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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA
TUCSON DIVISION

Jane Doe, *et al.*, Plaintiffs, v. Thomas C. Horne, in his official capacity as State Superintendent of Public Instruction, *et al.*, Defendants, and Warren Petersen, Senator, President of the Arizona State Senate; Ben Toma, Representative, Speaker of the Arizona House of Representatives, Intervenor-Defendants.	Case No. 4:23-cv-00185-JGZ **Intervenor-Defendants' Motion to Dismiss and Memorandum of Law in Support Thereof**

INTRODUCTION

Plaintiffs' Count III, which this Court has not yet addressed, should be dismissed because it fails to state a claim. Count III raises claims under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. Plaintiffs' alleged disability is gender dysphoria, which is *not* a disability for purposes of the ADA or the Rehabilitation Act. Both laws exclude from their scope people whose claimed disability constitutes "gender identity disorders not resulting from physical impairments" or "other sexual behavior disorders." The original public meaning of "gender identity disorders" at the time Congress enacted the exclusions—as shown by prevalent diagnostic criteria—matches the definition of gender dysphoria today. In addition, gender dysphoria falls within the laws' exclusion for "other sexual behavior disorders."

Plaintiffs do not point to any "physical impairment" that gave rise to their gender dysphoria diagnoses—and even if they could, they would still fall within the exclusion for other sexual behavior disorders. Plaintiffs also do not allege that a "major life activity" has been substantially impaired. Courts have consistently held that playing sports does not constitute a major life activity—even when sports is part of a student's academic career.

Counts I and II of the Complaint also fail to state a claim for relief for the reasons stated in Intervenors' previous briefing, which is incorporated by reference herein. This Court, to be sure, held that Plaintiffs were likely to succeed on Counts I and II in granting their motion for a preliminary injunction. Arizona Senate President Warren Petersen and Speaker of the Arizona House of Representatives Ben Toma (the "Legislative Leaders") acknowledge that ruling but respectfully submit that Counts I and II also fail to state a claim for relief for the reasons discussed in their preliminary-injunction briefing.

LEGAL STANDARD

A complaint should be dismissed under Rule 12(b)(6) if it fails "to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). "Dismissal can be based on the lack of a cognizable legal theory or the absence of sufficient facts alleged under a cognizable legal theory." *Balistreri v. Pacifica Police Dep't*, 901

F.2d 696, 699 (9th Cir. 1988) (internal citation omitted). "Conclusory allegations of law … are insufficient to defeat a motion to dismiss." *Lee v. City of Los Angeles*, 250 F.3d 668, 679 (9th Cir. 2001). "On a motion to dismiss, the court accepts the facts alleged in the complaint as true." *Balistreri*, 797 F.2d at 745.

ARGUMENT

I. Plaintiffs fail to state a claim in Count III.

Count III alleges violations of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. *See* Compl., Doc. 1, ¶¶81–85. "The Ninth Circuit has indicated that the ADA is to be judicially interpreted in the same manner as the Rehabilitation Act." *Armstrong v. Wilson*, 942 F. Supp. 1252, 1259 (N.D. Cal. 1996). Indeed, the provisions at issue are effectively the same. *See* 29 U.S.C. § 705(20)(B) (defining "individual disability" as "any person who has a disability as defined in" the ADA, 42 U.S.C. § 12102). The result should also be the same. *Williams v. Kincaid*, 45 F.4th 759, 766 n.1 (4th Cir. 2022) ("plaintiffs' ADA and Rehabilitation Act claims rise and fall together"); *accord Csutoras v. Paradise High Sch.*, 12 F.4th 960, 969 n.11 (9th Cir. 2021).

A. Plaintiffs' gender dysphoria is not a "disability" under the ADA and Rehabilitation Act.

Count III requires Plaintiffs to have a disability within the meaning of the ADA and the Rehabilitation Act. *See Taylor v. City and County of Honolulu*, 2023 WL 2753162, at *17 (D. Haw. Mar. 31, 2023). But gender dysphoria is not a "disability" under either law. *See Grimm v. Gloucester Cty. Sch. Bd.*, 972 F.3d 586, 611 (4th Cir. 2020) (noting the fact).

Both the ADA and the Rehabilitation Act exclude "gender identity disorders not resulting from physical impairments" from the definition of disability. 42 U.S.C. § 12211(b)(1); 29 U.S.C. § 705(20)(F)(i). And in enacting that exclusion, Congress intended to exclude gender dysphoria from the definition of "disability."

Statutory interpretation principles support this conclusion. Courts interpret words in a statute "consistent with their ordinary meaning … at the time Congress enacted the

statute." *Wis. Cent. Ltd. v. United States*, 138 S. Ct. 2067, 2070 (2018) (internal citation omitted). Because both exclusions were enacted within a year of each other, *see Grimm*, 972 F.3d at 611 (noting the fact), they are interpreted similarly. And the relevant interpretative aid is the diagnostic criteria for "gender identity disorders" in use at the time of the laws' passage—criteria in the Diagnostic and Statistical Manual (DSM) that Congress was well aware of when it enacted the exclusions. *See* 135 Cong. Rec. 19,871, 19,884-885 (1989); H.R. Rep. No. 101-596, at 88 (Conf. Rep.).

The DSM-III-R definition of "gender identity disorder of childhood" in effect at the time Congress enacted the exclusions encompasses Plaintiffs' gender dysphoria. *See* Am. Psych. Ass'n, Diagnostic and Statistical Manual 71-78 (3d ed., rev. 1987) (DSM-III-R), attached as Exhibit 1;[1] *see also Williams*, 45 F.4th at 781-84 (Quattlebaum, J., dissenting). In the DSM-III-R, for example, the "essential features" of "gender identity disorder of childhood" are "persistent and intense distress in a child about his or her assigned sex and the desire to be, or insistence that he or she is, of the other sex." DSM-III-R, at 71. One court examining this diagnostic criteria said "the 'gender identity disorders' subclass of psychosexual disorders [is] 'characterized by the individual's feelings of discomfort and inappropriateness about his or her anatomic sex and by persistent behaviors generally associated with the other sex.'" *Lange v. Houston County*, 608 F. Supp. 3d 1340, 1362 (M.D. Ga. 2022) (quoting APA, *Diagnostic and Statistical Manual of Mental Disorders – Third Edition* 261 (1980) [hereinafter DSM-III]); *see also* DSM-III-R at 71 (noting that "mild" cases of "gender identity disturbance" involve "discomfort and a sense of inappropriateness about the assigned sex"). Likewise, "the 'essential feature' of the gender identity disorders subclass" in the DSM-III is "'an incongruence between anatomic sex and gender identity.'" *Lange*, 608 F. Supp. 3d at 1362 (quoting DSM-III, *supra*, at 261); *see also* DSM-III-R, *supra*, at 71.

So at the time Congress passed the gender-identity-disorders exclusions in the ADA

[1] The Court may take judicial notice of DSM-III-R. *Hoffmann v. Life Ins. Co. of N. Am.*, 669 F. App'x 399, 400 (9th Cir. 2016).

and Rehabilitation Act, a person suffering from a "gender identity disorder" was experiencing an incongruence between sex and gender identity plus discomfort about the incongruence. That tracks the current diagnostic of gender dysphoria, including the diagnosis for gender dysphoria in children. *See* APA, *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition* 451–52 (2013) [hereinafter DSM-V]; *see also* APA, *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition Text Revision* 511—12 (2022) [hereinafter DSM-V-TR]. It also tracks the definition of gender dysphoria presented by Plaintiffs and their experts. Compl., Doc. 1, ¶ 32; Decl. of Dr. Stephanie Budge, Doc. 4, ¶¶ 23-24; Decl. of Dr. Daniel Shumer, Doc. 5, ¶¶ 27-28. "The clear result is that Congress intended to exclude from the ADA's protection both disabling and non-disabling gender identity disorders that do not result from a physical impairment. The majority of federal cases have concluded as much." *Parker v. Strawser Constr., Inc.*, 307 F. Supp. 3d 744, 754 (S.D. Ohio 2018) (citing *Gulley–Fernandez v. Wis. Dep't of Corr.*, 2015 WL 7777997, at *2 (E.D. Wis. Dec. 1, 2015); *Mitchell v. Wall*, 2015 WL 10936775, at *1 (W.D. Wis. Aug. 6, 2015); *Diamond v. Allen*, 2014 WL 6461730, at *4 (M.D. Ga. Nov. 17, 2014); *Kastl v. Maricopa Cty. Cmty. Coll. Dist.*, 2004 WL 2008954, at *4 (D. Ariz. June 3, 2004)).

The Fourth Circuit took a different course and held that gender dysphoria is not excluded as a gender identity disorder. *See Williams v. Kincaid*, 45 F.4th 759, 766–71 (4th Cir. 2022). The panel majority's reasoning rests on the APA's decision to remove "'gender identity disorder' from the DSM-[V]" and to add "the diagnosis of 'gender dysphoria.'" *Id.* at 767. Thus, the panel majority concluded, even "if there are similarities between the now-obsolete definition of gender identity disorder and the DSM-[V]'s definition of gender dysphoria, the diagnosis of gender identity disorder referred to in § 12211(b) no longer exists." *Id.* at 769 n.5; *see also Kincaid v. Williams*, 143 S. Ct. 2414, 2416 (2023) (Alito, J., dissenting from the denial of certiorari) (summarizing the analysis). Put simply, the panel majority treated the ADA's (and, by extension, the Rehabilitation Act's) exclusion of "gender identity disorders" not to be "fixed at the time the [laws were] enacted,"

Williams, 45 F.4th at 785 (Quattlebaum, J., dissenting), but subject to revision and erasure by the APA.

That is not how statutory analysis works. "[E]very statute's meaning is fixed at the time of enactment." *Badgley v. United States*, 957 F.3d 969, 977 (9th Cir. 2020) (quoting *Wisc. Cent. Ltd.*, 138 S. Ct. at 2070). For that matter, it is not how the Constitution works; Congress cannot "delegate regulatory power to private individuals." *Mistretta v. United States*, 488 U.S. 361, 373 n.7 (1989). A private organization like the APA cannot be delegated "power to effectively modify statutes passed by Congress and signed into law by the President." *Williams*, 45 F.4th at 785 (Quattlebaum, J., dissenting). The *Williams* majority never justifies its departure from basic tenets of statutory interpretation and non-delegation principles.

The *Williams* majority also ignored statutory context. Both the ADA and Rehabilitation Act exclude "other sexual behavior disorders" as well as gender identity disorders from their scope. 29 U.S.C. § 705(20)(F)(i); 42 U.S.C. § 12211(b)(1). That "final catch-all category suggests that Congress sought to prohibit the ADA's [and Rehabilitation Act's] application to conditions that are sufficiently similar to the more specific categories of conditions that precede," *Kincaid*, 143 S. Ct. at 2417 (Alito, J., dissenting from the denial of certiorari), which would mean the exclusion covers gender dysphoria even if the other listed exclusions do not. And that is the second reason why Plaintiffs are not disabled for purposes of the ADA and the Rehabilitation Act.

Thus, gender dysphoria is not a disability for purposes of the ADA and Rehabilitation Act. It either falls within the statutory exclusions for "gender identity disorders" or for "other sexual disorders."

B. Plaintiffs do not provide factual allegations that their gender identity results from a physical impairment.

Plaintiffs cannot avoid the gender identity disorder exclusion unless their gender dysphoria came from a physical impairment. *See* 29 U.S.C. § 705(20)(F)(i) (Rehabilitation Act); 42 U.S.C. § 12211(b)(1) (ADA). Plaintiffs' allegation that their gender dysphoria

results from physical impairments, Compl., Doc. 1, ¶ 84, is nothing more than a "conclusory allegation[ ] of law" that cannot "defeat a motion to dismiss for failure to state a claim," *Epstein v. Washington Energy Co.*, 83 F.3d 1136, 1140 (9th Cir. 1996). Courts have thus been properly skeptical of similar allegations and found no physical impairment was alleged. *See, e.g.*, *Lange*, 608 F. Supp. 3d at 1362–63; *Parker*, 307 F. Supp. 3d at 755.

The DSM-III-R informs what Plaintiffs needed to plead. As set forth in the DSM-III-R "gender identity disorder" sections, "[p]hysical abnormalities of the sex organs are rarely associated with Gender Identity Disorder of Childhood; when they are present, the physical disorder should be noted on Axis III." DSM-III-R, *supra*, at 73. That suggests "physical impairment" under the ADA and Rehabilitation Act refers to "a manifest physical condition that causes one's gender identity disorder." *Lange*, 608 F. Supp. 3d at 1363 n.18. There is nothing like that in the Complaint.

Here again, the Fourth Circuit concluded otherwise. *See Williams*, 45 F.4th at 770–72. "The ground on which the majority [so] concluded . . . is not entirely clear, but . . . appears to be that Williams has a physical need for hormonal treatment because, without it, Williams experiences 'physical distress.' " *Kincaid*, 143 S. Ct. at 2416 (quoting *Williams*, 45 F.4th at 771) (Alito, J., dissenting from the denial of certiorari). But that conflates the treatment with the cause and so ignores the statutory text. *See Williams*, 45 F.4th at 788 (Quattlebaum, J., dissenting) ("At most, it implies hormone therapy and/or surgery may be—not that it always is—helpful to treat the condition. But § 12211(b)(1) requires that a person's gender identity disorder result from a physical impairment. That means the physical impairment must come first."); *see also Kincaid*, 143 S. Ct. at 2418 (Alito, J., dissenting from the denial of certiorari) ("Many common mental impairments, such as depression and anxiety disorders, cause real and sometimes powerful physical distress and are treated by chemical interventions. That does not mean, however, that those mental impairments are caused by an independent physical trait that itself qualifies as an impairment.").

The *Williams* court also pointed to emerging "medical and scientific research

identifying possible physical bases of gender dysphoria." 45 F.4th at 771. But that "is not even an *ipse dixit*, it is an evolving possible *ipse dixit*." *Lange*, 608 F. Supp. 3d at 1363. In all events, it is unhelpful to Plaintiffs because nothing in the complaint links that emerging scientific research to their diagnoses. *See id.* ("Even if the Court were to accept Lange's expert report at face value, there is nothing in that report or anywhere else in the record suggesting Lange's gender dysphoria results from a 'physical impairment.' ").

It is also unhelpful to Plaintiffs because gender dysphoria also falls within the carveouts in the ADA and Rehabilitation Acts for "other sexual behavior disorders." That carveout applies regardless of the existence of physical impairments. *See* 29 U.S.C. § 705(20)(F)(i); 42 U.S.C. § 1221(b)(1).

C. Excluding gender dysphoria from the ADA's and Rehabilitation Act's scope does not raise constitutional issues.

The *Williams* court bolstered its analysis by claiming that excluding gender dysphoria from the ADA's reach—and, by extension, the Rehabilitation Act's reach, *see* 45 F.4th at 764 n.1—would raise constitutional issues under the Equal Protection Clause. *See id.* at 772–74. That was because, the panel said, the exclusions were driven by animus: "[W]e see no legitimate reason why Congress would intend to exclude from the ADA's protections transgender people who suffer from gender dysphoria. The only reason we can glean from the text and legislative record is a bare desire to harm a politically unpopular group, which cannot constitute a legitimate governmental interest." *Id.* at 773 (citations, quotations, and alterations omitted). In support, the panel pointed to statements from two senators. *Id.*

That analysis ignores that "the statements of a handful of lawmakers may not be probative of the intent of the legislature as a whole." *United States v. Carrillo-Lopez*, 68 F.4th 1133, 1140 (9th Cir. 2023) (gathering sources). It also gives short shrift to the "strong 'presumption of good faith' on the part of legislators," *id.* (quoting *Miller v. Johnson*, 515 U.S. 900, 915 (1995)), that reflects "the many considerations that [legislators] may have had in mind in adopting a piece of major legislation like the ADA" beyond animus,

Kincaid, 143 S. Ct. at 2418 (Alito, J., dissenting from the denial of certiorari); *see also Village of Arlington Heights v. Metropolitan Housing Development Corp.*, 429 U.S. 252, 265 (1977).

The *Williams* majority also ignores many legitimate governmental interests the ADA's and Rehabilitation Act's exclusion for gender identity disorders advance. For example, "Congress may also have thought that coverage of gender-identity-related conditions would raise special free speech and free exercise concerns." *Kincaid*, 143 S. Ct. at 2418 (Alito, J., dissenting from the denial of certiorari). Congress could have also decided that gender identity disorders that do not stem from physical impairments are sufficiently different from other types of disabilities the ADA and Rehabilitation Acts cover—for example, gender identity disorders stemming from physical impairments—so as to justify different treatment. The "legislature need not strike at all evils at the same time, and … reform may take one step at a time, addressing itself to the phase of the problem which seems most acute to the legislative mind." *Katzenbach v. Morgan*, 384 U.S. 641, 657 (1966) (quotations and citations omitted).

D. Plaintiffs do not allege a major life activity has been substantially limited.

Plaintiffs' claim falters even if they could somehow surmount the statutory exclusion. Under the ADA, "disability" is defined as "a physical or mental impairment that substantially limits one or more major life activities of such individual … ." 42 U.S.C. § 12102(1)(A). The Rehabilitation Act contains the same requirement. *See* 29 U.S.C. § 705(20)(B) (incorporating the ADA's definition for purposes of 29 U.S.C. § 794). "Thus, to be disabled for purposes of the [the two laws], a person must have an impairment, that impairment must limit a major life activity, and the limitation on the major life activity must be substantial." *E.E.O.C. v. United Parcel Serv., Inc.*, 306 F.3d 794, 801 (9th Cir.), *opinion amended on denial of reh'g*, 311 F.3d 1132 (9th Cir. 2002).

Plaintiffs have not alleged that a major life activity has been impaired, nor have they specified which major life activity they believe has been impaired. It cannot be athletics.

Playing sports is not a "major life activity" under the ADA. Regulations define "major life activities" to include, but not be limited to, "[c]aring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others, and working." 29 C.F.R. § 1630.2(i)(1)(i). But "courts [have] consistently held that sporting activities … d[o] not qualify as major life activities." *Marsh v. Terra Int'l (Okla.), Inc.*, 122 F. Supp. 3d 1267, 1279 (N.D. Okla. 2015) (citing *Griego v. Barton Leasing Inc.*, 2010 WL 618281, at *4 (D. Colo. Feb. 19, 2010) (holding that "participating in sports" and "playing sports with children" were not major life activities); *Robinson v. Lockheed Martin Co.,* 2006 WL 5629118, at *7 (E.D. Pa. Feb. 1, 2006) (holding that sporting activities were not major life activities); *Rosa v. Brink's Inc.,* 103 F. Supp. 2d 287, 290 (S.D.N.Y.2000) (holding that sports activities "are not major life activities at all")); *see also id.* at 1279 (concluding that the 2008 amendments to the ADA do not change the conclusion).

The intrinsic benefits sports can provide do not convert playing sports into a major life activity. "Unlike standing, sitting, breathing, thinking, communicating, interacting with others, or other examples in the regulation, a person can live (and many do) without ever participating in sports," reasoned the *Marsh* court. *Id.* "These activities may enhance one's life and may be important to particular individuals, but the ADA is ultimately aimed at ferreting out discrimination and ensuring that employers provide reasonable accommodations to disabled individuals." *Id.* Other courts have reached the same conclusion that playing sports is not a major life activity under the ADA. *Pritchard v. Fla. High Sch. Athletic Ass'n, Inc.*, 2020 WL 3542652, at *4 (M.D. Fla. June 30, 2020) ("From the outset, the Court finds that the inability to play sports does not constitute a substantial impairment of a major life activity.") (internal quotation omitted); *Walter v. Birdville Indep. Sch. Dist.*, 2018 WL 3974714, at *3 (N.D. Tex. Aug. 20, 2018) ("Participating in sports is not a major life activity.).

Nor is it sufficient to link sports to academic and social successes. *See Knapp v.*

Nw. Univ., 101 F.3d 473, 481 (7th Cir. 1996) ("Because learning through playing intercollegiate basketball is only one part of the education available to Knapp at Northwestern, even under a subjective standard, Knapp's ability to learn is not substantially limited."). For example, in *Pahulu v. University of Kansas*, 897 F. Supp. 1387 (D. Kan. 1995), the court concluded that prohibiting the plaintiff from playing football due to a medical condition he suffered was "not a substantial limitation upon the plaintiff's opportunity to learn." *Id.* at 1393. That same conclusion applies here. Moreover, "there are a myriad of other educational opportunities available to" Plaintiffs at their schools. *Id.* Thus, even without considering the fact that Plaintiffs could participate in school sports by playing on boys' or coed teams, *see* Ariz. Rev. Stat. § 15-120.02(B), Plaintiffs have failed to allege a major life activity is substantially limited.

Accordingly, because playing sports is not a major life activity under the ADA, Plaintiffs' ADA claim fails.

II. Count I and Count II should be dismissed for the reasons set out in the oppositions to Plaintiffs' preliminary injunction motion.

The Court should dismiss Counts I and II for the reasons set forth in the two oppositions to Plaintiffs' motion for a preliminary injunction. *See* Doc. 40 (Superintendent Horne's opposition); Doc. 82 (Legislative Leaders' opposition). "[A] complaint cannot state a plausible claim for relief if there is no chance of success on the merits." *Angelotti Chiropractic, Inc. v. Baker*, 791 F.3d 1075, 1087 (9th Cir. 2015) (quotation omitted). The same arguments and the same legal reasoning undermine Plaintiffs' complaint and motion for preliminary injunction. This overlap is because Plaintiffs have no chance of success on the merits. *See id.* The Legislative Leaders acknowledge the Court granted Plaintiffs' motion for a preliminary injunction on Counts I and II, *see* Doc. 127, but they respectfully submit that Counts I and II warrant dismissal for the reasons stated in their prior briefing.

CONCLUSION

The Court should dismiss Plaintiffs' Complaint for failure to state a claim.

Dated: September 12, 2023

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that, on September 12, 2023, I caused a true and correct copy of the foregoing to be filed by the Court's electronic filing system, to be served by operation of the Court's electronic filing system on counsel for all parties who have entered in the case.

/s/ Justin D. Smith

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

(THIRD EDITION - REVISED)

DSM-III-R

AMERICAN PSYCHIATRIC ASSOCIATION

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

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307.50 Eating Disorder Not Otherwise Specified

Disorders of eating that do not meet the criteria for a specific Eating Disorder.

Examples:

(1) a person of average weight who does not have binge eating episodes, but frequently engages in self-induced vomiting for fear of gaining weight
(2) all of the features of Anorexia Nervosa in a female except absence of menses
(3) all of the features of Bulimia Nervosa except the frequency of binge eating episodes

GENDER IDENTITY DISORDERS

The essential feature of the disorders included in this subclass is an incongruence between assigned sex (i.e., the sex that is recorded on the birth certificate) and gender identity. Gender identity is the sense of knowing to which sex one belongs, that is, the awareness that "I am a male," or "I am a female." Gender identity is the private experience of gender role, and gender role is the public expression of gender identity. Gender role can be defined as everything that one says and does to indicate to others or to oneself the degree to which one is male or female.

Some forms of gender identity disturbance are on a continuum, whereas others may be discrete. When gender identity disturbance is mild, the person is aware that he is a male or that she is a female, but discomfort and a sense of inappropriateness about the assigned sex are experienced. When severe, as in Transsexualism, the person not only is uncomfortable with the assigned sex but has the sense of belonging to the opposite sex.

Disturbance in gender identity is rare, and should not be confused with the far more common phenomena of feelings of inadequacy in fulfilling the expectations associated with one's gender role. An example of the latter would be a person who perceives himself or herself as being sexually unattractive yet experiences himself or herself unambiguously as a man or a woman in accordance with his or her assigned sex.

Although people who first present clinically with gender identity problems may be of any age, in the vast majority of cases the onset of the disorder can be traced back to childhood. In rare cases, however, an adult will present clinically for the first time with a gender identity problem and report that the first signs of the disturbance were in adult life.

302.60 Gender Identity Disorder of Childhood

The essential features of this disorder are persistent and intense distress in a child about his or her assigned sex and the desire to be, or insistence that he or she is, of the other sex. (This disorder is not merely a child's nonconformity to stereotypic sex-role behavior as, for example, in "tomboyishness" in girls or "sissyish" behavior in boys, but rather a profound disturbance of the normal sense of maleness or femaleness.) In addition, in a girl there is either persistent marked aversion to normative feminine clothing and insistence on wearing stereotypic masculine clothing, or persistent repudiation of her female anatomic characteristics. In a boy, there is either preoccupation with female stereotypic activities, or persistent repudiation of his male anatomic characteristics. This diagnosis is not given after the onset of puberty.

Girls with this disorder regularly have male companions and an avid interest in sports and rough-and-tumble play; they show no interest in dolls or playing "house" (unless they play the father or another male role). More rarely, a girl with this disorder refuses to urinate in a sitting position, claims that she has, or will grow, a penis, does not

want to grow breasts or menstruate, or asserts that she will grow up to become a man (not merely in role).

Boys with this disorder usually are preoccupied with female stereotypic activities. They may have a preference for dressing in girls' or women's clothes, or may improvise such items from available material when genuine articles are unavailable. (The cross-dressing typically does not cause sexual excitement, as in Transvestic Fetishism.) They often have a compelling desire to participate in the games and pastimes of girls. Female dolls are often their favorite toy, and girls are regularly their preferred playmates. When playing "house," the role of a female is typically adopted. Rough-and-tumble play or sports are generally avoided. Gestures and actions are often judged against a cultural stereotype of femininity, and the boy is usually subjected to male peer group teasing and rejection, whereas the same rarely occurs among girls until adolescence. Boys with this disorder may assert that they will grow up to become women (not merely in role). In rare cases a boy with this disorder claims that his penis or testes are disgusting or will disappear, or that it would be better not to have a penis or testes.

Some children refuse to attend school because of teasing or pressure to dress in attire stereotypical of their assigned sex. Most children with this disorder deny being disturbed by it, except that it brings them into conflict with the expectations of their family or peers.

Associated features. Some of these children, particularly girls, show no other signs of psychopathology. Others may display serious signs of disturbance, such as social withdrawal, separation anxiety, or depression.

Age at onset and course. The majority of the boys with this disorder begin to develop it before their fourth birthday. Social ostracism increases during the early grades of school, and social conflict is significant at about age seven or eight. During the later grade-school years, grossly feminine behavior may lessen. Studies indicate that from one-third to two-thirds or more of boys with the disorder develop a homosexual orientation during adolescence.

For females the age at onset is also early, but most give up an exaggerated insistence on male activities and attire during late childhood or adolescence. A minority retain a masculine identification, and some of these develop a homosexual orientation.

Whereas most adult people with Transsexualism report having had a gender identity problem during childhood, prospective studies of children with Gender Identity Disorder of Childhood indicate that very few develop Transsexualism in adolescence or adulthood.

Complications. In a small number of cases, the disorder becomes continuous with Transsexualism or Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type.

Impairment. Positive peer relations with members of the same sex are absent or difficult to establish. The amount of impairment varies from none to extreme, and is related to the degree of associated psychopathology and the reaction of peers and family to the person's behavior.

Prevalence. The disorder is apparently uncommon.

Sex ratio. In clinic samples there are many more boys with this disorder than girls. The sex ratio in the general population is unknown.

Familial pattern. No information.

Predisposing factors. Studies indicate that characteristics of the child, the parents, or of other social agents, such as parental substitutes and siblings, may be predisposing factors for the development of the disorder. In boys, the characteristics may include "feminine" physical features, an aversion to rough-and-tumble play, separation anxiety, and a history of early hospitalization. The relevant characteristics of parents and other influential people in the child's environment may include weak reinforcement of normative gender-role behavior, absence or unavailability of a father, and encouragement of extreme physical and psychological closeness with her son by a mother. In girls, a strong interest in rough-and-tumble play on the part of the child and weak reinforcement of normative gender-role behavior by the parents may contribute to the development of the disorder.

Differential diagnosis. Children whose behavior merely does not fit the cultural stereotype of masculinity or femininity should not be given this diagnosis unless the full syndrome is present. **Physical abnormalities of the sex organs** are rarely associated with Gender Identity Disorder of Childhood; when they are present, the physical disorder should be noted on Axis III.

Diagnostic criteria for 302.60 Gender Identity Disorder of Childhood

For Females:

A. Persistent and intense distress about being a girl, and a stated desire to be a boy (not merely a desire for any perceived cultural advantages from being a boy), or insistence that she is a boy.

B. Either (1) or (2):

(1) persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing, e.g., boys' underwear and other accessories

(2) persistent repudiation of female anatomic structures, as evidenced by at least one of the following:

(a) an assertion that she has, or will grow, a penis
(b) rejection of urinating in a sitting position
(c) assertion that she does not want to grow breasts or menstruate

C. The girl has not yet reached puberty.

For Males:

A. Persistent and intense distress about being a boy and an intense desire to be a girl or, more rarely, insistence that he is a girl.

B. Either (1) or (2):

(1) preoccupation with female stereotypical activities, as shown by a preference for either cross-dressing or simulating female attire, or by an intense desire to participate in the games and pastimes of girls and rejection of male stereotypical toys, games, and activities

(continued)

Diagnostic criteria for 302.60 Gender Identity Disorder of Childhood continued

(2) persistent repudiation of male anatomic structures, as indicated by at least one of the following repeated assertions:

(a) that he will grow up to become a woman (not merely in role)
(b) that his penis or testes are disgusting or will disappear
(c) that it would be better not to have a penis or testes

C. The boy has not yet reached puberty.

302.50 Transsexualism

The essential features of this disorder are a persistent discomfort and sense of inappropriateness about one's assigned sex in a person who has reached puberty. In addition, there is persistent preoccupation, for at least two years, with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex. Therefore, the diagnosis is not made if the disturbance is limited to brief periods of stress. Invariably there is the wish to live as a member of the other sex. In the rare cases in which physical intersexuality or a genetic abnormality is present, such a condition should be noted on Axis III.

People with this disorder usually complain that they are uncomfortable wearing the clothes of their assigned sex and therefore dress in clothes of the other sex. Often they engage in activities that in our culture tend to be associated with the other sex. These people often find their genitals repugnant, which may lead to persistent requests for sex reassignment by hormonal and surgical means.

To varying degrees, the behavior, dress, and mannerisms become those of the other sex. With cross-dressing and hormonal treatment (and for males, electrolysis), some males and some females with the disorder will appear relatively indistinguishable from members of the other sex. However, even after sex reassignment, many people still have some physical features of their originally assigned sex that the alert observer can recognize.

Cross-culturally, the Hijra of India and the corresponding group in Burma may have conditions that, according to this manual, would be diagnosed as male-to-female Transsexualism. The Hijra, however, traditionally undergo castration, not hormonal and surgical feminization (creation of a vagina).

Associated features. Generally there is a moderate to severe coexisting personality disturbance. Frequently the person experiences considerable anxiety and depression, which he or she may attribute to the inability to live in the role of the desired sex.

Course. Without treatment, the course of the disorder is chronic, but cases with apparently spontaneous remission do occur. The long-term outcome of combined psychiatric, hormonal, and surgical sex-reassignment treatment is not well known. Many people function better for years after such treatment, but a number of cases in which re-reassignment has been desired have also been reported.

People who have female-to-male Transsexualism appear to represent a more homogeneous group than those who have male-to-female Transsexualism in that they are more likely to have a history of homosexuality and a more stable course, with or without treatment.

Age at onset. People who develop Transsexualism almost invariably report having had a gender identity problem in childhood. Some assert that they were secretly aware of their gender problem, but that it was not evident to their family and friends. Although onset of the full syndrome is most often in late adolescence or early adult life, in some cases the disorder has a later onset.

Impairment and complications. Frequently, social and occupational functioning are markedly impaired, partly because of associated psychopathology and partly because of problems encountered in attempting to live in the desired gender role. Depression is common, and can lead to suicide attempts. In rare instances, males may mutilate their genitals.

Predisposing factors. Extensive, pervasive childhood femininity in a boy or childhood masculinity in a girl increases the likelihood of Transsexualism. It seems usually to develop within the context of a disturbed relationship with one or both parents. Some cases of Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type, evolve into Transsexualism.

Prevalence. The estimated prevalence is one per 30,000 for males and one per 100,000 for females.

Sex ratio. Males seek help at clinics specializing in the treatment of this disorder more commonly than do females. The ratio varies from as high as 8:1 to as low as 1:1.

Familial pattern. No information.

Differential diagnosis. Some people with disturbed gender identity may, in isolated periods of stress, wish to belong to the other sex and to be rid of their own genitals. In such cases a diagnosis of **Gender Identity Disorder Not Otherwise Specified** should be considered, since the diagnosis of Transsexualism is made only when the disturbance has been continuous for at least two years. In **Schizophrenia** there may be delusions of belonging to the other sex, but this is rare. The insistence by a person with Transsexualism that he or she is of the other sex is, strictly speaking, not a delusion, since 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 Transsexualism may coexist.

In both **Transvestic Fetishism** and **Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type**, there may be cross-dressing. But unless these disorders evolve into Transsexualism, there is no wish to be rid of one's own genitals.

Types. The disorder is subdivided according to the history of sexual orientation, as asexual, homosexual (toward same sex), heterosexual (toward opposite sex), or unspecified. In the first, "asexual," the person reports never having had strong sexual feelings. Often there is an additional history of little or no sexual activity or pleasure derived from the genitals. In the second group, "homosexual," a predominantly homosexual arousal pattern preceding the onset of the Transsexualism is acknowledged, although often such people deny that the orientation is homosexual because of their conviction that they are "really" of the other sex. In the third group, "heterosexual," the person claims to have had a heterosexual orientation.

Diagnostic criteria for 302.50 Transsexualism

A. Persistent discomfort and sense of inappropriateness about one's assigned sex.

B. Persistent preoccupation for at least two years with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex.

C. The person has reached puberty.

Specify history of sexual orientation: **asexual, homosexual, heterosexual,** or **unspecified.**

302.85 Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT)

The essential features of this disorder are a persistent or recurrent discomfort and sense of inappropriateness about one's assigned sex, and persistent or recurrent cross-dressing in the role of the other sex, either in fantasy or in actuality, in a person who has reached puberty. This disorder differs from Transvestic Fetishism in that the cross-dressing is not for the purpose of sexual excitement; it differs from Transsexualism in that there is no persistent preoccupation (for at least two years) with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex.

Some people with this disorder once had Transvestic Fetishism, but no longer experience sexual arousal with cross-dressing. Other people with this disorder are homosexuals who cross-dress. This disorder is common among female impersonators.

Cross-dressing phenomena range from occasional solitary wearing of female clothes to extensive feminine identification in males and masculine identification in females, and involvement in a transvestic subculture. More than one article of clothing of the other sex is involved, and the person may dress entirely as a member of the opposite sex. The degree to which the cross-dressed person appears as a member of the other sex varies, depending on mannerisms, body habitus, and cross-dressing skill. When not cross-dressed, the person usually appears as an unremarkable member of his or her assigned sex.

Associated features. Anxiety and depression are common, but are often attenuated when the person is cross-dressing.

Age at onset and course. Age at onset and course are variable. In most cases, before puberty there was a history of some or all of the features of Gender Identity Disorder of Childhood. However, by definition, GIDAANT is diagnosed only once puberty has been reached. The initial experience may involve partial or total cross-dressing; when it is partial, it often progresses to total. Cross-dressing, although intermittent in the beginning, often becomes more frequent, and may become habitual. A small number of people with GIDAANT, as the years pass, want to dress and live permanently as the other sex, and the disorder may evolve into Transsexualism.

Impairment. Unless there is another diagnosis in addition to GIDAANT, the impairment is generally restricted to conflicts with family members and other people regarding the cross-dressing.

Complications. The major complication is Transsexualism.

Predisposing factors. As noted above, both Gender Identity Disorder of Childhood and Transvestic Fetishism sometimes evolve into GIDAANT.

Prevalence. Although its prevalence is unknown, the disorder is probably more common than Transsexualism.

Sex ratio. The disorder is more common in males.

Familial pattern. No information.

Differential diagnosis. In **Transvestic Fetishism**, the cross-dressing is for the purpose of sexual excitement. In **Transsexualism**, there is a persistent (for more than two years) wish to get rid of one's primary and secondary sex characteristics and acquire the sex characteristics of the other sex. In those rare instances in which a person with GIDAANT develops Transsexualism, the diagnosis of GIDAANT is changed accordingly.

Subtypes. The disorder is subdivided according to the history of sexual orientation, as asexual, homosexual (toward same sex), heterosexual (toward opposite sex), or unspecified. In the first, "asexual," the person reports never having had strong sexual feelings. Often there is an additional history of little or no sexual activity or pleasure derived from the genitals. In the second group, "homosexual," a predominantly homosexual arousal pattern preceding the onset of the GIDAANT is acknowledged. In the third group, "heterosexual," the person claims to have had a heterosexual orientation.

Diagnostic criteria for 302.85 Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT)

A. Persistent or recurrent discomfort and sense of inappropriateness about one's assigned sex.

B. Persistent or recurrent cross-dressing in the role of the other sex, either in fantasy or actuality, but not for the purpose of sexual excitement (as in Transvestic Fetishism).

C. No persistent preoccupation (for at least two years) with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex (as in Transsexualism).

D. The person has reached puberty.

Specify history of sexual orientation: **asexual, homosexual, heterosexual,** or **unspecified.**

302.85 Gender Identity Disorder Not Otherwise Specified

Disorders in gender identity that are not classifiable as a specific Gender Identity Disorder.

Examples:

(1) children with persistent cross-dressing without the other criteria for Gender Identity Disorder of Childhood
(2) adults with transient, stress-related cross-dressing behavior
(3) adults with the clinical features of Transsexualism of less than two years' duration
(4) people who have a persistent preoccupation with castration or peotomy without a desire to acquire the sex characteristics of the other sex

TIC DISORDERS

Tics are the essential feature of the three disorders in this subclass: Tourette's Disorder, Chronic Motor or Vocal Tic Disorder, and Transient Tic Disorder. There is evidence from genetic and other studies that Tourette's Disorder and Chronic Motor or Vocal Tic Disorder represent different symptomatic expressions of the same underlying disorder. However, they are included in this manual as separate disorders because they generally involve different degrees of impairment (the former being more disabling) and they have different treatment implications.

A tic is an involuntary, sudden, rapid, recurrent, nonrhythmic, stereotyped, motor movement or vocalization. It is experienced as irresistible, but can be suppressed for varying lengths of time. All forms of tics are often exacerbated by stress and usually are markedly diminished during sleep. They may become attenuated during some absorbing activities, such as reading or sewing.

Both *motor* and *vocal tics* may be classified as either *simple* or *complex*, although the boundaries are not well defined. Common *simple motor tics* are eye-blinking, neck-jerking, shoulder-shrugging, and facial grimacing. Common *simple vocal tics* are coughing, throat-clearing, grunting, sniffing, snorting, and barking. Common *complex motor tics* are facial gestures, grooming behaviors, hitting or biting self, jumping, touching, stamping, and smelling an object. Common *complex vocal tics* are repeating words or phrases out of context, coprolalia (use of socially unacceptable words, frequently obscene), palilalia (repeating one's own sounds or words), and echolalia (repeating the last-heard sound, word, or phrase of another person, or a last-heard sound). Other complex tics include echokinesis (imitation of the movements of someone who is being observed).

Associated features. Discomfort in social situations, shame, self-consciousness, and depressed mood are common, especially with Tourette's Disorder.

Predisposing factors. A controversy exists as to whether or not the onset of some cases of Tic Disorders is precipitated by exposure to phenothiazines, head trauma, or the administration of central nervous system stimulants. It is estimated that in one-third of cases of Tourette's Disorder, the severity of the tics is exacerbated by administration of central nervous system stimulants, which may be a dose-related phenomenon.

Impairment. Social, academic, and occupational functioning may be impaired because of rejection by others or anxiety about having tics in social situations. In addition, in severe cases of Tourette's Disorder, the tics themselves may interfere with daily activities, such as reading or writing. Although most people with Tourette's Disorder do not have marked impairment, in general the impairment is more severe than in Chronic Motor or Vocal Tic Disorder. Impairment in Transient Tic Disorder rarely is marked.