In Defense of Gay Children? `Progay' Homophobia and the Production of Homonormativity

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Sexualities 2008 11: 455
DOI: 10.1177/1363460708091744

Article

SEXUALITIES

Abstract This article analyzes putatively homophobic rhetoric and practices and their antihomophobic responses to understand how homophobia and antihomophobia may work together to produce 'homonormative' gay subjects. It does so by investigating current debates over the pathologization of homosexuality and gender nonconformity, specifically examining charges that the psychiatric diagnosis Gender Identity Disorder of Childhood (GIDC) is homophobic. The author argues that emerging forms of homophobia, or 'progay homophobias', are key to our understandings of anti-queer sentiments in an era of increased tolerance for homosexuality.

Keywords gender identity disorder, homosexuality, psychiatry, transgender, transsexuality

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In Defense of Gay Children? 'Progay' Homophobia and the Production of Homonormativity

In her influential 2002 essay, Lisa Duggan outlines the features of what she calls *the new homonormativity* as 'a politics that does not contest dominant heteronormative assumptions and institutions, but upholds and sustains them, while promising the possibility of a demobilized gay culture anchored in domesticity and consumption' (2002: 179). At first glance, homonormativity seems familiar. It draws on a diverse set of contentious debates that are anything but new in LGBTQ politics and culture: separatist versus integrationist, assimilationist versus transgressive, queer versus gay/lesbian, and so on.

However, Duggan's account of these strands as they morph into what she sees as their most recent incarnation – the production of a neoliberal gay subject – gestures toward both their historical specificity and their broader sociopolitical significance. In an era where multiculturalism is reduced to 'corporate diversity management' (Gordon, 1995; Ward, 2008), where anti-racist politics become 'color blindness' (Bonilla-Silva,

Vol 11(4): 455–475 DOI: 10.1177/1363460708091744
http://sex.sagepub.com

2003; Brown et al., 2003; Gallagher, 2003), and where there is an ever-increasing fragmentation of market niches (think cable TV), Duggan outlines the logic and politics whereby minoritarian subjects are hailed, and domesticated, as 'good citizens' of the neoliberal state.

While Duggan refers to the *new* homonormativity, the term itself has been in circulation at least since the early 1990s, especially among transgender activists. Within the context of delineating relationships among transgender, queer, bisexual, lesbian and gay individuals and collectivities in the emerging sociopolitical formation called 'LGBTQ', Susan Stryker has suggested that the term homonormativity was used by trans-activists as 'an intuitive, almost self-evident, back-formation from the ubiquitous "heteronormative", suitable for use where homosexual community norms marginalized other kinds of sex/gender/sexuality difference' (Stryker, 2008: 147). Such a concept was useful for transgender activists and allies to argue that 'sexual orientation was not the only significant way to differ from heteronormativy' (Stryker, 2008: 146). Thus, while Duggan's account locates homonormativity within a matrix of neoliberal politics, Stryker's locates it within LGBTQ intergroup dynamics.

Both, however, gesture toward the role of gay conservatives, and conservative strands of gay culture, in producing homonormativity. In fact, the bulk of Duggan's (2003) analysis focuses on gay conservatives, especially high profile author and political commentator Andrew Sullivan. However, one of Duggan's examples illustrating homonormativity comes from a source that is more difficult to pigeonhole politically. She recounts how the National Coalition for Anti-Violence Programs (NCAVP), a US-based LGBT organization, responded to an instance of homophobia in the context of post-9/11 US foreign aggression. When reports surfaced that an Afghanistan-bound US bomb had been adorned with the words 'HIJACK THIS FAGS', the NCAVP publicly condemned the use of the antigay slogan but noticeably failed to comment on the bombing and the war. The accusation of homophobia coupled with silence around militarism and corporatized nation-building thus became, for Duggan, one site for the expression of homonormativity.

This article takes up the challenge that such a moment signals and explores in further depth the relationship between homophobia and homonormativity. I examine how discourses and practices associated with homophobia may function not merely as *expressions* of homonormativity, but also as key sites for the *production* of homonormativity. I show on one hand how some forms of homophobia endorse gayness as long as it manifests as gender conformity. On the other hand, I show how charges of homophobia may stigmatize other forms of queer expression.

In this article, I examine discussions about the continued pathologization of (homo)sexuality and gender nonconformity found in debates over

'Gender Identity Disorder of Childhood' (or GIDC),[1] a psychiatric diagnosis given to gender variant children and linked in important ways to homosexuality. To do so, I examine professional literature on gender variant children and GIDC from 1960 to the present; discussions of GIDC in LGBTQ community publications; interviews I conducted with GIDC researchers and critics; and fieldwork at professional and advocacy meetings. GIDC debates frequently center on the question of homophobia, that is, if and how the diagnosis is or is not homophobic. In the following sections, I analyze what I call the 'homophobia critique' of GIDC as well as responses to it, and argue that neither critics' characterization of the kind of homophobia at play nor GIDC researcher-clinicians' defenses against such charges adequately reckon with the 'work' that GIDC does vis-à-vis homosexuality. I argue that GIDC is a site where an idealized gender conforming gay subject is produced, and where gayness is valued over and above other forms of queerness, especially transsexual and transgender forms. Thus, ultimately I argue that both sides in debates over GIDC – its defenders and its critics – produce sometimes similar, sometimes distinct forms of homonormativity.

Psychiatry, gender variant boys, and homosexuality

Across the course of the 1960s, a psychiatric and psychological subspecialty on gender variant children began to coalesce. The new body of research and treatment – which focused at the time almost exclusively on gender-variant boys[2] – responded to a diverse set of enabling conditions, including the rise of psychological understandings of both personal troubles and social problems (Herman, 1995; Lunbeck, 1994), newly emerging medicopsychological theories of gender (Money et al., 1955a, 1955b, 1956, 1957; Stoller, 1964), and heightened anxiety about gender and sexual transgressors, especially transsexuality and homosexuality.[3] Researchers began studying gender-variant boys in the 1950s and 1960s to try to understand both normal and atypical psychosexual development, and especially as a way of understanding the antecedents of later nonnormative behaviors and identities, specifically transsexuality, transvestism, and homosexuality. At the same time, they treated those same boys by trying to encourage more typical (masculine) identifications and behaviors, in part in hopes of averting atypical adult psychosexual outcomes. By the beginning of the 1970s, a small body of literature on gender variant children had been published (Green, 1967, 1968, 1971; Green and Money, 1960, 1961, 1964, 1966; Green et al., 1972; Greenson, 1966; Stoller, 1968; Zuger, 1966, 1969), a few experts had claimed professional turf, and bits of institutional infrastructure including hubs of researchers supported by government funding had been built.

Despite such quick institutional norming of the subfield, the specter of homophobia has haunted the treatment of gender variant children almost from its beginnings. When researchers began to systematically study and treat gender variant boys in the 1950s and 1960s, justifying their work by suggesting that childhood gender nonconformity predicted homosexual (among other) outcomes elicited no public outcry. However, the relative calm did not last for long.

At the same time that a subfield on childhood gender variance was quietly being established, homophile associations were being noisily replaced by an emerging gay liberation movement. One of its early targets was psychiatry. Largely because of outside pressure from gay social movements combined with the work of activist professionals within psychiatry, the American Psychiatric Association (APA) removed homosexuality from its list of formal diagnoses in 1973.

While not focusing directly on children, gay liberation's 'Gay is Good' message and its assertion that psychiatry harmed homosexuals had a spillover effect into the first analyses of treatments of gender variant children. By the mid-1970s, both intraprofessional and lay critiques of the work on gender variant boys began to appear (Morin and Schultz, 1978; Nordyke et al., 1977; Rorvik, 1975; Winkler, 1977; Wolfe, 1979). Commentators charged in part that childhood gender variance programs targeted homosexuality. In one of the most forceful critiques, Morin and Schultz (1978) argued that 'The most insidious attempt to stamp out the development of gay identity in young children is the treatment program developed by the Gender Identity Project at UCLA' (1978: 142). However, whereas a small flurry of critiques in the 1970s linked psychological treatments of gender variant children to the treatment or prevention of homosexuality, the full force of such critiques did not arrive until the 1990s. Several developments occurred in the interim and were highly conducive to the 'homophobia critique' of GIDC.

During the 1970s, while critiques were made public and homosexuality was removed from psychiatry's official list of mental disorders, long-term prospective studies of gender variant boys were just under way – studies that would eventually follow boys from childhood into adulthood to see how they 'turned out' (e.g. Green, 1974). Then, in 1980, the APA introduced into its nomenclature a new psychiatric diagnosis for gender variant children, 'Gender Identity Disorder of Childhood', which drew on the research and treatment literature on gender variant boys that had been amassing during the previous 20 years. And by 1987, the most widely cited findings from the prospective studies of gender variant boys were published as *The Sissy Boy Syndrome and the Development of Homosexuality*, where psychiatrist Richard Green reported that three-quarters of the gender variant boys he had followed from childhood into adulthood turned out

to be gay or bisexual. Thus, by the beginning of the 1990s homosexuality was officially no longer a mental illness while childhood gender variance was, and gender-variant kids, it seemed, mostly grew up to be gay.

Critics have increasingly drawn on this series of events to point out links between GIDC and homosexuality. They especially note the delisting of homosexuality in 1973, the subsequent inclusion of GIDC in 1980, and researchers' own findings linking childhood gender variance to later homosexuality. They strategically deploy these developments to make claims about the relationship between GIDC and homosexuality, arguing that in practice if not by intent, GIDC functions homophobically.[4]

Debating homophobia

The homophobia critique

Some critics have suggested that the creation of GIDC responded directly to the delisting of homosexuality, and that it has acted as a 'backdoor maneuver' to keep homosexuality under the control of psychiatry. One of the first to hint at this was high-profile queer theorist Eve Sedgwick:

> The same *DSM-III* [*Diagnostic and Statistical Manual of Mental Disorders*] that, published in 1980, was the first that did not contain an entry for 'homosexuality', was also the first that *did* contain a new diagnosis, numbered (for insurance purposes) 302.60: 'Gender Identity Disorder of Childhood' . . . While the decision to remove 'homosexuality' from *DSM-III* was a highly polemicized and public one, accomplished only under intense pressure from gay activists outside the profession, the addition to *DSM-III* of 'Gender Identity Disorder of Childhood' appears to have attracted no outside attention at all – nor even to have been perceived as part of the same conceptual shift. (Sedgwick, 1991: 20)

While some have pointed out the irony of the timing of homosexuality's removal and GIDC's inclusion, noting that 'Perhaps this was no coincidence' (Bem, 1993: 107), others argue more strongly that GIDC was intentionally created as a response to homosexuality's removal. For example, journalist and author Phyllis Burke argues that:

> As funding for the study and treatment of gender nonconforming children increased, a need arose to create a specific psychiatric category for the condition in the Diagnostic and Statistical Manual (*DSM*) of the American Psychiatric Association . . . Complicating the issue of treating the gender nonconforming child was the 1973 decision by the APA to eliminate homosexuality as a mental disorder. If homosexuality was no longer a mental disorder, then treating children for gender deviance with an eye to preventing homosexuality did not make sense. Those who wished to continue treating nonconforming children had seven years in which to develop a new category of illness, because in 1980, the third edition of the *DSM* would be published (*DSM-III*) officially removing homosexuality as a disorder. (Burke, 1996: 60)

While none of these commentators argue that GIDC simply replaced homosexuality or had as its sole purpose the continued psychiatric surveillance and control of homosexuality, they did make a strong connection between the delisting of homosexuality and the subsequent inclusion of GIDC. They suggest that the motivation for or effect of creating GIDC was the continued pathologization of homosexuality.

Others have suggested that GIDC is an attempt on the part of some parents and clinicians to prevent homosexuality through treatment. For instance, Barlett et al. note that

> Regardless of the fact that homosexuality is not officially considered a disordered outcome, the prevention of homosexuality remains a significant reason for referral of children with GID. It would be naïve to believe that prevention of homosexuality is not a motivating factor for at least some of the clinicians who work with children referred for gender-atypicality. Indeed, some researchers and clinicians in the area of GID in children are quite open about such a goal, writing books or belonging to organizations devoted to the prevention of homosexuality. (Barlett et al., 2000: 770)

While some critics question GIDC's role in either replacing homosexuality or in attempting to prevent it, even more conclude that although GIDC may indicate a real condition, its clinical use is over-inclusive and therefore results in the misdiagnosis of children who will eventually turn out to be gay, itself a nonpathological outcome. Whether it was designed to do so or not, they argue, the diagnosis is wrongly applied to 'pre-homosexual' children (again, especially boys). For example, Corbett warns that 'the diagnostic category of GID [is] problematic, as homosexual boyhoods are at times mistaken for GID' (1999: 109). Richardson (1999) builds on Corbett's concern, raising questions about a specific subpopulation – 'pre-homosexual boys' (1999: 46) – that he worries might be misdiagnosed with GIDC.

Taken together, the series of 'homophobia critiques' suggests that GIDC and more generally the research on and treatment of gender variant children was and continues to be motivated by an association with later homosexuality; that the GIDC diagnosis was created partially or wholly as a response to the removal of homosexuality from the *DSM* in order to maintain psychiatric control over homosexuality; that, intentionally or not, the diagnosis wrongly captures 'pre-homosexual' kids in its diagnostic net; and that treatments for GIDC are often attempts at preventing later homosexuality. Critics argue instead that gender nonconformity exhibited by pre-homosexual children (especially boys) is a normal variation, not a pathological maladaptation, and that pre-homosexual children should therefore be excluded from diagnosis and treatment. The sum total of these critiques is that GIDC and associated treatments are both motivated by

and an expression of homophobia, and that an antihomophobic response that protects pre-homosexual children is warranted.

GIDC researcher-clinicians respond

Critics thus mount a broad challenge to the GIDC diagnosis based on their assertion that it is deeply infused with homophobia; as one critic succinctly put it, the work on GIDC 'largely reflect[s] a homophobic approach to children with this '"condition"' (Pickstone-Taylor, 2003: 266). GIDC researcher-clinicians, however, have their own sets of justifications and explanations for their work. For instance, Zucker – a leading GIDC clinician – and Spitzer – 'architect' of the *DSM-III* (APA, 1980) and *DSM-IIIR* (APA, 1994) revision processes – challenge the interpretation that GIDC was a 'backdoor maneuver' to keep homosexuality under the purview of psychiatry (Zucker and Spitzer, 2005), noting that even with the removal of homosexuality there were and still are *DSM* diagnoses that can be applied to homosexuality (Ego-Dystonic Homosexuality and later Sexual Disorder Not Otherwise Specified which still remains on the books today). They also point out that some of the people who argued vociferously for the delisting of homosexuality from the *DSM* were the same people who oversaw the creation of GIDC for *DSM-III* (for critiques that do acknowledge this, see Bem, 1993 and Erzen, 2006). Zucker and Spitzer thus question some critics' assertions that in terms of both need and motivation, GIDC's creation was directly related to the deletion of homosexuality.

GIDC researcher-clinicians also respond to the assertion or implication that their treatments are intended to prevent homosexuality. While some contemporary clinicians cite preventing homosexuality as their motivation for treating GIDC (see especially narth.com, n.d.), most do not. Leading contemporary GIDC researcher-clinicians Ken Zucker and Susan Bradley partly dodge this critique by noting that 'Until it has been shown that any form of treatment affects a child's future sexual orientation, [this] point is moot' (1995: 268). Elsewhere they report that because 'therapeutic intervention (of any type) does not affect the outcome with respect to sexual orientation . . . experienced clinicians, including ourselves, do not suggest (to parents) that their treatment efforts will have an impact on this component of psychosexual differentiation' (Bradley and Zucker, 1998: 244). Along with challenging parents' possible expectations that treatment may prevent homosexuality, Zucker and Bradley also deny more forcefully that *their* goal is preventing homosexuality. For instance, in response to the charge that their approach is 'homophobic' and their treatment suggestions are 'disturbingly close to reparative therapy for homosexuals' (Pickstone-Taylor, 2003: 266), they counter:

> In *none* of our publications have we ever endorsed prevention of homosexuality as a therapeutic goal in the treatment of children with GID, although we note that this might have been a goal of some therapists and also of some parents. We have simply pointed out that there is no empirical evidence at present that the extant treatment approaches are related to whether or not a child with GID later on differentiates a homosexual or heterosexual orientation. (Bradley and Zucker, 2003: 267)

GIDC defenders also respond to critiques by pointing out that childhood gender variance and later homosexuality are not isomorphic phenomena; that is, not all children with GID grow up to be homosexual. In doing so, they sometimes imply that critics have posited a direct 1:1 relationship between childhood gender nonconformity and later homosexuality when in fact they have not.[5] They thus cast doubt on critics' 'over-inclusivity' argument by suggesting that it overstates the relationship between childhood gender nonconformity and adult homosexuality.

While GIDC defenders point out the less than total concordance between childhood gender nonconformity and later homosexuality, they do not deny that there is a strong correlation between the two. They therefore provide explanations for what may look to some like the unjust targeting of homosexuality in childhood. GIDC defenders argue that although many children with GID may end up being homosexual, it is not homosexuality per se that is in question or being treated during childhood. Instead, GIDC defenders make distinctions between treating *gender* and treating *sexuality*, and argue that they are treating the former but not the latter. In addition, they marshal evidence to argue that children who meet the criteria for GIDC, regardless of their later sexual orientation, show signs of psychopathology that requires treatment (e.g. Bradley and Zucker, 1997, 1998; Coates and Wolfe, 1997; Zucker, 2005; Zucker and Bradley, 1995). They outline other treatment justifications and goals – resolving gender identity conflicts, reducing peer ostracism, treating associated psychopathology, and preventing transsexuality and other adult manifestations of Gender Identity Disorder (Cohen-Kettenis and Pfäfflin, 2003; Zucker, 2005; Zucker and Bradley, 1995) – which, they argue, are applicable to children diagnosed with GIDC regardless of their eventual sexual orientation.[6]

Is GIDC homophobic?

What, then, to make of the debates over whether or not GIDC is homophobic? On the one hand, it is possible to evaluate the merits of the claims themselves. For example, was GIDC developed as damage control for the delisting of homosexuality and as a means of maintaining psychiatric control over it? As Zucker and Spitzer (2005) argue, it is difficult to reconcile conspiracy theories with the historical record, as there

is no evidence that GIDC was created in direct response to the removal of homosexuality.

Yet, Zucker and Spitzer's analysis reduces the complicated, subtle, and changing relationship between homosexuality, homophobia, and GIDC into the narrower question of whether or not GIDC was intentionally created to replace homosexuality. With this question before them, they marshal evidence showing that GIDC was neither needed nor intended to replace homosexuality. However, while categories for diagnosing homosexuality technically remained on the books, their existence did not erase the writing on the wall concerning the future of homosexuality in psychiatry and mental health professions' changing position concerning it. Further, while it is true that many of the GIDC framers supported the removal of homosexuality from *DSM*, Zucker and Spitzer do not accurately characterize nor fully consider the complicated nature of those positions. For instance, while Richard Green, primary author of the original GIDC diagnosis, did argue publicly for the depathologization of homosexuality (Green, 1972), he also *concurrently* argued that gender variant children should be studied and treated in part because they might grow up to be homosexual (see e.g. Green, 1974). Neither critics, who generally ignore Green's role in the fight to delist homosexuality, nor Zucker and Spitzer, who ignore Green's somewhat ambiguous but generally negative position on homosexuality in his work on gender variant children, address the seeming contradiction embedded in Green's positions when taken together: tolerate homosexual adults, cure pre-homosexual children.

Along with the debates over the role of homosexuality in GIDC's creation, researcher-clinicians also respond to accusations that GIDC functions to *prevent* homosexuality. While GIDC clinician-researchers strongly object to any suggestion that they are trying to prevent homosexuality, their response leaves many questions about their orientation to homosexuality (and the ultimate goals associated with GIDC) in place. For example, Zucker and Bradley's argument, outlined in the previous section, goes something like this: we are not trying to prevent homosexuality, and even if we were, we are not able to. Their primary defense here is that preventing homosexuality does not work, as evidenced by the research finding that treatment for GIDC does not result in a reduction of homosexual outcomes. Yet, given this highly charged rhetoric of pragmatism and deniability which does not weigh in on the core ethics of treating homosexuality, we are left to wonder what their position would be if treatment practices existed that did in fact result in more 'efficacious' outcomes.

In sum, neither side in the debates over whether and how GIDC might be homophobic quite gets to the key point. On one hand, although GIDC

clinician-researchers respond in ways that deny their work is motivated by or expressive of homophobia, a closer inspection reveals ways that complicated forms of homophobia, including homophobia wrapped up with liberal discourses of tolerance, might still be operative. So, while GIDC may not have been created as a direct replacement for homosexuality, this does not mean that 'tolerant' yet anti-gay approaches to the question of gender-variant boys did not impinge on the creation of the diagnosis. And while most clinicians today do not treat GIDC in order to prevent homosexuality, their own statements about whether or not they would treat for homosexuality if they could are less than fully clear.

On the other hand, many of the ways in which critics charge that GIDC is 'homophobic' miss the mark as well; they neither adequately nor accurately specify the ways in which GIDC is homophobic. Perhaps their biggest limitation is the way that they tend to conceive of the relationship between GIDC and homosexuality in overly negative terms: that is, GIDC limits, eradicates, or otherwise harms homosexuality via repression. With their focus on the negative functions of GIDC vis-à-vis homosexuality, critics miss one of the most important aspects of the GIDC–homosexuality relationship – its *generative* functions. Instead of GIDC being seen primarily as a threat poised to eradicate homosexuality, or an example of the way that mental health professionals 'can't stop seeing the prevention of gay people as an ethical use of their skills' (Sedgwick, 1991: 25), GIDC should also be understood as one of the sites where forms of homosexuality, especially respectable homonormative forms of homosexuality, are *produced*.

Producing homonormativity

Creating homosexuals

The homophobia critique charges that GIDC targets pre-homosexual children; yet, an important distinction is that if it targets homosexuality, it only targets *certain kinds* of 'pre-homosexual' children: gender nonconforming pre-homosexual children. What is more, while many critics focus on the relationship between GIDC and pre-homosexual children, clinicians apply the diagnosis more broadly to a set of gender nonconforming children as yet undifferentiated in terms of eventual sexual orientation; many of these children grow up to identify as gay or bisexual, yet some of them do not.

While critics have often focused on the links of this body of work to questions of *sexuality*, most GIDC researcher-clinicians understand their work as being primarily about *gender*. So, while critics argue that GIDC attacks homosexuality, what is much clearer is both that researcher-clinicians see their work as being about gender, and that, in fact, GIDC

does target gender variance regardless of its relationship to an eventual sexual orientation.

Further, while there is a will to know and be able to predict which children will have which outcomes, such predictive tools do not exist; instead, gender variant children are typically seen as having the potential to differentiate in several directions, along both sexual orientation and gender identity axes. Given that gender variant children have multiple possible trajectories (and trajectories for individual young children are hard to predict), one of the goals across the 50 years of work on gender variant children, sometimes explicit but more often tacit, has been an attempt at encouraging some outcomes and discouraging others. One symptomatic result of this goal has been an implied hierarchy of preferred, acceptable, and unacceptable outcomes concerning sexual orientation and gender identity. The place of homosexuality in this hierarchy has been complicated and changing. And whereas critics have focused on homosexuality, it is a different outcome that has more persistently been the target for prevention, and has always remained at the bottom of the hierarchy of desired outcomes: Transsexuality. Thus a homosexual outcome, especially one without effeminacy but certainly anything that averts transsexuality, has at times been able to be counted as 'success'.

In fact, with such a hierarchy at least partially animating the work on gender-variant children, GIDC can actually become productive of some forms of homosexuality. As early as the 1970s, childhood gender variance researchers articulated a position that treating gender variant boys was not *curing* homosexuals, but rather was *encouraging* their development (Green, 1975). This articulation drew on a division between gender identity and sexual orientation that continues to be an important theoretical tool used to legitimate treatment for gender variant children while also deflecting versions of the 'homophobia critique'.

Green (1975) reviewed the small extant longitudinal literature on gender variant boys – studies that followed feminine boys into adulthood – and noted even then that most of the boys turned out to be homosexual. In a discussion of what clinicians were actually treating when they worked with gender variant boys, Green drew on his concept of 'sexual identity', which for him was made up of three components: (1) gender identity, (2) gender role (or behaviors), and (3) sexual orientation. Green explained the different configurations of these three components that resulted in transsexuality, transvestism, and homosexuality. So, according to Green, transsexuals are atypical for all three sexual identity components (Green used natal males in all his examples): They feel like women (atypical); they act like women (atypical); they are, generally, attracted to men (atypical).[7] Homosexuals, on the other hand, are only atypical for the sexual orientation component of sexual identity. Green then asked, 'Which

components of sexual identity are relevant when a child is brought for evaluation and possible treatment for boyhood femininity?' (1975: 343). His answer: Gender identity and gender role but not sexual orientation. According to Green, these first two components of sexual identity were the aspects where atypical behavior manifested as well as the site of conflict for the child and of parental concern. Treatment was targeted solely at the first two components of sexual identity, that is, gender identity and gender role, but not the third, sexual orientation, which children did not yet 'have', according to Green.

While this is an early example of a defense against the 'homophobia critique', Green went on to make a more important point lending insight into the generative relationship between GIDC and homosexuality. By treating gender identity and gender role but not sexual orientation, Green conjectured that 'It may be that transsexualism and perhaps transvestism is aborted by such intervention. However, since the third component of sexual identity (sexual orientation) is not considered or treated, it may be that these children will evolve into adult homosexuals' (1975: 343). In other words, Green was not simply denying that he was treating or preventing homosexuality. Instead, he suggested that treating feminine boys could turn would be transsexuals into homosexuals, concluding that

> the natural course of boyhood femininity when left unattended by parents or professional authorities may be the adult picture of transsexualism and in some cases transvestism. However, when that natural course is interrupted in the preadolescent years, the outcome may be a masculine homosexual adult. (1975: 343)

Green thus concluded that he was helping to create homosexuals, not cure them.

With the rise of gay and lesbian movements in the USA and the then-recent decision by the APA to remove homosexuality from the *DSM*, Green's argument was in part a function of the political moment of the day. Curing homosexuality was becoming more and more suspect. Yet, this did not mean that all forms of homosexuality were equally embraced or even tolerated. In such a political context, GIDC became not solely or primarily about curing gays, but about shaping (e.g. producing) them in their preferred form – as gender conforming, upstanding, 'very straight' gays. Thus, while the delisting of homosexuality was accomplished in the name of 'Gay is Good' progressive politics, it also helped set the stage for new, highly conformist modes of homosexual subjectivity.

The logic outlined in Green's early opus lives on in GIDC work today. The widespread acceptance of treating GIDC to prevent adult transsexuality, many clinicians' continued goal of reducing or eliminating gender nonconforming behaviors, and the repeated assertion that treatment for

GIDC does *not* alter later homosexuality, combined, reveal a field for producing gender conforming homosexual adults.

Defending homosexuality

The homophobia critique does not simply misdiagnose the workings of homonormativity; critics in turn produce their own set of homonormative effects. Defenses of pre-homosexual children may also result in 'a privileging of homosexual ways of differing from heterosocial norms and an antipathy (or at least an unthinking blindness) toward other modes of queer difference' (Stryker, 2006: 7). Exclusions typically occur when pre-homosexual children are defended by pointing to other children who are construed as the proper targets of the diagnosis. The others named in such defenses are those exhibiting 'gender dysphoria' (Haldeman, 2000), those with cross-gender desires expressed in terms of their identity (Bartlett et al., 2000, Wilson et al., 2002), or more simply stated, 'transgender' or 'pre-transsexual' children. In defending pre-homosexual children, these others become the justifiably pathologized class.

Thus, even in the context of strong critiques that seek to exclude pre-homosexual children from treatment, notions of pathology may still be left in place. For example, Bartlett et al. (2000) postulate that GIDC captures two populations of children: 'those children who present solely with dissatisfaction with the culture-specific gender role prescribed for their sex and children who present with persistent discomfort with their biological sex' (2000: 757). While they argue strongly that neither pre-homosexual children nor children who transgress only their gender 'role' should be treated, they are less certain of the status of children who exhibit discomfort with their biological sex. Similarly, Wilson et al. (2002: 348) conclude their critique by suggesting that 'the focus of clinical work remains on the pathology accompanying gender identity dysphoria rather than on treating gender role behaviour'. These critics suggest that while pre-homosexual children and those whose gender variance manifests solely via behaviors should not be diagnosed, children whose gender variance manifests via identity perhaps should. These kinds of critique point, sometimes tacitly and sometimes explicitly, to the transgender or 'pre-transsexual' child as GIDC's proper object.

Miriam Rosenberg, self-described as specializing in 'gay and lesbian patients of all ages' (2002: 619) and critical of conventional mental health approaches to childhood gender-variance, is one of several clinicians developing new, 'affirmative' approaches for gender variant children and their families. In contrast to conventional approaches that directly target children's cross-gender identity for intervention and change, Rosenberg describes her treatment approach as 'consisting in acceptance and support for the children just as they are' (2002: 619), with a therapeutic setting

where children's cross-gender identifications and behaviors are not only tolerated, but valorized. Rosenberg reports on the outcomes of her therapy: associated problems (anxiety, behavioral problems, depression) showed clinical improvement while children 'came to identify with their biological genders, and abandoned wishes to become the opposite gender, without abandoning interests stereotypical of the opposite gender' (p. 619). Rosenberg calls this final outcome 'adaptation to the reality of biological destiny' (p. 619), noting that

> Clinical work often involves helping patients to find a reasonably happy and comfortable adaptation to reality, while retaining their hopes and fantasies, and to find a way to accept and express formerly secret inner selves. Only in this area of gender dysphoria do we attempt to help patients by pretending to change reality. It is, after all, pretense because genetic gender is not changed . . . The fact that some adolescents continue to request sex reassignment need not be taken as a mandate. (Rosenberg, 2002: 621)

She tells us that, via her 'affirmative' approach, 'Most parents have feared a transsexual outcome but have been able to accept a homosexual outcome' (Rosenberg, 2002: 620).

Another critic who refers to GIDC as 'homophobic' lauds Rosenberg's approach for what appears to be the prevention of transsexuality: 'Most significantly of all, Rosenberg's children all lost the wish to be the opposite sex, which is the most disturbing and fundamental characteristic of GID' (Pickstone-Taylor, 2003: 266). GIDC critics' defenses of 'pre-homosexual' children as well as reports of new, affirmative therapeutic practices thus reveal exclusionary and pathologizing homonormative effects.

Conclusion

The 50 or so years of psychiatric and psychological work on gender variant children, formalized mid-stream as the GIDC diagnosis, has a complicated relationship to homosexuality. Commentators have often characterized that relationship as homophobic, where GIDC's *raison d'être* is to reduce or prevent homosexuality. No doubt such a vision has been an important component of the GIDC story. However, the more complicated and perhaps more insidious relationship between GIDC and homosexuality is not about the vision of a homosexual-free world, but rather about a world where homosexuality manifests in ways that are stamped with hetero-normative ideals. In this mode, GIDC threatens not homosexuality writ large, but rather particular forms of queer subjectivity and related social collectivities. In terms of homosexuality specifically, it does not simply tap into a wish that gay people did not exist à la Sedgwick's (1991) critique, but rather that *certain forms* of gayness did not exist. Along with the

damage that may be done to those people, including children, who embody the particular expressions that treating GIDC refashions, such a wish threatens queer subcultural formations that draw on, even rely on, visible queer gender nonconformity. Thus, while GIDC no doubt has the potential to harm individuals (see Scholinski, 1998), it also carries with it the potential to undermine broader queer collectivities. Further, GIDC reveals a desire, whether successfully exercised or not,[8] that certain kinds of homosexuals and more generally certain kinds of queer subjects exist and that others do not.

In an era of increasing tolerance toward gays and lesbians, the ways in which antigay sentiments are expressed have been transformed. Such transformations concern not only a retrenchment and reorganization of strongly anti-homosexual conservatism, but also emerging forms of more 'tolerant', less overt homophobias. In fact, the history of GIDC suggests particular attention be paid to forms of antigay sentiment that are not motored by the will to eradicate gays, but rather to produce homosexuality in approved – heteronormative, de-queered – forms. Further, the operation of such 'progay homophobias' has to be understood in light of more than attitudes toward homosexuality, but rather attitudes toward a whole range of queer possibilities. In such a context, heteronormative gayness may be preferred to other homosexualities as well as to other forms of non-heterosexuality, especially in this case, transsexual and transgender forms. If there is one 'outcome' or 'identity' that GIDC most clearly targets, it is not homosexuality but rather transsexuality. GIDC could therefore be characterized as transphobic. However, GIDC's transphobia does not replace homophobia. Instead, they have an interactive relationship. The form of homophobia that GIDC most clearly expresses refracts deep elements of transphobia, with gender nonconformity as the site of intervention. Homophobia also interacts with transphobia in critiques of GIDC, where critics' mischaracterization of GIDC's homophobia contribute to anti-trans effects.

Current debates over GIDC further lend insight into blindspots that result from failing to properly diagnose these 'progay' forms of homophobia. Critics of GIDC mount an antihomophobic defense of prehomosexual children to protect them from the stigma accompanying the diagnosis and any harm that might result from treatment. Such responses have included theorizing nonpathological gender nonconforming boyhoods, and have thus begun to provide some alternatives to the vision of gender conforming gays. However, the focus on defending homosexuality comes at the expense of other queer outcomes. In fact, some defenses of homosexuality work explicitly by pathologizing queer outcomes not necessarily organized around sexuality, especially transgender and transsexual ones. The result is a hierarchy of acceptable outcomes that

partially mirrors the hierarchy implicit in the GIDC work itself, with transsexual/transgender outcomes firmly entrenched at the bottom.

While debates over the legitimacy and meanings of GIDC are generally understood as adversarial, my analysis shows how GIDC-critics and GIDC-defenders inadvertently work together to produce both forms of homonormativity – Duggan's neoliberal subjects and Stryker's homohegemony. On one hand, GIDC researcher-clinicians have tended to approach 'pre-homosexual' children not with a clear goal of eradicating their homosexuality, but rather to seek to transform them into gender conforming, 'straight acting' homosexuals. On the other hand, existing critiques of GIDC have sought to protect 'pre-homosexual' children at the expense of others, thus constructing a hierarchy of value within possible queer outcomes. It is crucial that we continue to try to understand the ways that homophobia and antihomophobia sometimes work together. In doing so, I suggest that we stay attuned to emerging and complex forms of homophobia, such as the 'progay' homophobia outlined here, which impinge not only on gays and lesbians but also on other forms of queer subjectivity, politics, and collective life.

Acknowledgements

For helpful comments and support, I thank Francesca Degiuli, Sarah Fenstermaker, Avery Gordon, Hillary Haldane, Helene Lee, Jodi O'Brien, Beth Schneider, Mark Schuller, Salvador Vidal-Ortiz, and the *Sexualities* anonymous reviewers. Earlier versions of this article received the Charlotte Stough Award from UCSB's Women's Studies Program and a Graduate Student Paper Award from the American Sociological Association Sexualities Section. The research this article draws on was supported by the Sexuality Research Fellowship Program of the Social Science Research Council; the Sisters of Perpetual Indulgence, Inc.; a Martin P. Levine Memorial Fellowship from the American Sociological Association; and the Graduate Division and Department of Sociology at the University of California, Santa Barbara.

Notes

1. 'Gender Identity Disorder of Childhood' first appeared in *DSM-III* (APA, 1980); a version has remained in all subsequent *DSM* revisions. However, in *DSM-IV* (APA, 1994) GIDC was recategorized under an umbrella diagnosis, 'Gender Identity Disorder' (GID), with specifications for children, adolescents and adults. For all intents and purposes, the childhood variant of GID is the current version of GIDC. Throughout the article, I use GIDC to refer to the childhood GID diagnosis in order to signal the direct lineage linking versions of childhood GID from 1980 up to the present.
2. Research, treatment, and even formal diagnostic criteria for gender variant children have historically focused more on boys than girls. This disproportionate focus on boys has been noted by critics (e.g. Feder, 1999;

Sedgwick, 1991) as evidence that the interest in gender nonconforming children is driven by cultural anxieties. The ratio of prepubertal boys to girls seen at gender clinics today remains skewed toward boys, and has recently been reported at 5.75:1 in Canada, 2.93:1 in the Netherlands, and 3.81:1 in the UK (Cohen-Kettenis and Pfäfflin, 2003).

3. For a fuller discussion of these trends, see Bryant, 2006.
4. The putative link between childhood gender variance and later homosexuality is not the only way that critics have addressed GIDC and associated treatments. However, because of the focus of this article, I limit myself here to an analysis of the 'homophobia critique' of GIDC.
5. For example, Zucker (1999) began his response to Isay's (1997) critique of GIDC by stating, 'The general thrust of Isay's opinion piece treats the constructs of gender identity and sexual orientation as isomorphic' (1999: 5). Yet, Isay cited evidence suggesting that three-quarters (not 100%) of GIDC boys go on to have a homosexual or bisexual orientation. In another example, Bradley and Zucker replied to Menvielle's (1998) critique by charging 'What Dr Menvielle does not either appreciate, or agree with, is that GID is not simply isomorphic with later homosexuality' (Bradley and Zucker (1998: 244). However, like Isay, Menvielle cited a 75% homosexual outcome for GIDC boys and further stated, 'There is no way to predict what adult sexual/gender orientation an individual child with GID will have' (Menvielle, 1998: 243). In fact, people on both sides of the debate tend to cite the same evidence (e.g. Green, 1987 and other 'outcome' data) to suggest that there is a *probabilistic* relationship between childhood gender nonconformity and later homosexuality, with about 75% of GID children ending up as homosexual.
6. Drawing on the probabilistic relationship between gender nonconformity and homosexuality, 'gender identity conflicts' are conceptualized as related to *but distinct* from sexual orientation. Resolving gender identity conflicts can include encouraging children's same-sex identifications and gender typical behaviors as well as averting later adult transsexuality (Cohen-Kettenis and Pfäfflin, 2003; Zucker, 2005; Zucker and Bradley, 1995). Some critics suggest that reducing peer ostracism should focus on *peers*' attitudes and behaviors instead of on gender variant children's (e.g. Burke, 1996). The question of whether or not children with GID actually exhibit elevated levels of 'associated psychopathology' has been hotly debated as well (see e.g. Bartlett et al., 2000; Menvielle, 1998; Richardson, 1999).
7. Green and many other medical professionals at that time classified transsexuals by referring to their sex assigned at birth. Thus, 'male transsexual' was the standard medical term referring to 'male-to-female transsexual' (also widely referred to today as MtFs, Transwomen, or simply women). This way of conceptualizing and classifying transsexuals meant that a 'male transsexual' (MtF) who was sexually attracted to men would be referred to as a 'homosexual male transsexual' (someone who today might be referred to as a heterosexual MtF or simply a heterosexual woman). Because most of the MtF transsexuals that Green saw were sexually attracted to men, he considered them 'homosexual male transsexuals' and thus atypical in terms of their sexual orientation.

8. I do not mean to imply that GIDC or the treatments associated with it will actually succeed in obliterating particular forms of queer subjectivity or associated subcultures. The GIDC professional world is small, with only a few experts conducting research or providing treatment. Furthermore, the will to produce conformist adult homosexuals that GIDC expresses is not exercised unidirectionally. Children diagnosed with GIDC do not all grow up to be the kind of subjects envisioned.

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