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The Etiology of Boyhood Gender Identity Disorder: A Model for Integrating Temperament, Development, and Psychodynamics

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In this paper, we present a model for conceptualizing the etiology of boyhood gender identity disorder. We illustrate the model with a specific case of a three-year-old boy who developed a gender identity disorder in reaction to his mother’s depression after she had an abortion. We describe how the temperament of the child, his reaction to a psychic trauma during a sensitive period of mental representational development, and multigenerational transmission of psychodynamics lead to a gender identity disorder. We view the cross-gender fantasy as a compromise formation for the management of separation anxiety and aggression, and we view its enactment in behavior, in part, as a defensive attempt to understand an unmetabolizable experience of aggression. This case offers an unusual window into understanding how interpersonal experience, particularly in the face of severe anxiety, becomes transformed into intrapsychic phenomena and how pathological beliefs both encode experience and construct psychic reality.

Gender Identity Disorder (GID) in boys is a syndrome in which young boys not only wish to be girls but intensely dislike being boys as well. Their chronic suffering was expressed directly by

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one of our three-year-olds in the following way: "I hate myself. I don't want to be me. I want to be somebody else. I want to be a girl."

Boys with GID manifest a predominant interest in behavior and activities that are typical of the opposite sex. The wish to be a girl is enacted in their behavior by a persistent preference for, and interest in, stereotypically female activities, such as dressing up in girls' clothes and having an intense interest in cosmetics, in jewelry, and in doll play, and by a preference for taking the role of a woman rather than a man in playacting. In a variety of ways boys with GID express feelings of self-contempt or self-hatred. Many experience anatomical dysphoria that takes the form of a dislike of their penis.

One of the hallmarks of this disorder is that it emerges during a relatively narrow time frame in development. Although an early interest in the mother's clothes is often reported before the age of 18 months, in most boys the disorder consolidates between the ages of two and three. The consolidation of this disorder usually takes the form of a persistent interest in dressing up in mother's clothes, a persistent lack of interest in male clothes, and a persistent imitation in playacting the mother's behavior.

Boys with GID are referred more often for psychiatric services than are girls (Coates and Zucker, 1988). Although epidemiological data are lacking, clinical experience suggests that childhood GID is relatively rare (Coates and Zucker, 1988).

In prospective studies, about two-thirds of boys with childhood GID grow up to be homosexual (Money and Russo, 1979; Zuger, 1984; Green, 1985). Since we do not yet know what the specific multiple factors are that predict homosexuality or heterosexuality, having a GID cannot be used as a predictor of homosexuality in later life in any individual child. Furthermore, boys with GID represent a small subgroup of those who

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will become gay. Although most homosexual men have experienced nonstereotypic gender role behavior as children (often called gender-role nonconformity), most have not had a boyhood GID such as we describe in this paper (Saghir and Robins, 1973; Friedman, 1988).

GID in boys represents the extreme end point of a continuum involving the imitation of the other. One could think of one end of the continuum as having the ability to put oneself mentally in someone else's shoes, so to speak, in an effort to understand that person (an essential ingredient of empathy) and the other end as a rigid defense against separation anxiety and rage that involves a compulsive enactment of being the mother. These boys are not simply boys with androgynous and multiple interests but, rather, boys whose play is very constricted, compulsive, and rigid when compared to the range of play in their male and female peers (Zucker et al., 1982).

Boys with GID are bright, intense, perfectionistic children who are very affiliative and people-oriented, highly attuned to affect, and extremely vulnerable to humiliation. They are caretaking and solicitous when they experience their mother as angry or depressed. In new situations they are hypervigilant and quickly size up the affect of adults.

Boys with GID are highly overadapted in the sense of being extremely compliant, well-behaved children who are often teachers' pets and who make good grades. Nevertheless, because of their sense of omnipotence they often have difficulty with their peers. Frequently they are bossy and whiny. They insist on their own rules in games with their peers, and when they do not get their way, they either withdraw or have temper tantrums.

Before treatment, boys with GID spend considerable amounts of time in frozen fantasizing that is driven, repetitive, and inflexible and lacks the joyful characteristic of play. They have talent and giftedness but little capacity for genuine creativity. They are intense but not vital; they have fantasy, but they have an inhibited capacity to play. Their artistic talents are employed not in the service of creativity and inventiveness but rather in the compulsive management of anxiety. After treatment, they are unusually vital and creative. They often have a considerable capacity for empathy, and their capacity to play has been restored.

Our experience in therapy has been that these children have a powerful need to be understood, enormous affiliative needs, and the capacity, when they are in a safe holding environment, to express their inner experience in metaphor. They often begin therapy as if they had
been waiting for the opportunity to communicate their suffering to someone able to recognize their pain.

Studying GID is important not only for illuminating the origin of the disorder but also for understanding the process of acquisition of gender identity in general. The simultaneous study of these boys and their parents offers an unusual window on how interpersonal experiences become transformed into intrapsychic phenomena and how pathological beliefs both encode experience as well as construct psychic reality.

Etiology

The Role of Biology

Once the syndrome of GID was originally recognized, many presumed that it had a biological cause. Indeed, feminization of the brain had been proposed earlier by Krafft-Ebing (1898) as a basis for male homosexuality. This hypothesis was discounted by Freud (1905) because of the lack of supporting neurobiological evidence. The potential role of the brain as an influence on sex-typed behavior was revived in the past decade by the rapid explosion of knowledge in the brain sciences that has resulted from major advances in research technologies that were not available during Freud’s day.

There is now substantial research on the role of prenatal psychoneuroendocrine influences on the development of sexual and nonsexual behavior that is converging from many sources (Ehrhardt and Meyer-Bahlburg, 1981; Hines, 1982; McEwen, 1983; Ward, 1984; Ehrhardt et al., 1985). Prenatally and possibly postnatally, hormones have an organizational function. Early in fetal life, they organize the structures of reproductive morphology, and later they set receptor site sensitivities in the brain. At puberty hormones serve an activational function. Research on animals, on persons with spontaneously occurring endocrinological disorders, and on cases where hormones have been given to the mother prenatally suggests that prenatal hormones exert an effect on aspects of temperament but not on gender identity directly (Ehrhardt and Meyer-Bahlburg, 1981; Ehrhardt et al., 1985). For example, prenatal androgens influence aspects of temperament such as energy expenditure and rough-and-tumble play. The role of temperament must
be understood as predisposing the child to respond to environmental stimuli in predictable ways and also to influence his caretaker's behavior toward him. Contemporary psychoanalysis, in our view, must consider this body of data when constructing theories of normal and pathological gender identity acquisition.

Although boys with GID have not thus far been identified as having any specific biological markers, such as differences in reproductive morphology or in karyotyping of sex chromosomes (Green, 1976; Rekers et al., 1979), almost all demonstrate an aversion to aggression and to rough-and-tumble activities (Green, 1987; Zuger, 1988). They are timid, particularly in new situations where other boys are bold.

**Trauma and Disturbed Family Dynamics**

Although anecdotal reports of boys with cross-gender behavior have been in the literature for some years, systematic clinical descriptions began with Friend and his colleagues' report of three cases in 1954 (Friend et al., 1954). They linked the onset of GID to a pathological mother-child relationship and to castration anxiety.

Trauma as an etiologically significant factor in the onset of GID was first emphasized by Bloch (1978) and later by Coates (1985, 1990) and Meyer and Dupkin (1985). In 1985 Meyer (at Johns Hopkins) and Coates (at the Childhood Gender Identity Center of St. Luke's/Roosevelt Hospital), working in separate clinical research units, found that trauma played a major role in the onset of GID. Meyer and Dupkin (1985) found disturbed family functioning and trauma in all 10 of the cases of boys with GID that they evaluated. They observed that the onset of cross-gender behavior was often precipitated by traumatic experiences such as separation, sexual overstimulation, and maternal psychosis. Pregnancy and childbirth were also precipitants (Meyer and Dupkin, 1985). Coates (1985) found that in her first 25 cases of lower- and middle-class families of boys with GID nearly half of the mothers spontaneously reported having had traumatic experiences during the child's first three years of life. In a more recent sample of 22 middle- and upper middle-class families, 78% reported having traumatic experiences in the first three years of their son's life. These data either were elicited in our extensive initial evaluation or emerged after the child and family had been in treatment for some period of time.
Over 20 case reports on GID have appeared in the literature, and a variety of dynamic explanations has been proposed in an attempt to understand the meaning of cross-gender symptoms in these boys. In all of the cases described, gender identity disorder occurred in the context of disturbed family functioning (Friend et al., 1954; Frischhoff, 1964; Sperling, 1964; Charatan and Galef, 1965; Greenson, 1966; Stoller, 1966, Block, 1978; Gilpin, Raza, and Gilpin, 1979; Schultz, 1979; Roiphe and Galenson, 1981; Pruett and Dahl, 1982; Loeb and Shane, 1982; Herman, 1983; McDevitt, 1985; Meyer and Dupkin, 1985; Thacher, 1985; Bleiberg, Jackson, and Ross, 1986; Coates and Zucker, 1988; Lothstein, 1988; Galenson and Fields, 1990; Haber, 1991; Silverman, 1991).

Several clinicians connect the disorder to disturbances in the separation-individuation process (Greenson, 1966; Schultz, 1979; Gilpin et al., 1979; Loeb and Shane, 1982; Pruett and Dahl, 1982; McDevitt, 1985; Thacher, 1985; Galenson and Fields, 1990). McDevitt (1985) emphasized the mother's selective nurturing and attunement to the child's behavior as leading to femininity. Lothstein (1988) noted the mother's failure to mirror the boy's emerging masculinity. Castration anxiety was seen as the organizing dynamic by several clinicians (Friend et al., 1954; Sperling, 1964; Roiphe and Galenson, 1981; Pruett and Dahl, 1982; Herman, 1983; Haber, 1991). The fantasy of union with a phallic mother has been hypothesized as important in some cases (Sperling, 1964; Pruett and Dahl, 1982). In one case described separately by both Greenson (1966) and Stoller (1966), overgratification by the mother was seen as the central cause of separation-individuation difficulties. Overgratification was viewed as intensifying separation anxiety during the separation-individuation phase, anxiety that the child then defended himself against by equating "loving with becoming," in a form of primitive "identification and imitation" (Greenson, 1966).

Coates and Zucker (1988) described a boy who developed a GID when his mother, due to a traumatic event, precipitously became emotionally inaccessible to him. They viewed the symptom as a restitutive identification with the psychologically lost mother that took the form of a behavioral enactment of a self-fusion fantasy with the mother. In addition, they saw the cross-gender fantasy as a defensive strategy for protecting his maternal representation from his aggression.

Three reports have described actual loss as playing a significant role in the etiology of GID (Meyer and Dupkin, 1985; Bleiberg et al., 1986;
Galenson and Fields, 1990). Bleiberg et al. (1986) described a boy who at age 3 months lost his natural mother and whose adoptive mother died when he was 13 months. The authors viewed his cross-gender behavior as an identification with the lost mother.

**Blissful Symbiosis Hypothesis**

In 1968 Stoller put forth the first comprehensive theory of the etiology of boyhood Gender Identity Disorder. The term Gender Identity Disorder was not in use at that time, and Stoller referred to the boys as having extreme femininity (Stoller, 1968, 1975, 1985a,b). Stoller's (1975) theory has many resemblances to social learning theory in that he views the central mutative forces as involving conditioning or imprinting. He explicitly states that "extreme femininity" in boys is brought about by "nontraumatic forces" (p. 38). Stoller (1975) believes that this disorder comes about when a rare coincidence of four factors occurs. These are:

1. A bisexual mother.
2. A physically and psychologically absent father who permits the excessive symbiosis to develop and then does not interrupt it.
3. A period of several years in which mother and son can keep up their blissful symbiosis.
4. A special beauty in the boy [p. 55].

Stoller believes that the boys do "not seek femininity ... but rather receive it passively via excessive impingement of the too-loving bodies of their mothers" (p. 54). This position implies that an active process of identification does not take place but, rather, that a more primitive process occurs, such as "conditioning" or "imprinting." In Stoller's thinking these boys do not have a disturbance in ego functioning or even in body ego except in regard to their sense of femaleness. In Stoller's theory the cross-gender wish is not a compromise formation.

**Multiple-Factor Etiology**

In a series of previous papers Coates and her collaborators (Coates, 1985, 1988, 1990; Coates and Person, 1985; Tuber and Coates, 1985, 1989;
Coates and Tuber, 1988; Coates and Zucker, 1988; Marantz and Coates, 1991; Wolfe and Coates, 1991) began to specify ways in which a comprehensive etiological explanation of boyhood GID would need to include an understanding of the contribution of cumulative risk factors, such as the temperament of the child, mental representation level of the child, trauma, and parental psychodynamics, as well as the specific dynamics in an individual child.

GID as a Relational and Self-Disturbance

In systematic research conducted in the Childhood Gender Identity Center, we found that boyhood GID does not occur as a symptom that is limited to the boy's gender identity but rather occurs in the context of a disturbance in the child's relational experience and experience of the self. Boys with GID are separation anxious and depressed (Coates and Person, 1985; Lowry and Zucker, 1990) and have a variety of behavioral disturbances (Bates et al., 1974; Bates, Bentler, and Thompson, 1979; Bradley et al., 1980). They could be thought of as having an attachment disorder.

In systematic studies of the Rorschachs of boys with GID we found that their object representations were dominated by images of over-controlling, overpowering, and malevolent figures (Coates and Tuber, 1988; Tuber and Coates, 1989). They also showed evidence of significant boundary disturbances, as assessed by the Rorschach. Psychopathology involving chronic depression and anxiety and symptoms of borderline and narcissistic personality disorders, as assessed in structured clinical interviews, was widespread among the parents of boys with GID (Marantz and Coates, 1991; Wolfe and Coates, 1991).

Mothers of sons with GID are extremely attuned to aspects of their sons' functioning, particularly to what they perceive as their "creativity, talent, giftedness, and specialness." Many are stage mothers who encourage their sons to perform. They often use their sons to repair their own narcissistic vulnerabilities.

Mothers of boys with GID often demand that their sons be well behaved and give them little space and few options. Often they experience their sons as gentle or "angelic," unlike other boys whom they perceive as aggressive and destructive. At times the mothers experience
their sons as persecutory objects. As one mother said, "He is my Job. Sometimes I feel that he is my ultimate test. He is trying me to my outermost limit. He is trying to do me in." Most of the mothers in our unit experience their sons' aggression with intense anxiety and respond to it with fierce counteraggression.

The majority of mothers have child-rearing attitudes and practices that interfere with the development of their sons' autonomy. They have difficulty separating from their sons. They are intrusive and controlling and interfere with their sons' developing separate friendships. Mothers of boys with GID are particularly anxious about their sons' rough-and-tumble play, which they equate with violence. They are overinclusive and undiscriminating about the behaviors that they consider dangerous and as a result interfere with normal, playful, rough-and-tumble wrestling, such as pushing, shoving, or playing King of the Mountain. Furthermore, they label such play as "dangerous." For similar reasons these mothers also interfere with most motoric, adventurous, exploratory play. Mothers of boys with GID are preoccupied with physical injury and feel that both autonomy and rough-and-tumble play will lead to injury to the self, to the mother, and to others.

The fathers of boys with GID are usually emotionally intense men who present as either hypermasculine or shy and anxious. Most had tried to form a connection to their sons early on but had felt unable to do so. Many felt excluded from the mother-son bond and were ineffective at forging a separate relationship with their sons on their own. By the time of our initial evaluation none had developed a secure and tender relationship with their son. Many had been extremely sensitive to rejection, and if their sons failed to respond to their initial attempts to make contact, they usually withdrew in anger.

Most fathers of boys with GID tend to see themselves as envious, as being preoccupied with fantasies of unlimited success, power, and brilliance, and as constantly seeking attention, reassurance, and praise. Many describe themselves as thin-skinned, unforgiving of insults, and sometimes bearing grudges for years (Wolfe and Coates, 1991).

Many of the fathers also described themselves as subject to temper outbursts. Although their explosive outbursts at times resulted in the destruction of property, they did not harm people. Most described themselves as having been shy and anxious as children, and as adults many are socially isolated and do not have male friends.
Finally, the majority of mothers and fathers in our center have significant difficulties in regulating their self-esteem and have particular difficulties managing their assertiveness and aggression.

**GID in the Parents**

An obvious question is whether the parents themselves have Gender Identity Disorders. Only two of the parents from our sample of over 100 families had an overt gender disorder. One father was a transvestite; one mother was a lesbian with a masculine gender identity. In a study that we have just completed using Rorschach data, we found that one-third of the parents of boys with GID have gender-confused object representations. No evidence of gender confusion was seen on any of the Rorschachs of the normal control parents. We define gender-confused responses on the Rorschach as the following: (1) a response where one gender turns into the other, (2) a response where characteristics of both genders are seen in a single percept, and (3) a response where the subject spontaneously vacillates about the gender of the percept.

We found responses meeting these criteria in one-third of the mothers and one-third of the fathers of boys with GID (some were married to each other, and some were not) and in none of the controls.

A few examples convey the quality of these responses:

1. “Cowboy with ovaries.”
2. “Two-thirds is a man, and the rest is a lady.”
3. “A man with high-heel shoes.”
4. “It’s an absolute monster... The monster is approaching and I am laying down. The monster is in an extremely threatening position... It’s as if I’m trapped under glass and he’s standing up over top of me and looking down on me... The head on the monster looks like a woman's vulva, and this is the lips and the outer part is the whole nine yards. See, my wife and I are having serious marital problems, and at this point in time it’s appropriate that I see vulva as a monster because I'm not getting a lot. It’s as if pussy can be a real bitch.”

We believe that these subclinical gender confusions probably were expressed in the parent-child relationship in ways that we cannot yet identify.
Coates (1990) recently described the temperamental factors that she has frequently observed in boys with GID. An expanded version of these is presented below:

1. A sense of body fragility and vulnerability that expresses itself in avoidance of rough-and-tumble play.
2. Anxiety that expresses itself as timidity and fearfulness in the face of new situations.
3. Strong affiliative needs/intense orientation to people.
4. Extreme sensitivity to affect.
5. A vulnerability to separation and loss.
6. A remarkable ability to imitate.
7. Sensory sensitivities to sound, color, texture, odor, temperature, and pain.

Recent research on the effects of trauma on temperament has demonstrated that many of the response characteristics described above can be exacerbated or even created by extreme stress, especially during the first few years of life (van der Kolk, 1987; Kagan, 1989). Therefore, in any retrospective study, even in one that begins as early as ours, it is extremely difficult to tease out the effect of trauma on the development of temperament from a response style that might otherwise have been present. Kagan (1989), in his study of shy children, has found that severe stress, particularly in the early years of life, can lock in a shy temperament and make it more extreme and difficult to modify.

Kagan (1989) also noted that many of the shy children, like our boys with GID, had heightened sensory sensitivities. We do not yet understand the neurophysiological underpinnings for these sensitivities or why they are associated with shyness or GID.

GID and Trauma

As we described earlier, traumatic experiences in the family during the child's first three years of life were widespread. The traumata that we could identify as precipitants of GID were the following:
1. Death of a sibling, especially a female sibling.
2. Miscarriages and abortions.
4. Severe physical illness in a sibling.
5. Physical assault to the mother, including rape.
6. Death of the mother.
7. Severe physical injury to a father or close male relative.
8. Life threats to the father.

We believe that the specific events that occurred just before the onset of the boy’s GID were particularly traumatic for these mothers because of the meaning of the event to her and its significance in terms of her own early life history.

The families that did not have specific traumatic events had ongoing, severe marital problems that we believe resulted in a cumulative traumatic experience. In many of our cases, the fathers felt rejected and abandoned by their wives when their son was born. These fathers were unable to create gratifying roles as supporters of the mother-infant bond, and many felt resentful of their wives’ involvement with their babies. After the birth of their sons, many turned to drink or drugs or began having affairs. The father’s behavior, in turn, led to depression, rage, and withdrawal in many of the mothers. Massive anxiety was then created in the son as he experienced his mother’s depression, rage, and withdrawal and his father’s rageful, out-of-control behavior or withdrawal. Therefore, the severe, chronic marital discord, like the traumatic events discussed earlier, had a cascade effect on the son.

**GID and the Sensitive Period of Representational Development**

Converging evidence in the 1960s and 1970s from several different disciplines, including cognitive developmental psychology (Kohlberg, 1966), psychoendocrinology (Money and Ehrhardt, 1972), and psychoanalysis (Mahler, Pine, and Bergman, 1975), suggested that the first three years of life comprised a sensitive period for the development of gender identity.

GID in boys typically emerges at about age two, during the height of the rapprochement crisis, before emotional object constancy has been
established and when the boy is extremely vulnerable to issues of separation and loss. This developmental crisis fatefully coincides with the beginning of the boy's establishment of gender identity and makes it particularly vulnerable to disruption if an external threat of loss occurs.

Research on the development of gender categorization has demonstrated that children are able to discriminate between boys and girls by about age one. In this period of time, however, as Fast (1984) has described, gender is relatively undifferentiated, and children do not think of their behavior in terms of gender. Developmental studies of gender by Slaby and Frey (1975) have demonstrated that the child's verbal categorization of the self in gendered terms first emerges at about age two. By about two and one-half, most children can assign themselves and others to the correct gender. Once this categorization is made, most boys and girls begin to show a preference for activities that are stereotypically associated with their own gender (Fagot, 1985).

Although a child knows whether he belongs to the category of boy or girl by age two and one-half, his understanding of why he belongs to the category is limited. Until about age five or six most children believe they belong to one gender or the other because of external appearance such as hair length, clothes, or behavior. Thus, although two- to three-year-old boys know that they belong to the category "boy," they are often confused about the stability and constancy of their gender. Although all of the boys we evaluate know that they belong to the category "boy," they become confused when asked if they were a boy or a girl when they were born and if they will be a daddy or a mommy when they grow up. Until about age five or six, most children have not acquired the domain-specific knowledge that gender categorization is determined by genitals and that this categorization overrides all other cultural differences. Not until then do they understand that one's gender remains constant and stable over a lifetime (Bem, 1989). As Fagot (1989) has observed, it is therefore not surprising that when a boy wishes to be the opposite gender, he believes that, either by dressing like a girl or behaving like a girl, he can become one. We believe this stage of development, where object constancy and gender constancy have not yet been established, creates a fertile ground for the child to develop a GID, particularly if he experiences a trauma.

The first author has seen a number of cases where the boy had all of the risk factors, including temperament, trauma, and family dynamics, but the trauma occurred at an older age, after object constancy and
gender constancy had been established. In these cases the boys had cross-gender wishes that continued during the period of crisis in the family and then abated. In none of these cases did a Gender Identity Disorder become consolidated.

In sum, we have concluded that a concatenation of factors and circumstances, not any single factor or circumstance, converges in a common pathway to create this disorder.

Illustrative Case Report

In this paper we present a case of a three-year-old boy with GID to illustrate the complex interweaving of these factors and how they cumulatively interact to bring about this disorder. We explore the issue of the role of a trauma versus a blissful symbiosis as a central force in the etiology of this disorder. We extend our previous work on the role of loss in the onset of GID to include the role of aggression and projective and introjective identification. We believe that an understanding of the disorder at an increasing level of specificity is essential for developing effective treatment strategies and for developing preventive interventions.

We present a case that initially appeared as if the GID had emerged in the context of a blissful symbiosis. As the treatment unfolded, however, it became clear that the GID had emerged in response to the mother's reaction to a traumatic loss of a fetus. This loss led to a pathological bereavement reaction, which in turn had a profound effect on her son. The affective memory and significance of these events were inaccessible to the mother at the beginning of our work.

The data for our inferences are drawn from our initial psychiatric interview, from projective testing, from video recordings of the family and the child's school, and from the psychoanalytic psychotherapy of the child and each of his parents. In addition, the child participated in a research nursery school in a local college when he was age two. As a result we have been in the fortunate position of being able to cross-check some of our inferences with direct observations that were made before we worked with the child and his family.

Presenting Symptoms of GID

Colin, a 3-year-old, Caucasian, only child, is the first child of a middle-class couple who were in their late 30s at the time of his birth. Both
parents worked in the media in a creative capacity. Colin was referred by his nursery school teacher to a child psychiatrist for evaluation of social immaturity, isolation from other children, and frustration intolerance. The psychiatric consultation resulted in a referral to the Childhood Gender Identity Center. The intake evaluation revealed that Colin met criteria for a DSM-III R diagnosis of Gender Identity Disorder of Childhood. The following cross-gender behavior was evident:

1. He expressed the wish to be a girl.
2. He expressed the feeling that he hated being a boy.
3. He had frequently dressed in his mother's clothes since age two.
4. He had an intense interest in jewelry and makeup and would spend long periods of time cross-dressed while observing himself in a mirror.
5. He had a strong preference for female, stereotypical activities such as playing with dolls.
6. His favorite childhood stories were about the adventures of heroines such as Snow White, Alice in Wonderland, and Rapunzel.
7. He preferred girls to boys as playmates.
8. He had a marked aversion to, and avoidance of, rough-and-tumble play.

Notably, Colin seemed to have an age-appropriate interest, curiosity, and pleasure in his penis and did not have an aversion to it, as many boys with GID do. His genital morphology was normal.

Colin's psychological tests revealed superior intellectual functioning, first on the McCarthy Scales of Children's Abilities and later on the Wechsler Preschool and Primary Scale of Intelligence. Psychological testing also provided further evidence of Colin's cross-gender identification and gender confusion. He stated that it was better to be a girl than a boy because girls could wear pretty clothes and that it was not good to be a boy because boys were rough. He believed that when he was born, he was a girl and that if "you wore girls' clothes you could really become a girl." Although during testing he said that he "would grow up to be a Daddy," only a week before, he had told his mother that he was "going to grow up to be a girl."

On the Rorschach, themes of dread of annihilation, separation, and loss were evident. His predominant defense mechanism was a form of
splitting that was organized around gender content. Representations of females in particular were primitively idealized and devalued. Representations of males were notably absent.

**Onset of Symptoms**

The onset of these symptoms of GID occurred in the context of clinically significant turmoil in Colin's family. Colin had been planned for and was ultimately wanted by both parents. Although Mr. S wanted children from the outset, Mrs. S was ambivalent because she felt insecure about her potential competence as a mother and feared that she would be impatient and would derive little pleasure from the experience. Mr. S ultimately persuaded her to try to have a baby.

Both parents described Colin's arrival as having given them great pleasure. Mrs. S was surprised to discover that she liked being a mother and particularly enjoyed breast-feeding the baby. During the immediate postpartum phase, however, Mr. S, who had been involved during the pregnancy and was present at the delivery, felt unimportant and left out. In response, he withdrew.

During the pregnancy, Mrs. S's widowed mother moved in to assist her daughter. Following the immediate postpartum phase she took an apartment in the same building. Mrs. S experienced her mother as hypercritical, intrusive, demanding, and undermining. Mrs. S's mother criticized Mrs. S for not feeding and dressing Colin "properly" and repeatedly suggested that she was going to harm her son. As a result, the women had heated verbal fights daily. In a setting in which she felt psychologically abandoned by her husband's withdrawal and overwhelmed by her mother's criticism, Mrs. S became progressively anxious, depressed, and angry.

Despite all the turmoil in the family, Colin did not have obvious difficulties in his first year of life. His developmental milestones were all within normal limits. During the earliest months of his infancy the parents experienced him as an "easy" baby. Mrs. S described him as intense, as liking people, and as easy to soothe. She nicknamed him "peach" because he was "the softest thing I've ever held." He was easily drawn to, and highly involved with, people and seemed to notice everything. As Mrs. S put it, he would just "drink in" the world around him.
Mrs. S described experiencing pleasure from breast-feeding. She stopped, however, when Colin was eight months because he began to bite her nipples. She felt he was ready to stop nursing, but she was not. She reacted with a sense of loss and sadness and, in moments, with anger.

Colin had many sensory sensitivities similar to those first described by Bergman and Escalona (1949) and later by Weil (1970). For example, he would cry when he heard loud sounds such as the doorbell. His sensitivity, however, gave him pleasure, as well as causing him distress. He enjoyed music and pretty colors and was very attentive to small visual changes in the environment and seemed to enjoy them. Mrs. S remembers Colin at age one as a “laughing baby” who was loving and “always happy.” At age two, when he was interviewed for a nursery school program for mothers and children, Mrs. S remembers how emotionally connected he was to the interviewer and how much he seemed to want and enjoy the teacher’s attention.

Soon after this interview, Mr. S, Mrs. S, and Mrs. S’s mother planned a trip to Mrs. S’s country of origin. Because Colin became ill, Mrs. S decided to stay home with him. Mr. S had business to conduct, and Mrs. S’s mother had made plans to visit her son. Therefore Mr. S and Mrs. S’s mother made the trip together. When looking back at that time, Mrs. S initially commented, “Colin became inconsolable and cried until his father and grandmother returned.” Detailed questioning, however, revealed that she too became depressed and angry at having been left behind. After Mr. S and Mrs. S’s mother returned five days later, Colin appeared to develop a change in behavior. This time appears to be an important turning point because from this time on both parents viewed Colin as anxious and particularly sensitive to separations. We suspect that this separation was particularly painful to Mrs. S because it involved losing her mother to her brother, as she had in her early childhood.

When he began his nursery program in the fall, Mrs. S remembers that Colin seemed very shy and had difficulty adapting. He did not get along with the other children and would hit them if he did not get his way or he would scowl, cross his arms, and turn his face to the wall. At this time, he also began to have temper tantrums at home.

A few months later, Mr. and Mrs. S became concerned that Colin was too isolated from peers. They decided to have a second child “to provide Colin with companionship.” Mrs. S also remembered her pleasure with Colin as an infant and was eager to repeat that experience. During this pregnancy, however, her experience was quite different. She was fre-
quenty nauseated, weak, and bedridden during the first trimester. Her husband continued to be away from home frequently because of vocational responsibilities, and when present, he was emotionally detached.

This pregnancy ended in tragedy; amniocentesis led to the fetal diagnosis of Down syndrome. A trauma for all expectant parents, this diagnosis was even more so for Mrs. S, who herself had been involved in reporting a story on families of children with Down syndrome. The children and families she interviewed in the course of her research evoked feelings of pity and fear in her. She had worried about having such a child and, in her fantasies, decided that she could not possibly raise one. The news following amniocentesis, therefore, was experienced as an irrational fear come true. She immediately decided to abort the pregnancy, without consciously being aware of conflicted feelings about this decision. Her husband, also “shocked” by the diagnosis, was in full agreement.

Mr. and Mrs. S also learned that the fetus was female. Mr. S did not express any particular feelings about this fact. After his immediate reaction of shock, he was deeply saddened at the loss of a desired second child. But Mrs. S’s reaction was quite different. She named the fetus Miriam after a revered teacher. Had Colin been born female, he too would have been named Miriam. During a three-week delay between the decision to abort and the actual procedure (hypertonic saline injection into the uterus to induce vaginal delivery), the emotional significance of her tragic circumstance was denied by Mrs. S. Intellectually, she realized what had transpired. Nevertheless, she felt grateful for the delay period between diagnosis and abortion because it allowed her, as she put it, “to get to know Miriam.” She felt elated when she thought she experienced the fetus’s kicking.

Mrs. S claims to have felt nothing at the time of the abortion. There was a funeral, during which Mrs. S continued to experience an absence of affect. The fetus was cremated, and the ashes were given to the family. Mrs. S took the urn home and placed it in her bedroom closet. After several years of treatment, during which she worked through major issues involving loss, she became able to bury the ashes.

Although Mrs. S has experienced chronic anxiety and painful depression since then, she does not attribute either to the abortion or to unresolved grief. Mr. S, in contrast, experienced a grief reaction that gradually abated after the abortion. During our initial evaluation he
became tearful when describing the abortion, in contrast to his wife, who reported her experience calmly, with a conspicuous absence of painful feeling.

Within weeks following the abortion, when Colin was approximately two and a half, his behavior became markedly feminized, and cross-gender behavior rapidly assumed the repetitive, driven quality characteristic of children with the full syndrome of childhood GID. Both parents had artistic interests and viewed his cross-gender interest as part of his artistic and creative nature. Mr. S felt uneasy about his son's preference for female attire and activities but did not redirect it because he believed that it was temporary and that he would outgrow it. Mrs. S did not identify Colin's cross-gender preferences as of concern in any way. Neither was aware of any possible "cause" of Colin's behavior.

The Mother

As a child Mrs. S had a difficult and estranged relationship with her own mother, an anxious and controlling woman who openly preferred her son, a one-year younger asthmatic boy. Mrs. S's father was alternately tender, sentimental, and explosively violent. He openly favored his daughter, who not only bore his mother's name but reminded him of her physically as well. Mrs. S remembers that he was easily moved; if she read him an emotionally evocative story from a newspaper, he often became welled up with tears. In contrast, he was very distant from his son. Thus, the family was split: mother-son, father-daughter.

Mrs. S remembers spending time either alone or with her father, not with her mother or her brother. Her mother referred to her as her father's child. Mrs. S remembers with great pleasure that her father brought her to their local village, where they would spend time talking to the townspeople. At home he taught her, rather than her brother, to use tools. She experienced herself, however, not as boylike but as father's special, favorite child. Until adolescence she felt that he appreciated and admired her femininity. Despite the time that she enjoyed with her father, she also remembers that he would beat both herself and her brother "if we did not behave." She denies having ever been bothered by these violent outbursts.

When Mrs. S was two years old, her mother had a miscarriage; the
fetus was female. Mrs. S's mother held herself responsible for “killing” this baby because “she had walked up and down stairs too often.” Throughout Mrs. S's childhood, her mother grieved over the loss of her third child and to this day often cries when she thinks about it. Mrs. S remembers her mother as alternately grieving or anxious and as enraged at nearly everything that Mrs. S did. In constant dread that she and her brother would get hurt and die, their mother forbade them to explore the environment or take any physical risks. Mrs. S particularly remembers her mother's taking them to a brook and allowing them to float a toy boat but forbidding them even to stick their feet in the water. Her mother had no outside activities or friends. She was an isolated woman whom Mrs. S experienced as being a “martyr.” In this atmosphere Mrs. S grew up depressed, lonely, and fearful.

The close father-daughter relationship deteriorated dramatically at puberty. He forbade Mrs. S to wear lipstick and called her a prostitute when she wore her hair down instead of in a braid. Mrs. S was bewildered, hurt, and angry and felt betrayed at this unexpected turn of events. During her adolescence and adulthood, the two were virtually without contact, until shortly before his death, when some degree of reconciliation was achieved at her initiative.

Mrs. S was first attracted to Colin's father because he was sensitive, tender, and sensual, a man with artistic abilities who was nurturant and liked to cook. She said that she was not attracted to stereotypically masculine men, whom she perceived as aggressive and self-centered. She particularly appreciated that Mr. S felt she was beautiful and enjoyed her body. Their sexual relationship has always been important to her and her husband and continues to be so today.

Maternal Psychodynamics

Throughout Mrs. S's life she was afflicted with the psychological consequences of having been emotionally abandoned by her mother when she was two years old. Although Mrs. S's mother had been chronically anxious all of her life, the family mythology was that her behavior as a mother changed significantly after her miscarriage. She became angry and depressed and blamed herself for “killing her daughter.” We speculate that Mrs. S, then only two years of age, must have experienced the mixed emotions that most two-year-olds would feel in
the face of the arrival of a new sibling. We assume that part of her wanted a sibling and part of her wanted this anticipated sibling dead. The fact that the sister actually “died” functioned as a wish come true. In therapy we were able to reconstruct Mrs. S’s belief that she had caused the death of her sister and, as a result, her mother’s chronic, pathological bereavement and rage. This conviction left her with a dilemma. How could she stay connected to a mother whom she believed she had hurt and who she believed hated her? How did she repair this loss, and how did she salvage her self-esteem?

Splitting

We postulate that Mrs. S came to develop a defensive strategy that involved the use of splitting. Mrs. S’s ideal self-image became that of a beautiful, strong, nurturant, and effective woman. Her devalued and split-off experience of herself was as a hypercritical, nonnurturant, destructive “killer” with “ugly teeth” (her metaphor for dissociated aggression). We believe that Mrs. S had unusual difficulties developing an integrated representation of her mother and subsequently of herself, in part because her actual experience with her mother made this integration extremely difficult. That is, Mrs. S’s mother in reality had been involved with her in the early years of her life and then precipitously became emotionally inaccessible following a miscarriage. Mrs. S’s defensive use of splitting to protect her maternal representation from her rage at her mother placed an even further strain on her already fragile defenses and increased her already internally split experience.

Mrs. S both idealized and devalued men. The idealized representation was based on her nurturant relationship with her father, whereas the devalued representation was based on her experience of her father as insensitive, abandoning, and aggressive. Negative images of men also symbolized partial self-representations, which were largely unconscious. Aggressive feelings were censored, projected onto males, and consciously responded to with disma and derision.

Mrs. S’s use of splitting was played out with Colin. She clearly enjoyed aspects of her son’s behavior that we found she categorized as “masculine” traits, such as intellectual curiosity and intense inquisitiveness. The specific aspects of her son’s masculinity that were negative in her eyes involved destructiveness and aggression, hated aspects of herself.
Mrs. S's earliest effort to repair the loss of her mother was her search to find the nurturant mother in her father. She became her father's special daughter, the child he adored. But his attention only temporarily mitigated the loss of her mother, because when she reached menarche, he too abandoned her. A similar pattern occurred in her choice of a spouse, whom she perceived as “maternal and nurturant.” When she first decided to try to get pregnant, she wanted a girl so that she could mother her as she had “never been mothered” herself. She had fantasies of sewing her daughter dresses to make her beautiful, as her own mother had done for her as a child. We believe that in fantasy Mrs. S was attempting to restore her connection to the lost mother of her early childhood. Although she was initially disappointed that Colin was a boy, she reports that she soon felt happy with him. Notably, however, she experienced him as soft, gentle, and sensitive, the kind of boy she could love.

Management of Aggression

In Mrs. S's adult life, she experienced rage in reaction to events involving loss and abuse that had a contextual similarity to her childhood deprivations. Her rage was also evident on the Rorschach, where she elaborated a fantasy of Romulus and Remus drinking from the breast of a wolf. She then transformed the percept of the wolf into a “mad antelope” that was “dripping venom out of its mouth” onto its two babies. She, like her mother, unconsciously experienced herself as a destroyer of children.

In the context of these split internal representations of self and other, where idealized and devaluated representations of self were unintegrated and where rage in particular was dissociated and projected onto men, Mrs. S decided to have a second baby.

At about the time of the abortion Colin began to have temper tantrums when he did not get his way. Mrs. S experienced these as an abandonment, a loss of his previously adoring behavior, much as she had experienced his biting her nipples earlier. After years of therapy she remembered that she strongly censured these outbursts. She would shake Colin and yell at him. When the tantrums occurred, she felt utterly unable to cope either with him or with her own angry feelings. In
therapy she recalled that when she would shake him, she would “look into his eyes and realize that he was afraid that I might kill him.” She began to feel threatened that her rage was turning both her son and herself into “monsters” and feared that she might “destroy” Colin.

Reparation to Her Mother

Mrs. S allowed her mother to live with them when Colin was born and to assume partly the role of mother to the newborn. After the first few months of Colin’s life Mrs. S’s mother assumed even greater responsibility for his care. Mrs. S had conscious fantasies of filling the emptiness and void in her mother’s life by giving her a child to take care of: “She has nothing to live for. Colin is her only reason for living.” We believe that it is likely that on an unconscious level she was, in part, giving a baby to her mother as an act of reparation for the one that she in fantasy had taken away from her.

Loss of Her Fantasized Daughter

During her second pregnancy, Mrs. S imagined that she would be a wonderful mother who would treat her daughter (herself) as she longed to be treated. During the delay between diagnosis of Down syndrome and abortion of the pregnancy, Mrs. S acted as if the fetus were actually an idealized daughter. She had seen the fetus after the abortion and described it as a “perfectly formed little baby girl.” This hypothesis both explains why Mrs. S named the damaged fetus Miriam, after an idealized authority figure, and accounts for her desire to “get to know” the fetus inside her during the three weeks between diagnosis and abortion.

Meaning of the Loss

After several years of therapy, Mrs. S’s recollection of the abortion produced associations that led her to remember that she had believed that she had “killed” her mother’s other daughter and, in so doing, “permanently damaged her mother” and emotionally lost her. After her abortion, we believe, she became determined to keep her fantasized daughter alive, and she acted on this fantasy in relation to Colin. In moments, she experienced Colin as the idealized, blissful, nurturant
mother for whom she longed. "He was always tuned into my feelings. He always knew how I felt." She began to call him "lovey." She valued both his sensory "sensitivity" and his sensitivity to her "moods." She admired his "artistic nature." Mrs. S transformed aspects of Colin's gender by reinforcing, sometimes in very subtle ways, aspects of femalelike and maternal behavior and by negatively reinforcing aspects of malelike, assertive, and aggressive behavior. She developed a fusion fantasy with her "nurturant, maternal" son as a means of reclaiming her lost internal tie to her mother. Simultaneously, she restored her internal tie to the sensitive aspects of her father. By preventing her son from becoming "too rambunctious" or too aggressive, she avoided reexperiencing the dissociated rage that she felt toward her father for his physical abuse and abandonment of her.

We also believe that at times Mrs. S thought of Colin as a girl, much as Winnicott (1971, p. 74) described in a case of a woman who wanted a girl but gave birth to a boy. In Winnicott's case the mother experienced her son as a girl and related to him as if she failed to see him as a boy. The boy, in turn, experienced this wish and attempted to fit himself into her idea that he was a girl.

The Father

Colin's father also had one sibling, a brother, who was 18 months younger. His family too was psychologically split into factions, his father in alliance with his brother, his alcoholic mother with him. Colin's father, who was the older sibling, was the more submissive, passive, and fearful of the two boys. He describes his younger brother as "sadistic" and himself as "masochistic."

This father grew up as a small, fearful boy, plagued by obsessional worries of germs, illness, and disease. He had great anxiety about managing his aggressive impulses and experienced his body as fragile. When he was physically attacked by other boys, he would not fight back. Throughout his development, he saw himself as inadequate as a male.

Mr. S has had many worries about his masculinity and sexuality. The development of his secondary sexual features lagged behind that of his peers; he was extremely self-conscious that "he was the last to grow pubic hair" at age 16. Although Mr. S denied ever having homosexual experi-
ences or fantasies, he worried that he was homosexual when he was a teenager because of his extreme shyness and inability to relate to girls. Mr. S did not begin dating until his last year of college, and it was not until after college that he first had intercourse. His homosexual worries subsided after he became heterosexually active.

Paternal Psychodynamics

As with Mrs. S, Mr. S's dynamics also played a role in the etiology of his son's disorder. Mr. S wanted a baby and eagerly looked forward to becoming a father. He was not prepared for the degree to which he felt left out, particularly when his wife was breast-feeding Colin, even though he had both encouraged and supported her. He experienced his wife's involvement with Colin as an abandonment and became depressed and withdrawn in response to feeling "left out." The feeling evoked memories of his own alcoholic mother and father, who had been neglectful, inaccessible, and abandoning in his own childhood. As a result, he was unable to support Mrs. S in a mothering role, and in response he withdrew emotionally. Over time, he became resentful that his son seemed more responsive to his wife than to himself. When his active attempts to engage Colin were not immediately responded to, he withdrew even further. Thus, he created a further wedge between himself and his wife and son, rather than forging a separate and different relationship with Colin.

Subsequent to Colin's birth, Mr. S began to express his anger by having isolated episodes of violent rage. For example, he once impulsively destroyed a garbage can. Four or five times a year he would have inexplicable amounts of rage, during which he would scream and pound his fists on the wall but not hurt people. This behavior seemed to him to arise out of nowhere and both alarmed and perplexed him.

When Mr. S was asked what kind of boy he wanted Colin to be, he reported that his only goal for Colin was that he feel his own "power," even if this meant allowing Colin to do things that he, Mr. S, did "not approve of." Mr. S had felt powerless as a child and he did not want his son to feel similarly powerless. This goal served as the father's rationale for his lack of concern about Colin's overtly feminine behavior once it began. Thus, he inadvertently reinforced Colin's cross-gender behavior by not redirecting it or setting any limits on it.
By age two Colin was often angry at his father. He would not allow him to touch him or pick him up and would at times take things and throw them at him. Remarkably, his father did not stop this behavior because he considered it to be one of the ways that Colin was expressing his “power.” Mr. S did not attempt to limit or to socialize Colin’s aggression. He did not engage in rough-and-tumble play, nor did he serve as a model that would help his son learn to modulate aggression. He did not seem to understand the importance of his role in his son’s development. (For a discussion of the father’s role in the son’s development see Greenson, 1968; Abelin, 1971; Lamb, 1976; Herzog, 1982.)

Both parents idealized Colin’s aesthetic side. This idealization included fostering his interest in drawing, his fascination with colors and textures, and his playacting. They admired his sensory sensitivities and saw them as part of his artistic temperament. They wanted him to be recognized and noticed by others as special, gifted, and talented. They also were highly invested in his physical appearance.

The Child

A more detailed account of Colin’s psychodynamics will appear in a forthcoming publicaition. Here we present a brief summary based on our interviews with him during our intake evaluation, his psychological testing, and the central issues as they unfolded in treatment.

As we described earlier, Colin’s separation anxiety began when he was left for five days by his father and grandmother. His grandmother, in particular, had been a primary caretaker. His mother also began to become depressed at this time. The onset of Colin’s intense cross-dressing and preoccupation with the wish to be a girl, however, began after his mother’s severe depression, withdrawal, and anger that followed her abortion.

In our initial meeting with Colin, he was extremely attentive to both interviewers. He studied our faces and immediately noticed the colors we were wearing. He seemed eager to talk, appeared uninterested in toys, and behaved like a compliant adult about to be interviewed. Throughout the interview he seemed riveted to our faces as if he was intensely studying every expression. Of particular note during our initial contact
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was his preoccupation with “ladies with angry eyes.” He talked about how afraid he was of a girl in his class who had angry eyes. In studying the family’s home video tapes, we discovered that he would cross-dress in front of a mirror and make the “angry eyes” that he demonstrated to us in our initial interview. He would pause and study his angry face as if trying to metabolize something that he could not comprehend.

During the initial phase of treatment he was preoccupied with issues of object permanence. At the beginning of each session he would study the room to see what had changed and whether everything was still in place. When issues of separation or anger arose, they would be followed with fantasies of aggression and bodily intactness, and then he would begin to talk about spinning ballerinas, or he would mold a girl out of play dough or begin stroking Barbie’s hair. In the context of fantasy play, he often expressed confusion about what was real and what was pretend, what was animate and inanimate, and what was male and female. In spite of these confusions he did not have a thought disorder, and his reality testing was impaired only in such unstructured situations.

At the end of sessions, after his therapist would tell him that they were going to stop in a few minutes, he would stroke Barbie’s hair, or he would create images of women by drawing them or constructing them with clay. Somewhat later in our work after he was able to create images of boys, he would destroy them and create a girl whenever the threat of separation came up.

In addition to issues involving separation, loss, and aggression, he was preoccupied with the issue of whether he could exist if he and the other person were different. Could he be connected to the other only if he was the same as the other? And could he remain emotionally connected to someone he cared for only if he was taking care of them?

In the second year of treatment Colin continued to be preoccupied with idealized, glamorous ladies, but, in addition, he also became preoccupied with witches. He drew pictures of an overpowering, witchlike woman, drawn in black ink, with fierce angry eyes and elongated clawlike fingernails, whom he identified as “Mommy.”

After two and one-half years of therapy, when his cross-gender behavior and anxiety about loss and aggression had significantly decreased and he had become able to represent more clearly his inner experience in metaphor, he created the following story. He drew a series of pictures and called them “My Story.”
Colin's Story

The cat is angry that she's turning into a lady. She doesn't know why she's turning into a lady.

"She's screaming because she's so mad she's turning into a lady."

"She's crying and sad she's turning into a lady. She already has hair."
"She's crying and she's almost a lady. She still has her tail."

"She almost lost her tail."

"She's screaming so loudly her hair is going up and her tears are going up."
"She's so mad she bit her tongue and she lost her tears."

"She's eating her mother and she looks like a weirdo. She's mad but not at her mother. She ate her mother because she's so mad."
"She's going to the bathroom; she got her mother out and her mother is dead. She's not sad."

**Discussion**

**The Child’s Psychodynamics**

Colin’s case history illustrates the complex way that the constitution of the child, parental psychodynamics, trauma, and the mental representational level of the child interact to influence the child’s psychodynamics.

Colin’s sensory sensitivities influenced his development in a variety of ways prior to his displaying an intense interest in cross-gender activities and fantasies. First, they contributed to his anxiety about his mother’s and grandmother’s heated, daily arguments, his father’s aggressive explosions, and his mother’s rages toward him. Second, they influenced his avoidance of rough-and-tumble play, his fear of aggression, and his sense
of body vulnerability, as he experienced such play as too intense, too dangerous, and potentially too painful. These sensitivities also contributed to his interest in activities that are not traditionally masculine, such as the visual arts. Finally, his ability to imitate found expression in his enjoyment of playacting.

Colin's sensory sensitivities were so unusual that he seemed to experience the world as if an inner amplifier had been turned up too high. It was as if he were porous in relation to his environment. We have wondered whether the traumatic stress in his life may have aggravated his temperamental sensitivities. This conjecture would be compatible with the observation made by Kagan (1989) that severe stress during the first three years of life can make a shy, sensitive temperament even more extreme and the reports of van der Kolk (1987) that suggest that trauma in young children creates hypervigilance and hypersensitivities.

Mrs. S's withdrawal and rage after the abortion produced massive separation anxiety in a temperamentally sensitive boy, who was already separation-anxious. In therapy Colin was extremely sensitive to separations from his therapist, and his cross-gender behavior always escalated at times of separations, such as vacations or whenever his mother became more inaccessible due to depression.

We hypothesize that several psychodynamics then became involved. We believe Colin's cross-gender behavior involved an attempt to regain a psychological connection to his inaccessible mother. He enacted a self-fusion fantasy by imitating her. We use the term "enactment" as it has been defined by Fast (1985) as "a goal-oriented action . . . brought into being by its own action, in which self and what is created by the self are not yet distinguished" (p. 23). Colin, in effect, confused "having mommy" with "being mommy." He was not playing at being mommy, but rather, in the moment of the enactment, he experienced himself as mommy. A similar dynamic has been reported in adult men with gender confusion (Ovesey and Person, 1973).

To regain a connection to her Colin responded to the trauma of his mother's withdrawal and anger with heightened attentiveness to her needs as he urgently tried to comply with her wishes. He also became highly sensitized to her anger, which gave rise to his fear of women with "angry eyes." The radical change in his mother's behavior was incomprehensible to him, and he began to imitate her in an effort to comprehend what he had experienced. His standing in front of a mirror cross-dressed
for long periods of time and imitating his mother’s “angry eyes,” therefore, represented an attempt to understand his mother’s rage.

We draw on the work of the psychoanalyst Emch, who in a 1944 paper discussed “the need to know” as related to identification and acting out. In this paper she suggests:

The tension belonging to the child’s experience of the unknown and unexpected can be dealt with by conversion of the unknown into the known, if the situation is one which the child can know, i.e., has the capacity to assimilate. But when quantitatively or qualitatively, the experience is one which cannot yet be assimilated by the child, the next best tool at its command is the attempt to know through an attenuated repetition of the disturbing stimulus-experience, especially as it relates to the mediator of that experience vis.: “If I act like that person—become him—crawl into his skin, I shall know him and be able to predict what he will do and not be surprised—hurt by him” [p. 14].

She goes on to say that “knowing by acting out the likeness of a situation,” which she calls identification-knowing, “takes place very early, expressing itself in motor ways whose patterns of mimicry soon become astonishingly faithful to the life, and are frequently as keen as exposition and economical a representation as the most caustic of caricatures” (p. 14).

Ghent (1990) extends the concept of “the need to know” to further the understanding of the defense of identification with the aggressor. He asks, “Could it be that the child or infant uses his available medium, his quite plastic self, as a way of attempting to specifically understand aggression that is incomprehensible and unmetabolized” (p. 130). Although Colin’s cross-gender behavior involved introjective identification, it was recently pointed out to us that it could also be considered an example of projective identification, where the child can enact his rage without owning it; that is, he can both express and disown his rage at his mother (Elsa First, 1991, personal communication).

We believe that Colin’s imitative behavior in front of the mirror involved an attempt to master anxiety that was created by his experience of his mother’s aggression. His imitation expressed both a defensive need to know and an identification with the aggressor.
Colin became driven to be the boy his mother wanted, a gentle, loving, nurturant, and aesthetically pleasing boy who was never angry and never aggressive. He came to feel that his mother could love him only if he were a girl. Colin, therefore, began defensively using a form of splitting that was organized around gender content as he projected his aggression onto men, whom he devalued, and he identified with women, whom he idealized. By so doing he protected his maternal and self-representations from his aggression.

We believe that Colin's vulnerabilities resulting from his developmental representational level, his temperamental sensitivities, and the traumatic loss of his mother combined to make him extremely sensitive to his mother's projective identifications. He was almost porous in the ease with which he accepted the identifications placed in him by his mother. This porousness was markedly enhanced by the severe anxiety state that was brought on by his mother's inaccessibility and rage and by his attendant hypervigilance to her needs that followed. He became extremely tuned into his mother's reparative wish for a female child, and he attempted to give her the girl whom she wanted. This compromise formation could be seen as a variation on what Ogden (1982) has called magically restoring the damaged object.

In considering what the mediating mechanisms are that can bring about extreme compliance, Ogden (1982) suggests the following: "If the infant fails to comply, he would cease to exist for the mother. This threat is the muscle behind the demand for compliance. 'If you are not what I need you to be, you don't exist for me.' Or in other language, 'I can see in you only what I put there. If I don't see that, I see nothing' " (p. 16). As Colin's story vividly demonstrates, he experienced himself as being aggressively transformed by his mother's powerful need for him to be a girl.

His story also reveals his active participation in the process as well as the cost of his defensive strategy. Colin experienced himself as being annihilated by being transformed into a girl. He represents this annihilation, in part, as a castration experience. He then transforms the passive experience into an active process of defensively incorporating the mother. In this self-fusion fantasy, he loses his rage, he loses his sadness, and he loses his experience of himself and his mother as separate, individuated persons. Although this defensive strategy allowed him to maintain a connection in fantasy to his mother, it was at an extraordinary cost. He lost his vitality and became psychologically deadened.
Finally, we believe that Colin’s behavior was also motivated in part by a wish to repair his mother’s depression by giving her the girl that she had lost and now longed for. He both needed her to become available to him again and also sought to assuage a feeling of guilt that he had done something to cause her depression, withdrawal, and anger. Thus, his behavior was, in part, an act of reparation.

**Genital Impulses and Phallic Strivings**

Most boys with GID have little interest in their penis. They do not masturbate and show little phallic striving. It is notable, however, that this is not the case with all boys with Gender Identity Disorder (as was true with Colin), at least not early on in the development of the disorder. We know from the work of psychoanalytic observers (Roiphe and Galenson, 1981) and from the work of cognitive developmental researchers (Kohlberg, 1966; Slaby and Frey, 1975; Fagot, 1985) that the genitally experienced self and the cognitively gendered self develop in major ways during the second year of life. We believe that the cognitively gendered self and the genitally experienced self develop to some degree separately but in parallel. These senses of self begin to become integrated when the boy becomes aware of genital differences, and they consolidate further once the boy understands that gender categorization is determined by one’s genitals.

In the boy with GID, the self-fusion fantasy with the mother ultimately has a profound effect on his phallic strivings, particularly once it is clear to him that his penis is the emblem of the gender he is trying to be rid of. At this stage, boys often urinate only by sitting down. They tape their penis between their legs and pretend they have a vagina, and in some cases they talk about wanting to have their penis cut off. In our experience phallic strivings do not develop or, in the cases where they have been lost, do not return until the underlying conflicts over separation and aggression are significantly resolved.

**Trauma versus the Blissful Symbiosis Hypothesis**

In evaluating Stoller’s etiological theory of boyhood GID, Meyer and Dupkin (1985) point out that Stoller (1979) has not indicated how many
cases had been seen in order to select his subgroup of 15 extreme cases and that “by adolescence or adulthood, conflicts may have become encapsulated within the transexual symptom. Retrospective self-justification (in both patients and parents) may cover early traumata” (p. 265). None of the over 130 cases seen at the St. Luke’s/Roosevelt Childhood Gender Identity Center or in a similar number of cases seen in the Toronto Childhood Gender Identity Clinic have fitted the blissful symbiosis pattern (Coates and Zucker, 1988; Coates, 1990).

How can one account for this difference in the findings? Stoller has made the argument that the boys he observed were a qualitatively different subgroup that he defines as “the most feminine of all.” Although it is possible that Stoller has seen a subgroup that other clinical researchers have not observed, we find this argument unconvincing, particularly since the St. Luke’s/Roosevelt sample selected the most extreme cases for study and not a single case of a blissful symbiosis emerged in over a decade of referrals. We propose an additional explanation. We were impressed that in the first few evaluation sessions many of these boys and their families seemed relatively well integrated. Often the degree of psychological suffering in the boy and a history of massive stress in the family emerged only after the family and child were in long-term treatment and knew us well enough to discuss painful realities or became able to recover dissociated memories. Stoller (1978) also notes that he was unable to engage any of the fathers in treatment around the care of their son. In contrast, we have succeeded in actively involving all of the fathers who were still in intact families, although it often took considerable persistence on our part to bring about this involvement. We have also wondered whether the task may have been easier because the fathers in our study were initially contacted and evaluated by female clinicians. As a result of our work with the fathers, we have had an opportunity to develop a more comprehensive picture of these families than other researchers have.

In the case that we have presented here, we believe that both mother and son experienced moments of blissful symbiosis, particularly in the early months of Colin’s life. The blissful aspect was not, however, the ongoing quality of the relationship, particularly after Colin was eight months old. There was not any evidence of a blissful symbiosis that lasted for years, which Stoller (1975) has described as necessary to produce this disorder. Rather, frustration, inaccessibility, and anger were a part of the ongoing mother-child interaction.
We have noted that a subgroup of our mothers expressed a manifest wish for a blissful symbiosis. One mother said, "If I had to die, I would like for it to be with him [her son] on my shoulder. It was perfect bliss." We believe, with Meyer and Dupkin (1985), that this was the expression of the mother's reparative fantasy for coping with her own conflicts about loss. Although our own research has demonstrated that a majority of our mothers fostered a symbiotic tie to their sons (Marantz and Coates, 1991), in none of the cases did our continuing evaluation confirm that this fantasy had, in fact, reflected an ongoing, blissful mother-child relationship. To the contrary, these relationships were characterized by severe, chronic stress and trauma, particularly after the first few months of life. We feel reasonably confident of our conclusions, since most of our referrals occurred by age four, which was relatively close to the onset of the GID symptoms (at least within a year or two) and were not based on adolescent or adult reconstructions made years later, as was true in many of Stoller's cases.

Despite this disagreement with Stoller's view of the role of a blissful symbiosis in the development of boyhood gender disorder, we agree with many of his observations. Many of these mothers are, indeed, depressed, and many of the fathers are inaccessible. We, like Stoller, have found that many of the mothers experienced their sons as beautiful. We feel, however, that Stoller did not appreciate the role of loss, aggression, and massive anxiety in the development of Gender Identity Disorder in boys.

**Gender Identity Disorder and Homosexuality**

As we noted earlier, follow-up studies of children with GID indicate that most, but not all, become homosexual adults. Many details of Colin's adaptation as revealed in psychotherapy are outside the scope of the present report. Suffice it to say here, however, that Colin's sexual orientation is unclear. There has not been any evidence at this time that he is sexually attracted either to males or to females. It is important for conceptual reasons to preserve the distinction between erotic experience and gender-related experience. Some clinicians have argued that children such as Colin should be considered homosexual children (Zuger, 1988). We believe that this position is a mistake on empirical and conceptual grounds. Evidence from the most extensive prospective study of boys with GID to date has not demonstrated that homosexuality is the
inevitable outcome of childhood GID (Green, 1987a). In our view, gender identity differentiation, erotic development, and erotic object crystallization reciprocally influence each other at multiple levels of organization. We believe that conceptually to conflate gender identity, erotic development, and erotic object orientation, at this point in our understanding of these issues, will obscure the development of a differentiated conceptualization of this disorder and interfere with scientific progress in this area of research.

Summary and Conclusion

A multiple-determinant approach toward etiology is now widely accepted by scientific researchers for sexual differentiation of behavior generally, as well as for most psychopathologies. We note that a spectrum model with an interactionist framework would posit that the relative weight of one factor over another would vary from one child to another. Were a boy to have a bold temperament instead of a shy, sensitive temperament, we believe that the weight of forces in parental character psychopathology and psychodynamics and in the severity of intercurrent stress would have to be much greater to bring about a GID. We believe that one of the reasons that boyhood Gender Identity Disorder is so rare is that multiple factors must all come together within a narrow time frame during development to bring about this disorder. None of these factors by itself is sufficient to cause this disorder.

We believe, however, that in the fertile context that we have described, the consolidation of a GID in most cases occurs in response to trauma and is always influenced by parental psychodynamics. In the majority of the cases that we have seen at the Childhood Gender Identity Center, the mother is attempting to repair the loss she experienced in relation to her inaccessible mother and to repair the tie to a father whom she both loved but also experienced as psychologically or physically abusive. The father too is responding to unresolved conflicts from his past, and this response interferes with his capacity to respond effectively to either his wife's or his son's needs during the period of severe stress. The inaccessibility of both parents leaves the child feeling abandoned and forces him to fall back on his very limited developmental resources to handle massive anxiety. At the time of referral to our unit, the parents are unaware of the impact of their behavior on their son. Once they
become aware of their son’s suffering, they are usually extremely pained, as was the case with Colin’s family, and will go to great lengths to provide him and themselves with the help that is necessary to relieve their son’s suffering.

We believe that for psychoanalysis to create a well-grounded and comprehensive psychoanalytic theory of developmental psychopathology that includes an understanding of the origins of specific disorders, it will be necessary to move between the analytic frame and a research frame. By integrating knowledge from each frame, we can reach a comprehensive understanding of disorders, in which cumulative risk factors involving the child’s biology as expressed in temperament, the child’s developmental level of representational ability, and multigenerational family dynamics can be understood in the context of the child’s interpersonal experience. An understanding of GID at this level of specificity will begin to shed light on how interpersonal experience first becomes encoded, then transformed, and finally constructed into an individual’s psychodynamics.

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