

Gender Atypical Youth: Clinical and Social Issues

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Abstract: School psychologists must often address the challenges presented by gender atypical youth; for example, girls who are referred to by their peers as “tomboys” and boys who are referred to by their peers as “sissified.” Such children often are the targets of harassment and abuse from peers, as well as being the focus of concern for parents and school personnel. This article summarizes the theoretical and treatment literature in this area, which has historically pathologized the gender-nonconforming child and based treatment upon adaptation to social norms. A social constructionist perspective is provided as a lens through which the school psychologist may view the gender-nonconforming child in an effort to de-pathologize some aspects of gender atypicality and avoid the automatic confabulation of gender behavior and sexual orientation. Suggestions for interventions with a spectrum of gender-nonconforming children as well as with family and/or school systems are offered.

Girls who are referred to as “tomboys” and boys who are called “sensitive” by their peers are familiar to most school psychologists. These boys and girls attend schools in rural and urban areas, come from all ethnic and cultural groups, and belong to diverse socioeconomic strata. Some-times, their behavior passes with little more than sneers from schoolmates. At other times, such nonconforming children become the targets of harassment, abuse and violence (D’Augelli, 1998). Historically, school personnel have had little guidance in working with such children. Are gender atypical children truly psychiatrically ill? What approaches should school psychologists consider when working with them as well as those students who victimize them? Due to the frequency with which school personnel encounter gender atypical children and the safety concerns that are central to learning, such questions are important and need greater examination in the literature. Further, school personnel need guidance with respect to which cases need serious intervention and which do not.

Our expectations for appropriate gender role behavior for children are as deeply embedded in culture and society as are our expectations that

the sun will rise in the morning and set in the evening. So automatic and profound are these expectations that we often ignore the fact that normative gender role behavior is socially constructed and maintained. Nonetheless, such expectations create the lens through which parents and teachers view the social behavior of children. Boys are traditionally expected to engage in rough and tumble activities and to select cars, trucks, and weapons for play. Girls, on the other hand, are expected to demonstrate maternal and/or artistic behaviors and favor dolls and domestic items for play. These norms often go unquestioned, and for the majority of children, they may apply, at least, to some degree.

But what of the child whose behavior appears to be at odds with the socially constructed expectations associated with gender? At a minimum, such a child may arouse the anxiety of the adults in her or his life and be subject to peer harassment and rejection. “Gender atypical” youth, for example, girls who go through life engaged in commando fantasies, and boys who prefer Barbie to baseball, are typically described in the literature as troubled, withdrawn, and anxious (Zucker & Bradley, 1995). At the

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extreme, some children may be convinced that they were born into the body of the wrong sex. The reasons for their distress have been poorly understood. Researchers studying and treating gender atypical children have consistently assumed that anxiety, social withdrawal, rage, and other emotional reactions are intrinsic features of gender atypicality, either due to the child's frustration at being restricted from preferred cross-gender activities (Stoller, 1978) or to personal or systemic psychopathology in the family (Coates & Person, 1985). Researchers have not considered the possibility that these emotional factors may be normative responses to disapproving families and hostile peer groups. Further, researchers in this area have not considered the possibility that gender atypical behavior may, in some cases, be of benefit to the individual by expanding her or his behavioral repertoire. In any case, parents of such children often manifest considerable anxiety about them: parental referral of such children for treatment has formed the bases for the scientific study of gender atypical children and the diagnostic foundation of their treatment, Gender Identity Disorder (Zucker & Bradley, 1995).

Etiologic Theories

Gender Identity Disorder (GID), is the diagnostic classification used to treat gender atypical youth since its first appearance in the *DSM-III* (American Psychiatric Association, 1980). The scope of this article permits but a cursory review of the scientific literature that serves as the basis for GID. There remains considerable ongoing debate about the etiologic factors of GID. Some researchers are persuaded that constitutional factors will be found to account for gender atypicality (Coates & Wolfe, 1995), while others believe that the manifestation of gender atypical sociobehavioral characteristics is the result, in each individual, of a complex interaction between the individual's constitution and environment (Fausto-Sterling, 1993).

Biologic theories have included both endocrine and morphological explanations. For instance, the relationship between hormonal-behavioral interactions in humans has been studied in an examination of the effects of congenital adrenal hyperplasia (CAH), an inherited recessive disorder of adrenal steroidogenesis. This disorder causes ambiguous or fully masculinized external genitalia in genetic

females. A number of studies summarized by Zucker and Bradley (1995) indicated that such females are significantly more likely to manifest gender atypical behaviors and attitudes. Hormonal effects on prenatal determination of both gender identity and sexual orientation have been considered by many scientists, most prominently Dorner, Rohde, Seidel, Haas, and Schott (1976). Dorner et al. theorized that gender identity disorder and homosexual orientation in males results from "a predominantly female-differentiated brain" (p. 2) as well as a "central nervous system pseudohermaphroditism, possibly caused by an absolute or relative androgen deficiency during the critical hypothalamic organizational phase in prenatal life" (p. 6). These conclusions have been extensively debated, however, due to their sporadic replicability, small samples, and the complexities associated with inferring behavior and attitudinal variabilities from neuroendocrine data (Burke, 1996). Zucker and Bradley (1995) provided a comprehensive review of neuroendocrine and brain morphology studies in the examination of etiologic factors in gender atypicality and sexual orientation. They reported,

Regarding children with gender identity disorder, we have adduced evidence for between-group differences in the areas of cognitive abilities, sibling sex ratio, birth order, temperament, and physical attractiveness. In all instances, the underlying biological influences . . . remain unclear. (p. 197)

Other theorists have considered psychosocial factors to explain gender atypicality. Money, Hampson, and Hampson (1955) theorized that in place of a theory of instinctive masculinity or femininity which is innate . . . psychologically, sexuality is undifferentiated at birth and becomes differentiated as masculine or feminine in the course of the various experiences of growing up. (p. 308)

At present, however, research in this field has veered away from entirely psychosocial explanations for gender atypicality. Purely psychoanalytic theories of GID are difficult to verify empirically (Burke, 1996) and ignore the body of literature that suggests biological influence or determination of gender identity and sexual orientation. Other, more recent studies that have attempted to show gender atypicality as the result of a particular family constellation suffer from lack of control groups. For example, Green

(1987), in his analysis of the legendary family constellation most likely to produce homosexual and/or gender atypical children (an overly intimate mother and an absent or distant father), suggested that it is difficult to discern whether effeminate boys are rejecting their fathers or being rejected by them.

The theoretical explanations for gender atypicality in girls have been even sketchier and more poorly examined than with boys (Burke, 1996). Zucker and Bradley (1995) noted that far fewer girls are brought for GID treatment than boys (by a ratio of 1:6.3). Misogyny, heterosexism, and the general undervaluing of women's issues could help explain why girls are understudied and underreferred in this area (Ames, 1996). Finally, several studies suggest that gender atypical behavior in girls is generally viewed as less troublesome in the perceptions of parents and peers (Weisz & Weiss, 1991; Zucker et al., 1995). D'Augelli (1998) suggested that girls' gender atypical behavior "mimics conventional 'masculine' characteristics" (p. 189) and that, generally, society endorses masculine behaviors more readily than feminine behaviors. It follows that the more socially desirable the behavior, the less likely it is to become the focus of gender atypicality therapies. This serves to underscore the socially constructed nature of GID.

Ultimately, any attempts to understand gender atypicality that rely on a unitary explanation fail, due to the complexity of the personal and social construction of gender itself. Recent theorists (Coates, 1992; Zucker & Bradley, 1995) have made an effort to address the complex variables associated with the multifaceted nature of GID by acknowledging the interactive effects of constitutional predispositions and environmental effects. Still, these theorists describe the social implications for gender atypical boys in the context of "a state of inner insecurity that arises out of the interaction between a boy's temperamental vulnerability to high arousal and an insecure mother-child relationship" (Zucker & Bradley, 1995, p. 262), or that gender atypical behaviors and fantasies function to manage separation anxiety and aggression (Coates, 1992).

Corbett (1998) identified a more basic flaw in the GID literature: all of our concepts of normative gender behavior are socially constructed and this construction has an arbitrary, albeit commonly accepted, basis. Gender behavior is socially constructed; its perceived normalcy, or lack thereof, rests wholly in the

perspective of the observer. What is acceptable female or male behavior in one culture may be unacceptable in another. This perspective, of course, transfers the pathology from the gender atypical child to the familial and cultural systems. Nevertheless, it begs the question with respect to the young girl who, for example, prefers to play with G.I. Joe: What is wrong with such a child unless she exhibits behavior that has a priori been judged to be unacceptable, based upon socially constructed norms? Corbett (1998), in his examination of "homosexual boyhoods" suggested that it is of greater clinical import to understand the personal and emotional meanings of the child's play, rather than to attempt to redirect or extinguish the child's attachment to gender atypical toys altogether. Thus, the etiologic factors used to explain GID have missed a careful examination of the interactive effects between child and environment.

Diagnostic Issues

A diagnostic classification for gender atypical boys first appeared in the 1980 edition of the *Diagnostic and Statistical Manual* (American Psychiatric Association, 1980). In its 1987 revision, the criteria for this diagnosis were expanded to include girls (American Psychiatric Association, 1987). Burke (1996) asserted that this heretofore unknown category was developed following the removal of homosexuality from the DSM in 1973. According to Burke, given that there was no longer a reason to treat suspected "prehomosexual" children, funding for such research was jeopardized. Burke stated that those "who wished to continue treating nonconforming children had seven years to develop a new category of illness" (1996, p. 60).

At that time, the diagnosis for gender atypical female children required significant "gender dysphoria," demonstrated by the child's "persistent and intense distress" about being a girl, and a stated desire to be, or an insistence that she actually is, a boy. Additionally, the diagnosis required that the girl either demonstrate an aversion to "normative feminine clothing" and insist on wearing male attire, and/or repudiate female anatomical structures. The latter criterion could be met by the girl's assertion that she will grow a penis, does not wish to develop breasts and/or menstruate, and rejects urinating in a sitting position.

Similarly, boys could meet the diagnostic

criteria for childhood GID by demonstrating intense and persistent distress about being a boy and/or intense desire to be a girl. The boy with GID further shows a preoccupation with stereotypical female activities, such as cross-dressing, and/or by an intense desire to participate in the games and pastimes of girls, and a rejection of stereotypical male toys, games, and activities. This may be accompanied by a repudiation of the boy's male genitalia, including the complaint that his penis and/or testes are disgusting, and that it would be better not to have them, and/or that he will grow up to be a woman.

In the *DSM-IV* (American Psychiatric Association, 1994), the criteria for girls and boys were combined, but also were significantly broadened. The once critical feature requiring the child to voice her or his "persistent and intense distress" with being a member of the assigned biological sex was no longer a prerequisite. At present, it is conceivable that a child could be diagnosed with GID exclusively on the basis of preference for gender atypical activities or play objects. It should be noted that the adolescent and adult GID criteria as they appear in the *DSM-IV* retain the requirement that the individual state her or his "persistent and intense" discomfort with membership in the genetically assigned sex and that the change in the children's criteria was made based upon their less developed verbal abilities. Nevertheless, the diagnostic net has been cast much wider with the most recent revision; while it still would likely include youngsters whose genetic sex is a matter of profound subjective disturbance, it also may include simply "tomboyish" girls or "sensitive" boys. This opens the door to treatment for a much wider range of gender atypical children. Early detection of gender atypicality has aroused sufficient concern that there is now a GID category for gender atypical children in the National Center for Clinical Infant Program's *Zero to Three* manual for early childhood psychopathology (National Center for Clinical Infant Programs, 1994). The suggested diagnostic criteria in this manual are similar to those for adults and adolescents found in the *DSM-IV*, though no guidance specific to the assessment of GID in toddlers is provided.

Treatments for GID

Burke (1996) reported on several GID treatment studies, two of which are briefly described. Though both studies are old, they are

selected as still representative of behavioral treatments for GID. A more comprehensive review of the treatment literature may be found in Zucker and Bradley (1995). Rekers and Mead (1979) described a case in which a preadolescent "tomboy" girl is treated through play reconditioning therapy. During a course of 32 play reconditioning sessions, the 8-year-old girl's behaviors and selection of toys go from "exclusively masculine" to "exclusively feminine." Similarly, her gestures become restrained, her gait more dainty, and her choice of attire more stereotypically feminine. At a 14-week follow-up, she is considered to be "cured," given that she requests a Barbie doll for Christmas. As no data exist beyond this follow-up, it is difficult to assess the stability of this treatment. Nor is it possible to determine the overall effect on the child's sense of autonomy and self-esteem, given that she was observed to change from an assertive child to a dependent, restrained one during the course of treatment (Burke, 1996). Whether these outcomes were in the child's best interest is questionable, and what ultimate effect this treatment had on the girl's overall psychosocial development is unknown. In any case, whatever personal and/or social benefit might be derived from gender atypical behavior (assertiveness in girls, sensitivity in boys) is ignored by the unidirectional nature of GID treatments.

Another case (Rekers & Lovaas, 1974) described the attempt to socially recondition a gender-nonconforming boy through behavioral means. In this treatment, the boy's mother participated in the play reconditioning strategy, reinforcing him for engaging in male-stereotypical activities, and ignoring him for engaging in female play. During the course of 56 sessions, the investigators noticed what was described as a "miraculous turnaround" in which the boy made a special point of verbally rejecting his previously preferred, female stereotypical toys and manifested a compensatory enthusiasm for toy weapons. Several years posttreatment, the boy's mother reported concerns that he had become delinquent, possibly in a desire to overcorrect for his "shameful" gender atypical behavior, and that the boy's relationship with his father had deteriorated markedly. Burke (1996) reported that by late adolescence, the boy became aware of conflicts about his own sexuality. He responded by attempting suicide with a salicylate overdose and was reported feeling quite ashamed of both his gender atypical play and the treatment history

intended to correct it.

The aforementioned cases are still typical of interventions designed to treat GID, and, yet, they offer little information by way of long-term effects on the subjects or whether they ameliorate the social ostracism that they are intended to address. Because GID itself is problematic due to the social opprobrium and disapproval associated with gender atypical behavior, it is to be expected that the goal of treatment would be an improved sense of social adjustment. Most typically, however, the outcome criteria are the therapist's subjective impression of the extent to which the child's behavior has become more gender stereotypical. We do not know, in most cases, if the individual's distress about being socially marginalized is alleviated or if the "condition" in question is amenable to treatment in the first place, so poor are outcome data for most studies of GID.

Responding to Gender Atypical Youth

Proponents of GID treatment programs for GID enumerate three primary objectives: minimization of social ostracism; treatment of underlying psychopathology; and as a prophylaxis against the development of adult transsexualism (Rekers & Lovaas, 1974; Zucker & Bradley, 1995). Transsexualism is defined as an enduring sense that the psychological experience of one's gender does not match the genetic sex of the individual. Adult transsexuals often self-characterize as feeling imprisoned in a body of the wrong gender, and the extent to which they need to "pass" as their anatomical gender feels intensely ego-dystonic.

Given the treatment interventions described previously, what recommendations can be made to school psychologists working with gender atypical youth? The first rationale on which GID treatment has been based is reducing social ostracism. There is no question that there are numerous ways in which youth who either identify as lesbian, gay or bisexual, or are presumed to be, have been victimized (D'Augelli, 1998). Much of this victimization is accompanied by serious psychological sequelae. Although many gender atypical youth do not identify as lesbian, gay, or bisexual, it is reasonable to consider this literature in the present discussion.

Burke (1996) noted that most researchers in this area believe that it is easier to change individuals than it is to change society. Neverthe-

less, before recommending treatment to improve gender conformity, the social premise on which such treatment rests needs to be carefully considered. To be sure, the experience of social rejection and harassment can be painful for many youngsters, particularly, because many of them actually are conflicted about their sexual orientation, and their victimization places them at risk for continued problems with adjustment (D'Augelli, 1998). In light of the widespread harassment of children with epithets such as "Fag!" (even for children who are not gender nonconforming), it is tempting to accept the notion that the route that minimizes risk for further harm is conformity. However, if the problem resides not with the child's intrinsic discomfort, but with society's negative response, it seems both unfair and cruel that the child should bear the responsibility for coping with it. As with treatments designed to change sexual orientation, treatments aimed at changing gender conformity never assess the potential harm that may result to the individual's sense of well-being. If such treatments indirectly communicate to children that they are somehow "broken," then it is reasonable to consider that the negative effects on self-esteem from social rejection could be exacerbated by the treatment itself. For even if it is possible to redirect a child's interests and affections without causing internal damage, should not the families, peers, and institutions in the child's life take responsibility for becoming more welcoming, safe places for a diverse range of behaviors? School psychologists, counselors and teachers can, through their own behavior and their specific recommendations, make an impact on the school's climate for tolerance.

The second justification for GID treatments involves the comorbidity of associated psychopathology, either personal or systemic, for the gender atypical child. One research program, for instance, hypothesizes that the manifestation of GID may often be an expression of an underlying syndrome, such as separation anxiety (Coates & Person, 1985). In a case such as this, assessment and treatment of the underlying issue(s), rather than the gender-nonconforming behavior itself, would be the appropriate target of treatment. This perspective is shared by many proponents of GID treatments (Zucker & Bradley, 1995); however, it locates the treatment beyond the domain of individual treatment for GID and places it in the arena of general family or individual therapy.

The third justification for treating GID is to

provide a prophylaxis for adult transsexualism. Justifying GID treatment to prevent adult transsexualism may be problematic for several reasons: first, the direct link between gender atypicality in youth and transsexualism in adulthood has not been established. It is true that most adult transsexuals report having experienced those symptoms that would have qualified them for a GID diagnosis as children, even if they concealed them from others. However, no research yet has shown that most youth with GID become adult transsexuals. In light of the current breadth of the GID diagnosis, this is another area in which relatively common, socially constructed patterns of gender behavior could be grossly distorted to suggest that an individual may develop a truly rare disorder. Further, for those who do become transsexual in adulthood, the experience of gender atypicality is described as being firmly established by an early age and not likely amenable to change from psychotherapeutic intervention.

Most potentially problematic about this justification, however, is the way in which it leads to a confabulation between gender identity and sexual orientation. GID is still considered a mental illness; homosexuality is not. Incredibly, the GID literature still seems to hold the question open (Zucker & Bradley, 1995). Many articles on GID cite outdated theories or studies wholly without scientific merit, decades after all of the mental health professions have dropped homosexuality as a mental disorder. Because gender-nonconforming behavior is often associated with prehomosexuality in youth, many anxious parents present their children for GID treatments, convinced that the additional masculinization of their boys or the increased feminization of their girls will ward off any latent or obvious tendencies toward same-sex erotic attraction. Green (1987) was of the opinion that parents should be free to select such treatment options for their children, if they so desire. This position has recently been contradicted by the policies of the American Psychological Association and the National Association of School Psychologists.

The possible confabulation of gender identity and sexual orientation is dangerous to youth for several reasons. First, it represents interference on a fundamental level with the child's autonomy. The treatments that use emotional reinforcement contingencies from significant attachment figures are particularly liable, it would seem, to cause further pain and confusion in the mind of the

young person. The American Psychological Association's (1997) *Resolution on Appropriate Therapeutic Responses to Sexual Orientation* noted that children and youth are particularly susceptible to influence from peers and society and must not be treated in a coercive manner. The resolution also reasserts the fact that homosexuality is not a mental illness and that all individuals are to be respected in treatment, including children. There is no reason to conclude, from available evidence, that gender-redirective play therapy helps gender atypical children fit in better socially or that it does not diminish overall self-concept.

Most social scientists agree that primary sexual orientation in the majority of the population is established at an early age. No scientifically reliable evidence exists that demonstrates that sexual orientation can be changed, even if it were desirable to do so (Haldeman, 1994). Zucker and Bradley (1995) acknowledged that "there are simply no formal empirical studies demonstrating that therapeutic intervention in childhood alters the developmental path toward either transsexualism or homosexuality" (p. 270). Therefore, the parents who bring in a child of eight are likely too late if it is their hope to change a suspicioned homosexual orientation. They are not too late, however, to instill added shame upon the young person, thus compounding whatever effects of social stigma the child is experiencing. Lastly, such treatments risk teaching children that they themselves are to blame for society's inability to accommodate diverse (gender-nonconforming) individuals. Most youth do not have the requisite ego strength or perspective from life experience to rebuke the stigmatizing effects of such a message.

Summary and Recommendations

Considering the literature supporting the diagnosis and treatment of GID, one has to wonder: Whose problem is it? Negative reactions to gender atypical individuals in society are a matter of fact, but are they corrected by obliging some children to modify their own behavior and interests? And, are youth in critical stages of psychosocial development at risk to be harmed in some way by treatments aimed at reorienting gender identity? These questions highlight the complex implications of conducting treatment for this diagnosis and serve to remind the school counselor or psychologist to proceed very

carefully when GID appears to be at issue.

Some adult transsexuals would argue that the GID category is necessary to secure third party reimbursement for psychotherapy and/or sex reassignment surgery. While this may, sometimes, be the case, diagnostic criteria are to be based upon scientific, not economic, justification. Nonetheless, as mentioned previously, most true adult transsexuals report having been aware of gender dysphoric feelings very early in life. What benefit might have been derived by such individuals to have had access to a value-neutral therapeutic environment in which to explore and understand their gender-nonconforming feelings? No such programs are examined in the literature; rather, interventions designed to neutralize and reverse gender-nonconforming behavior are described. But if there is a legitimate application for GID, perhaps it is to facilitate gender atypical youth coming to terms with their own experience, free from outside influence or pressure. Such work also might involve educating the young person's family about the "different but equal" value and of the potential benefits of gender atypicality. Most individuals who report having been gender-nonconforming in childhood also report a lack of familial and peer support. It would be helpful to examine the effects of active support rather than efforts to change such youth.

Homosexuality was removed from the DSM because the science purporting to support its inclusion was found inadequate and because an extensive literature revealed no significant differences between homosexual and heterosexual subjects on a number of variables related to psychological adjustment (Gonsiorek, 1991). Such parallels do not exist for transsexualism, and it is the general consensus of those involved in the study of GID that it indeed merits pathological status (Zucker & Bradley, 1995). However, the GID diagnosis as it is written is too broad. Using present criteria, any boy who, for example, displays an even passing interest in art, music, or cooking could, conceivably, be diagnosed as GID by a therapist who has been persuaded by anxious parents that this child might become gay. Similarly, a girl whose innate energy and competitiveness is perceived as "unladylike" could be susceptible to modification of adaptive qualities in the name of gender nonconformity treatment. It is important for the school psychologist to differentiate between those cases that suggest a serious underlying emotional disturbance thought to be very rare (Zucker &

Bradley, 1995) and those that simply suggest a preference for gender atypical behavior and play. If there is any legitimate use of GID as a diagnostic classification for youth, then it should be reserved for those extreme cases in which gender dysphoria is accompanied by a profound sense of distress. The criteria should be rigorous and not overly broad; they should set parameters that would make the disorder the rare occurrence it truly is. Youth whose confusion and despair about gender atypicality leads to severe emotional dysfunction, extreme social withdrawal, fantasies of genital mutilation and/or suicide, are appropriately served by the GID classification and likely require the services of a specialist.

On the other hand, girls who simply enjoy roughhousing and boys who delight in giving a tea party ought not to be automatically assumed to be maladaptive. Rather, the therapist should interact with the child, depending upon age, in a play and/or talk therapy format intended to assess the underlying meanings, if any, of such behavior. Does the girl's "space commando" fantasy really suggest an underlying gender dysphoria, or is she simply making her parents uncomfortable? There is no evidence that suggests that "tomboyism" in girls and effeminate behavior in boys predict either psychopathology or lack of capacity for success in adulthood; thus, there is no reason to discourage or modify gender atypical behavior in and of itself. Such behavior may be consonant with the child's developing identity and also may provide a means of exploring gender atypical ways of being that could be useful. When examining social comfort, it is important to understand the young person's social system. Is she or he facing harassment at school? If so, what interventions are possible to correct the situation by protecting the individual? Is the child's behavior unacceptable to the family's norms? If so, it may be important to work with the entire family or, at least, with the parents.

Of further concern to the school counselor or school psychologist is the potential confabulation of gender identity and sexual orientation. It has been suggested that about two-thirds of gender atypical boys ultimately identify as homosexual in adulthood (Green, 1987). This means that there is not a 100% concordance between gender atypicality in youth and adult homosexual orientation, so presumably many of these gender atypical boys will identify as heterosexual adults. Even more likely is the danger of misinterpreting a normative prehomo-

sexual childhood way of being in the world for a disordered identity of gender. The attempt to pathologize same-sex sexual orientation has long been discredited by the organized mental health professions, but persists because of ongoing social devaluation of lesbians, gay men, and bisexuals. Social prejudice should not be reinforced by stigmatizing the natural inclinations and preferences of gender atypical youth. If they are in treatment, such youth should be allowed to explore freely their own feelings without undue outside influence.

Such a treatment approach is indeed radical, for our culture—even the culture of psychotherapy—has yet to acknowledge what Corbett (1998) called a “proto-homosexual” childhood. This approach may be particularly challenging for school personnel who are under significant pressure to uphold culturally sanctioned norms of psychosexual development. Expectations of normative gender behavior are deeply embedded in our society and its institutions, including the family, the church, and, of course, school. But given the number of youth who have suffered well into adulthood from childhood attempts at gender reorientation, perhaps it is time to reconsider psychology’s approach to gender atypical youth. Perhaps it is time to step back and refrain from placing a culturally designed template on gender atypical youth. Our treatment efforts might be better directed toward those who truly experience gender dysphoria in the extreme and toward the bullies who victimize them.

References

- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd rev. ed.). Washington, DC: Author.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychological Association. (1997). *Resolution on appropriate therapeutic responses to sexual orientation*. Washington, DC: Author.
- Ames, L. (1996). Homo-phobia, homo-ignorance, homo-hate: Heterosexism and AIDS. In E. Rothblum & L. Bond (Eds.), *Preventing heterosexism and homophobia* (pp. 239-252). Thousand Oaks, CA: Sage.
- Burke, P. (1996). *Gender shock*. New York: Doubleday.
- Coates, S. (1992). The etiology of boyhood gender identity disorder: A model for integrating temperament, development, and psychodynamics. *Psychoanalytic Dialogues*, 1(4), 481-523.
- Coates, S., & Person, E. (1985). Extreme boyhood femininity: Isolated behavior or pervasive disorder? *Journal of The American Academy of Child Psychiatry*, 24, 702-709.
- Coates, S., & Wolfe, S. (1995). Gender identity disorder in boys: The interface of constitution and early experience. *Psychoanalytic Inquiry*, 15, 6-38.
- Corbett, K. (1998). Cross-gendered identifications and homosexual boyhood: Toward a more complex theory of gender. *Journal of Orthopsychiatry* 68(3), 352-360.
- D’Augelli, A. (1998). Developmental implications of victimization of lesbian, gay and bisexual youths. In G. Herek (Ed.), *Psychological perspectives on lesbian and gay issues. Vol. 4: Stigma and sexual orientation: Understanding prejudice against lesbians, gay men and bisexuals* (pp. 187-210). Thousand Oaks, CA: Sage.
- Dörner, G., Rohde, W., Seidel, K., Haas, W., & Schott, G. (1976). On the evocability of a positive estrogen feedback action on LH secretion in transsexual men and women. *Endokrinologie*, 67, 20-25.
- Fausto-Sterling, A. (1993, March/April). The five sexes: Why male and female are not enough. *The Sciences*, 261, 20-25.
- Gonsiorek, J. (1991). The empirical basis for the demise of the mental illness model of homosexuality. In J. Gonsiorek & J. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 115-136). Newbury Park, CA: Sage.
- Green, R. (1987). *The “Sissy Boy Syndrome” and the development of homosexuality*. New Haven, CT: Yale University Press.
- Haldeman, D. (1994). The practice and ethics of sexual orientation conversion therapy. *Journal of Consulting and Clinical Psychology* 62(2), 221-227.
- Money, J., Hampson, J., & Hampson, J. (1955). Hermaphroditism: Recommendations concerning assignment of sex, change of sex, and psychologic management. *Bulletin of the Johns Hopkins Hospital*, 97, 284-300.
- National Center for Clinical Infant Programs. (1994). *Zero to three: Diagnostic classification of mental health and developmental disorders of infancy and early childhood*. Arlington, VA: Author.
- Rekers, G., & Lovaas, I. (1974). Behavioral treatment of deviant sex-role behaviors in a male child. *Journal of Applied Behavior Analysis*, 7(2), 173-190.
- Rekers, G., & Mead, S. (1979). Early intervention for female sexual identity disturbance: Self-monitoring of play behavior. *Journal of Abnormal Child Psychology*, 7(4), 405-423.
- Stoller, R. (1978). Boyhood gender aberrations: Treatment issues. *Journal of the American Psychoanalytic Association*, 26, 541-558.
- Weisz, J., & Weiss, B. (1991). Studying the referability of child clinical problems. *Journal of Consulting and Clinical Psychology*, 59, 266-273.
- Zucker, K., & Bradley, S. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.