeles [UCLA]) began to publish their reports on small groups or single case studies of feminine boys (Green, 1968; Green & Money, 1960, 1961, 1964, 1966; Greenson, 1966; Stoller, 1966, 1967, 1968; Zuger, 1966, 1969). From then and continuing through to the present, the research and clinical work on gender-variant children has been a small and somewhat obscure subspecialty. In the 1950s and 1960s, there were just a few gender researchers—all men—who worked and published in the area. Key published researchers at the time included Bernard Zuger, a clinician in New York, and Robert Stoller, a psychoanalyst at UCLA. However, most important among the small group were Johns Hopkins' medical psychologist John Money and his student Richard Green. Green and Money began studying gender-variant boys in the 1950s while Green was a medical student, originally as a yearlong student research project with Money as Green's faculty mentor (R. Green, interview with author, September 12, 2003). Their first publication on gender-variant boys appeared in 1960; they eventually published a series of articles across the 1960s that produced some of the first aggregate-level systematic studies of gender-variant boys (Green & Money, 1960, 1961, 1964, 1966). By the end of the 1960s, Green (then an assistant professor in the UCLA Department of Psychiatry and director of its Gender Identity Research and Treatment Program) had emerged as the leading expert in the field of childhood gender variance. Green and Money's publications are still frequently referenced by those in the field as having laid the groundwork for subsequent research and treatment (Zucker, 2000; Zucker & Bradley, 1995).

During this early period, published reports explicitly laid out the legitimating rationale for studying and treating this population and, in the process, both established professional dominance over feminine boys and transformed sissies (or some subset of profound sissies) into a medicalized patient and research population. The researchers argued that whereas most popular and some medical understandings passed off childhood gender variance as just a phase, in fact gender-variant children were at increased risk of growing up to be homosexuals, transvestites, or transsexuals. Therefore, they argued, it was necessary both to study these children to try to understand psychosexual development and to treat them to try to prevent ostensibly suboptimal adult outcomes.

There were variations in the particular outcome—homosexuality, transvestitism, or transsexuality—that each researcher emphasized. Some individual researchers shifted focus over time and between contexts, for example, first emphasizing the putative link between boyhood

femininity and adult homosexuality and later emphasizing its supposed link to adult transsexuality.⁶ During the 1960s and early 1970s, however, these shifts were rarely based on concrete data. Rather, the lack of data refuting any of these outcomes, combined with the assumption that boyhood femininity was linked to these outcomes, directed researchers to hold open the possibility that boyhood femininity would result in homosexuality, transvestism, or transsexuality later in life. To remedy the general lack of supporting data on outcomes, researchers called for and began to undertake prospective, longitudinal studies that followed feminine boys (and in the case of one study, matched control “normal” boys) into adulthood. Researchers (e.g., Green & Money, 1964; Zuger, 1969) began reporting follow-ups on gender-variant boys as early as the 1960s. However, the most influential follow-up data were not reported on until the end of the 1970s and the 1980s, with Green’s (1987) publication of *The “Sissy Boy Syndrome” and the Development of Homosexuality* providing the most important of these findings.

By the end of the 1960s, the gender researchers outlined the following feminine boys’ defining features: They preferred to play with girls, in fantasy play they pretended to be girls and women, they avoided “rough and tumble” play, they cross-dressed frequently, they exhibited “feminine mannerisms,” and they sometimes said that they were or wanted to be girls and women. As one set of researchers (Green et al., 1972) succinctly summed things up, “These boys prefer the dress, toys, activities, and companionship of girls, and state their wish to be girls” (p. 213).

While the researchers debated causes without coming to much of a conclusion (their explanations ranged from inchoate biological theories to a range of pathological family dynamics, including the classic overbearing mother/passive father), the tentative nature of their knowledge about both the causes and the outcomes of boyhood gender variance did not translate into hesitation about treatment. While researcher-clinicians reported on a range of treatment approaches (for an overview of several case reports focusing on treatment,

see Green et al., 1972; for a detailed case study using classical analysis to treat boyhood femininity, see Greenon, 1966), the overarching goal was the same: to eradicate or reduce the boys’ femininity and promote forms of masculinity.

By the beginning of the 1970s, then, a small body of research on gender-variant boys had been established. With the help of federal and private grants, the founding of university-affiliated gender identity research centers, and the publication of a small but growing body of scientific literature on gender-variant boys, a subfield on childhood gender variance began to flourish. Over the course of a few years, a small group of gender researchers had described the features of boyhood femininity, debated its possible causes, developed diagnostic techniques, treated feminine boys and their families, and begun to track long-term outcomes.

New Directions in Research and Treatment

By the late 1960s and early 1970s, UCLA’s departments of psychiatry and psychology had become hot spots for the study of gender-variant boys. Green was deep in the throes of what would come to be known as the UCLA Feminine Boy Study, his large-scale, government-funded, 15-year prospective study that compared 66 feminine boys and their families with matched control masculine boys and their families (Green, 1974, 1987). In answering the call for long-term, prospective research, Green’s central goal was to shed light on the adult psychosexual outcomes that boyhood femininity actually portended. While some findings from the study did begin to appear in the 1970s (e.g., Green 1974, 1976, 1979; Green & Fuller, 1973a, 1973b; Green, Fuller, & Rutley, 1972; Green, Fuller, Rutley, & Hendler, 1972), Green’s longitudinal research design, which allowed him to follow feminine boys into young adulthood, meant that the bulk of his findings would not appear until many years later.

At the same time, a group of researchers in the UCLA Department of Psychology were working on their own projects. They explored several areas, for instance, aiming for more precision in describing gender-variant boys and the features associated with the disorder (e.g., Bates, Bentler, & Thompson, 1979; Bates, Skilbeck, Smith, & Bentler, 1974) and developing diagnostic technologies specifically for use with gender-variant boys and their families (e.g., Bates & Bentler, 1973; Bates, Bentler, & Thompson, 1973). They also worked toward more precision in theorizing about gender variance and the disorders associated with it and proposed a new schema wherein gender-variant boys were divided into two broad categories representing two syndromes: boys with a disorder of *gender role* and

6 For instance, Green and Money (1966) emphasized the link between boyhood gender variance and adult homosexuality, whereas a few years later Green (1971) emphasized the link to adult transsexuality. In contrast, Zuger more consistently than others underscored the link between boyhood femininity and later homosexuality; as early as 1969 he asserted that “follow-up studies on boys with early effeminate behavior (cross-gender identity) have indicated that its manifestations persist and that it subsequently terminates in homosexuality in a large percentage of instances” (p. 375).

boys with a disorder of *gender identity* (e.g., Bentler, Rekers, & Rosen, 1979; Rekers, Bentler, Rosen, & Lovaas, 1977; Rosen, Rekers, & Friar, 1977).⁷

However, among the several new directions and extensions that were in evidence in the UCLA Department of Psychology, one aspect stood out at the time and has in some ways, at least in terms of critiques of GIDC, had the greatest lasting impact: reports on behavior modification treatments of gender-variant boys. Psychologist George Rekers, a member of the UCLA psychology department in the early 1970s,⁸ was then and continues to be today most associated with this body of literature. With his focus on altering childhood gender variance through behavior modification techniques, Rekers became a lightning rod for critics. Although the fundamentalist Christian motivation for his work was barely apparent in his early opus, Rekers openly expressed it in later publications (e.g., Rekers, 1982a, 1982b).

Previous work with feminine boys had always implicitly or explicitly sought behavioral change. With boyhood gender variance now established as a legitimate medicopsychological problem and with an equally established set of treatment justifications, Rekers made the goal of changing behaviors the centerpiece of his work. This focus also meshed well with his general theoretical orientation: social learning models of both childhood gender identity and behaviors, or gender roles, as Rekers and his colleagues called these behaviors. These models lent themselves to therapeutic intervention in the form of behavior modification.

Rekers and colleagues' treatments used classic reinforcement techniques to extinguish feminine behaviors and replace them with masculine ones (e.g., Rekers, 1975, 1979; Rekers & Lovaas, 1974; Rekers, Lovaas, & Low, 1974; Rekers & Varni, 1977). They used various reward and punishment systems, including a token economy system in which the boy being treated was given blue tokens for positive reinforcement (e.g., for masculine play with his brother) and red tokens for negative reinforcement (e.g., for feminine play with his sister). At the end of the day,

rewards or punishments were doled out depending on the number of each color he had amassed.

The treatments targeted a wide range of behaviors: play activities, play partners (in one case, the researchers tried to reduce time spent playing with the boy's sister, and at the end of treatment reported that the subject's play time with his sister was at "zero or near zero level" [Rekers et al., 1974, p. 106]), gestures, and speech (including "feminine inflection" and "feminine content"). The treatment in each case typically extended over many months.

From the child and family's perspectives, these treatment approaches resulted in a host of new adults intervening in their lives. A small army of researchers and research assistants descended upon the boy and his family—in the clinic of course, but also in the home and the school where they observed periodically (sometimes several visits per week) and trained others to take over as therapist in their absence. As a result, key adults in the boy's life took on new roles. Parents and teachers monitored his behavior in a systematized manner and provided rewards or punishments based on how he performed.

An important and ongoing part of the research concerned questions of both stimulus generalization and response generalization. The researchers looked for stimuli that generalized beyond the specific site or situation where they occurred. They also looked for response generalization, that is, for stimuli that affected a greater range of feminine behaviors beyond the specific one being targeted. In lay terms, they searched for the most effective intervention technique, the magic bullet stimulus that would work across a range of situations and sites (e.g., in the home, the school, and the clinic) and that would work to extinguish a broad range of undesirable behaviors (e.g., feminine speech, mannerisms, play behaviors). Clearly, they did not expect to find a single efficacious cure; however, the focus on stimulus and response generalization remained at the heart of their methodology. As a result, they repeatedly established baseline measures, since it was important to determine whether or not there had been a change in behavior that generalized across sites.

For the child being treated, this meant that the rules of the game were constantly in flux. The behavior that he was asked to modify changed every few weeks. Sometimes the targeted behaviors were cumulative, that is, the child was asked to add new behaviors to the existing repertoire being treated. Other times the new target behavior replaced the old one. In addition, periods of observation without treatment to reestablish baseline measures were interspersed with periods of active treatment. Behaviors that resulted in punishments one week might be ignored

⁷ These two syndromes went by various names in the publications from the period, including *gender role behavior disturbance/gender identity disturbance* (Rekers et al., 1977), *gender behavior disturbance/cross-gender identification* (Rosen et al., 1977), and *sex-role behavior disturbance/sex-role identity disturbance* (Bentler et al., 1979).

⁸ Rekers received his PhD from UCLA in 1972 and based his early publications on data from his dissertation (e.g., Rekers & Lovaas, 1974). Although the Green (1987) study and Rekers's (1972) work were separate projects, Rekers generated part of his treatment sample from the boys that Green was studying (R. Green, interview with author, September 12, 2003).

the next, while a new target behavior became the source of everyone's attention.

The First Critiques

It was this body of research—Rekers and colleagues' (e.g., Rekers, 1975; Rekers & Lovaas, 1974; Rekers et al., 1974) reports on various aspects of their behavior modification treatments—that provided fodder for the first wave of published critiques of research on gender-variant boys. By the mid-1970s, critiques of Rekers's work began to appear primarily in professional journals (Morin & Schultz, 1978; Nordyke, Baer, Etzel, & LeBlanc, 1977; Winkler, 1977; Wolfe, 1979) and also in at least one popular outlet (Rorvik, 1975). These writers drew on an explicitly feminist (and sometimes gay liberationist) framework to critique Rekers's treatment of gender-variant boys.

Along with the published critiques, local activists responded to the UCLA programs. In his *Rolling Stone* exposé, Rorvik (1975) reported briefly on the Coalition Against the Dehumanization of Children, a Los Angeles-based group that protested the UCLA child gender program. This coalition condemned childhood gender studies for their complicity in fostering "so-called 'normal masculine role behavior' [which] is nothing more than the outdated stereotype of dominant, competitive, violence-prone males, who are oppressors of women, gays and all peoples" (p. 53).

Critics leveled a number of objections to the work on gender-variant boys, some of which have become permanent features of the ongoing critiques of this body of research. They charged that Rekers's work in particular—and by extension the broader field of research and treatment of gender-variant boys—mistakenly recast a broad social problem in terms of individual pathology. As Rorvik (1975) put it, "How will society ever change if accommodating psychotechnologists keep changing *us* to conform to society?" (p. 53). Nordyke and colleagues (1977) further argued that Rekers and Lovaas evidently accepted and supported existing sex role stereotyping, thereby "failing to contribute to the solution of a larger social problem" (p. 553).

Several critics also questioned the forms of traditional masculinity and femininity that underwrote Rekers's treatment program. Not surprisingly, they also took issue with the specific methods of intervention that Rekers and his colleagues used. For example, Nordyke and colleagues (1977) questioned the severity of Rekers's techniques, citing a basic therapeutic rule to use the least severe intervention possible.

Finally, they all questioned and challenged the legitimating rationale that Rekers and colleagues (Rekers & Lovaas, 1974; Rekers et al., 1974) used to justify their work

on gender-variant boys. Rekers and colleagues' rationale had been built on existing justifications established in the 1960s. In the simplest terms, these authors argued that gender-variant children should be treated in order to avoid what they labeled as undesirable adult outcomes, such as transsexuality, transvestitism, and effeminate homosexuality, and because of the disapproval, especially peer disapproval, and social isolation that feminine boys suffered. They asserted that treating gender variance by stamping it out would result in better psychosocial and psychosexual adjustment in the present and the future.

Critics targeting Rekers's work drew on scientific discourses of androgyny from feminist psychology (e.g., Bem, 1974) to support their arguments. This new body of research suggested that androgyny was potentially the healthiest sex role for both men and women. Critics making use of this discourse argued that, instead of working to expand concepts of gendered behaviors and thus moving toward more androgynous outcomes, Rekers's treatment redirected children toward a very narrow set of traditional behaviors and identifications while trying to eradicate cross-gender identifications and behaviors. For instance, Winkler (1977) argued that Rekers's approach, which assumed that stereotypically masculine behaviors would lead to the greatest happiness for boys, might not in fact lead to optimal outcomes. Instead, Winkler turned to Bem's (1974) work and suggested that developing "androgynous target behaviors" (p. 551) might be the best course to take.

Rekers and his colleagues' (Rekers, 1977; Rekers, Bentler, Rosen, & Lovaas, 1977; Rekers, Rosen, Lovaas, & Bentler, 1978) response to this criticism was multifaceted. On one front, they returned anew to their existing justificatory rationale for treating gender-variant children. But they also responded to the critiques in ways that reframed and reinterpreted their own work. These responses encompassed a new way of framing the problem that they purported gender-variant children manifested and new goals concerning the purpose of treatment. Their primary response was to claim that their treatments had always aimed at producing androgynous boys with a wide repertoire of gendered behaviors. In order to show that this was the case, they described gender-variant boys in new ways. Prior to the critiques of their work, descriptions of pre-treatment boys focused on the amount of gender-variant behavior the boy manifested. After the critiques began to appear, however, they shifted the focus of their descriptions to the quality of gender variant behavior being manifested. Whereas in the past expressions of femininity had been identified as the primary problem for these boys, now they focused more on the inflexibility and narrowness of

their gendered behaviors, which happened also to be feminine.⁹ For example, in their initial report on a patient known as Kraig, Rekers and Lovaas (1974) opened their article by telling us that the population of interest (which Kraig represented) was “young boys with feminine sex-typed behaviors” (p. 173). In a post-critique retelling of the same case study, Rekers (1977) opened his article by describing Kraig as “a 5-yr-old boy with pronounced sex-role inflexibility and stereotypic extremes in gender behavior” (p. 559). In Rekers’s new framing, the emphasis had shifted away from Kraig’s femininity per se, which in strict terms is not mentioned at all in this description, and focused instead on the rigidity of his gender behaviors.

The gender researchers used other techniques to underscore the move away from femininity as the core problem. They began to illustrate their work with examples of disordered gender other than the feminine boy. For instance, a group of UCLA psychologists (Rekers et al., 1977) opened a post-critique article in the following way:

Normal children, as they grow, will typically explore the various aspects of their sex-role behaviors. . . . This exploration and flexibility of sex-typed behaviors, typical of many boys and girls, is normal and healthy. On rare occasions, this normal trying out of opposite sex-role behaviors becomes excessive. *One such example is given by the pathological, “super-masculinity” of boys who are violent and can show no gentleness or sensitivity to others. Such boys desperately need psychological treatment* [italics added]. The other extreme is seen in boys who insist that they are girls, rejecting their male role. (p. 2)

In essence, through their strategic use of examples, these researchers suggested that gender disorders occurred across the full gender spectrum and could express themselves in either gender-conforming or gender-nonconforming ways. In one sense, the focus on the inflexibility of behaviors combined with the assertion that these disorders could be expressed across the gender spectrum ostensibly created a level playing field (the disordered gender could be expressed in many ways) where gender per se was not really at the core of the problem.

With the problem effectively redefined, the goals of treatment and solutions sought were also revamped. For example, in a report from the pre-critique period, the

researchers’ stated goals were “to suppress feminine sex-typed behaviors and to increase masculine sex-typed behaviors” (Rekers et al., 1974, p. 99). Likewise, in their first report on Kraig, Rekers and Lovaas (1974) had described the goal of their work succinctly as “exploring environmental manipulations that might normalize [gender variant boys’] deviant sex-role behavior” (p. 175). However, in Rekers’s post-critique version of Kraig’s treatment, the goal became “to treat sex-role rigidity” (Rekers, 1977, p. 559).

Rekers and colleagues responded to critiques by drawing on the androgyny literature in seemingly contradictory ways. On the one hand, they claimed that their treatments encouraged an increased range of gendered behaviors, thus echoing core tenets of new androgyny theories. For instance, they said that they aimed for “sex-role flexibility” (Rekers, 1977, p. 561) and the development of select masculine and feminine characteristics (Rekers et al., 1977) in the boys they treated. On the other hand, Rekers argued that the androgyny literature supported treating boys specifically for femininity. Arguing that Bem’s findings indicated “high femininity in *females* is not an optimal characteristic” (Rekers, 1977, p. 559), Rekers extended that argument to assert that “high femininity in *males* would be at least equally problematic” (Rekers, 1977, p. 559). While he adopted the androgyny literature in a way that ostensibly created an equal playing field for gender disorders of all sorts, Rekers also drew on that literature to pinpoint both femininity and gender nonconformity as the most disordered gender behaviors, thus leading him back to the feminine boy.

Rekers and others from the UCLA psychology department thus responded to critiques by reasserting old justifications and reinterpreting their work through the lens of feminist psychological research on androgyny. However, their other publications from the same era and later suggested that day-to-day practices in the clinic changed little if at all (e.g., Rekers, 1979; Rekers & Mead, 1979, 1980; Rekers & Varni, 1977; Rekers, Willis, Yates, Rosen, & Low, 1977). Although Rekers and colleagues (Rekers, 1977; Rekers et al., 1977; Rekers et al., 1978) talked about expanding the repertoire of children’s gender behaviors, their work continued to focus on eradicating feminine behaviors in boys and replacing them with masculine ones. And while they proposed a broader range of gender disorders, including highly masculine boys and highly feminine girls, their work continued to focus on feminine boys, thus limiting gender disorders in practice to cross-gender behavior and identity in boys. The only real expansion of their research took the form of increasing numbers of masculine girls among their subjects (Bentler et al., 1979; Rekers & Mead, 1979, 1980).

⁹ In publications from the early 1970s, gender-variant boys’ behavior was sometimes typified as inflexible or obsessive. However, these characteristics were not described as the centerpiece of the problem until after the critiques of Rekers and colleagues’ work were published in the mid- and late 1970s.

Rekers's newfound emphasis on narrow and obsessive pretreatment cross-gender behavior and posttreatment expansion of behaviors became a mainstay of the subsequent GIDC literature up to and including the present.¹⁰ In essence, debates over the legitimacy of the work on gender-variant children shaped subsequent GIDC discourse and practice. The critiques and their responses changed the ways that researchers and clinicians were encouraged to see and describe gender-variant children. It pushed them to frame the nature of the disorder in ways that were not solely tied to gender nonconformity. They thus developed new justificatory schemes that purported to respond to but in fact sidestepped feminists' objections.

A New Diagnosis, a Continuing Controversy

The 1970s also saw the construction of *DSM-III* (APA, 1980), which provided the framework for the creation of the diagnosis GIDC. The addition of GIDC to the *DSM* would fundamentally shape subsequent research on gender-variant children, as well as the critical response to that work. The diagnosis generated controversy before it was even officially on the books.

The publication of *DSM-III* (APA) in 1980 was nothing less than revolutionary. *DSM-III* responded to a diverse set of pressures facing psychiatry. These included public controversies, waning resources, diminishing professional dominance for psychiatry, and intraprofessional schisms. Psychiatry increasingly faced both internal and external challenges. In short, psychiatry found its legitimacy called into question on a number of fronts.¹¹

DSM-III (APA, 1980) responded to this crisis with attempts to employ a more scientific approach to questions of diagnosis. It moved more strongly toward a medical model premised on separate and discernible disease categories and built upon more or less precise, directly observable (often behaviorally based) diagnostic criteria. In addition, *DSM-III* strived for internal consensus by attempting to avoid some points that would be contentious, especially questions of etiology that different schools of thought had approached very differently. Instead, it claimed to be atheoretical and addressed questions of etiology only when there was broad consensus among psychiatrists about the sources of a given disorder. *DSM-III*

further aimed for consensus through inclusiveness, with the goal of incorporating all the generally agreed-upon disorders that mental health professionals treated.

Several aspects of *DSM-III* (APA, 1980) cohered well with the existing work on gender-variant boys. For instance, the *DSM-III* framers' desire to avoid discussions of etiology fit well with the lack of findings and agreement concerning the sources of boyhood femininity. More importantly, the behavioral and descriptive bent of *DSM-III* matched perfectly with the emphasis in the existing literature on describing the behavioral components associated with boyhood femininity. Finally, the *DSM-III* goal of exhaustiveness and inclusiveness meant that a diagnosis for gender-variant children—which would affect a small population of patients and would likely be used in a small number of specialty clinics—could still make the cut. The fact that Robert Spitzer—the architect of *DSM-III*—was familiar with Green's work and thus called upon him to write the first draft of the diagnosis helped as well (R. Green, interview with author, September 12, 2003).

The work of making or revising diagnoses for the *DSM-III* (APA, 1980) happened officially via a set of advisory committees, with the entire process supervised by the Task Force on Nomenclature and Statistics. The members of the *DSM* advisory committees were chosen in principle to represent a range of expertise within the committee's broad areas of focus.

In or around 1975, Spitzer asked Green to prepare a document on Gender Role Disorders that would be used in constructing *DSM-III* (APA, 1980) (R. Green, letter to R. Spitzer, December 14, 1976; R. Green, interview with author, September 12, 2003). It was almost certainly in this document that Green wrote the first version of what would eventually become GIDC. Thus GIDC was developed under the auspices of the Gender Identity Disorders Committee of the APA (also sometimes called the Gender Role Disorders Committee and the Gender Identity/Role Disorders Committee), itself a subcommittee of the Psychosexual Disorders Committee (also called the Sex Committee and the Sexual Disorders Committee).

Although others worked on the diagnosis over the next few years, GIDC was in large part the product of Green's work. During this period, Spitzer repeatedly linked the childhood diagnosis¹² to Green, referring to it in one memo

10 In more recent studies, the emphasis on narrow and obsessive pretreatment cross-gender behavior is most apparent in the work of Coates (e.g., 1985, 1990), who developed a trauma theory of the causes of GIDC.

11 For a comprehensive discussion of the shift that *DSM-III* (APA, 1980) represented, and the "legitimation crisis" that it responded to, see Horwitz, 2002; Kirk and Kutchins, 1992; Mayes and Horwitz, 2005; and Wilson, 1993.

12 The diagnosis that would become GIDC went through several name changes while being developed—from Psychosexual Identity Disorder to Gender Role Disorder of Childhood to Gender Identity or Role Disorder of Childhood, and finally to Gender Identity Disorder of Childhood. In this section, unless I am referring to a specific named version of the diagnosis, I refer to it as the *childhood diagnosis*.

as “the category originally described by Richard Green” (R. Spitzer, memo, January 26, 1977). The available evidence (e.g., R. Spitzer, memo, January 26, 1977; R. Spitzer & R. Friedman, letter to R. Green & R. Stoller, December 3, 1976; R. Spitzer & R. Friedman, memo, December 27, 1976; R. Spitzer & R. Friedman, memo, January 5, 1977) suggested that early on (i.e., during the latter part of 1975, through 1976, and into early 1977) there were few major concerns about the childhood diagnosis. The major issues at hand were what to call it (Green had originally termed it Psychosexual Identity Disorder) and whether and how intersex children thought to exhibit gender problems might be included in the diagnosis.

While committee members may have deferred to Green’s expertise on matters concerning the childhood diagnosis, the most drastic changes to the diagnosis would not be initiated by Green—they occurred in response to outside critiques. These changes included having separate criteria for diagnosing boys and girls and moving to a clearer focus on issues of identity.

During the spring of 1977, critiques of the diagnosis began to appear behind the scenes. As part of the process for putting together *DSM-III* (APA, 1980), Robert Spitzer circulated draft versions of diagnoses to various constituencies within the mental health professions for their appraisal and input. Either through this process or by other means, San Francisco psychiatrist Ann Chappell, a member of the APA Committee on Women, received a draft of the Psychosexual Disorders diagnoses sometime in the first half of 1977. Chappell was most concerned about three diagnoses—Gender Identity or Role Disorder of Childhood, Other Gender Identity or Role Disorders of Adult Life, and Sexual Sadism. Based on her concerns, she circulated a Dear Colleague letter to members of the Committee on Women and to others in her professional networks. The letter outlined Chappell’s objections and asked for recipients to respond with their input. The response to Chappell’s call was evidently quite significant. Via both Chappell and through direct correspondence, Spitzer and the advisory committee received what Spitzer characterized at the time as “voluminous correspondence” on the matter (R. Spitzer, memo, July 11, 1977). These letters came primarily from feminist mental health professionals.

The critiques of the childhood diagnosis first and foremost questioned the inclusion of girls in the diagnostic criteria, especially given the fact that the existing research and clinical evidence was based solely on studies and treatment of boys. As one writer put it, “in a civilization in which adult males, by and large, have more status, privilege and power than adult females, it is natural

that perceptive little girls would identify somewhat with males” (C. Wolman, letter to R. Spitzer, May 30, 1977). While the bulk of the criticisms focused on how the diagnosis was inappropriate for girls, some extended the criticism of “stereotypes” as applied to boys as well.

Many were also concerned with the ways that the diagnosis mixed together gender role and gender identity. As Chappell put it in her summary letter to Spitzer, “The category tries, but fails, to differentiate true identity confusion from failure to follow sex stereotyped roles in an era of increasing emphasis on androgyny and freeing up from sex role stereotyped restrictions” (A. Chappell, letter to R. Spitzer, June 29, 1977).

Chappell asked letter recipients to make specific recommendations for rewording the diagnosis. Some suggested that the diagnosis be scrapped altogether; others thought it should apply only to boys, or at the very least that it should be split by sex with separate discussions and different criteria for boys and girls. Some suggested that girls have more stringent criteria than boys. Several urged care that “normal” or “moderate” tomboys not be caught up in the diagnostic net. Others had suggestions about how to limit the category to a clear disorder of identity instead of role. For example, Carol Nadelson suggested eliminating all of the “sex stereotyped material” (letter to A. Chappell, June 13, 1977), including references to clothing and play preferences for both boys and girls.

While Chappell’s letter writers had clear and trenchant critiques of the diagnosis, most also held on to some notion of (or at least the possibility of) a legitimate childhood gender disorder diagnosis. The clearest illustration of this belief was evident in the way that they had mapped a health/pathology distinction onto a role/identity distinction. For example, one letter writer who argued against treating girls who showed evidence of “masculine role identification” or those who might “develop a homosexual arousal pattern” still maintained that “it is important to treat the very rare pre-transsexual girl” (C. Wolman, letter to R. Spitzer, May 30, 1977). Even those who thought the diagnosis should be scrapped altogether did not dismiss completely the idea of a gender disorder. Instead, they suspended final judgment, noting, for example that “little is really known about these issues and so perhaps waiting to include them until more studies have been reported might be more scientific” (E. Welsch, letter to V. Bernard, May 25, 1977).

In late June 1977 Chappell wrote to Spitzer to summarize the letter writers’ concerns about the GIDC diagnosis in formation. Spitzer took the criticisms seriously and along with putting them forward to the committee also invited Chappell to advise the committee on steps it could

take to make the diagnosis more acceptable (A. Chappell, letter to R. Spitzer, October 26, 1977; R. Spitzer, memo, July 11, 1977).

In the next few months the diagnosis underwent significant changes, and in the end the critiques from the Committee on Women had considerable impact on the final diagnosis that appeared in *DSM-III* (APA, 1980). They were successful in moving the diagnosis toward a focus on questions of gender identity, especially as evidenced in anatomic dysphoria. In addition, the diagnosis formed in the wake of their critiques instituted for the first time separate criteria for boys and girls with gender disorder, with narrower diagnostic criteria for girls. In addition, the diagnosis included some small references to the differential social value placed on boys and girls and men and women, and it attempted to acknowledge the ways that this might manifest nonpathologically in girls' gendered behaviors and identifications.

Lessons for Contemporary Debates

In 1980 *DSM-III* (APA) was published and included the diagnosis Gender Identity Disorder of Childhood. After more than 20 years of research and treatment and several years of critique and debates, the work on feminine boys and increasingly on masculine girls had been formalized in the APA's listing of mental disorders. Since then, as outlined at the beginning of this article, the diagnosis has been subject to critique with the debates over its legitimacy escalating over the course of the 1990s. Current critiques have sometimes drawn on earlier published works, for instance using Rekers's work as an example of either the most egregious form of treatment gender-variant children have been subjected to (e.g., Bem, 1993) or as the paradigmatic example of the typical treatments gender-variant children have received (e.g., Burke, 1996; Feder, 1997). However, the early work that I have reviewed, including the first critiques of the childhood gender disorder concept, have been overlooked in their potential to fully inform current debates. So, what can be learned from the early period that I have been outlining?

In a very basic sense reviewing this history draws attention to the way that clinician-researchers constructed the notion of feminine boys in response to their own professional needs and interests. This early work on boyhood femininity established several important and enduring orienting frames. Specifically, researchers defined gender variance as a problem, thus directing their attention toward signs of pathology instead of, for example, resiliency. They also defined the clinical phenomenon and its indicators largely in terms of sets of behaviors instead of, for example, meanings, identity, or

even existence or extent of psychic pain. And their work was largely fueled by their interest in a narrow set of possible adult outcomes, namely sexual orientation and gender identity instead of, for example, general psychosocial adjustment.

While scientists of various stripes tend to understand their work as a form of discovery of what already exists, my review of the early studies of gender-variant boys shows the ways that researchers also framed and constructed the concept of feminine boys in response to their own existing professional concerns and crises. In so doing, they responded to taken-for-granted assumptions about the nature and value of gender and sexual nonconformity. Many critics over the years have challenged aspects of these framings. However, there are portions of the original orienting frames that live on, even in and through the critiques that would otherwise challenge GIDC and the work associated with it. For example, the assumption that gender variance is necessarily, in some form or another, evidence of pathology has permeated both the defenses and the critiques of GIDC. While this has not universally been the case—Corbett (1997), for example, warned against mapping a health-pathology model onto a gender conformity-nonconformity continuum—some critics have argued that certain forms of nonpathological gender nonconformity be excluded from the diagnostic net by identifying (or at least hinting at) the truly pathological forms of gender variance (e.g., Bartlett et al., 2000; Haldeman, 2000; Richardson, 1999).

This approach overlaps with another way in which the early framings have endured, even via critiques. As I have shown, the will to understand (and control) psychosexual development has motivated the research on gender-variant children. As such, there has been a deep interest in the adult sexual orientations and gender identities of gender-nonconforming children. For clinicians who treat GIDC, this has been (and continues to be) partly motivated by the promise of preventing some outcomes and encouraging others. For many contemporary critics, there has also been a clear interest in psychosexual outcomes, although with an important twist. Drawing on the findings from longitudinal studies of gender-variant children, critics have noted that large portions of GIDC children will grow up to be homosexual (e.g., Bartlett et al., 2000; Bem, 1993; Burke, 1996; Haldeman, 2000; Isay, 1997; Moore, 2002; Morgan, 2001; Neisen, 1992; Sedgwick, 1993). Some of these critics have then mounted a critique of GIDC in the name of protecting pre-homosexual children, citing the APA delisting of homosexuality and arguing that because they will eventually grow up to be homosexual—a nonpathological

outcome—pre-homosexual children should not be pathologized and treated during childhood using GIDC.¹³ This may seem like a legitimate, logical, and strategically savvy use of researchers' findings to challenge their own clinical work. However, it reinforces the original framing device of understanding the behaviors of gender-variant children as precursors of adult sexual orientations and gender identities only. The goal therefore becomes protecting certain kinds of children (specifically, pre-homosexual children) from the GIDC diagnosis based on their presumed adult sexual orientation. With this approach, however, we risk losing a focus on the possible negative effects of GIDC diagnoses and treatments on the general psychosocial (not psychosexual) adjustment of all GIDC children, regardless of their eventual adult sexual orientation and gender identity.¹⁴

Just as the history of early framings has important lessons for the contemporary moment, so do the first round of critiques that took place in the mid- and late 1970s. With some small amount of historical distance on this period, the outcomes of the early debates—such as the critiques of Rekers's treatments and the reformulations of the diagnosis-in-formation within the APA—are easier to see. Scientific controversies, either between lay and scientific groups or schisms among scientists, have become the site for important analyses of the production of scientific knowledge. Scholars have shown, for example, the ways that lay interests can mobilize to either promote (e.g., Arksey, 1994; Riessman, 1983; Rittenhouse, 1991;

Scott, 1990) or challenge (e.g., Bayer, 1987; Figert, 1995) existing or potential medical categories. Others have examined schisms among scientists and have argued that even dissenting views among scientists, including positions that are never adopted, are key in the construction of scientific knowledge (Armstrong, 1998). Epstein (1996) brought these strands together in his examination of the interplay of AIDS activists and a variety of claims about AIDS based on scientific knowledge. He argued that “knowledge emerges out of *credibility struggles*” (p. 3). In other words, scientific controversies, both controversies among scientists and controversies fueled by lay interests, are key sites for the construction of subsequent scientific knowledge.

The early debates that I have outlined underscore Epstein's (1996) contention that knowledge emerges from credibility struggles. But with respect to GIDC it is important to consider the eventual form that resulting knowledge has taken; what have these credibility struggles wrought? In the case of critiques of Rekers's work that drew on feminist theories of androgyny, I have outlined a process of cooptation whereby the critiques were absorbed into the researchers' own work in a way that ignored the spirit and deep substance of those critiques. Critics drew on new feminist psychology to call for a thorough rethinking of the way that gender-variant children were defined as a problem and to question the behavioral treatment approaches used to treat gender-variant boys. Although Rekers and his colleagues responded by also adopting the language of feminist psychology, their work continued to define gender-variant children as a problem and their treatment approaches continued to encourage gender conformity as a solution to that problem.

The effects of this round of critiques can also be detected in later omissions from official knowledge about gender-variant children. Whereas the 1960s and 1970s publications included many detailed accounts of the treatment of gender-variant boys, usually in the form of the single case study report, the treatment literature began to dwindle in the 1980s. Making an assessment of the contemporary state of GIDC treatment literature, a leading GIDC defender told me that “there are no systematic, comparative, treatment studies . . . nobody ever publishes data about what happens in therapy” (interview with author, October 22, 2003). While there are several explanations for the paucity of treatment literature, including the way that the appearance of an official diagnosis shifted knowledge production to questions of diagnostic reliability and validity, it is plausible that the critiques of Rekers's treatments played a part in encouraging GIDC researchers and clinicians to focus their published works on areas other than issues related to treatment.

13 Critics' focus on homosexuality is also a function of the way that the APA's delisting of homosexuality is interpreted as analogous to contemporary efforts to remove GIDC from the *DSM*. While both GIDC critics and defenders note many parallels between the ultimately successful efforts to delist homosexuality and current critiques of GIDC, they are distinct in important ways. For instance, the effort to delist homosexuality had the full force of a burgeoning social movement behind it (see Bayer, 1987); efforts at reforming or delisting GIDC have been piecemeal at best and primarily (although not exclusively) take place as intraprofessional debates.

14 Zucker and Spitzer (2005) challenged some critics' (Bem, 1993; McCarthy, 2003; Moore, 2002; Morgan, 2001; Sedgwick, 1993; Wilson et al., 2002) interpretation that GIDC was a backdoor mechanism for keeping homosexuality under the purview of psychiatric control. Instead they argued that GIDC's (and transsexualism's) entrée into the *DSM* was primarily the result of “expert consensus” (p. 31). Although they made several important points concerning the limitations of conspiracy theory interpretations of the inclusion of GIDC in the *DSM*, they do not fully address the historical forces leading to GIDC's inclusion discussed in this article. In addition, they do not address the varied ways in which GIDC may function to reinforce homophobic forces; for a more complete discussion, see Bryant (2006a).

An area where there was seemingly more successful leveraging of critique is found in the APA Committee on Women's interventions with the diagnosis-in-formation. To understand the full impact of these critiques, however, it is necessary to look forward to the way the diagnosis has evolved since its initial formation. Throughout the revision process, the diagnosis has gradually gone through a process of domain expansion, whereby increasing numbers of children can potentially be caught up in its diagnostic net. One of the ways that this has occurred has been through making the girls' and boys' diagnoses more equivalent.¹⁵ Thus, in some ways the original gains resulting from the letter-writing campaign have been rolled back. However, another important issue to examine is the effectiveness of these gains in the first place. While the diagnosis did give guidelines about whom to diagnose, these were in no way hard-and-fast (the literature is replete with discussions of subclinical populations of children who are studied and sometimes treated). Further, an important omission from the *DSM* is a discussion of the kinds of treatment that GIDC children should receive. (This omission is a general orientation of the *DSM* and not unique to GIDC). Beginning with the APA Committee on Women and continuing up to the present, critics have devoted a great deal of energy to critiquing and reworking the diagnosis itself, but the actual impact that the diagnosis has may be quite limited and can have both positive and negative effects. The *DSM* certainly has important symbolic and material effects; however, these effects are varied and limited. While the GIDC diagnosis makes a value statement about forms of childhood gender variance (i.e., that they can be pathological and should be treated), the actual day-to-day uses of the diagnosis are less clear. The *DSM* is full of residual categories (the Not Otherwise Specified diagnoses) and general diagnoses that can be used as substitutes in cases where a clinician decides that he or she does not want to give a diagnosis such as GIDC.¹⁶ Removing or revising the diagnosis may have little to no impact on the actual practices of clinicians who work with gender-variant children. In fact, if the diagnosis were to be removed from *DSM*, it is plausible that the kinds of debates reviewed in this article—debates that have shined light on existing mental health

approaches to gender-variant children—might dwindle, thus allowing existing clinical approaches to operate off the critical radar. In addition, the diagnosis may have unforeseen positive effects. One of the earliest and most prominent critics of GIDC told me in an interview that he has come to see the diagnosis as a red herring in advocacy work for gender-variant children. Among other things, he pointed out that the diagnosis has actually proven beneficial in some instances, for example in securing rights for children in public schools to dress in the manner that is appropriate for their gender identity (interview with author, May 21, 2003).

Conclusions: Looking Back and Moving Forward

How, then, given the existence of GIDC, can we support and advocate for gender-variant children within the context of mental health service provision? The picture I have painted seems bleak. Challenges to dominant knowledge formations are met with incorporation or disregard and potential gains turn into losses or turn out to be inconsequential. I believe that the putative failures of the critiques are due in part to their narrow focus on GIDC itself. When the focus of critiques is narrowly on the GIDC diagnosis, they can be commandeered and reframed by GIDC supporters.¹⁷ There needs to be, therefore, a reorientation in focus away from GIDC in particular and onto the general psychosocial health of children, specifically here on gender-variant children. In this case, revising or eliminating the diagnosis becomes secondary to the more immediate (and I would argue more important) task of developing new models of mental health support for gender-variant children.

I want to end by suggesting that the development of the new models that I am calling for has in fact begun. And, while the critiques I examined have had limited utility in changing the immediate target of their criticism (that is, the GIDC diagnosis itself), they have actually been instrumental in catalyzing the beginnings of a cultural shift in the mental health professions vis-à-vis the meanings attached to childhood gender variance. It is this cultural shift that holds the most promise for generating new models of affirmative support for gender-variant children.

15 For example, whereas in *DSM-III-R* (APA, 1987) girls but not boys had to state a desire to be the opposite sex in order to qualify for the diagnosis, in *DSM-IV* (APA, 1994) neither girls nor boys needed to make such statements.

16 One published GIDC researcher and clinician reported that she never used the GIDC diagnosis in her work with gender-variant boys (interview with author, December 2, 2003).

17 For both for its critics and defenders, a narrow focus on GIDC is made infinitely more problematic in light of recent developments attributable largely to transgender activism. The proliferation of new meanings of gender variance and the associated appearance of new social subjectivities arguably render GIDC untenable in ways not fully explored here. For a discussion of these and related issues, see Bryant (2006b).

Many critics have fought for specific reforms, from tweaking GIDC's diagnostic criteria to eliminating the diagnosis altogether. Yet, arguably their greatest impact has been to draw attention to the shortcomings of status quo mental health approaches to gender-variant children and, in doing so, to open up intellectual terrain where practitioners and others can imagine new ways of providing services to gender-variant children. Alternative approaches (e.g., Menvielle & Tuerk, 2002; Children's National Medical Center, 2003) that do not define the gender-variant child as the problem have begun to appear and are beginning to infiltrate terrain that was once held solely by GIDC researchers and clinicians. Their reorientation to gender-variant children has, for example, redefined the problem not in terms of the gender variance itself but instead in terms of the stigma to which gender-variant children are subjected. As such, the goal of mental health service provision becomes helping children and their families cope with stigma instead of trying to change gender-variant behavior itself (e.g., Menvielle & Tuerk). It is these kinds of programs that hold out the greatest promise for a future where mental health professions play a key role in providing meaningful support to gender-variant children.

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