Twitter Thread by aNonnaMiss



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It's often claimed that "The Concept of Autogynephilia and the Typology of Male Gender Dysphoria" by @BlanchardPhD has been debunked.

I thought it would be interesting to see, at a basic level, how the concept and typology compares to the DSM-5.

A. The definition of AGP.

antidepressant discontinuation syndrome A set of symptoms that can occur after abrupt cessation, or marked reduction in dose, of an antidepressant medication that had been taken continuously for at least 1 month.

anxiety The apprehensive anticipation of future danger or misfortune accompanied by a feeling of worry, distress, and/or somatic symptoms of tension. The focus of anticipated danger may be internal or external.

anxiousness Feelings of nervousness or tenseness in reaction to diverse situations; frequent worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful and apprehensive about uncertainty; expecting the worst to happen. Anxiousness is a facet of the broad personality trait domain NEGATIVE AFFECTIVITY.

arousal The physiological and psychological state of being awake or reactive to stimuli.

asociality A reduced initiative for interacting with other people.

attention The ability to focus in a sustained manner on a particular stimulus or activity. A disturbance in attention may be manifested by easy DISTRACTIBILITY or difficulty in finishing tasks or in concentrating on work.

attention seeking Engaging in behavior designed to attract notice and to make oneself the focus of others' attention and admiration. Attention seeking is a facet of the broad personality trait domain ANTAGONISM.

A **autogynephilia** Sexual arousal of a natal male associated with the idea or image of being a woman.

avoidance The act of keeping away from stress-related circumstances; a tendency to circumvent cues, activities, and situations that remind the individual of a stressful event experienced.

avolition An inability to initiate and persist in goal-directed activities. When severe enough to be considered pathological, avolition is pervasive and prevents the person from completing many different types of activities (e.g., work, intellectual pursuits, self-care).

bereavement The state of having lost through death someone with whom one has had a close relationship. This state includes a range of grief and mourning responses.

biological rhythms See CIRCADIAN RHYTHMS.

callousness Lack of concern for the feelings or problems of others; lack of guilt or remorse about the negative or harmful effects of one's actions on others. Callousness is a facet of the broad personality trait domain ANTAGONISM.

catalepsy Passive induction of a posture held against gravity. Compare with WAXY FLEXIBILITY.

cataplexy Episodes of sudden bilateral loss of muscle tone resulting in the individual collapsing, often occurring in association with intense emotions such as laughter, anger, fear, or surprise.

circadian rhythms Cyclical variations in physiological and biochemical function, level of sleep-wake activity, and emotional state. Circadian rhythms have a cycle of about 24 hours, *ultradian* rhythms have a cycle that is shorter than 1 day, and *infradian* rhythms have a cycle that may last weeks or months.

cognitive and perceptual dysregulation Odd or unusual thought processes and experiences, including DEPERSONALIZATION, DEREALIZATION, and DISSOCIATION; mixed sleep-wake state experiences; and thought-control experiences. Cognitive and perceptual dysregulation is a facet of the broad personality trait domain PSYCHOTICISM.

coma State of complete loss of consciousness.

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B. Transvestism is often accompanied by AGP.

C. The presence of AGP in transvestism increases the likelihood of [developing] Gender Dysphoria.

Specifiers

C

The presence of fetishism decreases the likelihood of gender dysphoria in men with transvestic disorder. The presence of autogynephilia increases the likelihood of gender dysphoria in men with transvestic disorder.

Diagnostic Features

The diagnosis of transvestic disorder does not apply to all individuals who dress as the opposite sex, even those who do so habitually. It applies to individuals whose cross-dressing or thoughts of cross-dressing are always or often accompanied by sexual excitement (Criterion A) and who are emotionally distressed by this pattern or feel it impairs social or interpersonal functioning (Criterion B). The cross-dressing may involve only one or two articles of clothing (e.g., for men, it may pertain only to women's undergarments), or it may involve dressing completely in the inner and outer garments of the other sex and (in men) may include the use of women's wigs and make-up. Transvestic disorder is nearly exclusively reported in males. Sexual arousal, in its most obvious form of penile erection, may co-occur with cross-dressing in various ways. In younger males, cross-dressing often leads to masturbation, following which any female clothing is removed. Older males often learn to avoid masturbating or doing anything to stimulate the penis so that the avoidance of ejaculation allows them to prolong their cross-dressing session. Males with female partners sometimes complete a cross-dressing session by having intercourse with their partners, and some have difficulty maintaining a sufficient erection for intercourse without cross-dressing (or private fantasies of cross-dressing).

Clinical assessment of distress or impairment, like clinical assessment of transvestic sexual arousal, is usually dependent on the individual's self-report. The pattern of behavior "purging and acquisition" often signifies the presence of distress in individuals with transvestic disorder. During this behavioral pattern, an individual (usually a man) who has spent a great deal of money on women's clothes and other apparel (e.g., shoes, wigs) discards the items (i.e., purges them) in an effort to overcome urges to cross-dress, and then begins acquiring a woman's wardrobe all over again.

Associated Features Supporting Diagnosis

B

Transvestic disorder in men is often accompanied by *autogynephilia* (i.e., a male's paraphilic tendency to be sexually aroused by the thought or image of himself as a woman). Autogynephilic fantasies and behaviors may focus on the idea of exhibiting female physiological functions (e.g., lactation, menstruation), engaging in stereotypically feminine behavior (e.g., knitting), or possessing female anatomy (e.g., breasts).

Prevaience

The prevalence of transvestic disorder is unknown. Transvestic disorder is rare in males and extremely rare in females. Fewer than 3% of males report having ever been sexually aroused by dressing in women's attire. The percentage of individuals who have cross-dressed with sexual arousal more than once or a few times in their lifetimes would be even lower. The majority of males with transvestic disorder identify as heterosexual, although some individuals have occasional sexual interaction with other males, especially when they are cross-dressed.

Development and Course

In males, the first signs of transvestic disorder may begin in childhood, in the form of strong fascination with a particular item of women's attire. Prior to puberty, cross-dressing produces generalized feelings of pleasurable excitement. With the arrival of puberty, dressing in women's clothes begins to elicit penile erection and, in some cases, leads di-

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D. Gender Dysphoria (GD) in natal males is categorized as either early-onset or late-onset.

crete, behavioral manner than those for adolescents and adults. Many of the core criteria draw on well-documented behavioral gender differences between typically developing boys and girls. Young children are less likely than older children, adolescents, and adults to express extreme and persistent anatomic dysphoria. In adolescents and adults, incongruence between experienced gender and somatic sex is a central feature of the diagnosis. Factors related to distress and impairment also vary with age. A very young child may show signs of distress (e.g., intense crying) only when parents tell the child that he or she is "really" not a member of the other gender but only "desires" to be. Distress may not be manifest in social environments supportive of the child's desire to live in the role of the other gender and may emerge only if the desire is interfered with. In adolescents and adults, distress may manifest because of strong incongruence between experienced gender and somatic sex. Such distress may, however, be mitigated by supportive environments and knowledge that biomedical treatments exist to reduce incongruence. Impairment (e.g., school refusal, development of depression, anxiety, and substance abuse) may be a consequence of gender dysphoria.

Gender dysphoria without a disorder of sex development. For clinic-referred children, onset of cross-gender behaviors is usually between ages 2 and 4 years. This corresponds to the developmental time period in which most typically developing children begin expressing gendered behaviors and interests. For some preschool-age children, both pervasive cross-gender behaviors and the expressed desire to be the other gender may be present, or, more rarely, labeling oneself as a member of the other gender may occur. In some cases, the expressed desire to be the other gender appears later, usually at entry into elementary school. A small minority of children express discomfort with their sexual anatomy or will state the desire to have a sexual anatomy corresponding to the experienced gender ("anatomic dysphoria"). Expressions of anatomic dysphoria become more common as children with gender dysphoria approach and anticipate puberty.

Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary. In natal males, persistence has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%. Persistence of gender dysphoria is modestly correlated with dimensional measures of severity ascertained at the time of a childhood baseline assessment. In one sample of natal males, lower socioeconomic background was also modestly correlated with persistence. It is unclear if particular therapeutic approaches to gender dysphoria in children are related to rates of long-term persistence. Extant follow-up samples consisted of children receiving no formal therapeutic intervention or receiving therapeutic interventions of various types, ranging from active efforts to reduce gender dysphoria to a more neutral, "watchful waiting" approach. It is unclear if children "encouraged" or supported to live socially in the desired gender will show higher rates of persistence, since such children have not yet been followed longitudinally in a systematic manner. For both natal male and female children showing persistence, almost all are sexually attracted to individuals of their natal sex. For natal male children whose gender dysphoria does not persist, the majority are *androphilic* (sexually attracted to males) and often self-identify as gay or homosexual (ranging from 63% to 100%). In natal female children whose gender dysphoria does not persist, the percentage who are *gynephilic* (sexually attracted to females) and self-identify as lesbian is lower (ranging from 32% to 50%).

In both adolescent and adult natal males, there are two broad trajectories for development of gender dysphoria: early onset and late onset. *Early-onset gender dysphoria* starts in childhood and continues into adolescence and adulthood; or, there is an intermittent period in which the gender dysphoria desists and these individuals self-identify as gay or homosexual, followed by recurrence of gender dysphoria. *Late-onset gender dysphoria* occurs around puberty or much later in life. Some of these individuals report having had a desire to be of the other gender in childhood that was not expressed verbally to others. Others do not recall any signs of childhood gender dysphoria. For adolescent males with late-onset gender dysphoria, parents often report surprise because they did not see signs of gender

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E. Natal males with early-onset GD are almost always androphilic. The majority of natal males with late-onset GD are gynephilic; additionally, they frequently [have histories of] engaging in transvestic behavior with sexual excitement.

dysphoria during childhood. Expressions of anatomic dysphoria are more common and salient in adolescents and adults once secondary sex characteristics have developed.

E Adolescent and adult natal males with early-onset gender dysphoria are almost always sexually attracted to men (androphilic). Adolescents and adults with late-onset gender dysphoria frequently engage in transvestic behavior with sexual excitement. The majority of these individuals are gynephilic or sexually attracted to other posttransition natal males with late-onset gender dysphoria. A substantial percentage of adult males with late-onset gender dysphoria cohabit with or are married to natal females. After gender transition, many self-identify as lesbian. Among adult natal males with gender dysphoria, the early-onset group seeks out clinical care for hormone treatment and reassignment surgery at an earlier age than does the late-onset group. The late-onset group may have more fluctuations in the degree of gender dysphoria and be more ambivalent about and less likely satisfied after gender reassignment surgery.

In both adolescent and adult natal females, the most common course is the early-onset form of gender dysphoria. The late-onset form is much less common in natal females compared with natal males. As in natal males with gender dysphoria, there may have been a period in which the gender dysphoria desisted and these individuals self-identified as lesbian; however, with recurrence of gender dysphoria, clinical consultation is sought, often with the desire for hormone treatment and reassignment surgery. Parents of natal adolescent females with the late-onset form also report surprise, as no signs of childhood gender dysphoria were evident. Expressions of anatomic dysphoria are much more common and salient in adolescents and adults than in children.

Adolescent and adult natal females with early-onset gender dysphoria are almost always gynephilic. Adolescents and adults with the late-onset form of gender dysphoria are usually androphilic and after gender transition self-identify as gay men. Natal females with the late-onset form do not have co-occurring transvestic behavior with sexual excitement.

Gender dysphoria in association with a disorder of sex development. Most individuals with a disorder of sex development who develop gender dysphoria have already come to medical attention at an early age. For many, starting at birth, issues of gender assignment were raised by physicians and parents. Moreover, as infertility is quite common for this group, physicians are more willing to perform cross-sex hormone treatments and genital surgery before adulthood.

Disorders of sex development in general are frequently associated with gender-atypical behavior starting in early childhood. However, in the majority of cases, this does not lead to gender dysphoria. As individuals with a disorder of sex development become aware of their medical history and condition, many experience uncertainty about their gender, as opposed to developing a firm conviction that they are another gender. However, most do not progress to gender transition. Gender dysphoria and gender transition may vary considerably as a function of a disorder of sex development, its severity, and assigned gender.

Risk and Prognostic Factors

Temperamental. For individuals with gender dysphoria without a disorder of sex development, atypical gender behavior among individuals with early-onset gender dysphoria develops in early preschool age, and it is possible that a high degree of atypicality makes the development of gender dysphoria and its persistence into adolescence and adulthood more likely.

Environmental. Among individuals with gender dysphoria without a disorder of sex development, males with gender dysphoria (in both childhood and adolescence) more commonly have older brothers than do males without the condition. Additional predisposing

F. In many cases of natal males with late-onset GD, transvestic behavior with sexual excitement is a precursor to their GD.

ment or pressure to dress in attire associated with their assigned sex. Also in adolescents and adults, preoccupation with cross-gender wishes often interferes with daily activities. Relationship difficulties, including sexual relationship problems, are common, and functioning at school or at work may be impaired. Gender dysphoria, along with atypical gender expression, is associated with high levels of stigmatization, discrimination, and victimization, leading to negative self-concept, increased rates of mental disorder comorbidity, school dropout, and economic marginalization, including unemployment, with attendant social and mental health risks, especially in individuals from resource-poor family backgrounds. In addition, these individuals' access to health services and mental health services may be impeded by structural barriers, such as institutional discomfort or inexperience in working with this patient population.

Differential Diagnosis

Nonconformity to gender roles. Gender dysphoria should be distinguished from simple nonconformity to stereotypical gender role behavior by the strong desire to be of another gender than the assigned one and by the extent and pervasiveness of gender-variant activities and interests. The diagnosis is not meant to merely describe nonconformity to stereotypical gender role behavior (e.g., "tomboyism" in girls, "girly-boy" behavior in boys, occasional cross-dressing in adult men). Given the increased openness of atypical gender expressions by individuals across the entire range of the transgender spectrum, it is important that the clinical diagnosis be limited to those individuals whose distress and impairment meet the specified criteria.

Transvestic disorder. Transvestic disorder occurs in heterosexual (or bisexual) adolescent and adult males (rarely in females) for whom cross-dressing behavior generates sexual excitement and causes distress and/or impairment without drawing their primary gender into question. It is occasionally accompanied by gender dysphoria. An individual with transvestic disorder who also has clinically significant gender dysphoria can be given both diagnoses. In many cases of late-onset gender dysphoria in gynephilic natal males, transvestic behavior with sexual excitement is a precursor.

Body dysmorphic disorder. An individual with body dysmorphic disorder focuses on the alteration or removal of a specific body part because it is perceived as abnormally formed, not because it represents a repudiated assigned gender. When an individual's presentation meets criteria for both gender dysphoria and body dysmorphic disorder, both diagnoses can be given. Individuals wishing to have a healthy limb amputated (termed by some *body integrity identity disorder*) because it makes them feel more "complete" usually do not wish to change gender, but rather desire to live as an amputee or a disabled person.

Schizophrenia and other psychotic disorders. In schizophrenia, there may rarely be delusions of belonging to some other gender. In the absence of psychotic symptoms, insistence by an individual with gender dysphoria that he or she is of some other gender is not considered a delusion. Schizophrenia (or other psychotic disorders) and gender dysphoria may co-occur.

Other clinical presentations. Some individuals with an emasculinization desire who develop an alternative, nonmale/nonfemale gender identity do have a presentation that meets criteria for gender dysphoria. However, some males seek castration and/or penectomy for aesthetic reasons or to remove psychological effects of androgens without changing male identity; in these cases, the criteria for gender dysphoria are not met.

Comorbidity

Clinically referred children with gender dysphoria show elevated levels of emotional and behavioral problems—most commonly, anxiety, disruptive and impulse-control, and de-

Observation 1:
There appears to be a strong correlation between the “early-onset GD” group in the DSM-5 and the “homosexual transsexual” (HSTS) group in the Blanchard typology.

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Observation 2:
There appears to be a strong correlation between the “late-onset GD” group in the DSM-5 and the “nonhomosexual transsexual” (autogynephilic/AGP) group in the Blanchard typology.

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Observation 3:
The DSM-5 categorizes its GD groups based on age of onset, while the Blanchard typology categorizes its groups based on sexual orientation.

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Although this creates room for incongruence between the DSM-5 groups and the Blanchard typology groups, it also demonstrates a strong resemblance, given that the DSM-5 indicates such a strong relationship between age of GD onset and sexual orientation.

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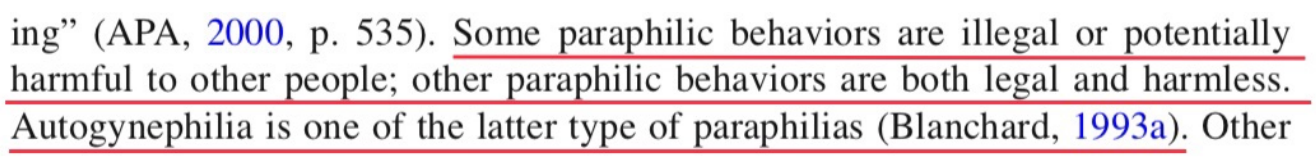
Observation 4:
The DSM-5 draws a clear link between transvestic AGP and the late-onset GD group.

The other subtypes of AGP (anatomic, behavioral and physiologic) aren’t really covered, but it seems plausible that they are similarly linked to the late-onset GD group.

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Summary:
There is a strong resemblance between the DSM-5 and the Blanchard typology. One would not expect to see such a strong resemblance if the Blanchard typology had truly been debunked.

On a final note:


ing” (APA, 2000, p. 535). Some paraphilic behaviors are illegal or potentially harmful to other people; other paraphilic behaviors are both legal and harmless. Autogynephilia is one of the latter type of paraphilias (Blanchard, 1993a). Other