Ask the Expert

Gender Identity Disorder

Case and reply from John Michael Bostwick, M.D., Associate Professor of Psychiatry, Mayo Clinic College of Medicine, and Consultant, Department of Psychiatry and Psychology, Mayo Clinic and Foundation:

M, a 36-year-old genetic male serving in the military, was ordered by his commander to see a psychiatrist. A neighbor, a fellow military man, had reported seeing M leave his house dressed as a woman, and the commander felt she had no other choice than to find out if M was mentally ill. M had been a moderately effeminate boy who had preferred female playmates and knew he wanted to be "one of the girls." He had chosen dolls over trucks and playing house over roughhousing. Until puberty M had selectively chosen "girlish" activities and had known that he was somehow "different" from other boys, but, berated and humiliated by his father, he had embarked on a hypermasculine adolescence that culminated in his military enlistment. He adorned his triceps with a four-inch tattoo and volunteered for the most arduous assignments, including a year in a combat zone. His military record was impeccable until he was reported for his cross-dressing behavior. Neither the psychiatric evaluation nor psychological testing revealed any overt psychopathology. He reported that he had started dressing as a woman several years earlier with his then-wife when they were having marital problems. He found it remarkably calming, and they got along better "woman-to-woman" than they ever had as husband and wife. "We could relate to each other so much more easily," he said. M had been married and divorced twice. Both his wives agreed that he was more maternal than they, and he had become the custodial parent to all three children, one from his first marriage and two from his second. He had increased the time that he was presenting as a woman from occasionally dressing up to donning female garb immediately on arriving home from work and staying in it until he left the next morning. His children now called him "Mom," and he was an officer in his son's Parent-Teacher Association as a woman. He said that he had always known he felt "different" but had no words to describe it until well into his second marriage, when he began to explore his gender identity on the Internet. He had never had a homosexual experience and had no interest in being a man with a man. His intent was to retire from the military at the first opportunity that preserved his pension, to spend a year on female hormones while living the Real-Life Test, and to undergo sexual reassignment surgery. He intended to blend into the civilian community as a woman, and he hoped to find a husband and function as a wife. He had absolutely no qualms about making the transition to being female. "It's who I am inside."

Reply:

Encountering a patient like M forces the clinician either to try to persuade the subject that he or she is ill or to wrestle with the real possibility that a binary view of gender identity is insufficient to explain the breadth of possibilities nature offers up. "Gender dysphoria" applies to a spectrum of individuals with varying degrees of discontent with their given gender. Carroll (1) proposes four general categories of outcomes for gender dysphoria, including "an unresolved outcome, acceptance of biological gender and roles, engaging in the cross-gender role on an intermittent basis, or adopting the other gender role full-time." As a transsexual, M represents the extreme of the spectrum: a person prepared to undergo a complete physical transformation to make the outside match the perceived inside.

While DSM-IV-TR provides us with a category for M, gender identity disorder, the condition is ultimately a cultural construction. People who fit the criteria are not acting the way they are supposed to, and thus they challenge the way men and women ought to be. The dichotomy between what is and what should be comes into especially sharp relief in an institution like the U.S. military, with its rigid views of what constitutes correct sexual and gender behavior. The differential diagnosis of gender identity disorder is broad, including psychotic disorders, borderline personality disorder, dissociative identity disorder, transvestism, and ego-dystonic homosexuality, among other conditions. The psychiatrist in this case could find no axis I or axis II pathology in M other than the discrepancy between the patient's phenotype and his assertion of whom he knew himself to be inside.

Children typically know their core gender identity by age 2. Regardless of eventual sexual orientation, the vast majority know at the core they are male or female, consistent with their chromosomal sex. The problem of gender discrepancy had always been there for M. His history typifies at least one developmental path for transsexual patients. While a high proportion of those whom Richard Green (2) labeled "sissy boys" for their preadolescent effeminate predilections grow into men with homosexual orientations, a few question their core gender identity before they have words or concepts to understand themselves. M was one of these. He knew no one like himself, a girl trapped in a boy's body. As he described it, his eruption into adolescent hypermasculinity was entirely derivative and reactionary, an attempt to copy "real men" so that he might somehow become one himself and win his father's admiration rather than his ridicule. In the process, he acquired a distinguished military career, two wives, several children, and an extreme dissatisfaction with the appurtenances of masculinity, although not with the institutions of marriage or parenting. Physical reality notwithstanding, M experienced himself as a she, wife, and mother rather than the he, husband, and father his community took him to be.

A growing scientific literature supports the idea that body and brain are not always synchronized with respect to anatomical/chromosomal sex and gender identity. In mammals such as rats, hormonal disruptions at critical perinatal ages can cause an animal of either chromosomal sex to exhibit mating behaviors typical of the other sex, irrespective of castration (3). In human beings, brain masculinization in utero appears to occur independently of genital development (4), supporting the possibility of situations like that of M, who thinks and feels that he should not have to possess alien—but otherwise normal—male parts.

M is not a hermaphrodite or intersexual. He does not have physical attributes of both sexes, as occurs in such conditions as congenital adrenal hyperplasia or 5-alpha reductase deficiency (5, 6). He is not a transvestite, a genetic male possessing both a solid male core gender identity and a fetish for wearing women's clothing. Unlike transvestites, who are typically sexually aroused by donning female attire, M finds dressing as a woman calming and affirming of whom he believes himself to really be.

M's story exemplifies the potential fluidity of both sexual orientation and object choice. As a man, his sexual activities were exclusively heterosexual. As a woman, she expects also to be exclusively heterosexual insofar as sexual orientation is defined in terms of the gender presentations of the partners rather than their chromosomal constitutions. (Some legal constituencies, such as Bexar County, Texas [San Antonio], follow a chromosomal standard that has permitted—unintentionally—legal marriages between couples in which one is a transsexual, with both showing up for the wedding as either men or women.) Object choice may not change, even though the label applied to the individual's sexuality may. J, a female-to-male transsexual, lived as a lesbian until after sexual reassignment. From then on, continuing to have sexual relations only with women, she identified herself as a heterosexual man.

Sexual reassignment surgery is obviously regarded as an irrevocable step. Before making the final cuts, most patients are required to undergo the Real-Life Test, explicated in the Harry Benjamin International Gender Dysphoria Association Standards of Care for Gender Identity Disorders (7), the most widely followed guidelines for medical treatment of transsexuals. The Real-Life Test typically includes spending at least a year before surgery living exclusively in the desired gender. Patients may take hormones during this time and are expected to have an ongoing relationship with a mental health clinician who is required to write a letter in support of surgical transformation.

My own experience of working with gender-disordered patients has forced me to challenge my basic assumptions about the structure of sex and gender in the animal kingdom in general and in human beings in particular. Bagemihl (8) points out that examples of aberrancies from gender stereotypes are rife throughout the natural world. In the absence of major axis I or II psychopathology that could offer an alternative explanation for patients' assertions that they are not the women or men they appear to be, I work with them to find some accommodation—up to and including the Real-Life Test and sexual reassignment surgery. My overarching goal is to help them survive—even thrive—in a culture that maintains the illusion of only two innate gender possibilities.

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