

Can Cultural Beliefs Cause a Gender Identity Disorder?

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ABSTRACT. Gender identity disorder (GID) is a relatively rare disorder with an unclear etiology. This case report involves a boy from Thailand who was thought by his parents at birth, on the basis of a birthmark, to be the reincarnation of his maternal grandmother. He subsequently demonstrated cross-gender behavior. A link between his parents' cultural beliefs and the boy's cross-gender behavior is explored. Implications for the causes of other cases of GID are explored, and in particular, the question of whether parental expectations, as exemplified by these parents' cultural beliefs, can be a contributor to the formation of GID is considered. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>> © 2001 by The Haworth Press, Inc. All rights reserved.]

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INTRODUCTION

In cultures with a belief in reincarnation, children are sometimes identified by their families as being the rebirth of a deceased individual such as a family member, a family friend, or, at times, a stranger (Stevenson, 1987). This identification is usually made on the basis of physical features of the child, statements the child makes about a previous life, or, at times, dreams that a parent or family member has had. Some families make marks on the body of a deceased individual in the hope that when that person is reborn, he or she will have a birthmark at the site where the deceased person was marked (Stevenson, 1997). This practice has been termed "experimental birthmarks" by Stevenson (1997), and he stated that it occurs in several Asian countries. Other authors have also described the practice (Parry, 1932; Mi Mi Khaing, 1962), including the Dalai Lama (1962), who reported that the body of his deceased brother was marked with a smear of butter before another brother was born with a pale birthmark in the same location. In such situations, the child is usually identified at birth by its parents as the deceased family member reborn, but how this belief may affect the subsequent development of the child is unclear.

The following case report describes a boy, thought on the basis of an experimental birthmark to be his grandmother reborn, who subsequently demonstrated a gender identity disorder.

Gender identity disorder (GID) is a disorder in which a child demonstrates behaviors that indicate cross-gender identification and persistent discomfort with his or her sex or gender role. While it has been the subject of considerable study, its etiology is still largely undetermined. Current thinking focuses on a number of factors, with the idea being that "GID in boys does not occur unless an unlikely number of biopsychodevelopmental factors interact during a critical and limited period of development" (Coates, 1990, p. 434). Prenatal sex hormones have been thought to play a possible role in GID, though direct evidence is lacking. Possibly related to this, temperament is considered to play an important predisposing role. Boys with GID have been noted to have temperaments that include lower activity levels and less participation in rough and tumble play (Eaton and Enns, 1986).

There is no clear evidence that mothers of boys with GID wanted to have a girl more than control mothers (Zucker et al., 1994), but the disappointment that some mothers of boys with GID feel about not having had a girl may influence the way they relate to their sons (Bradley and Zucker, 1997). In particular, Zucker and Bradley (1995) described the

reactions of some of these mothers to bearing a son as examples of pathological mourning for the wished-for daughter. The behavior included such things as photographing the son in hair curlers and pink baby clothes. In another case, the mother said that she had delayed naming her son for eight weeks before eventually naming him Jackie, commenting that "he was supposed to be Jacqueline" (Zucker et al., 1993). Zucker and Bradley (1995) reported that such extreme reactions only occurred in their cases (with one exception) if the mother had wanted a daughter and had had only older sons.

There are several other factors thought to be associated with the development of GID, including parental psychopathology (Marantz and Coates, 1991), separation anxiety disorder in many of the cases (Coates and Person, 1985), and other psychodynamic factors, such as a distant father-son relationship and a mother's perception of females as more nurturing and less aggressive than males (Bradley and Zucker, 1997). These may be reinforced by a parental ability to tolerate cross-gender behavior (Green, 1987), but it is not a parent's wish to have a child of the opposite sex *per se* that leads to the development of the disorder.

One aspect that has received little attention is the effect that cultural beliefs may have in causing the disorder in some children, and studying cases in which they appear to play a significant role may lead to a better understanding of the causes of the disorder in general.

There have been a number of reports on adult transsexuals in other cultures. Ruan et al. (1989) reported correspondence with seven transsexuals in China. Johnson (1997) described the phenomenon among hairdressers in the Southern Philippines, and MacFarlane (1984) reported on transsexual prostitution by persons of Maori extraction in New Zealand. Tsoi (1988) reported on the prevalence of transsexualism in Singapore.

Several authors have written about "two-spirits" or "berdaches" among various Native American groups (Lang, 1998; Roscoe, 1998; Williams, 1986). These terms generally refer to biological males who often wear women's clothing and are viewed as distinct from either gender. With only retrospective summaries of their backgrounds available, it is difficult to know if all these individuals have gender identity disorders; they certainly demonstrate homosexual behavior and at times show identification with women, but without detailed individual histories, it is hard to determine if they showed gender identity disorder symptoms at an early age or simply effeminacy.

Nanda (1985) described the hijras of India, biological males who choose to undergo emasculation, dress as women, and have a place in

society performing religious rituals. They are thought of as holding a third gender role, and while Nanda described one individual as experiencing himself as a "female trapped in a male body" (p. 44), it is not clear that they all have female gender identities. Coleman et al. (1992) described the acault of Myanmar, males showing cross-gender behavior. The authors gave descriptions of three cases, only one of whom showed cross-gender behavior at an early age and had a clear female gender identity as an adult.

A cross-cultural comparison between Sweden and Australia found significant differences in the frequency and sex ratio of transsexualism, and societal influences were thought to influence the number of transsexuals presenting as patients (Ross et al., 1981). These influences, however, were thought to include differences in sex-role differentiation and anti-homosexual attitudes rather than any specific cultural beliefs.

The cross-cultural example most similar to the current case is probably that of "Mimi," a transsexual prostitute from Vietnam who, as a sickly child, was dressed as a girl in order to disguise him from the evil spirits that were after him (Heiman and Lê, 1975). It was noted, however, that such cross-dressing was a common cultural practice, and the children generally resumed dressing in a way appropriate to their gender at age 10 without difficulty. Therefore, it is not clear that this cultural practice contributed to the patient's gender identity development. A connection between specific cultural beliefs and gender identity disorder has not been made in any of these cases. In fact, a literature search using Medline and PsycINFO produced no matches when gender identity disorder and transsexualism were crossed with "cultural beliefs" and only three matches when they were crossed with "cultural characteristics." Thus, the present case may offer a new perspective on potential cultural factors involved in the etiology of GID.

CASE REPORT

We learned of this case during a field trip in Thailand in November 1998. We conducted multiple interviews: one with the subject's mother; one with the subject, his father, and his maternal great-aunt; and one with his maternal aunt by marriage, who lived with the subject's grandmother for a time before her death. These interviews were conducted in Thai through the use of a native Thai interpreter. We followed the usual procedures for psychiatric interviews and avoided lead-

ing questions, except when necessary to assist an informant. In so doing, we were able to learn the basic history of this child and his family's expectations for him.

CT, the subject's grandmother, lived in the Mukdahan Province of Thailand. At one point, she told her daughter-in-law that she would like to be reborn as a male so that she could have a mistress as her husband did. She had diabetes mellitus, and she died in November 1989 at the age of 45. The day after she died, her daughter-in-law used white paste to make a mark on the back of CT's neck so that she could recognize CT when she was reborn.

KM, the subject of the case, was born in October 1990, being the second of two sons born to his parents. When his mother was three months pregnant with him, she had dreamed that CT, her mother, said that she wanted to be reborn to her. KM's mother had seen the mark made on the body of her mother, and when KM was born after an uneventful pregnancy and delivery, his mother noted that he had a hypopigmented birthmark on the back of his neck in the same location as the mark made on his grandmother's neck. As soon as she saw the birthmark, she associated it with the mark made on her mother. In a separate interview, the daughter-in-law who made the mark confirmed to us that the locations were the same. We attempted to find another witness to the marking but were unsuccessful. Thus, it is possible that the two women were either mistaken or dishonest, though they would appear to have little motivation for dishonesty.

During the time that KM was between one and three years of age, he made several statements that his family felt indicated that he was his grandmother reborn. He said, "I am CT," and told his mother, "I am your mother." He also told his great-aunt that CT's rice field belonged to him.

KM also said that he wanted to be a girl, and he showed a number of feminine behaviors. When he was younger, he generally sat to urinate. After starting school, he did this less but continued to sit at times. He also repeatedly enjoyed wearing women's clothing. He wore his mother's lipstick, her earrings, and her dresses many times. At school, he participated in the girls' games, and he did not like to climb trees or engage in other masculine behaviors typical for boys in that area. He also preferred to spend time with his female classmates rather than his male ones. All of these behaviors continued despite his father's attempts to make KM more masculine. Both of KM's parents complained about his feminine behaviors, and they said that they never talked to him about being reborn.

While one may question whether KM met full criteria for a diagnosis of gender identity disorder, he clearly showed enough features to warrant a provisional diagnosis, and we hope to conduct a follow-up visit at some point in the future. When we interviewed him and his family, they did not report any other problems with his development. He appeared to be a cheerful 8-year-old boy, and the family did not report any problems with disruptive behaviors at home or at school. His birthmark was still clearly visible as a hypopigmented area on the back of his neck that was approximately 2 inches long and ½ inch wide.

DISCUSSION

If one assumes that the present case of GID is similar to Western cases reported, then explaining its etiology becomes a challenge. It may be that temperament, parental psychopathology, and other specific psychodynamic factors in the family led KM to develop GID quite apart from the beliefs about the previous life. Unfortunately, we did not do a formal assessment of the parents' psychological functioning, though no gross psychopathology was apparent during the interviews. Nonetheless, Stevenson (1987) has reported that the children he has studied who claim to remember past lives as members of the opposite sex frequently show traits that are characteristic of the claimed former sex. In one report, he noted 121 cases of children claiming to remember lives as members of the opposite sex, but he did not say how many showed cross-gender behavior (Stevenson, 1986). In another, out of 34 children that he had studied who survived past infancy and were said to have had previous lives as members of the opposite sex, 21 (62%) of them showed in childhood marked behavior appropriate for the opposite sex (Stevenson, 1997). These cases have generally involved children in cultures with a belief in reincarnation, and it seems extremely unlikely that so many of them could develop this rare disorder independent of the past life beliefs. Stevenson also says, however, that he has followed a number of these cases as they have gotten older, and the majority, though certainly not all, eventually stop cross-dressing and accept their anatomical sex. Therefore, these cases may represent a variant of GID that is ultimately less pervasive than in other cases.

In this case, one may speculate that once KM was identified as a re-birth of his grandmother, his parents unconsciously steered his behavior toward the feminine, despite their statements that they did not talk to

him about the previous life and discouraged his cross-gender behaviors. But could this have led to the gender identity disorder?

The case could include the pathological mourning aspect described by Zucker and Bradley (1995), with it being the mother's grief for her mother rather than for a daughter. The parents did not report, however, that the mother had exhibited the extreme reactions described by Zucker and Bradley. Moreover, it is still not clear how much a mother's wishes or expectations influence a child's subsequent gender identity. Bradley et al. (1998) described a case of a boy reared as a girl following traumatic loss of the penis in infancy in which the patient developed a female gender identity but had a childhood history of being a "tomboy" and developed a bisexual sexual identity with predominate attraction to women. Recent follow-up of another case of penis loss in infancy shows just how unsuccessful parental attempts to steer gender identity can be (Diamond and Sigmundson, 1997). In that one, and in similar ones described by Reiner (1997), the child developed a gender identity as a male despite the best efforts of his parents to rear him as a girl, so it is far from certain that KM's parents' view of him as his grandmother reborn could have led unintentionally to interactions with him that were powerful enough to produce a GID. In addition, Stevenson (1987) has reported cases in which children with cross-gender behavior described previous lives as members of the opposite sex who were unknown to the parents, so expectations would not have played a part in creating the behavior. He even reported one case of an American girl who showed cross-gender behavior and spoke extensively about having had a previous life as a man (who was unknown to her parents and was never identified). Her parents had a Protestant Christian background and did not believe in reincarnation at the time that she began talking about a previous life.

Nonetheless, parental expectations contributing to the development of a gender identity disorder may be the preferred explanation for cases such as the present one, given the lack of alternative ones. There likely is a link, though not necessarily a causative one, between the parents' beliefs and the cross-gender behavior in this case and the similar ones cited by Stevenson, unless the presence of both is simply a coincidence in dozens of cases. If there is such a link, then possible causes for it other than parental expectations are limited. Stevenson (1977, p. 207) has put forth the alternative argument that "Western psychiatrists and psychologists should seriously consider and investigate further the basis for the Southeast Asian interpretation of cases of gender dysphoria"; that is, that they are caused by residues of a previous life as a member of

the opposite sex. Such an explanation would, at least, explain the examples of cross-gender behavior in children whose claims of past lives as members of the opposite sex were not expected by the parents. In the present case, however, the possibility of parental expectations being an important etiologic factor for the child's GID requires careful consideration.

In any event, these cases suggest that there may be as-yet-unappreciated factors present in the formation of GID, be they rebirth issues or parents' cultural beliefs and expectations. Regarding parental expectations, parents, even if not wishing for a child of the opposite sex, may have more subtle expectations that influence their child's subsequent gender identity. Western parents rarely think that their child is the reincarnation of a deceased family member. They may, however, say that their child reminds them of another family member or has similar features or a similar personality. It is unclear how much such observations can influence a child's gender identity, but these cases suggest that parental beliefs and expectations may play a role in the creation of GID. Money (1994, p. 163) has said, "there is, as yet, no comprehensive and detailed theory of causality" for GID. Such a theory, when developed, may include this pattern of cases in which cultural beliefs regarding a child's rebirth appear alongside the formation of the disorder.

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