TREATMENT OF GENDER IDENTITY CONFUSION IN CHILDREN: Research Findings and Theoretical Implications for Preventing Sexual Identity Confusion and Unwanted Homosexual Attractions in Teenagers and Adults[1]

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Gender identity disorder in childhood and adolescence is an identifiable precursor to adulthood homosexual tendencies in children and adolescents. Because research soundly demonstrates that these precursors place the minor at high risk of adolescent and adulthood homosexual behavior with the associated higher risk for affective disorders, suicidality, substance abuse, and life-threatening sexually-transmitted disease, it is ethically appropriate and clinically imperative that clinicians cooperate with parents seeking therapy for their child or adolescent to prevent adulthood homosexual behavior. Specific interview techniques and clinical psychological testing methods have been shown be effective for differentiating problematic child and adolescent conditions in need of intervention from patterns within normal limits of child development. Research and clinical experience demonstrates that gender identity disorder and gender non-conformity are treatable if the parents and minor cooperate with and complete a course of therapy using the techniques summarized in this article.

One major precursor to an adulthood homosexual orientation and a homosexual behavior is gender non-conformity in childhood and adolescence. When parents observe deviance in gender identity development or cross-gender behavior in their child, they often intuitively fear a possible developmental course leading towards homosexual inclinations in their child. Parents are typically concerned and many contact a mental health professional for an evaluation for potential treatment to normalize the psychosexual development of their son or daughter.

When early detection of childhood precursors is possible, even though the complete adulthood dysfunctional pattern has not yet fully developed, it is standard clinical practice to

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conduct a thorough assessment of a child or adolescent for accurate early identification and early therapeutic intervention for early developmental deviations that, in the absence of therapy, would otherwise likely lead to a dysfunctional adulthood condition. This general developmental perspective on the causes of adulthood dysfunctions has its parallel, in many cases, to detecting deviant gender development in children that can eventuate towards unwanted adulthood homosexual attraction and adult homosexual behavior.

There are several different and interacting childhood or adolescent routes to the same destination of adulthood homosexual behavior and homosexual orientation (Rekers, 1988, 1999). Retrospective studies of adult homosexuals and prospective longitudinal studies of the development of children with gender disturbances into adulthood have identified the following deviant developmental factors that often contribute to the development of an adult homosexual orientation:

- childhood gender identity disorder,
- gender non-conformity in childhood and/or adolescence,
- inadequate identification and modeling after a same-sex parent figure, often coupled with an abnormal identification and modeling after the opposite-sex parent figure,
- sexual abuse (by a same-sex perpetrator; or for girls, sexual abuse by a male perpetrator can contribute to fear of men and/or revulsion towards any kind of sexual relations with a male, which can later develop into adulthood homosexual attraction instead; or for boys, sexual abuse by a female can lead to fear of women or revulsion towards any kind of sexual relations with a male, which can later develop into adulthood homosexual attraction instead),
- initiation into repeated same-sex sexual behavior by a peer, and/or
- one or more of the above in combination with exposure to homosexual pornography or sex education or other mainstream media messages that inaccurately portray homosexual behavior as though it were a “normal” variation without unique risk for

adverse emotional or health consequences and a lifestyle that is equally acceptable as heterosexual marriage.

In a long-term follow-up study (in a series of periodic follow-ups) of fifty-five *untreated* effeminate young boys into young adulthood, Zuger (1984) found that 63.6% had developed a homosexual orientation while 5.5% had developed a heterosexual orientation; the outcome for 18% was uncertain, and 9% were lost to follow-up. In a prior twenty-year prospective follow-up of these same young men from childhood, Zuger (1978) reported that 63% had a homosexual orientation, 12% had a heterosexual orientation, 6% became transsexual (gender identity disorder of adulthood), and 6% became transvestite. Significant for the urgency of providing therapy to effeminate boys while they are children, Zuger (1978) also found that 25% of the young men had attempted suicide and 6% had actually committed suicide. Zuger (1978) also found that 25% of the young men had attempted suicide and 6% had actually committed suicide; this tragic finding underscores the urgency of providing therapy to effeminate boys while they are still children, with the reasonable hope that the psychodynamics that lead to suicide can be prevented. As a result of this prospective research on the outcome of effeminacy in boys who do not receive psychotherapeutic intervention for their cross-gender behavior, Zuger (1988) offered this theoretical interpretation, "It is concluded that early effeminate behavior is not merely a forerunner of homosexuality in that it forecasts homosexuality, but that it is in fact the earliest stage of homosexuality itself" (p. 509).

In addition to this prospective study of effeminate boys into adulthood, there have been even more numerous studies of the retrospectively reported childhood histories of adult homosexuals compared to adult heterosexuals (see a review of this research by Rekers, 1999). For example, in their detailed interview study of 686 adult homosexual males compared to 337 adult heterosexual males in a convenience sample, Bell, Weinberg, and Hammersmith (1981) analyzed the data with a path analysis, exploring numerous possible precursors to the development of an adult homosexual orientation. Bell and

colleagues found that childhood gender non-conformity was the strongest predictor of adult homosexual preference. Some of the homosexual men who had gender non-conformity in their childhood recalled that their first experience of being sexually aroused by another male, the mean age was 11.6 years of age.

Even though most parents are not specifically aware of this body of research, the vast majority of parents become intuitively concerned when their child or adolescent [1] exhibits persisting cross-gender behavioral patterns, and/or [2] makes repeated cross-gender identity statements.. It is appropriate for clinicians to provide a thorough evaluation of a child when these behaviors are reported because the etiology of adulthood homosexual tendencies and homosexual behavior often involves the occurrence of such behaviors in childhood or adolescence (Nicolosi & Nicolosi, 2002; Rekers, 1977; Rekers & Heinz, 2001; Rekers & Kilgus, 1995; Rekers & Mead, 1980). As will be seen from the research cited below, parents and clinicians clearly have every reason to be concerned about and pursue therapeutic intervention for children and adolescents manifesting these precursors to homosexual tendencies.

Rationale for Early Identification and Early Therapeutic Intervention

The vast majority of parents prefer that their child or teenager grow up to have a normal heterosexual adjustment (see review of evidence by Stein, 1999, pp. 313-317). This parental desire is consistent with a large body of scientific research that has found that an adolescent or adult homosexual orientation and homosexual behavior is not only associated with substantially greater risk for health problems (Sandfort, Bakker, Schelievis, & Vanwesenbeeck, 2006; Sandfort, de Graaf, & Bijl, 2003), including sexually-transmitted illnesses and life-threatening HIV infection and AIDS (Rekers, 1989), but is also associated with substantially higher rates of adulthood psychiatric disorders, substance abuse, and suicide attempts compared to heterosexuals (King, Semlyen, Tai, Killaspy, Osborn, Popelyuk, and Nazareth, 2008; Sandfort, de Graff, Bijl, & Schnabel, 2001; Sandfort et al.,

2003; Sandfort et al., 2006; Phelan, Whitehead, & Sutton, 2009; see also numerous representative population based studies summarized in the review by Rekers, 2006).

Therefore, from the perspective of a substantial body of research, parents clearly have every reason to be concerned that if their child continues in the development of a homosexual orientation, they will be at significantly greater risk for experiencing serious medical and mental health problems than would be the case if their child developed a normal heterosexual adjustment. In brief summary, mental health professionals have substantial professional and ethical reasons to offer clinical evaluation and therapeutic interventions to children or adolescents presenting with cross-gender behavioral patterns, or repeated cross-gender identity statements (see extensively detailed rationale for clinical interventions presented by Rekers, 1977; Rekers, 1995b; Rekers & Mead, 1980; Rekers, Rosen, Lovaas, & Bentler 1978; Rosen, Rekers, & Bentler, 1978; Phelan et al., 2009). Child and adolescent precursors to adulthood homosexual tendencies should be psychologically treated for these major reasons: (a) Clinical intervention is necessary to detect and treat the minor's current psychological maladjustment that is associated with gender non-conformity and gender identity disorder in childhood and adolescence. (b) Clinical intervention is necessary to detect and treat the minor's social maladjustment among family and peers that is associated with gender non-conformity and gender identity disorder in childhood and adolescence. (c) Clinical intervention is necessary to prevent adulthood gender dysphoria and/or adulthood homosexual tendencies because of those adulthood conditions are substantially associated with greater life-threatening health risks, associated risks for suicide, associated risks for debilitating psychiatric disorders, and associated risks for self-harm by substance abuse. Thus, clinical intervention to detect and treat the minor's precursors to adulthood homosexual tendencies is ethically, clinically, and legally appropriate in response to parental requests.

Case Examples

Before summarizing the goals and methods for the diagnostic assessment and treatment of gender identity disorder in children and adolescents, two childhood cases will be presented to illustrate the presenting problems and therapeutic approaches that have been experimentally demonstrated to be effective.

Craig: A Young Boy with Gender Identity Disorder of Childhood

Rekers and Lovaas (1974) reported a case of gender identity disorder in a boy aged 4 years 11 months at time of referral. Both parents lived in his home, and he had a psychologically normal brother 8 years of age and a sister 9 months old. Although evaluated as physically normal by his physician, Craig had been cross-dressing in female garments from the age of 2 when he also began playing with cosmetic items belonging to his mother and grandmother. When girls' clothing was unavailable, Craig would improvise by using a mop or towel on his head for "long hair" and his father's t-shirt for a "dress." He could remarkably imitate many of the subtle feminine behaviors of an adult woman, displaying high and exaggerated rates of very pronounced feminine gestures, mannerisms, and gait, together with an exaggeratedly high feminine voice inflection. Feminine topics dominated his speech. He avoided boyish play, regularly avoided playing with his brother, and clearly preferred to play with girls. In playing "house" with girls, he would invariably insist on playing the part of "mother," and rigidly refused to take the role of "father." He satisfied the current diagnostic criteria for Gender Identity Disorder of Childhood.

Using intrasubject replication designs and multiple baseline designs, Craig was treated sequentially in the clinic and home environments by training his mother to be his "therapist." The mother was taught to reward masculine behaviors and to extinguish feminine behaviors by using social reinforcement in the clinic and a token economy procedure in the home. This treatment resulted in a sharp decrease in feminine behavior and an increase in masculine behaviors. It was found necessary to strengthen several masculine behaviors and to weaken several prominent feminine behaviors in both the clinic and home settings. Follow-up psychological evaluations three years after treatment began

indicates that Craig's gender behaviors became normalized. An independent clinical psychologist evaluated Craig and found that post-treatment that he had a normal male identity. Using intrasubject replication designs, this published case was the first experimentally demonstrated reversal of a cross-gender identity with psychological treatment, and the journal article on this case was among the top 12 cited articles in clinical psychology in the 1970s.

Becky: A Young Girl with Gender Identity Disorder of Childhood

Rekers and Mead (1979) reported an intrasubject treatment study of a girl, Becky, who was diagnosed with gender identity disorder by two independent clinical psychologists. She had been referred for therapy at the age of 7 years 11 months. Her father was absent from her home, due to divorce, and she had two sisters, aged 2 and 6. For as long has her mother could remember, Becky had been exclusively wearing boys' pants, frequently with cowboy boots, and she consistently refused to wear dresses and other girls' garments, and she showed no interest in feminine jewelry. The only time she would use cosmetic articles were the times she repeatedly drew a moustache and/or a beard on her face to appear as a man. She continually displayed exaggerations of masculine arm gestures, body mannerisms, and style of walking. She frequently projected her voice as low as she could to sound like a man, coupled with taking male roles in play and making repeated statements that she wanted to be a boy. She occasionally masturbated in public, rubbing her body up against girls in a "humping" fashion. She did not relate well with girls, and clearly preferred playing with boys. Reportedly, she largely suppressed these gender-atypical patterns of behavior while in school out of fear of disapproval from her teacher.

Becky's mother explained to her that she was coming to therapy because she "acted too much like a boy" and because she did not want her to "be like a boy" when she grew up. Becky seemed to accept this uncritically and appeared to enjoy clinic sessions to play with toys. After baseline measures, therapy in the clinic took place over a period of 16 weekly 30 to 45 minute sessions. She was given a writs counter to wear with the instructions, "You

may play with any of the toys that you like, but you can only press the wrist counter when playing with girls' toys." Each toy was labeled as a "girls' toy" or a "boys' toy" by the therapist. In initial sessions, Becky was prompted to press the writs counter from the observation room through a "bug-in-the-ear" device worn on her ear. These prompts were gradually faded out. Becky became emotionally attached to the female therapist and seemed eager to please her. After the first three therapy sessions of self-monitoring, this intervention resulted in a consistently high level of feminine play in the absence of masculine play. Eventually, the wrist counter was phased out and treatment generalization occurred without it.

In a multiple baseline design, data on masculine and feminine behavior was also collected in the home setting. A self-monitoring procedure combined with fading out of behavioral prompts was also applied in the home environment over a 12-week period by the therapist who made home visits. Exclusive feminine play resulted at home.

Becky's frequency of low voice projection was monitored throughout therapy, and without treating it directly, treatment generalization occurred and the male-like voice projection ceased.

Between play sessions in the clinic, the female therapist had brief conversations with her. Early in treatment, Becky overtly stated that she wished she were a boy and that she did not want to deliver a baby when she grew up. She stated, "I look ugly in dresses." Then as therapy progressed, her statement indicated ambivalence toward the new feminine behaviors she was engaging in; for example, playing with cosmetics in the playroom, she said out loud, "I'm getting this stuff off of me, and I ain't kidding, I better not smell like a girl," but then minutes later she asked, "Where's the makeup? You should have gotten the makeup. Doesn't a lady wear makeup?" Later in treatment, when her therapist asked her, "Would you like to be a boy?" she replied, "No, because boys can't have babies."

Becky spontaneously began wearing jewelry and perfume at home. Her mother was encouraged to attend to and to praise Becky's feminine behaviors.

Treatment was terminated after 7 months, and follow-up evaluations indicated durability of the treatment effects of normalizing her gender identity and gender role behaviors.

Goals of Clinical Diagnosis and Subsequent Therapy

The procedures for clinically evaluating and assessing a child or an adolescent presenting with potential precursors to adulthood homosexual tendencies differ depending upon the particular presenting problems.

If the child or adolescent is referred because of cross-gender identity statements, and/or gender non-conformity, and/or inadequate identification and modeling after a same-sex parent figure, and/or an abnormal identification and modeling after the opposite-sex parent figure, the following goals will be involved:

1. Establish the chief complaint in the perception of the child or adolescent, and separately in the eyes of the parent(s) or guardian(s). Evaluate for concurrent psychiatric disorders, particularly depression, suicidal ideation and plans, and overall family, academic, and personal adjustment. Assess whether clinical psychological testing is needed for clarification of differential diagnosis.
2. Evaluate the range and frequency of cross-gender behaviors compared to the range and frequency of same-gender behaviors, recognizing that it is the cluster, ratio, rigidity, and frequency of feminine sex-typed play behaviors and gestures compared to masculine sex-typed behaviors and gestures that is of diagnostic significance in gender non-conformity (Bentler, Rekers, & Rosen, 1979; Rosen, Rekers, & Brigham, 1982).
3. In addition to the goal of assessing for a condition of gender non-conformity, clinically evaluate for the presence of a gender identity disorder of childhood, using DSM-IV diagnostic criteria (American Psychiatric Association, 2000).
4. The overarching clinical goals are to expand the child's gender behavioral repertoire and flexible expression of same-gender play and gestures to be within the range of

normal same-aged same-gendered children, to assure that the child imitates the gender behaviors of an emotionally warm and affectionate same-gendered parent-figure (or parent substitute), and that the child becomes psychologically secure in a gender identity that matches the child's anatomy (Rekers, 1977b; Rekers, & Kilgus, 1995; Rekers, & Mead, 1980; Rosen et al., 1982).

Initial Evaluation and Treatment Planning Sessions

The initial sessions must focus on developing a comprehensive treatment plan based on a thorough diagnostic assessment of the child or adolescent. While preschool children will usually openly display and talk about their cross-gender play and interests, older children are aware of social disapproval and tend to "go underground," such that rapport needs to be built for them to be comfortable dealing with their gender non-conformity with the clinician. For these reasons, the first three sessions for older children and adolescents may be spent in gathering diagnostic information from the parent[s] and building rapport, a therapeutic alliance, and shared treatment goals with the older child or adolescent; thus for them, the first three sessions cannot be predicted with any more precision than this general statement. However, the initial three sessions for preschool and early elementary aged children presenting with potential gender disturbance are fairly predictable as follows:

The first session must be focused on initial separate parent and child interview assessment to differentiate normal variations in child development from deviant gender and/or sexual development. While parents typically spill out their concerns, rapport must be built with the child or adolescent in the first session. Because the presenting complaint of same-sex sexual contact is often found in a child or adolescent who has gender non-conformity or a gender identity disorder, the initial diagnostic interviews of the parent(s) and the child individually, should include inquiry as to the minor's [1] pattern of same-gender and cross-gender behavior, [2] history of indicators of a potential gender identity disorder, [3] history of same-sex sexual contact and opposite-sex sexual contact, and [4] history and current presence of any other DSM-IV disorder. The parent(s) should be told

that the clinician's formal diagnosis and current treatment recommendations will be offered in session three.

The second session will typically involve the return of take-home parent-report inventories to the clinician and extend the clinical assessment to include further interviewing and behavioral observations of the child or adolescent. When indicated, psychological testing will usually occur in this second session.

The third session will involve providing a formal diagnosis or diagnoses, together with treatment recommendations to the parent(s) individually, a conjoint family meeting of the parent(s) with the child or adolescent for the clinician to share recommendations and provide a description of the first steps of therapy to the young person as well. Then the formal individualized treatment begins in this third session, including guidance to the parent(s) and initial therapeutic work with the child or adolescent.

Clinical Assessment and Therapeutic Techniques

Depending on the presenting complaint(s) and initial diagnostic interview findings in the first session, a particular child or adolescent case may require either an assessment of gender behavior and gender identity or an assessment of same-sex sexual behavior and orientation, or both. Then depending on the outcome of the assessment, a particular child or adolescent would then be offered treatment for gender problems, sexual orientation problems, or sexual behavior problems, or some combination of the three. The diagnostic assessment and therapeutic techniques briefly described here are presented in much greater detail in Rekers (1995c), which further cites dozens of specific journal articles that provide even more extensive assessment and clinical treatment research for these child and adolescent problems.

Clinical Assessment Techniques for Evaluating Gender Behavior and Identity

Interviewing the Parents or Caretakers. If there is more than one parent or caretaker, each should be interviewed separately, asking the same questions of each, because cross-gender behavior and cross-gender identity statements are often situation specific or

concealed from one parent but revealed to the other parent. The following questions have been found to assist diagnosis of gender non-conformity and cross-gender identity:

1. What masculine behavior do you observe in your child, and how often does each occur?
2. What feminine behavior do you observe in your child, and how often does each occur?
3. With whom does your child identify? (Follow-up question if necessary: Does your child identify with father, a father figure, a brother, some other male, or with mother, a mother figure, a sister, or some other female?)
4. To what extent does your child interact with boys?
5. What are the ages of each of the boys with whom your child relates?
6. To what extent does your child interact with girls?
7. What are the ages of each of the girls with whom your child relates?
8. To what extent does your child feel comfortable with and identify with his or her sexual anatomy?
9. To what extent does your child understand the future reproductive functions of his or her sexual anatomy?
10. To what extent does your child understand the future reproductive functions of a member of the other sex?
11. What is the history and frequency of each of the following behaviors?
    - Cross-dressing
    - Masculine gestures and mannerisms
    - Feminine gestures and mannerisms
    - Play with girls' toys and activities
    - Play with boys' toys and activities
    - Avoidance of play with peers of the same sex
    - Avoidance of play with members of the opposite sex

- Play with cosmetic items, real or imagined
- Masculine voice inflection
- Feminine voice inflection
- Desire to be called by a name of the other sex
- Sexual behaviors—describe them
- Masturbation with cross-dressing articles—name the cross-dressing articles
- Masturbation with heterosexual pornography
- Masturbation with homosexual pornography

12. Does your child insist on being or pretending to be a member of the other sex?
13. Has your child ever asked for a sex-change operation, and if so, how often?
14. What is your response towards your child's masculine behaviors and activities?
15. What is your response towards your child's feminine behaviors and activities?

Parent Report Inventories for Preadolescent Children. Rekers (1995a, pages 274-275) describes the use of specific parent report measures that have been validated with normal children at various ages, which are useful for diagnostic screening for gender behavior deviance. The *Games Inventory* (Bates & Bentler, 1973) has a composite index for Feminine Play Behavior which Rekers and Morey (1990) found to be correlated significantly with degree of severity of gender disturbance. The *Gender Behavior Inventory* (Bates, Bentler, & Thompson, 1973) has a Feminine Behavior subscale on which Rekers and Morey (1989b) found that gender disturbed boys score significantly above the mean of the standardized group of normal boys. The *Gender Identity Questionnaire* developed by Elizabeth and Green (1984) has been demonstrated to have reasonable psychometric properties (Zucker & Torkos, 1987).

Clinical Diagnostic Interview with the Child or Adolescent. The clinical interview needs to be individualized to the child or adolescent to elicit indicators of cross-gender identification, cross-gender behaviors, and peer relationships in a rather indirect manner. For example, it is helpful to ask the young person to name their friends at school and in their neighborhood, as a means to determine the ratio of male to female names of playmates. Clinicians should ask the child or adolescent to name his or her favorite people, places, activities, and things and ask about the amount of time spent with each. Rekers, Sanders, Strauss, Rasbury, and Morey (1989) published a study of clear sex differences in reported participation in 11 to 18 year old adolescents as a baseline to which an evaluated adolescent can be compare clinically.

Clinical Observation of Sex-Typed Play Behavior in Children. The sex-typed play behavior of children aged 3 to 8 years old can be validly assessed with the behavioral play assessment procedure developed by Rekers (1975) that employs boys' and girls' toys. Rekers and Yates (1976) found that using a standard of 70% cross-gender play to 30% of same-gender play to assess gender deviance will yield rare "false positives," although use of this assessment tool alone may be more vulnerable to instances of "false negatives," particularly among children who are aware of their gender deviance and seek to suppress it in public. See Rekers and Yates (1976) for the list of specific toys and assessment procedures.

Observation of Sex-Typed Gestures and Mannerisms. Although children and adolescents with gender non-conformity and/or a cross-gender identity can learn to conceal their overt cross-gender play behavior (Rekers, 1975) and suppress statements expressing a cross-gender identity in the presence of a clinician and others in their environment, their sex-typed hand and arm gestures and body mannerisms are difficult for them to suppress at will (Rekers, Willis, Yates, Rosen, & Low, 1977). Therefore, systematic behavioral observations of gestures and mannerisms can be especially helpful in diagnosing deviant gender development. Rekers, Lovaas, and Low (1974) observed and operationally defined

expressive effeminate gestures clinically, and subsequently, studies of these same gestures in normal boys and girls aged 4 to 18 years were conducted to provide a normative comparison (Rekers, Amaro-Plotkin, & Low, 1977; Rekers and Rudy, 1978; Rekers, Sanders, & Strauss, 1981). Then in a study of gender-disturbed boys ages 7 to 17, Rekers and Morey (1989c) found that gender disturbed boys have significantly higher frequencies of three gestures: "limp wrist," "hand clasp" (touching the hands together in front of the body), and "hyperextension" (the extreme opposite of "limp wrists" in which the hand[s] move in the direction of the posterior surface of the forearm). For a precise quantification of these three gestures compared to base rates in normal boys and girls at the child or adolescent client's age, these journal articles contain the procedures and normative data. If these three gestures appear at a very high frequency, the clinician observing them has a good indication that gender disturbance is present.

Clinical Psychological Testing and Clinical Ratings. Clinical research indicates that a child's cross-gender responses on several conventional psychological tests are correlated with independent clinicians' diagnoses of gender disturbance (Bentler et al., 1979). Although the results of one test alone should not be completely relied upon, the following tests can be helpful in a battery of assessment methods that includes data collected from the above-described behavioral assessment and diagnostic interview methods: the *Draw-A-Person Test* (Rosen, Rekers, & Morey, 1990; Skilbeck, Bates, & Bentler, 1975; Zucker, Finegan, Doering, & Bradley, 1983) in which gender disturbed children more often draw a figure of the opposite sex first, the *Brown IT Scale for Children* (Rosen et al., 1990), and the *Schneidman Make-a-Picture-Story Test* (Rosen et al., 1990). For adolescents, the *Feminine Gender Identity Scale for Males* (Freund, Langevin, Satteerberg, & Steiner, 1977) helps diagnostically differentiate the conditions of gender identity disorder, transvestism, and homosexuality. Other general clinical psychological tests should be used to rule out other psychological disorders, in that some research indicates that gender disturbance co-exists with other forms of psychopathology (Rekers & Morey, 1989a).

Assessment of Athletic Game Skills in Boys. Gender-problem boys typically develop deficits in athletic game skills due to the loss of practice because of their avoidance and lack of motivation for boys' activities. It is helpful, if parents give permission, to contact a boy's physical education teacher to obtain a report on the level of a boy's athletic game skills relative to his same-aged peers. Developing a level of skills in at least the average range can become a therapeutic goal for a boy diagnosed with a gender problem.

Assessment in the Home Setting. Behavioral checklists for parents to use in a time sampling procedure can be individually designed for a child or adolescent. Based upon the diagnostic interview data collected on occurrence of masculine and feminine behaviors, the checklist would include such behaviors as "play with girls," "play with boys," "play with dolls," "cross-dressing," "taking feminine roles in play," "taking masculine roles in play," and the three diagnostic behavioral gestures mentioned above—"limp wrist," "hand clasp," and "hyperextension" (Rekers & Lovaas, 1974; Rekers, Lovaas, & Low, 1974; Rekers et al., 1977). Parents are asked to observe the child's behavior for 10 minutes at a time, at two or three specified times daily. This becomes a baseline measure against which later treatment effects can be evaluated.

Assessment in the School Setting. If the child's school teacher is aware of gender disturbance, the clinician can also devise a similar behavior checklist for the teacher to complete (Rekers, 1995b; Rekers & Varni, 1977b).

Medical Examination. The majority of children diagnosed with a gender behavior disturbance or gender identity disorder have not been found to have any detectable physical abnormalities in their prenatal history, medical history, physical examination of the external genitals, chromosome analysis, and sex chromatin studies (Rekers, Crandall, Rosen, & Bentler, 1979). However, to rule out hermaphroditism, hormonal abnormalities, or other contributing medical condition, it is good practice to obtain a copy of a recent physical examination by the child or adolescent's physician(s).

Techniques for Treating Cross-Gender Behavior and Gender Identity Disorder

General Management Strategies. Prior to the early 1970's, there was no known therapy to reverse cross-gender identity in children or adolescents, but a series of studies experimentally demonstrated that specific behavior therapy and family therapy techniques can effectively normalize a boy's gender identity disorder and/or pattern of gender non-conformity (Rekers, 1972; 1979; Rekers & Lovaas, 1974; Rekers et al., 1974) and a girl's gender identity disorder (Rekers & Mead, 1979). As a result of extensive programmatic clinical research and decades of clinical experience treating gender identity disorder, several general management strategies have been found effective (Rekers, 1995a):

1. Counsel the same-sex parent to develop a warm, nurturing, and verbally and physically affectionate relationship with the child or adolescent, investing time and positive recreation and interaction with the child, while scrupulously avoiding criticism of him or her. If a same-sex parent is unavailable, recommend that a substitute same-sex adult be found to provide a positive role model—perhaps an extended relative or a mentor from a child service organization. A gender-disturbed boy benefits from an emotionally close father-son relationship or other substitute adult male relationship (Mead & Rekers, 1979; Nicolosi & Nicolosi, 2002; Rekers, 1986; Rekers, Mead, Rosen, & Brigham, 1983; Rekers & Swihart, 1989). In addition, for girls, a healthy relationship with mom, in which mom shares her emotional self and vulnerabilities and builds a mutual relationship with her daughter, provides the most important foundation for healthy gender identity and heterosexuality (Nicolosi & Nicolosi, 2002, chap. 7). Nicolosi & Nicolosi (2002) recommend that fathers provide emotional comfort to their sons, engage in physically aggressive play with their sons, shower with their young sons, and involve their boys in routine errand running and other outings together (p. 89). They quote Dr. Charles Socarides as having said "...anything that parents can do to make their kids feel proud of their identity—as young men, as young women—will help the [treatment] process" (p. 154).

2. Mothers who are over-involved with their sons should be encouraged to "back-off" because Nicolosi and Nicolosi (2002, p. 71-72) report that researchers have found a triadic

family pattern in the family backgrounds of homosexual men in which there is a detached father, an over-involved mother, and a temperamentally sensitive, emotionally attuned boy who fills in for the father in meeting the mother's emotional needs. In addition, they state that fathers should provide love and positive regard for their daughters, but not promote the identification of their daughters with themselves, instead, reflecting their gender differentness with respect and appreciation (p. 156-157).

3. Encourage the parent of a boy to consider the “Big Brother” program, or the parent of a girl to consider the “Big Sister” program in the community to provide the child with an additional appropriate same-sex role model with which to develop a warm, nurturing relationship.

4. Recommend that the parent not over-react to cross-gender behavior whenever possible (Rekers, 1995a), and when it occurs, [a] actively but gently discourage the cross-gender distortions consistently, without rejecting the child (cf., Nicolosi & Nicolosi, 2002, pp. 72, 190), [b] redirect the child to more appropriate gender-related behavior as a substitute activity (Rekers, 1995a), and [c] be open with the child that you (the parent) are gradually replacing the gender-inconsistent collection of toys with gender-appropriate toys (Nicolosi & Nicolosi, 2002, p. 189).

5. Encourage the parent to praise the gender appropriate behavior, and avoid excessive verbal reprimands for cross-gender behavior. Advise parents to provide various rewarding activities to the child or adolescent in response to appropriate gender behavior and gender appropriate gestures or mannerisms.

6. Provide the parent with appropriate sex education information to provide to the child or adolescent. If the parent is reluctant to do so, with the parent’s permission, the clinician should provide sex education information and abstinence education to the child or adolescent.

7. Schedule regular clinical office visits for the child and parent figure[s] to monitor and assess progress in developing more appropriate ratios of gender behavior, and to provide therapeutic assistance.

8. Request that the parent[s] periodically confer with the teachers at school to inquire about the child's or adolescent's peer relationships. Advise the parent[s] not to disclose or label the child as a "gender problem" to school personnel. Have the parent ask the school's personnel whether it would be possible for them to "team up" their child or adolescent with same sex peers as friends.

9. In the case of gender disturbed males, encourage the parent[s] to provide the child or adolescent some type of opportunity for non-threatening and non-punitive training experiences for developing athletic skills. Ideally, this should be done by the father or a father substitute (such as an uncle or grandfather or family friend) or a "Big Brother." According to Nicolosi & Nicolosi (2002), "Poor body image is very common among homosexuals... Indeed, the boy who does not romanticize the strength of other males but endeavors to develop it in himself will be less likely to develop homosexually" (p. 131-132).

10. Parents should encourage the expression of their child's feelings, even when they are negative or blaming, in order to keep their child connected to them (Nicolosi & Nicolosi, 2002, p. 82).

11. Parents should be counseled to accept and love their child unconditionally, while supporting and encouraging their child to consider the possibility of change (Nicolosi & Nicolosi, 2002, p. 133).

12. Adolescents should be strongly encouraged, but not be forced, to pursue or continue in therapy (Nicolosi & Nicolosi, 2002, p. 145).

Specific Behavior Therapy Techniques for Children. Clinical research has successfully developed specific behavior therapy and family therapy techniques for shaping gender appropriate behavior in children. While the specific procedures would too numerous and detailed to summarize in this article, clinicians with a preschool or elementary aged gender-

disturbed girl can refer to the article by Rekers and Mead (1979), and clinicians with a preschool or elementary aged gender-disturbed boy can refer to a number of publications describing specific parent-mediated behavior therapy methods that have been successful in increasing gender-appropriate behavior and extinguishing cross-gender behaviors (Nicolosi & Nicolosi, 2002; Rekers, 1979, 1995a, Rekers & Heinz, 2001; Rekers & Kilgus, 1995; Rekers, Kilgus, & Rosen, 1990; Rekers & Lovaas, 1974; Rekers, Lovaas, & Low, 1974; Rekers, Willis, Yates, Rosen, & Low, 1977; with replications by Zucker, & Bradley, 1995) and behavioral self-control methods that a clinician can therapeutically convey to gender-disturbed boys (Rekers & Varni, 1977a, 1977b). These behavior therapy methods have not resulted in negative effects, such as rigid stereotyping, but instead have been demonstrated to reverse cross-gender behavior patterns and normalize a gender identity that is consistent with the child's anatomy without causing rigid or otherwise harmful sex-role stereotyping (Rosen, Rekers, & Brigham, 1982).

Specific Behavior Therapy Techniques for Gender Identity Disorder in Adolescents. According to the prospective longitudinal research of Zuger (1978, 1984, 1988) described above and the extensive clinical experience of Nicolosi and Nicolosi (2002), "Homosexually oriented adolescents classified as 'feminine' are at the highest risk for suicide attempts, drug abuse, prostitution, arrest, and by implication, the deadly health problems associated with unprotected anal sex" (p. 120). Thus, intervention is of great importance for these adolescents. Barlow, Reynolds, and Agras (1973) developed specific and detailed behavioral interventions that successfully reversed a homosexual arousal pattern and a cross-gender identity in a 17-year-old boy, which included a classical conditioning procedure to increase heterosexual arousal, and covert sensitization techniques to reduce homosexual arousal.

Psycho-educational Intervention For Abstinence from High Risk Same-Sex Sexual Behavior. Early in therapy, it is urgent to therapeutically address the need for the modification of any high-risk homosexual behavior that is life threatening. In part, this is a

psycho-educational task of providing the child or adolescent with the scientific facts of sexually-transmitted diseases, including HIV/AIDS, and providing abstinence sex education with a solid rationale for postponing sexual activity (see Rekers & Hohn, 1998; Schumm & Rekers, 1984). Bennett (1988) and Lundy and Rekers (1995b) have helpfully offered guidelines for abstinence education that include the following:

1. Help the child or adolescent develop clear standards of right and wrong, presenting sex education within a moral context.
2. Encourage taking responsibility for the welfare of others in personal relationships.
3. Help the child or adolescent acquire social skills to resist social pressures to engage in dangerous activities by helping them identify negative pressures and ways to cope with those pressures. Identify high-risk situations for sexual involvement to avoid, such as a gay bar, a house empty of adults, or the back seat of a car.
4. Instruct the child or adolescent about AIDS and reasons for abstinence, restraint, and responsibility.

Relevant Research and Treatment Outcomes

While describing assessment and therapy procedures above, we have already cited representative articles that report clinical research studies of treatment outcome. The above cited treatment studies by Rekers and colleagues report intra-subject replication designs to establish the efficacy of the treatment techniques summarized above.

In addition, successful long-term effects of treatment for childhood gender disturbances have been reported by Rekers, Kilgus, and Rosen (1990) and by Zucker and Bradley (1995). When the parents cooperated with completing a course of weekly therapy sessions, behavioral therapies for childhood cross-gender identity have been experimentally demonstrated to reverse female identities in boys to a normal male identification as assessed by an independent clinical psychologist in a follow-up occurring a mean of 4 years and 3 months after the termination of treatment (Rekers et al., 1990). The younger children responded more rapidly than older children.

For treating gender identity disorder and homosexual arousal in an adolescent, the study cited above by Barlow and colleagues (1973) reported a detailed intra-subject replication design demonstrating therapeutic effectiveness in a single case, and Barlow similarly treated other cases with similar outcomes of successfully normalizing gender identity and eliminating homosexual arousal while substituting heterosexual arousal.

Concluding Comment

Limitations of page length have necessitated brief overviews of specific assessment and treatment techniques, and so the clinician providing services to a child or adolescent with the above discussed clinical issues should consult the specific references cited for more specific guidance in implementing the clinical assessment and treatment techniques that have been demonstrated to be effective with other clients.

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