Diversity in Health and Care 2010;7:83–6

Guest editorial

Gender identity and sexuality: what's in a name?

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In the balcony scene of Shakespeare's *Romeo and Juliet*, Juliet clearly delineates the dilemmas posed by identity and the serious conflicts that she has to face. She has fallen in love with Romeo, a young man from the Montague family, who are enemies of her own family, the Capulets. Romeo and Juliet's personal identities, signified by their family names, are the obstacles to their dream of marrying and living together. Juliet's description of her predicament implies that identity has three components, namely the body, self-perception and social role. At the peak of her turmoil she finds a typical adolescent solution to her problem. This is idealistic and pure. She is enthusiastic and optimistic, and she wishes to overcome the old barriers between the two families. What she proposes is appealing in its simplicity. Here is her solution to the problem posed by their identities:

> '... wherefore art thou Romeo?
> Deny thy father and refuse thy name;
> Or, if thou wilt not, be but sworn my love,
> And I'll no longer be a Capulet ...
> 'Tis but thy name that is my enemy;
> Thou art thyself, though not a Montague.
> What's Montague? It is nor hand, nor foot,
> Nor arm, nor face, nor any other part
> Belonging to a man. O, be some other name!
> What's in a name? That which we call a rose
> by any other name would smell as sweet;
> So Romeo would, were he not Romeo call'd,
> Retain that dear perfection which he owes
> Without that title. Romeo, doff thy name;
> And for that name which is no part of thee
> Take all myself.'
>
> (Shakespeare, *Romeo and Juliet*, Act II, Scene 1)

The psychological dynamics implied here are between the wish to change things within a simple paradigm and the ability to face the complexity that this involves. Romeo and Juliet are considered nowadays as adolescents, but adolescence is a modern concept that emerged after World War II. In Shakespeare's day they were simply young people who aspired to be like their parents. Juliet provided a simple solution to the antagonism between their families: just change your name and everything will be solved. She does away with the cumbersome and frustrating dynamics of grown-ups which in our work we refer to as 'complexity', and we might take into account Romeo and Juliet's personal history and family and group identity, and people's reactions to them in her society. One can imagine Juliet responding by saying 'Boring!' to anyone who suggests that she should consider this, much like an adolescent of today.

Juliet's words are used here as a metaphor to illustrate the difference in the understanding of gender identity development within a simple paradigm and a complex paradigm. Gender identity development within a simple paradigm is based only on biological factors, whereas gender identity development within a complex paradigm takes into consideration the influence and interaction between biological, psychological and social factors. These paradigms have arisen following the definition of the concept of gender identity in the early 1960s. Before 1955, there was no concept of gender identity, and the word *gender* was mainly confined to the domain of grammar. The only determinant of male and female was the body, and therefore people for whom the perception did not match the appearance of their body could not articulate their human experience with any clarity. In 1955, John Money introduced the concept of *gender role*. The term *gender identity* appeared in the early 1960s in association with the establishment of a gender identity study group at the University of California. Stoller (1992, p. 78) defined it as:

> A complex system of beliefs about oneself: a sense of one's masculinity or femininity. It implies nothing about the origins of that sense (e.g. whether that person is male or female). It has, then, psychological connotations only: one's subjective state.

Money, in a paper about the history of gender identity disorder presented at the conference that I organised in 1992, concluded:

> in the second half of the 20th century ... what did emerge was a new name for a new concept, gender identity, which brought about a reformulation in how we think about sex and its disorders. This reformulation diffused far beyond the confines of medicine, where it began, and permeated the policies and politics of sex in society at large. It did so to such an extent that the social history of our era cannot be written without naming gender, gender role and gender identity as organising principles.
>
> (Money, 1994, p. 176)

What has occurred is a sort of Copernican revolution in the field of sexuality. Before Copernicus, previous literature and common sense seemed to suggest that the sun revolved around the earth and Galileo, who supported Copernicus' views that the earth revolved around the sun, had to abjure his beliefs to save himself. Similarly, before the definition of the concept of *gender identity*, the determinants of our gender were only the physical appearance of the body as common sense would suggest. However, we now also have to consider our own mental perceptions, i.e. our experience of gender identity embedded in brain functioning. In the last two or three decades neuroscientific research has attempted to establish what contribution brain function can make to the development of gender identity in interaction with individual early experience in the course of development. As yet we do not have a satisfactory understanding of gender identity development and of the interaction between brain functioning, hormones and experience. 'What's Montague?' One could probably answer now that it is an identity which is part of the mind and brain, and the experience of being a Montague cannot easily be disowned as Juliet was assuming.

Following the definition of *gender identity*, in 1980 *gender identity disorder (GID)* made its appearance in the *Diagnostic and Statistical Manual of Mental Disorders*, *Third Edition (DSM-III)* published by the American Psychiatric Association, and thus became a medical condition. This diagnostic category was revised in DSM-III-R and DSM-IV. Recognition of GID allowed the development of new research and therapeutic models to deal with the distress caused by the disharmony between self-perception and the body.

Our model of management at the Tavistock and Portman NHS Foundation Trust has been informed by the fact that the causation of the phenomenon of GID remains unclear and it is probably multifactorial. Our therapeutic experience has shown that children, particularly adolescents, are very sensitive and easily feel intruded upon by anyone attempting to change who they feel they are, and by those who minimise their feelings. Therefore at the Gender Identity Development Service we have developed a model of management in which altering an individual's perceived gender identity is not a primary therapeutic objective. Instead, emphasis is placed on the following list of current therapeutic aims (Di Ceglie, 1998):

- fostering recognition and non-judgemental acceptance of gender identity problems
- ameliorating associated behavioural, emotional and relationship difficulties (Coates and Spector Person, 1985)
- breaking the cycle of secrecy
- activating interest and curiosity by exploring the impediments to them
- encouraging exploration of the mind–body relationship by promoting close collaboration among professionals in different specialties, including paediatric endocrinology
- allowing mourning processes to occur (Bleiberg *et al*, 1986)
- enabling symbol formation and symbolic thinking (Segal, 1957)
- promoting separation and differentiation
- enabling the child or adolescent and their family to tolerate uncertainty in gender identity development
- sustaining hope.

It is important to add to this list the need to combat stigma, which is often associated with the experience of atypical gender identity, and is at times internalised by the individual who is experiencing GID. It is also valuable to alleviate the feeling of shame that some children and adolescents experience, and to enable people to develop skills in handling social interactions and dealing with possible hostility. This can lead to a new perception that in fact the experience of diversity is enriching the world that we inhabit.

It is possible that assisting development may secondarily change gender identity development and therefore in some cases resolve the experience of gender dysphoria. It is unclear which factors are involved in contributing to these shifts. Long-term follow-up studies have shown that only in a small proportion (10–20%) of pre-pubertal children who presented with the features of a GID did the gender dysphoria persist through adolescence and adulthood, with or without any therapeutic intervention (Green, 1987; Zucker and Bradley, 1995; Drummond *et al*, 2008; Wallien and Cohen-Kettenis, 2008). The shift usually occurs before or at the beginning of puberty, and the more common outcome is homosexuality or bisexuality. In describing the experience of persistent or desistent gender dysphoria, I found Britton's differentiation between beliefs and imagination useful:

> Beliefs have consequences: they arouse feelings, influence perceptions and promote actions. ... Fantasies, conscious or unconscious, which are not the object of belief, do not

> have consequences: disavowal therefore can be used to evade these consequences.
>
> (Britton, 1998, p. 11)

It is unclear what factors are involved in contributing to the persistence or desistence of GID, and this is an area of current research. Particular styles of thinking that are influenced by some autistic features may play a role (Jones *et al*, 2009).

In the last few years the term GID has become unpopular among service users and families, and this area of human experience has now come under the heading of *diversity*, together with ethnic identity, gay and lesbian identities, etc. Units that deal with diversity issues have developed within health, education and police organisations. Children and adolescents who experience the features of a GID are now referred to as *gender-variant children*. In 2004, Parliament passed the Gender Recognition Act, which allows people with gender dysphoria to change their birth certificate in line with their perceived identity. For many years now young people with gender dysphoria have been able to change their name by deed poll and alter their passport accordingly. This is often the first step towards further legal recognition of their persistent atypical gender identity.

Work is in progress to issue a new *DSM-V* in 2012 and *ICD-11* in 2014. There are currently a number of service users and professionals who would like to have GID removed from the psychiatric classification. This point of view is understandable, as at the core of GID there is an identity issue. However, the removal of this diagnostic category could lead to publicly funded services being discontinued and this type of help no longer being available to current and future service users. If the presentations of these children and adolescents are perceived or misconstrued as a choice rather than a clinical condition, social institutions, such as schools, might start to adopt policies which would cause further distress to these young people and their families. In fact, one could no longer state from a position of authority that the perceptions and behaviours of these children are part of a well-recognised diagnosable condition and not the result of a conscious choice.

For these reasons, I think that the diagnostic category of what is now referred to as GID should be retained, with different wording, on the basis that this is a condition that can cause considerable distress during development, and for which appropriate therapeutic input should be provided based on a developmental approach (Di Ceglie, 2009). In terms of terminology, the experience in our service suggests that the word *disorder* is not acceptable to a number of professionals and service users and does not capture the distressing nature of the condition. My suggestion would be to replace the word *disorder* with the word *dysphoria*, and to change the diagnosis to *gender identity development dysphoria (GIDD)*. The word dysphoria is generally more acceptable. I have included the word *development* as it emphasises both the developmental nature of the condition and the variable nature of its outcome in adolescence and adulthood. It also does not restrict the young person with regard to future change.

In the play, Juliet's solution to the problem that she faced did not succeed, and in her case this had tragic consequences. In our case, we have to accept that the solutions we find to the problems that we face in classifying gender identity presentations and issues are only temporary, and are likely to change in the future.

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