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Gender Identity Disorder and Courtship Disorder

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A hypothetical connection between gender identity disorder and courtship disorder was investigated in 274 heterosexual male patients of the following types: nontransvestic fetishists for female attire; transvestic fetishists; patients with gender identity disorder of adolescence and adulthood, nontranssexual type; and transsexuals. Of these patients, 53 had also demonstrated one or more of the putative expressions of courtship disorder. The proportion each of these types contributed to this group of 53 patients with a courtship disorder was compared with the same type's proportional contribution to the group of 221 gender identity patients without a courtship disorder. The transvestic fetishists contributed a significantly larger percentage and the transsexuals a significantly smaller percentage of individuals to the group with a courtship disorder than to that without a courtship disorder. Theoretical implications of this asymmetry are discussed.

KEY WORDS: transvestism; courtship disorder; paraphilia.

INTRODUCTION

The revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R; American Psychiatric Association, 1987) lists the following paraphilias: (1) Exhibitionism, (2) Fetishism, (3) Frotteurism, (4) Pedophilia, (5) Sexual Masochism, (6) Sexual Sadism, (7) Transvestic Fetishism, (8) Voyeurism, and a residual category, "Paraphilia Not Otherwise Specified." It may be said in advance that the present report uses the term "disorder" only with constellations of phenomena that DSM-III-R also calls disorders and that can be roughly characterized as arousing therapeutic concern (Freund, 1977). The term "normal," where used in the present

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report, is also only a rough characterization for a pattern that does not demand therapeutic concern.

In an earlier study, a simple reference system was proposed for the description of paraphilic patterns (Freund and Kolarsky, 1965), and was intended to represent the typical succession of human erotic or sexual interaction, which it depicts as comprising four phases. These are (i) location and first appraisal of a suitable partner; (ii) pretactile interaction, consisting mainly of looking, smiling, posturing, and talking to a prospective partner; (iii) tactile interaction; (iv) effecting genital union.

A number of paraphilic patterns mentioned in DSM-III-R appear to deviate in basically the same way from the typical succession of sexual interaction in that one or another of the four phases of this progression is extremely intensified and distorted, such that it may then be seen as a caricature of the normal. In such cases, the remaining phases are either entirely omitted or are retained only in a vestigial way. These paraphilic patterns appear to be out of phase, rigidified pathological shortcuts of the typical succession.

When compared with the typical succession, (i) the voyeuristic behavior pattern can be seen as an exaggeration and distortion of the first phase of normal sexual interaction — location and first appraisal of a potential erotic partner, with the other phases being only vestigially present or not at all discernable; (ii) the exhibitionistic pattern can be seen analogously as a distortion of the phase of normal pretactile interaction; (iii) the toucheuristic–frotteuristic pattern can be seen as a distortion of the phase of normal tactile interaction, and (iv) the preferential rapist's erotically preferred pattern can be seen as an erotic preference for genital union (or fellatio) with little or no preceding erotic interaction. The degree of violence employed by preferential rapists is usually near the minimum necessary to subdue the target person (according to the offender's ability to judge this minimum).

There is a further group of paraphilic patterns that are most likely related to the considered group of paraphilias. These are obscene telephone calling, designated by Hirschfeld (1921, according to Haire, 1966, p. 602) as a verbal variant of exhibitionism, and a variant of voyeurism usually called triolism or "Candaulism" (after a Greek historic figure). The latter is a man's erotic preference for viewing (or listening to) his spouse interacting sexually with another man or watching her disrobing where other men also might observe her. In such cases, the patient's own spouse appears to be substituting for a strange woman by depicting her as belonging to another man. It is also likely that an erotic preference for prostitutes as compared to more familiar sexual partners, and a chronic inability of an otherwise well-organized man to sustain an

erotic interest in a partner for the length of time as is usual for the region and social stratum to which the man belongs may also be a variant of courtship disorder. In the following, these patterns are being referred to as "related paraphilias."

Most of these paraphilic patterns are also connected with anomalies of target choice. At present, three such anomalies have been identified: (i) an almost obligatory preference for strangers, observed in regard to exhibitionism by Mohr *et al.* (1964), and demonstrated in an earlier study (Freund and Watson, 1990) to be most likely present in all of the paraphilic patterns of the discussed group; (ii) a loosening of the age limits of target persons of paraphilic activities to include physically mature persons as well as children (Freund and Blanchard, 1986); and (iii) fetishism for female attire or transvestism. A heterosexual patient with a gender identity disorder (GID) is at least partly his own erotic target person (Blanchard, 1989) and fetishism is also the result of a target breakup or "loosening." Relatively frequent co-occurrence of transvestism with exhibitionism has been observed by Lang *et al.* (1987) and Rooth (1973), and its co-occurrence with other putative expressions of courtship disorder was also demonstrated (Freund and Watson, 1990).

The Freund and Watson (1990) study also investigated whether it is warranted to generalize a clinically observed difference between two subgroups of heterosexual male patients with nontransvestic fetishism for female attire or with GID. One of these two subgroups had also demonstrated at least one of the putative expressions of courtship disorder, the other had not. The clinical observation suggested that a substantial difference may exist between the two subgroups with regard to the percentage each of the different types of GID patients (the nontransvestic fetishists for female attire included) contributes to the subgroup with a courtship disorder as compared with the percentage the same type contributes to the group of patients who do not demonstrate any symptoms of a courtship disorder. In agreement with the earlier clinical observation, the result of this study suggested that the set of patients who also had a courtship disorder were less likely to be gender dysphoric than those who did not have a courtship disorder (although the statistical differentiation only "closely approached" significance). The term "gender dysphoria" was coined by Fisk (1973) to designate a person's profound unhappiness with the anatomic gender of her or his body.

The types of GID and the nontransvestic fetishists for female attire were diagnosed in that study only in a rough clinical way, according to DSM-III-R, without any detailed analysis. The result of that preliminary differentiation, however, suggested that a repeat of the comparison, after differentiating these types in a more rigorous way, may be worthwhile.

This was done in a subsequent study (Freund *et al.,* 1991). This study reexamined the rationale of DSM-III-R for dividing the spectrum of clinical pictures of heterosexual GID in males into the three types: transvestic fetishism; (heterosexual) gender identity disorder of adolescence and adulthood, nontranssexual type (GIDAANT); and (heterosexual) transsexualism.

In the Freund *et al.* (1991) study, the differential diagnosis between the types in question was made by means of a set of three hierarchically ordered questions in a questionnaire routinely used in our department — the Erotic Preferences Examination Scheme (EPES, unpublished). This diagnostic process is described in Procedures below, and in more detail in the earlier paper. The validity of this differentiation into types was tested by means of a factor analysis of a large number of relevant items in the EPES.

This analysis yielded three sufficiently strong factors on the basis of which three miniscales were developed (see Freund *et al.,* 1991). They measure degrees of fetishism, gender dysphoria, and "pseudo"-androphilia. The latter term denotes a heterosexual GID patient's feeling or pretending to feel to erotically prefer men to women, or a feeling of being attracted to males and females equally. Ellis (1928, p. 101) used the term "secondary androphilia," and Blanchard (1985, p. 257) wrote about "secondary erotic interest in males."[3] The gender dysphoria factor scale differentiated significantly between all four conditions of nontransvestic fetishism for female attire, transvestic fetishism, GIDAANT, and heterosexual transsexualism. The validation of the differentiation of these clinical types made possible using this differential diagnostic procedure in the present study.

METHOD

A total of 274 patients in our data bank demonstrating the pattern of one of the types in question were included in the study. Of these individuals, 53 had also demonstrated at least one of the putative expressions of courtship disorder. An additional 9 individuals who had demonstrated a GID and had also raped (or had attempted rape), but did not also dem-

[3]The term "pseudo-homosexuality" is used here as a denotation of the claim of the more gender dysphoric heterosexual GID patients to develop an androphilic erotic preference. We are inclined to see this as a conscious demonstration by these patients of how very feminine they are. However, one could also imagine that a real secondary androphilia may develop from these patients' erotic preference of the female role in heterosexual intercourse. This question has been investigated for some time by means of the phallometric test (Freund, 1961, 1963; Freund and Watson, 1990).

Table I. Group Characteristics

	Non-transvestic fetishists and gender identity disorder patients	
	Without courtship disorder	With courtship disorder
n	221	53
Mean age ($\bar{x}$ ± SD)[a]	33.20 ± 10.01	29.04 ± 9.48
Median education[a,b]	12	12

[a] $p < .01$.
[b] At least 12 grades education, but no more.

onstrate behavior typical of one of the core patterns of courtship disorder (voyeurism, exhibitionism, toucheurism–frotteurism, or any of the "related paraphilias") were excluded. The reason for this exclusion was that rape-proneness often appears not to be indicative of the preferential rape pattern (Freund and Watson, 1990). An additional 8 heterosexual patients who had demonstrated a paraphilic pattern of any of the types in question as well as an expression of courtship disorder were excluded from the study —3 were pedophiles (1 of these a sadistic murderer) and for 5 patients the answers to one or more of the relevant questionnaire items were not available. Table I demonstrates mean age and median educational achievement for each of the subject groups. Virtually all participants were Caucasian. The table also includes the results of the comparison of age by *t* test, and education by Mann-Whitney test.

Procedures

The senior author interviewed each of these patients and completed Section 1 of the EPES, which covers all the paraphilic patterns investigated in the present study. Each pattern is covered in two ways: (i) by an entry for number of target persons and observed paraphilic activities in charges or accusations (which may or may not have ensued in charges), and (ii) by an entry indicating whether the patient admitted to having practiced this paraphilic behavior at least once. Each of these paraphilic patterns was treated as a dichotomous variable indicating its presence or absence. It did not make any difference whether the information was obtained from documents on charges or accusations or from the interviewed individual's own admission. As mentioned above, the differential diagnosis between the types in question (nontransvestic fetishism for female attire, transvestic fetishism, heterosexual GIDAANT, and heterosexual transsexualism) in the current study was accomplished, as in the Freund *et al.* (1991) study. The

putative expressions of courtship disorder are defined by DSM-III-R as separate, clinically discernible paraphilic patterns and were diagnosed in the same way by means of the EPES as the GID.

For each type of GID and for the nontransvestic fetishists for female attire, the proportion the same type constituted among the patients who also demonstrated any of the putative expressions of courtship disorder ($n = 53$) was then compared with the proportion the same type constituted among the patients of the types in question who (to our knowledge) had never demonstrated any putative expression of courtship disorder ($n = 221$). The comparisons were by t tests of proportions, with correction for small samples.

RESULTS

The transvestic fetishists constituted a significantly larger percentage $t(272) = 3.416, p < 0.01$, and the (heterosexual) transsexuals a significantly smaller percentage $t(272) = 3.597, p < 0.001$, among the GID patients (nontransvestic fetishists for female attire included), who also demonstrated any of the putative expressions of courtship disorder, than among those GID patients without courtship disorder (Fig. 1). There were no other significant differences.

DISCUSSION

This study was undertaken to investigate an earlier clinical observation that in heterosexual gender GID patients who also demonstrate any of the expressions of a courtship disorder (voyeurism, exhibitionism, toucheurism–frotteurism, any of the "related paraphilias," and the preferential rape pattern) the distribution of the various types of GID (transvestic fetishism; gender identity disorder of adolescence and adulthood, nontranssexual type; transsexualism) differs from the distribution of these types in GID patients who do not demonstrate any of the expressions of a courtship disorder. Those individuals who also demonstrated an expression of a courtship disorder appeared to be substantially less gender dysphoric. An earlier crude preliminary test of this clinical observation resulted only in a nearly significant validation (Freund and Watson, 1990).

The current study is the second part of a repeat of this test and is more detailed and rigorous than the earlier study. The first part of this repeat analysis (Freund *et al.*, 1991) is a test of the soundness of the still only clinical differentiation between the various types of GID by DSM-III-R (with the inclusion of nontransvestic fetishism for female attire). The result supports the differentiation into the types chosen by DSM-III-R.

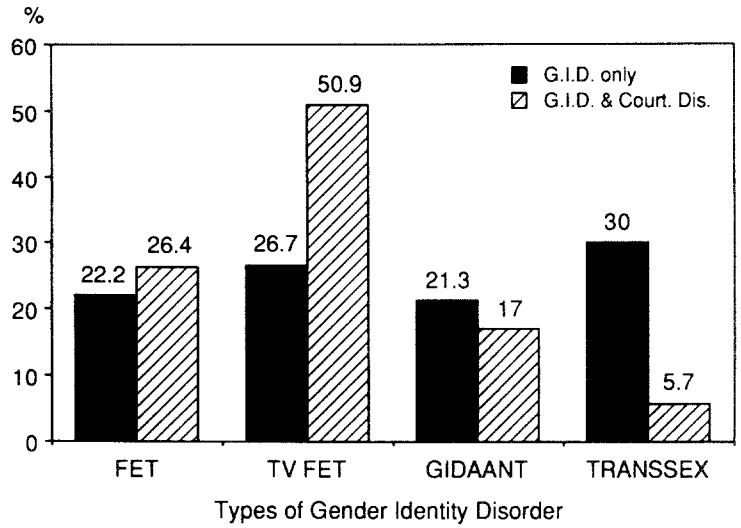

Fig. 1. Illustrates the proportions each of the four types assessed (FET = nontransvestic fetishism for female attire; TV FET = transvestic fetishism; GIDAANT = [heterosexual] gender identity disorder of adolescence and adulthood, nontranssexual type; TRANSSEX = heterosexual transsexualism) represented of the total number of all subjects with a gender identity disorder without an attendant courtship disorder (GID only, n = 221) and of the total number of individuals who also exhibited one or more of the putative expressions of courtship disorder (GID & Court. Dis., n = 53).

The current part of this reinvestigation compares a group of patients of the types in question who demonstrated an expression of courtship disorder (n = 53) with a group of such patients (n = 221) who had not demonstrated an expression of a courtship disorder. The results demonstrate that transvestic fetishists constituted a significantly larger and transsexuals a significantly smaller percentage of the group with a courtship disorder than of the group without a courtship disorder.

The comparisons were carried out for each GID type separately. Therefore, it appears unlikely that the asymmetry of the distribution of types found in the present study could be an artifact due to the ample availability of transsexuals to the department in which the authors are working. If the found asymmetry is genuine one may conjecture that, in contrast to GID patients who do not have a courtship disorder, a majority of GID patients who have a courtship disorder never develop into transsexuals. It appears also possible that the demonstrated difference may be an indication of the existence of two partly different etiologies of GID

(one developing, the other not developing into transsexualism). It is also tempting to hypothesize in this context that the group of patients with gender identity disorder of adolescence and adulthood, nontranssexual type may be a mixture of these (at least) two kinds of GID. A suitable model for such partial etiological differences appears to be the various forms of classical and partial testosterone insensitivity syndrome (Imperato-McGinley *et al.,* 1991; Marcelli *et al.,* 1991; Prochazka and Leiter, 1991). This perspective may constitute an advantageous hypothetical orientation for further research.

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