

**IN THE UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF GEORGIA  
ATHENS DIVISION**

SKYLER MUSGROVE,	)
	)
Plaintiff,	)
	)
v.	)
	)
THE BOARD OF REGENTS OF THE	)
UNIVERSITY SYSTEM OF GEORGIA,	)
JAMES HULL, in his official capacity as Chair	)
of the Board of Regents of the University	)
System of Georgia, UNIVERSITY OF	)
GEORGIA, JERE MOREHEAD, in his official	)
capacity as President of the University of	)
Georgia, KARIN ELLIOT, in her official	)
capacity as Interim Vice Chancellor of Human	)
Resources of the University System of Georgia,	)
BLUE CROSS BLUE SHIELD	)
HEALTHCARE PLAN OF GEORGIA, INC.,	)
METROPOLITAN LIFE INSURANCE	)
COMPANY, and METLIFE, INC.,	)
	)
Defendants.	)
<hr style="border: 0.5px solid black;"/>	

CASE NO.  
3:18-cv-00080-CDL

**DEFENDANT BLUE CROSS BLUE SHIELD HEALTHCARE PLAN  
OF GEORGIA, INC.'S REPLY IN SUPPORT OF ITS  
MOTION TO DISMISS PLAINTIFF'S COMPLAINT**

Defendant Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (“BCBSHP”) files this Reply Brief in Support of its Motion to Dismiss Plaintiff’s Complaint as follows:

#### INTRODUCTION

As BCBSHP explained in support of its Motion to Dismiss, BCBSHP is not a proper defendant in this case. First, BCBSHP has no contractual relationship with the Board of Regents of the University System of Georgia (“BOR”), and it should be dismissed for that reason alone. Plaintiff cannot overcome the documents attached to the Complaint that establish this fact. Even if Plaintiff were permitted to amend its Complaint to add Blue Cross and Blue Shield of Georgia, Inc. (“BCBSGA”) as a defendant, though, Plaintiff could not state a claim. First, BCBSGA is not Plaintiff’s “employer” under Title VII or the Americans with Disabilities Act (“ADA”). Second, Plaintiff has failed to state a claim under Title III of the ADA because that title addresses public accommodations, and the BOR’s benefits plan for its employees is not a public accommodation – whether or not Title III applies to the substance of insurance plans. Finally, Plaintiff cannot state a claim under Section 504 of the Rehabilitation Act because Plaintiff cannot allege that BCBSGA is a recipient of “federal financial assistance” as that term is defined under federal law.

Moreover, Plaintiff cannot state a claim substantively under either Title VII or the ADA. The Eleventh Circuit has held that Title VII does not protect transgender individuals as a class, and Plaintiff is effectively alleging class-based discrimination. The ADA’s exclusion of transsexualism and gender identity disorders precludes Plaintiff’s claim under that statute.

Finally and most fundamentally, neither BCBSGA nor BCBSHP have control over the benefits decisions about which Plaintiff complains. Plaintiff’s Complaint confirms that his alleged injuries are not traceable to nor redressable by BCBSGA or BCBSHP, and Plaintiff does not have standing under Article III to pursue claims against BCBSGA or BCBSHP.

**ARGUMENT AND CITATION OF AUTHORITY****I. Plaintiff's Claims Should Be Dismissed Pursuant to Rule 12(b)(6).****A. BCBSHP Is Not a Proper Defendant.**

Plaintiff fails to address the fact that the operative documents attached to his Complaint definitively state that BCBSGA, not BCBSHP, serves as the claims administrator for the health benefits plan offered by the BOR (the "Plan"). Plaintiff refers to passing references to BCBSHP on documents that also refer to BCBSGA. (Doc. 1-2 p. 109; Doc 1-4 p. 4.) But the Plan documents and the correspondence with Plaintiff consistently confirm that "[BCBSGA] was chosen to administer this Plan." (Doc. 1-2 p. 87.) Plaintiff's references to "BCBS" in his Response, an obvious attempt to conflate the two entities, must be rejected since BCBSGA and BCBSHP are distinct companies, and BCBSHP must be dismissed.

**B. BCBSGA Is Not Plaintiff's "Employer" Under Title VII Or The ADA.**

Plaintiff's Response fails to rebut BCBSGA's arguments that it is not Plaintiff's employer for purposes of Title VII and the ADA. Tellingly, Plaintiff fails to meaningfully distinguish binding authority from the Eleventh Circuit holding that it is "patently frivolous" for a plaintiff to claim that an employer's insurer or claims administrator qualifies as an employer under these statutes. *Cramer v. State of Florida*, 117 F.3d 1258, 1263-64 (11th Cir. 1997). Plaintiff responds only by saying that the courts in that case and other cases failed to address expressly that the statutory definition of "employer" includes an employer's "agent." (Doc. 32 pp. 7-9.) The Eleventh Circuit, however, has held that the inclusion of "agent" within the definition of "employer" does not expand the definition to include service providers like BCBSGA.

For example, in *Mason v. Stallings*, the court interpreted "agent" in the definition of employer simply to "ensure *respondeat superior* liability of the employer for the acts of its agents," and not to render other persons proper defendants. 82 F.3d 1007, 1009 (11th Cir. 1996) (holding

that individual employees, while “agents” of employer, are not potential defendants under ADA). Rather, an entity can be an “employer” only when that entity preforms core employment functions. In *Williams v. City of Montgomery*, cited by Plaintiff, the court observed, “‘Where the employer has delegated control of some of the employer’s traditional rights, such as hiring or firing, to a third party, the third party has been found to be an “employer” by virtue of the agency relationship.’” 742 F.2d 586, 588 (11th Cir. 1984) (citations omitted). When an employer delegates such core employment functions to another entity, Title VII and the ADA may permit that entity to be a defendant. (*See* Doc. 24 pp. 8-10.) But Plaintiff has not alleged a delegation of core employment functions to BCBSGA here.

Plaintiff’s reliance on *Boyden v. Conlin* is similarly misplaced. In that case, the court concluded that state government entities “tasked with setting benefits terms and contracting with health insurers for all state employees” could be an “employer.” 2018 WL 4473347 at \*15 (W.D. Wis. Sept. 18, 2018). Here, the BOR set the benefits terms and contracted with health insurers, and the case has no relevance to these facts. Plaintiff cites other cases from other circuits that predate the Eleventh Circuit’s holding in *Cramer*, and they are otherwise inapposite. *See, e.g., Carparts Distrib. Ctr., Inc. v. Automobile Wholesaler’s Ass’n of New England, Inc.*, 37 F.3d 12, 17 n.5 (1st Cir. 1994) (observing that where an insurance company does not “exercise control over the level of benefits provided to employees,” such insurer “could not be deemed [an] ‘employer[.]’”) (internal citations omitted). BCBSGA is not Plaintiff’s “employer” or its “agent” under Title VII or the ADA, and these counts should be dismissed.

### **C. BCBSGA Cannot Be Liable Under Title III.**

As BCBSGA explained in support of its Motion, Title III does not apply to the substance or administration of health benefits plans offered to employees like Plaintiff. (Doc. 24 pp. 10-11.)

This interpretation of Title III aligns with the holdings of the Third, Sixth, and Eighth Circuits, which have rejected efforts to extend Title III to the substance of insurance policies. (*Id.*)

Even if Title III could extend to the substance of insurance policies, as Plaintiff contends, it would only apply to those policies that are *publicly available*. See *Morgan v. Joint Admin. Bd., Ret. Plan of the Pillsbury Co. and Am. Fed. of Grain Millers*, 268 F.3d 456, 459 (7th Cir. 2001) (Posner, J.) (“No one could walk in off the street and ask to become a plan participant. The plan was a private deal, not a public offering, and so the plaintiffs’ public accommodations claim fails as well.”); see also *Pallozzi v. Allstate Life Ins. Co.*, 198 F.3d 28, 32 n.3 (2d Cir. 1999). Plaintiff’s effort to distinguish these cases on the ground that they do not involve “a disability-specific health insurance exclusion in the employment context,” (Resp. at 11-12 n.3) is unavailing. The point of these cases is that Title III governs *public* accommodation; it does not speak to arrangements between employers and employees, which are covered by other portions of the ADA. Plaintiff cites no authority extending Title III to such an arrangement. Count Three should be dismissed.

**D. Plaintiff Cannot State A Claim Under Section 504.**

BCBSGA noted that Plaintiff could not rely on the conclusory allegations that BCBSGA received federal funds to support his claim. Recognizing his Complaint’s bare legal conclusion as insufficient under the *Twombly* and *Iqbal* pleading standards, Plaintiff attempts to expand on his legal conclusion in his Response by claiming that BCBSHP received “federal funds via premium tax credits,” though the allegation is not contained in the Complaint. (Doc. 32 p. 12.) It is “plainly inappropriate” for a plaintiff to cite to new facts not alleged in the complaint to avoid dismissal. *Brown v. J.P. Turner & Co.*, 2011 WL 1882522, at \*5 (N.D. Ga. May 17, 2011).

Even if Plaintiff could raise new allegations now, tax credits are not considered “federal financial assistance” under Section 504. For example, in *Chaplin v. Consolidated Edison Co. of*

*New York, Inc.*, the court rejected the plaintiff's argument that a utility company received federal financial assistance for purposes of Section 504 liability based on its receipt of tax credits for certain capital expenditures. 628 F. Supp. 143, 145-46 (S.D.N.Y. 1986); *see also Dana v. Baker Hughes, Inc.*, 2015 WL 5576880, at \*5-\*6 (M.D. Pa. Sept. 21, 2015) (granting motion to dismiss Rehabilitation Act claim and noting that "[t]he term 'federal financial assistance' as used in § 794 does not comprehend government procurement contracts but rather refers to the form of grant assistance that goes primarily to public entities") (citations omitted); 45 C.F.R. § 84.3(h) (defining "federal financial assistance" for purposes of Rehabilitation Act as, among other things, "any grant, loan, contract (other than a procurement contract *or a contract of insurance or guaranty*") (emphasis added). Plaintiff's new allegation that BCBSHP receives certain federal funds does not support a claim under the Rehabilitation Act.

**E. Plaintiff's Response Does Not Save His Title VII Claim From Dismissal.**

Plaintiff's contention that Title VII protections extend to transgender individuals as a class is simply incorrect. (Doc. 32 p. 4.) As the Eleventh Circuit has expressly recognized, "Title VII does not protect transsexuals as a class." *Evans v. Georgia Reg'l Hosp.*, 850 F.3d 1248, 1266 (11th Cir. 2017) (Rosenbaum, J., concurring in part and dissenting in part). Plaintiff refers in his Response to other circuits that have concluded that discrimination against transgender persons as a class violates Title VII. (Doc. 32 pp. 5-6.) These cases have adopted the rationale that any discrimination against a transgender person constitutes discrimination on the basis of sex and thus violates Title VII. The Eleventh Circuit has not adopted that reasoning.

Rather, the Eleventh Circuit has stated that a transgender person is protected under Title VII to the extent his or her employer discriminates based on animus caused by gender non-conformity. *See, e.g., Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011). Plaintiff's reliance on

*Glenn* is misplaced. In *Glenn*, the plaintiff was fired after informing her supervisor that she was changing her name and would begin presenting as a female. *Id.* at 1314. The Eleventh Circuit, following the Supreme Court’s decision in *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989), held that alleged discrimination based on gender nonconformity is a form of proscribed discrimination. *Id.* at 1317. But not all alleged discrimination against transgender persons is actionable under Title VII. As Judge Pryor explained in *Evans*, “*Price Waterhouse* and *Glenn* concerned claims that an employee’s *behavior*, not status alone, deviated from a gender stereotype held by an employer.” 850 F.3d at 1259 (Pryor, J., concurring) (emphasis in original).

Plaintiff’s claim here is not based on any allegation that the BOR – or BCBSGA – acted based on his behavior as a man or what a man “should be.” Plaintiff does not allege that he was singled out because of his behavior or that the BOR took any action specifically against him. Rather, Plaintiff’s claim is a prototypical class-based claim: that the BOR should offer health benefits that include offerings for transgender persons as a group. Such class-based claims are not cognizable in the Eleventh Circuit, and Plaintiff’s Title VII claim should be dismissed.

**F. Plaintiff’s Alleged Disability Is Excluded From the ADA and Section 504.**

As courts in this circuit have held in the cases BCBSGA cited in support of its Motion, Plaintiff’s gender dysphoria is specifically excluded from coverage under the ADA and Section 504. Both statutes expressly exclude both (1) transsexualism and (2) gender identity disorders not resulting from a physical impairment. 42 U.S.C. § 12211(b)(1); 29 U.S.C. § 705(20)(F). Plaintiff’s claim is barred because his condition meets the definitions of transsexualism and of a gender identity disorder not resulting from a physical impairment.<sup>1</sup> Plaintiff asserts that his diagnosis is

---

<sup>1</sup> Plaintiff’s Response does not distinguish between the transsexualism exclusion and the gender identity disorder exclusion, instead addressing them together as the “GIDs Exclusion.” (Doc. 32 p. 13.) The distinction is crucial; Plaintiff’s claims fail separately under each exclusion.

fundamentally different from these express exclusions, but Plaintiff's narrow parsing cannot overcome Congress's clear expression of its intent. Plaintiff's claim is barred by these statutes.

The transsexualism exclusion is straightforward and bars Plaintiff's claim. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (the "DSM-V," attached in part as Exhibit 1) defines "transsexual" as "an individual who seeks, or has undergone, a social transition from male to female or female to male, which in many, but not all, cases involves a somatic transition by cross-sex hormone treatment and genital surgery (sex reassignment surgery)." (Ex. 1 p. 451.) Plaintiff meets the definition of "transsexual" based on the allegations in his Complaint. (Doc. 1 ¶¶ 46–50.) Accordingly, the exclusion in the ADA and Section 504 of transsexualism as a covered disability bars Plaintiff's claim under these statutes.

The exclusion for gender identity disorders not resulting from a physical impairment also applies here. Plaintiff contends in his Response that his diagnosis of "gender dysphoria" under the DSM-V is a new and distinct diagnosis from its predecessor, "gender identity disorder," and that the ADA and Section 504 exclusions therefore do not apply. (Doc. 32 pp. 12–19.) A review of these diagnoses under the DSM-IV and V, however, reveal that they are equivalent for purposes of interpreting these exclusions. *See Michaels v. Akal Sec., Inc.*, 2010 WL 2573988, at \*6 (D. Colo. June 24, 2010) ("Gender dysphoria, as a gender identity disorder, is specifically exempted as a disability by the Rehabilitation Act.") (emphasis added).

The DSM-V notes that the term "gender dysphoria" is simply "more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se." (Ex. 1 p. 451.) The DSM explains that the underlying symptomology and clinical presentations for patients are the same between the two diagnoses. The diagnostic criteria for both diagnoses in adults are the same in both the DSM-IV, attached in part as Exhibit 2, and

the DSM-V. (*Compare* Ex. 1 p. 452 A.1-A.6 with Ex. 2 p. 581 A and B.) The consistency of these diagnostic criteria confirms that the ADA's exclusion of gender identity disorders extends to the DSM-V diagnosis of gender dysphoria.

Plaintiff also argues that the gender identity disorder exclusion does not apply here because there is an exception to the exclusion: the statutory exclusion does not apply to gender identity disorders "resulting from a physical impairment." (Doc 32 pp. 18–19.) Plaintiff contends that because "burgeoning medical research underlying gender dysphoria points to a physical etiology," (*id.* p. 18), the physical impairment exception should swallow the entire gender identity disorder exclusion and effectively render the exclusion a nullity. Congress intended this limited exception to apply to gender identity disorders resulting from clear physical impairments such as congenital adrenal hyperplasia, not generally to all types of gender dysphoria.

The DSM-V explains how gender dysphoria may result from a physical impairment in discussing the condition as associated with a "disorder of sex development," such as 46, XY disorder. (Ex. 1 p. 457.) The DSM also addresses other examples of disorders of sex development that may constitute physical impairments, including cloacal bladder exstrophy, penile agenesis, and congenital adrenal hyperplasia. (*Id.*) The statutory exception pertaining to gender identity disorders "resulting from a physical impairment" applies only in such situations, where a disorder of sexual development corresponds with a clear and traceable underlying physical condition.

In short, the DSM-V's description of gender dysphoria does not alter the intent of Congress to exclude these conditions from the scope of the ADA and Rehabilitation Act. No court in this circuit has held that gender dysphoria is now covered by these statutes. The Court should apply the ADA and Section 504 as they are written and dismiss Plaintiff's claims.

**G. The Constitutional Avoidance Doctrine Does Not Apply Here.**

Plaintiff contends that the Court must interpret the applicable statutes in his favor to avoid a constitutional infirmity under the constitutional avoidance doctrine. Courts employ the doctrine of constitutional avoidance as “a tool for choosing between competing plausible interpretations of a statutory text,” not “when the text of the statute is unambiguous.” *Price v. Time, Inc.*, 416 F.3d 1327, 1342 (11th Cir. 2005), *as modified on denial of reh’g*, 425 F.3d 1292 (11th Cir. 2005) (internal citations omitted). Plaintiff has not shown that the provisions of the ADA and Section 504 are ambiguous or that any “grave and doubtful” constitutional issues are presented.

First, as explained above, the exclusions of the ADA and Section 504 are not ambiguous. 42 U.S.C. § 12211(b)(1); 29 U.S.C. § 705(20)(F). The applicable legal and clinical definitions are clear and unequivocal, and Plaintiff offers no contrary argument. Moreover, no authority binding on this Court has held that transgender status, standing alone, is a suspect classification subject to heightened scrutiny under the Equal Protection Clause. *See generally Glenn, supra*, 663 F.3d at 1317-19 (holding only that discrimination based on gender nonconformity, not alleged here, is prohibited). The constitutional avoidance doctrine has no application here.

**II. Plaintiff Lacks Article III Standing to Sue BCBSGA.**

As BCBSGA has previously explained, Article III standing requires Plaintiff to show an “injury in fact” that is “fairly traceable” to BCBSGA’s conduct and “that is likely to be redressed by a favorable judicial decision.” *Bank of Am. Corp. v. City of Miami, Fla.*, 137 S. Ct. 1296, 1302 (2017). Plaintiff’s Complaint establishes that the BOR Plan’s exclusion of benefits for transgender services is the source of his alleged injury. Because Plaintiff’s alleged injuries are not traceable to nor redressable by BCBSGA, Plaintiff does not have standing to sue BCBSGA here.

The Plan documents specifically provide that the Plan's terms are chosen "by the Plan Sponsor [the BOR] to fund and provide delivery of the Employer's health benefits." (Doc. 1-2 p. 92.) Consistent with that allocation of responsibility, BCBSGA's letter denying Plaintiff's appeal explains that the BOR funds the Plan and, as such, BCBSGA had no flexibility to override BOR's choice of benefits. (Doc. 1-6 p. 2.) Plaintiff acknowledges that he petitioned the BOR, as "the body responsible for determining coverage," to change the terms. (Doc. 1 ¶ 55.) The Complaint acknowledges that BCBSGA has no authority to change the Plan's coverage. (Doc. 1-2 p. 92.)

Recognizing these problems, Plaintiff has now attempted to embellish BCBSGA's role in crafting the Plan. Plaintiff contends no fewer than eight times in his Response (Doc. 32 pp. 1–3, 7–8) that BCBSHP "created" the Plan's terms or otherwise "provided" a model policy that was adopted by the BOR. A plaintiff cannot cite to new facts not alleged in the complaint to avoid dismissal. *See, e.g., Brandywine Communications Tech., LLC v. T-Mobile USA, Inc.*, 904 F. Supp. 2d 1260, 1272 n.13 (M.D. Fla. 2012). More fundamentally, Plaintiff's new allegations are inconsistent with the Plan documents establishing that the BOR controls the benefits it offers. It is irrelevant whether BCBSGA provided a draft policy; the Complaint acknowledges, as it must, that BOR had the sole authority and responsibility to decide which benefits ultimately would be offered. Accordingly, the alleged injury is not traceable to BCBSGA. *Cf. Tovar v. Essentia Health*, 857 F.3d 771, 773 (8th Cir. 2017) (permitting claim to go forward under Affordable Care Act because insurer was alleged to have had control over terms of plan documents).

Second, the element of redressability requires that "it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision" against the defendant. *Lujan*, 504 U.S. at 561. As Plaintiff recognizes, BCBSGA has no authority to change the Plan's coverage. (Doc. 1 ¶ 55; Doc. 1-2 p. 92; Doc. 1-6 p. 2.) All benefits are payable by the BOR. (*Id.*) Even if

Plaintiff were successful, then, relief is available only from the BOR. Because his claims are not traceable to BCBSGA nor redressable by BCBSGA, Plaintiff lacks standing to sue BCBSGA.

**CONCLUSION**

For these reasons, the Court should thus dismiss all of the claims against BCBSHP with prejudice and not permit Plaintiff to re-plead its claims against BCBSGA.

Respectfully submitted, this 19th day of October 2018.

/s/ John S. Gibbs III  
James A. Washburn  
State Bar No. 738845  
james.washburn@troutman.com  
John S. Gibbs III  
State Bar No. 154250  
evan.gibbs@troutman.com

TROUTMAN SANDERS LLP  
600 Peachtree Street, NE  
Suite 3000  
Atlanta, GA 30308  
(404) 885-3000 (phone)  
(404) 885-3900 (facsimile)

Counsel for Blue Cross Blue Shield  
Healthcare Plan of Georgia, Inc.

**CERTIFICATE OF SERVICE**

I hereby certify that on October 19, 2018, I filed the foregoing Defendant Blue Cross Blue Shield Healthcare Plan of Georgia's Reply in Support of its Motion to Dismiss Plaintiff's Complaint via the Court's CM/ECF system which will serve a copy on all counsel of record.

/s/ John S. Gibbs III

Counsel for Blue Cross Blue Shield  
Healthcare Plan of Georgia, Inc.

## Gender Dysphoria

In this chapter, there is one overarching diagnosis of gender dysphoria, with separate developmentally appropriate criteria sets for children and for adolescents and adults. The area of sex and gender is highly controversial and has led to a proliferation of terms whose meanings vary over time and within and between disciplines. An additional source of confusion is that in English "sex" connotes both male/female and sexuality. This chapter employs constructs and terms as they are widely used by clinicians from various disciplines with specialization in this area. In this chapter, *sex* and *sexual* refer to the biological indicators of male and female (understood in the context of reproductive capacity), such as in sex chromosomes, gonads, sex hormones, and nonambiguous internal and external genitalia. Disorders of sex development denote conditions of inborn somatic deviations of the reproductive tract from the norm and/or discrepancies among the biological indicators of male and female. *Cross-sex* hormone treatment denotes the use of feminizing hormones in an individual assigned male at birth based on traditional biological indicators or the use of masculinizing hormones in an individual assigned female at birth.

The need to introduce the term *gender* arose with the realization that for individuals with conflicting or ambiguous biological indicators of sex (i.e., "intersex"), the lived role in society and/or the identification as male or female could not be uniformly associated with or predicted from the biological indicators and, later, that some individuals develop an identity as female or male at variance with their uniform set of classical biological indicators. Thus, *gender* is used to denote the public (and usually legally recognized) lived role as boy or girl, man or woman, but, in contrast to certain social constructionist theories, biological factors are seen as contributing, in interaction with social and psychological factors, to gender development. *Gender assignment* refers to the initial assignment as male or female. This occurs usually at birth and, thereby, yields the "natal gender." *Gender-atypical* refers to somatic features or behaviors that are not typical (in a statistical sense) of individuals with the same assigned gender in a given society and historical era; for behavior, *gender-nonconforming* is an alternative descriptive term. *Gender reassignment* denotes an official (and usually legal) change of gender. *Gender identity* is a category of social identity and refers to an individual's identification as male, female, or, occasionally, some category other than male or female. *Gender dysphoria* as a general descriptive term refers to an individual's affective/cognitive discontent with the assigned gender but is more specifically defined when used as a diagnostic category. *Transgender* refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender. *Transsexual* denotes an individual who seeks, or has undergone, a social transition from male to female or female to male, which in many, but not all, cases also involves a somatic transition by cross-sex hormone treatment and genital surgery (*sex reassignment surgery*).

*Gender dysphoria* refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se.

## Gender Dysphoria

### Diagnostic Criteria

#### Gender Dysphoria in Children

**302.6 (F64.2)**

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):
1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  3. A strong preference for cross-gender roles in make-believe play or fantasy play.
  4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
  5. A strong preference for playmates of the other gender.
  6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
  7. A strong dislike of one's sexual anatomy.
  8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

*Specify if:*

**With a disorder of sex development** (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

**Coding note:** Code the disorder of sex development as well as gender dysphoria.

#### Gender Dysphoria in Adolescents and Adults

**302.85 (F64.1)**

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
  4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

- B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*Specify if:*

**With a disorder of sex development** (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

**Coding note:** Code the disorder of sex development as well as gender dysphoria.

*Specify if:*

**Posttransition:** The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen—namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

## Specifiers

The posttransition specifier may be used in the context of continuing treatment procedures that serve to support the new gender assignment.

## Diagnostic Features

Individuals with gender dysphoria have a marked incongruence between the gender they have been assigned to (usually at birth, referred to as *natal gender*) and their experienced/expressed gender. This discrepancy is the core component of the diagnosis. There must also be evidence of distress about this incongruence. Experienced gender may include alternative gender identities beyond binary stereotypes. Consequently, the distress is not limited to a desire to simply be of the other gender, but may include a desire to be of an alternative gender, provided that it differs from the individual's assigned gender.

Gender dysphoria manifests itself differently in different age groups. Prepubertal natal girls with gender dysphoria may express the wish to be a boy, assert they are a boy, or assert they will grow up to be a man. They prefer boys' clothing and hairstyles, are often perceived by strangers as boys, and may ask to be called by a boy's name. Usually, they display intense negative reactions to parental attempts to have them wear dresses or other feminine attire. Some may refuse to attend school or social events where such clothes are required. These girls may demonstrate marked cross-gender identification in role-playing, dreams, and fantasies. Contact sports, rough-and-tumble play, traditional boyhood games, and boys as playmates are most often preferred. They show little interest in stereotypically feminine toys (e.g., dolls) or activities (e.g., feminine dress-up or role-play). Occasionally, they refuse to urinate in a sitting position. Some natal girls may express a desire to have a penis or claim to have a penis or that they will grow one when older. They may also state that they do not want to develop breasts or menstruate.

Prepubertal natal boys with gender dysphoria may express the wish to be a girl or assert they are a girl or that they will grow up to be a woman. They have a preference for dressing in girls' or women's clothes or may improvise clothing from available materials (e.g., using towels, aprons, and scarves for long hair or skirts). These children may role-play female figures (e.g., playing "mother") and often are intensely interested in female fantasy figures. Traditional feminine activities, stereotypical games, and pastimes (e.g., "playing house"; drawing feminine pictures; watching television or videos of favorite female characters) are most often preferred. Stereotypical female-type dolls (e.g., Barbie) are often favorite toys, and girls are their preferred playmates. They avoid rough-and-tumble play and competitive sports and have little interest in stereotypically masculine toys (e.g., cars, trucks). Some may pretend not to have a penis and insist on sitting to urinate. More

rarely, they may state that they find their penis or testes disgusting, that they wish them removed, or that they have, or wish to have, a vagina.

In young adolescents with gender dysphoria, clinical features may resemble those of children or adults with the condition, depending on developmental level. As secondary sex characteristics of young adolescents are not yet fully developed, these individuals may not state dislike of them, but they are concerned about imminent physical changes.

In adults with gender dysphoria, the discrepancy between experienced gender and physical sex characteristics is often, but not always, accompanied by a desire to be rid of primary and/or secondary sex characteristics and/or a strong desire to acquire some primary and/or secondary sex characteristics of the other gender. To varying degrees, adults with gender dysphoria may adopt the behavior, clothing, and mannerisms of the experienced gender. They feel uncomfortable being regarded by others, or functioning in society, as members of their assigned gender. Some adults may have a strong desire to be of a different gender and treated as such, and they may have an inner certainty to feel and respond as the experienced gender without seeking medical treatment to alter body characteristics. They may find other ways to resolve the incongruence between experienced/expressed and assigned gender by partially living in the desired role or by adopting a gender role neither conventionally male nor conventionally female.

## **Associated Features Supporting Diagnosis**

When visible signs of puberty develop, natal boys may shave their legs at the first signs of hair growth. They sometimes bind their genitals to make erections less visible. Girls may bind their breasts, walk with a stoop, or use loose sweaters to make breasts less visible. Increasingly, adolescents request, or may obtain without medical prescription and supervision, hormonal suppressors ("blockers") of gonadal steroids (e.g., gonadotropin-releasing hormone [GnRH] analog, spironolactone). Clinically referred adolescents often want hormone treatment and many also wish for gender reassignment surgery. Adolescents living in an accepting environment may openly express the desire to be and be treated as the experienced gender and dress partly or completely as the experienced gender, have a hairstyle typical of the experienced gender, preferentially seek friendships with peers of the other gender, and/or adopt a new first name consistent with the experienced gender. Older adolescents, when sexually active, usually do not show or allow partners to touch their sexual organs. For adults with an aversion toward their genitals, sexual activity is constrained by the preference that their genitals not be seen or touched by their partners. Some adults may seek hormone treatment (sometimes without medical prescription and supervision) and gender reassignment surgery. Others are satisfied with either hormone treatment or surgery alone.

Adolescents and adults with gender dysphoria before gender reassignment are at increased risk for suicidal ideation, suicide attempts, and suicides. After gender reassignment, adjustment may vary, and suicide risk may persist.

## **Prevalence**

For natal adult males, prevalence ranges from 0.005% to 0.014%, and for natal females, from 0.002% to 0.003%. Since not all adults seeking hormone treatment and surgical reassignment attend specialty clinics, these rates are likely modest underestimates. Sex differences in rate of referrals to specialty clinics vary by age group. In children, sex ratios of natal boys to girls range from 2:1 to 4.5:1. In adolescents, the sex ratio is close to parity; in adults, the sex ratio favors natal males, with ratios ranging from 1:1 to 6.1:1. In two countries, the sex ratio appears to favor natal females (Japan: 2.2:1; Poland: 3.4:1).

## **Development and Course**

Because expression of gender dysphoria varies with age, there are separate criteria sets for children versus adolescents and adults. Criteria for children are defined in a more con-

crete, behavioral manner than those for adolescents and adults. Many of the core criteria draw on well-documented behavioral gender differences between typically developing boys and girls. Young children are less likely than older children, adolescents, and adults to express extreme and persistent anatomic dysphoria. In adolescents and adults, incongruence between experienced gender and somatic sex is a central feature of the diagnosis. Factors related to distress and impairment also vary with age. A very young child may show signs of distress (e.g., intense crying) only when parents tell the child that he or she is "really" not a member of the other gender but only "desires" to be. Distress may not be manifest in social environments supportive of the child's desire to live in the role of the other gender and may emerge only if the desire is interfered with. In adolescents and adults, distress may manifest because of strong incongruence between experienced gender and somatic sex. Such distress may, however, be mitigated by supportive environments and knowledge that biomedical treatments exist to reduce incongruence. Impairment (e.g., school refusal, development of depression, anxiety, and substance abuse) may be a consequence of gender dysphoria.

**Gender dysphoria without a disorder of sex development.** For clinic-referred children, onset of cross-gender behaviors is usually between ages 2 and 4 years. This corresponds to the developmental time period in which most typically developing children begin expressing gendered behaviors and interests. For some preschool-age children, both pervasive cross-gender behaviors and the expressed desire to be the other gender may be present, or, more rarely, labeling oneself as a member of the other gender may occur. In some cases, the expressed desire to be the other gender appears later, usually at entry into elementary school. A small minority of children express discomfort with their sexual anatomy or will state the desire to have a sexual anatomy corresponding to the experienced gender ("anatomic dysphoria"). Expressions of anatomic dysphoria become more common as children with gender dysphoria approach and anticipate puberty.

Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary. In natal males, persistence has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%. Persistence of gender dysphoria is modestly correlated with dimensional measures of severity ascertained at the time of a childhood baseline assessment. In one sample of natal males, lower socioeconomic background was also modestly correlated with persistence. It is unclear if particular therapeutic approaches to gender dysphoria in children are related to rates of long-term persistence. Extant follow-up samples consisted of children receiving no formal therapeutic intervention or receiving therapeutic interventions of various types, ranging from active efforts to reduce gender dysphoria to a more neutral, "watchful waiting" approach. It is unclear if children "encouraged" or supported to live socially in the desired gender will show higher rates of persistence, since such children have not yet been followed longitudinally in a systematic manner. For both natal male and female children showing persistence, almost all are sexually attracted to individuals of their natal sex. For natal male children whose gender dysphoria does not persist, the majority are *androphilic* (sexually attracted to males) and often self-identify as gay or homosexual (ranging from 63% to 100%). In natal female children whose gender dysphoria does not persist, the percentage who are *gynephilic* (sexually attracted to females) and self-identify as lesbian is lower (ranging from 32% to 50%).

In both adolescent and adult natal males, there are two broad trajectories for development of gender dysphoria: early onset and late onset. *Early-onset gender dysphoria* starts in childhood and continues into adolescence and adulthood; or, there is an intermittent period in which the gender dysphoria desists and these individuals self-identify as gay or homosexual, followed by recurrence of gender dysphoria. *Late-onset gender dysphoria* occurs around puberty or much later in life. Some of these individuals report having had a desire to be of the other gender in childhood that was not expressed verbally to others. Others do not recall any signs of childhood gender dysphoria. For adolescent males with late-onset gender dysphoria, parents often report surprise because they did not see signs of gender

dysphoria during childhood. Expressions of anatomic dysphoria are more common and salient in adolescents and adults once secondary sex characteristics have developed.

Adolescent and adult natal males with early-onset gender dysphoria are almost always sexually attracted to men (androphilic). Adolescents and adults with late-onset gender dysphoria frequently engage in transvestic behavior with sexual excitement. The majority of these individuals are gynephilic or sexually attracted to other posttransition natal males with late-onset gender dysphoria. A substantial percentage of adult males with late-onset gender dysphoria cohabit with or are married to natal females. After gender transition, many self-identify as lesbian. Among adult natal males with gender dysphoria, the early-onset group seeks out clinical care for hormone treatment and reassignment surgery at an earlier age than does the late-onset group. The late-onset group may have more fluctuations in the degree of gender dysphoria and be more ambivalent about and less likely satisfied after gender reassignment surgery.

In both adolescent and adult natal females, the most common course is the early-onset form of gender dysphoria. The late-onset form is much less common in natal females compared with natal males. As in natal males with gender dysphoria, there may have been a period in which the gender dysphoria desisted and these individuals self-identified as lesbian; however, with recurrence of gender dysphoria, clinical consultation is sought, often with the desire for hormone treatment and reassignment surgery. Parents of natal adolescent females with the late-onset form also report surprise, as no signs of childhood gender dysphoria were evident. Expressions of anatomic dysphoria are much more common and salient in adolescents and adults than in children.

Adolescent and adult natal females with early-onset gender dysphoria are almost always gynephilic. Adolescents and adults with the late-onset form of gender dysphoria are usually androphilic and after gender transition self-identify as gay men. Natal females with the late-onset form do not have co-occurring transvestic behavior with sexual excitement.

**Gender dysphoria in association with a disorder of sex development.** Most individuals with a disorder of sex development who develop gender dysphoria have already come to medical attention at an early age. For many, starting at birth, issues of gender assignment were raised by physicians and parents. Moreover, as infertility is quite common for this group, physicians are more willing to perform cross-sex hormone treatments and genital surgery before adulthood.

Disorders of sex development in general are frequently associated with gender-atypical behavior starting in early childhood. However, in the majority of cases, this does not lead to gender dysphoria. As individuals with a disorder of sex development become aware of their medical history and condition, many experience uncertainty about their gender, as opposed to developing a firm conviction that they are another gender. However, most do not progress to gender transition. Gender dysphoria and gender transition may vary considerably as a function of a disorder of sex development, its severity, and assigned gender.

## **Risk and Prognostic Factors**

**Temperamental.** For individuals with gender dysphoria without a disorder of sex development, atypical gender behavior among individuals with early-onset gender dysphoria develops in early preschool age, and it is possible that a high degree of atypicality makes the development of gender dysphoria and its persistence into adolescence and adulthood more likely.

**Environmental.** Among individuals with gender dysphoria without a disorder of sex development, males with gender dysphoria (in both childhood and adolescence) more commonly have older brothers than do males without the condition. Additional predisposing

factors under consideration, especially in individuals with late-onset gender dysphoria (adulthood), include habitual fetishistic transvestism developing into autogynophilia (i.e., sexual arousal associated with the thought or image of oneself as a woman) and other forms of more general social, psychological, or developmental problems.

**Genetic and physiological.** For individuals with gender dysphoria without a disorder of sex development, some genetic contribution is suggested by evidence for (weak) familiarity of transsexualism among nontwin siblings, increased concordance for transsexualism in monozygotic compared with dizygotic same-sex twins, and some degree of heritability of gender dysphoria. As to endocrine findings, no endogenous systemic abnormalities in sex-hormone levels have been found in 46,XY individuals, whereas there appear to be increased androgen levels (in the range found in hirsute women but far below normal male levels) in 46,XX individuals. Overall, current evidence is insufficient to label gender dysphoria without a disorder of sex development as a form of intersexuality limited to the central nervous system.

In gender dysphoria associated with a disorder of sex development, the likelihood of later gender dysphoria is increased if prenatal production and utilization (via receptor sensitivity) of androgens are grossly atypical relative to what is usually seen in individuals with the same assigned gender. Examples include 46,XY individuals with a history of normal male prenatal hormone milieu but inborn nonhormonal genital defects (as in cloacal bladder exstrophy or penile agenesis) and who have been assigned to the female gender. The likelihood of gender dysphoria is further enhanced by additional, prolonged, highly gender-atypical postnatal androgen exposure with somatic virilization as may occur in female-raised and noncastrated 46,XY individuals with 5-alpha reductase-2 deficiency or 17-beta-hydroxysteroid dehydrogenase-3 deficiency or in female-raised 46,XX individuals with classical congenital adrenal hyperplasia with prolonged periods of non-adherence to glucocorticoid replacement therapy. However, the prenatal androgen milieu is more closely related to gendered behavior than to gender identity. Many individuals with disorders of sex development and markedly gender-atypical behavior do not develop gender dysphoria. Thus, gender-atypical behavior by itself should not be interpreted as an indicator of current or future gender dysphoria. There appears to be a higher rate of gender dysphoria and patient-initiated gender change from assigned female to male than from assigned male to female in 46,XY individuals with a disorder of sex development.

## **Culture-Related Diagnostic Issues**

Individuals with gender dysphoria have been reported across many countries and cultures. The equivalent of gender dysphoria has also been reported in individuals living in cultures with institutionalized gender categories other than male or female. It is unclear whether with these individuals the diagnostic criteria for gender dysphoria would be met.

## **Diagnostic Markers**

Individuals with a somatic disorder of sex development show some correlation of final gender identity outcome with the degree of prenatal androgen production and utilization. However, the correlation is not robust enough for the biological factor, where ascertainable, to replace a detailed and comprehensive diagnostic interview evaluation for gender dysphoria.

## **Functional Consequences of Gender Dysphoria**

Preoccupation with cross-gender wishes may develop at all ages after the first 2–3 years of childhood and often interfere with daily activities. In older children, failure to develop age-typical same-sex peer relationships and skills may lead to isolation from peer groups and to distress. Some children may refuse to attend school because of teasing and harass-

ment or pressure to dress in attire associated with their assigned sex. Also in adolescents and adults, preoccupation with cross-gender wishes often interferes with daily activities. Relationship difficulties, including sexual relationship problems, are common, and functioning at school or at work may be impaired. Gender dysphoria, along with atypical gender expression, is associated with high levels of stigmatization, discrimination, and victimization, leading to negative self-concept, increased rates of mental disorder comorbidity, school dropout, and economic marginalization, including unemployment, with attendant social and mental health risks, especially in individuals from resource-poor family backgrounds. In addition, these individuals' access to health services and mental health services may be impeded by structural barriers, such as institutional discomfort or inexperience in working with this patient population.

## Differential Diagnosis

**Nonconformity to gender roles.** Gender dysphoria should be distinguished from simple nonconformity to stereotypical gender role behavior by the strong desire to be of another gender than the assigned one and by the extent and pervasiveness of gender-variant activities and interests. The diagnosis is not meant to merely describe nonconformity to stereotypical gender role behavior (e.g., "tomboyism" in girls, "girly-boy" behavior in boys, occasional cross-dressing in adult men). Given the increased openness of atypical gender expressions by individuals across the entire range of the transgender spectrum, it is important that the clinical diagnosis be limited to those individuals whose distress and impairment meet the specified criteria.

**Transvestic disorder.** Transvestic disorder occurs in heterosexual (or bisexual) adolescent and adult males (rarely in females) for whom cross-dressing behavior generates sexual excitement and causes distress and/or impairment without drawing their primary gender into question. It is occasionally accompanied by gender dysphoria. An individual with transvestic disorder who also has clinically significant gender dysphoria can be given both diagnoses. In many cases of late-onset gender dysphoria in gynephilic natal males, transvestic behavior with sexual excitement is a precursor.

**Body dysmorphic disorder.** An individual with body dysmorphic disorder focuses on the alteration or removal of a specific body part because it is perceived as abnormally formed, not because it represents a repudiated assigned gender. When an individual's presentation meets criteria for both gender dysphoria and body dysmorphic disorder, both diagnoses can be given. Individuals wishing to have a healthy limb amputated (termed by some *body integrity identity disorder*) because it makes them feel more "complete" usually do not wish to change gender, but rather desire to live as an amputee or a disabled person.

**Schizophrenia and other psychotic disorders.** In schizophrenia, there may rarely be delusions of belonging to some other gender. In the absence of psychotic symptoms, insistence by an individual with gender dysphoria that he or she is of some other gender is not considered a delusion. Schizophrenia (or other psychotic disorders) and gender dysphoria may co-occur.

**Other clinical presentations.** Some individuals with an emasculation desire who develop an alternative, nonmale/nonfemale gender identity do have a presentation that meets criteria for gender dysphoria. However, some males seek castration and/or penectomy for aesthetic reasons or to remove psychological effects of androgens without changing male identity; in these cases, the criteria for gender dysphoria are not met.

## Comorbidity

Clinically referred children with gender dysphoria show elevated levels of emotional and behavioral problems—most commonly, anxiety, disruptive and impulse-control, and de-

pressive disorders. In prepubertal children, increasing age is associated with having more behavioral or emotional problems; this is related to the increasing non-acceptance of gender-variant behavior by others. In older children, gender-variant behavior often leads to peer ostracism, which may lead to more behavioral problems. The prevalence of mental health problems differs among cultures; these differences may also be related to differences in attitudes toward gender variance in children. However, also in some non-Western cultures, anxiety has been found to be relatively common in individuals with gender dysphoria, even in cultures with accepting attitudes toward gender-variant behavior. Autism spectrum disorder is more prevalent in clinically referred children with gender dysphoria than in the general population. Clinically referred adolescents with gender dysphoria appear to have comorbid mental disorders, with anxiety and depressive disorders being the most common. As in children, autism spectrum disorder is more prevalent in clinically referred adolescents with gender dysphoria than in the general population. Clinically referred adults with gender dysphoria may have coexisting mental health problems, most commonly anxiety and depressive disorders.

## Other Specified Gender Dysphoria

---

### 302.6 (F64.8)

---

This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The other specified gender dysphoria category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for gender dysphoria. This is done by recording "other specified gender dysphoria" followed by the specific reason (e.g., "brief gender dysphoria").

An example of a presentation that can be specified using the "other specified" designation is the following:

**The current disturbance meets symptom criteria for gender dysphoria, but the duration is less than 6 months.**

---

## Unspecified Gender Dysphoria

---

### 302.6 (F64.9)

---

This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The unspecified gender dysphoria category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for gender dysphoria, and includes presentations in which there is insufficient information to make a more specific diagnosis.

---

## 302.9 Paraphilia Not Otherwise Specified

This category is included for coding Paraphilias that do not meet the criteria for any of the specific categories. Examples include, but are not limited to, telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine).

## Gender Identity Disorders

---

### Gender Identity Disorder

#### Diagnostic Features

There are two components of Gender Identity Disorder, both of which must be present to make the diagnosis. There must be evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex (Criterion A). This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex (Criterion B). The diagnosis is not made if the individual has a concurrent physical intersex condition (e.g., partial androgen insensitivity syndrome or congenital adrenal hyperplasia) (Criterion C). To make the diagnosis, there must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion D).

In boys, the cross-gender identification is manifested by a marked preoccupation with traditionally feminine activities. They may have a preference for dressing in girls' or women's clothes or may improvise such items from available materials when genuine articles are unavailable. Towels, aprons, and scarves are often used to represent long hair or skirts. There is a strong attraction for the stereotypical games and pastimes of girls. They particularly enjoy playing house, drawing pictures of beautiful girls and princesses, and watching television or videos of their favorite female characters. Stereotypical female-type dolls, such as Barbie, are often their favorite toys, and girls are their preferred playmates. When playing "house," these boys role-play female figures, most commonly "mother roles," and often are quite preoccupied with female fantasy figures. They avoid rough-and-tumble play and competitive sports and have little interest in cars and trucks or other nonaggressive but stereotypical boys' toys. They may express a wish to be a girl and assert that they will grow up to be a woman. They may insist on sitting to urinate and pretend not to have a penis by pushing it in between their legs. More rarely, boys with Gender Identity Disorder may state that they find their penis or testes disgusting, that they want to remove them, or that they have, or wish to have, a vagina.

Girls with Gender Identity Disorder display intense negative reactions to parental expectations or attempts to have them wear dresses or other feminine attire. Some

may refuse to attend school or social events where such clothes may be required. They prefer boys' clothing and short hair, are often misidentified by strangers as boys, and may ask to be called by a boy's name. Their fantasy heroes are most often powerful male figures, such as Batman or Superman. These girls prefer boys as playmates, with whom they share interests in contact sports, rough-and-tumble play, and traditional boyhood games. They show little interest in dolls or any form of feminine dress-up or role-play activity. A girl with this disorder may occasionally refuse to urinate in a sitting position. She may claim that she has or will grow a penis and may not want to grow breasts or to menstruate. She may assert that she will grow up to be a man. Such girls typically reveal marked cross-gender identification in role-playing, dreams, and fantasies.

Adults with Gender Identity Disorder are preoccupied with their wish to live as a member of the other sex. This preoccupation may be manifested as an intense desire to adopt the social role of the other sex or to acquire the physical appearance of the other sex through hormonal or surgical manipulation. Adults with this disorder are uncomfortable being regarded by others as, or functioning in society as, a member of their designated sex. To varying degrees, they adopt the behavior, dress, and mannerisms of the other sex. In private, these individuals may spend much time cross-dressed and working on the appearance of being the other sex. Many attempt to pass in public as the other sex. With cross-dressing and hormonal treatment (and for males, electrolysis), many individuals with this disorder may pass convincingly as the other sex. The sexual activity of these individuals with same-sex partners is generally constrained by the preference that their partners neither see nor touch their genitals. For some males who present later in life (often following marriage), the individual's sexual activity with a woman is accompanied by the fantasy of being lesbian lovers or that his partner is a man and he is a woman.

In adolescents, the clinical features may resemble either those of children or those of adults, depending on the individual's developmental level, and the criteria should be applied accordingly. In a younger adolescent, it may be more difficult to arrive at an accurate diagnosis because of the adolescent's guardedness. This may be increased if the adolescent feels ambivalent about cross-gender identification or feels that it is unacceptable to the family. The adolescent may be referred because the parents or teachers are concerned about social isolation or peer teasing and rejection. In such circumstances, the diagnosis should be reserved for those adolescents who appear quite cross-gender identified in their dress and who engage in behaviors that suggest significant cross-gender identification (e.g., shaving legs in males). Clarifying the diagnosis in children and adolescents may require monitoring over an extended period of time.

Distress or disability in individuals with Gender Identity Disorder is manifested differently across the life cycle. In young children, distress is manifested by the stated unhappiness about their assigned sex. Preoccupation with cross-gender wishes often interferes with ordinary activities. In older children, failure to develop age-appropriate same-sex peer relationships and skills often leads to isolation and distress, and some children may refuse to attend school because of teasing or pressure to dress in attire stereotypical of their assigned sex. In adolescents and adults, preoccupation with cross-gender wishes often interferes with ordinary activities. Relationship difficulties are common, and functioning at school or at work may be impaired.

## Specifiers

For sexually mature individuals, the following specifiers may be noted based on the individual's sexual orientation: **Sexually Attracted to Males**, **Sexually Attracted to Females**, **Sexually Attracted to Both**, and **Sexually Attracted to Neither**. Males with Gender Identity Disorder include substantial proportions with all four specifiers. Those who are attracted to males usually first experience the disorder beginning in childhood or early adolescence, while those males attracted to females, both genders, or neither usually report their gender dysphoria beginning in early to mid-adulthood. Those men attracted to neither gender are often isolated individuals with schizoid traits. Virtually all females with Gender Identity Disorder will receive the same specifier—Sexually Attracted to Females—although there are exceptional cases involving females who are Sexually Attracted to Males.

## Recording Procedures

The assigned diagnostic code depends on the individual's current age: if the disorder occurs in childhood, the code 302.6 is used; for an adolescent or adult, 302.85 is used.

## Associated Features and Disorders

**Associated descriptive features and mental disorders.** Many individuals with Gender Identity Disorder become socially isolated. Isolation and ostracism contribute to low self-esteem and may lead to school aversion or dropping out of school. Peer ostracism and teasing are especially common sequelae for boys with the disorder. Boys with Gender Identity Disorder often show marked feminine mannerisms and speech patterns.

The disturbance can be so pervasive that the mental lives of some individuals revolve only around those activities that lessen gender distress. They are often preoccupied with appearance, especially early in the transition to living in the opposite sex role. Relationships with one or both parents also may be seriously impaired. Some males with Gender Identity Disorder resort to self-treatment with hormones and may very rarely perform their own castration or penectomy. Especially in urban centers, some males with the disorder may engage in prostitution, which places them at high risk for human immunodeficiency virus (HIV) infection. Suicide attempts and Substance-Related Disorders are commonly associated.

Children with Gender Identity Disorder may manifest coexisting Separation Anxiety Disorder, Generalized Anxiety Disorder, and symptoms of depression. Adolescents are particularly at risk for depression and suicidal ideation and suicide attempts. In adults, anxiety and depressive symptoms may be present. In clinical samples, associated Personality Disorders are more common among males than among females. Adult males who are sexually attracted to females, to both males and females, or to neither sex usually report a history of erotic arousal associated with the thought or image of oneself as a woman (termed *autogynephilia*). In most cases, the individual would qualify, at least in his past, for a diagnosis of Transvestic Fetishism. In others, however, the individual's favorite fantasy emphasizes feminine attributes other than clothing. Some men, for example, masturbate while picturing themselves

as nude women, focusing on their imagined breasts and vulvas; others masturbate while picturing themselves engaged in some stereotypically feminine activity such as knitting.

**Associated laboratory findings.** There is no diagnostic test specific for Gender Identity Disorder. In the presence of a normal physical examination, karyotyping for sex chromosomes and sex hormone assays are usually not indicated. Psychological testing may reveal cross-gender identification or behavior patterns.

**Associated physical examination findings and general medical conditions.** Individuals with Gender Identity Disorder have normal genitalia (in contrast to the ambiguous genitalia or hypogonadism found in physical intersex conditions). Adolescent and adult males with Gender Identity Disorder may show breast enlargement resulting from hormone ingestion, hair denuding from temporary or permanent epilation, and other physical changes as a result of procedures such as rhinoplasty or thyroid cartilage shaving (surgical reduction of the Adam's apple). Distorted breasts or breast rashes may be seen in females who wear breast binders. Postsurgical complications in genetic females include prominent chest wall scars, and in genetic males, vaginal strictures, rectovaginal fistulas, urethral stenoses, and misdirected urinary streams. Adult females with Gender Identity Disorder may have a higher-than-expected likelihood of polycystic ovarian disease.

## Specific Age and Gender Features

Females with Gender Identity Disorders generally experience less ostracism because of cross-gender interests and may suffer less from peer rejection, at least until adolescence. In child clinic samples, boys with this disorder are referred for evaluation much more frequently than are girls. In adult clinic samples, men outnumber women by about two or three times. In children, the referral bias toward males may partly reflect the greater stigma that cross-gender behavior carries for boys than for girls.

## Prevalence

There are no recent epidemiological studies to provide data on prevalence of Gender Identity Disorder. Data from smaller countries in Europe with access to total population statistics and referrals suggest that roughly 1 per 30,000 adult males and 1 per 100,000 adult females seek sex-reassignment surgery.

## Course

For clinically referred children, onset of cross-gender interests and activities is usually between ages 2 and 4 years, and some parents report that their child has always had cross-gender interests. Only a very small number of children with Gender Identity Disorder will continue to have symptoms that meet criteria for Gender Identity Disorder in adolescence or adulthood. Typically, children are referred around the time of school entry because of parental concern that what they regarded as a "phase" does not appear to be passing. Most children with Gender Identity Disorder display

less overt cross-gender behaviors with time, parental intervention, or response from peers. By late adolescence or adulthood, about three-quarters of boys who had a childhood history of Gender Identity Disorder report a homosexual or bisexual orientation, but without concurrent Gender Identity Disorder. Most of the remainder report a heterosexual orientation, also without concurrent Gender Identity Disorder. The corresponding percentages for sexual orientation in girls are not known. Some adolescents may develop a clearer cross-gender identification and request sex-reassignment surgery or may continue in a chronic course of gender confusion or dysphoria.

In adult males, there are two different courses for the development of Gender Identity Disorder. The first is a continuation of Gender Identity Disorder that had an onset in childhood. These individuals typically present in late adolescence or adulthood. In the other course, the more overt signs of cross-gender identification appear later and more gradually, with a clinical presentation in early to mid-adulthood usually following, but sometimes concurrent with, Transvestic Fetishism. The later-onset group may be more fluctuating in the degree of cross-gender identification, more ambivalent about sex-reassignment surgery, more likely to be sexually attracted to women, and less likely to be satisfied after sex-reassignment surgery. Males with Gender Identity Disorder who are sexually attracted to males tend to present in adolescence or early adulthood with a lifelong history of gender dysphoria. In contrast, those who are sexually attracted to females, to both males and females, or to neither sex tend to present later and typically have a history of Transvestic Fetishism. Typically, after sex reassignment, those males who were attracted to females wish to live with another woman in either a lesbian relationship or as sisters. If Gender Identity Disorder is present in adulthood, it tends to have a chronic course, but spontaneous remission has been reported.

## Differential Diagnosis

Gender Identity Disorder can be distinguished from simple **nonconformity to stereotypical sex-role behavior** by the extent and pervasiveness of the cross-gender wishes, interests, and activities. This disorder is not meant to describe a child's nonconformity to stereotypic sex-role behavior as, for example, in "tomboyishness" in girls or "sissyish" behavior in boys. Rather, it represents a profound disturbance of the individual's sense of identity with regard to maleness or femaleness. Behavior in children that merely does not fit the cultural stereotype of masculinity or femininity should not be given the diagnosis unless the full syndrome is present, including marked distress or impairment.

**Transvestic Fetishism** occurs in heterosexual (or bisexual) men for whom the cross-dressing behavior is for the purpose of sexual excitement. Aside from cross-dressing, most individuals with Transvestic Fetishism do not have a history of childhood cross-gender behaviors. Males with a presentation that meets full criteria for Gender Identity Disorder as well as Transvestic Fetishism should be given both diagnoses. If gender dysphoria is present in an individual with Transvestic Fetishism but full criteria for Gender Identity Disorder are not met, the specifier **With Gender Dysphoria** can be used.

The category **Gender Identity Disorder Not Otherwise Specified** can be used for

individuals who have a gender identity problem with a **concurrent congenital intersex condition** (e.g., partial androgen insensitivity syndrome or congenital adrenal hyperplasia).

In **Schizophrenia**, there may rarely be delusions of belonging to the other sex. Insistence by a person with a Gender Identity Disorder that he or she is of the other sex is not considered a delusion, because what is invariably meant is that the person feels like a member of the other sex rather than truly believes that he or she is a member of the other sex. In very rare cases, however, Schizophrenia and severe Gender Identity Disorder may coexist.

---

### **Diagnostic criteria for Gender Identity Disorder**

- A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

In children, the disturbance is manifested by four (or more) of the following:

- (1) repeatedly stated desire to be, or insistence that he or she is, the other sex
- (2) in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
- (3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
- (4) intense desire to participate in the stereotypical games and pastimes of the other sex
- (5) strong preference for playmates of the other sex

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

- B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

- C. The disturbance is not concurrent with a physical intersex condition.
- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**Diagnostic criteria for Gender Identity Disorder (continued)**

Code based on current age:

**302.6 Gender Identity Disorder in Children**

**302.85 Gender Identity Disorder in Adolescents or Adults**

*Specify if (for sexually mature individuals):*

**Sexually Attracted to Males**

**Sexually Attracted to Females**

**Sexually Attracted to Both**

**Sexually Attracted to Neither**

---

### **302.6 Gender Identity Disorder Not Otherwise Specified**

This category is included for coding disorders in gender identity that are not classifiable as a specific Gender Identity Disorder. Examples include

1. Intersex conditions (e.g., partial androgen insensitivity syndrome or congenital adrenal hyperplasia) and accompanying gender dysphoria
2. Transient, stress-related cross-dressing behavior
3. Persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex

### **302.9 Sexual Disorder Not Otherwise Specified**

This category is included for coding a sexual disturbance that does not meet the criteria for any specific Sexual Disorder and is neither a Sexual Dysfunction nor a Paraphilia. Examples include

1. Marked feelings of inadequacy concerning sexual performance or other traits related to self-imposed standards of masculinity or femininity
2. Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used
3. Persistent and marked distress about sexual orientation