Social Issues, Justice and Status

Gender Identity

Disorders, Developmental Perspectives and Social Implications

Beverly L. Miller
Editor

NOVA

SOCIAL ISSUES, JUSTICE AND STATUS

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BEVERLY L. MILLER
EDITO

nova publishers
New York

Library of Congress Cataloging-in-Publication Data

Gender identity : disorders, developmental perspectives and social implications / editor, Beverly L. Miller.
pages cm. -- (Social issues, justice and status)
Includes index.
ISBN: 978-1-63321-488-0 (hardcover)
1. Gender identity. 2. Gender identity disorders. 3. Sex role. I. Miller, Beverly L.
BF692.2.G4673 2014
155.3'3--dc23

2014025208

Published by Nova Science Publishers, Inc. † New York

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PREFACE

In this book, gender identity is examined as a disorder, along with developmental perspectives and social implications. Some of the topics discussed include gender identity as a personality process; the intersection of gender and sexual identity development in a sample of transgender individuals; gender dysphoria; representations of teachers about the relation between physical education contents and gender identities; and common hypothetical etiology of excess androgen exposure in female-to-male transsexualism and polycystic ovary syndrome.

Chapter 1 – Within psychology and psychiatry, *gender identity* has developed at least two distinguishable meanings: awareness of anatomy and endorsing specific traits that are stereotypical of different gender groups. However, neither existing approach has considered gender identity to be a self-categorization process that exists within personality science. In this chapter, the author develops the argument that gender identity can be fruitfully explored as a personality process. The author use both classic and modern personality process approaches to demonstrate that theorizing about gender identity from the personality perspective clarifies and complements—rather than eclipses—prior theorizing. Additionally, several unique insights are available to researchers when gender identity is approached as a personality process, and some of these insights are identified within this chapter.

Chapter 2 – This study investigated relationships among the experience of trauma, identity development, distress, and positive change among 908 emerging adults with a mean age of 19.99 (SD = 1.97) years. Greater identity exploration was associated with more distress, whereas greater identity commitment was associated with positive change after the trauma. Participants with a PTSD diagnosis reported more distress and identity exploration as compared to participants without PTSD who reported more positive change and identity commitments. Regression analyses found the centrality of the trauma event to one's identity predicted identity distress above and beyond the experience of trauma. Identity distress and the centrality of the trauma together predicted identity exploration, while only identity distress predicted identity commitments. Identity development predicted positive change above and beyond identity distress, centrality of the trauma event, and the experience of trauma. Collectively, these results indicate that aspects of distress and growth occur after traumatic events.

Chapter 3 – Studies of gender identity development in transgender individuals suggest that for these individuals an awareness of their non-heteronormative gender identity typically occurs in early childhood, with awareness and self-definitions of sexual identity typically

occurring later on in puberty and young adulthood. In this chapter the authors describe the findings from eleven self-identified transgender individuals (4 MTF, 6 FTM, 1 intersex) who were interviewed about the age at which they became aware of their non-heteronormative gender identity and about whether they recalled specific life events associated with their awareness of their gender identity. Consistent with the previous literature, seven of the participants gave specific early childhood ages at which they became aware of their non-heteronormative gender identity. Most of these transgender individuals did not cite any specific event that made them aware of their non-heteronormative gender identity, instead recalling that they just knew they were different. The four other transgender participants (all FTMs), however, reported that their non-heteronormative gender identity awareness did not become solidified until their teen years and beyond and that this gender identity awareness occurred in the context of their sexual identity. These findings are discussed in terms of the intersectionality of gender and sexual identity in the development of non-heteronormative gender/sexual identities.

Chapter 4 – Since the origins of humanity the possibility of an area existing beyond the binary subdivision of sexual genders has been incorporated into myth and symbolic representations as expressed through rite, from Plato's Androgyne to Hermaphrodite, from the myth of Attis and Cybele to the figure of Venus Castina. At the same time different cultures have envisaged, and in some cases continue to envisage, outside any "pathologized" category, the possibility of there being a non-correspondence between an individual's biological sex and their subjective experience of belonging to a given sexual gender: for example, the Neapolitan *Femminiello*, the *"two-spirits"* among American natives, and the *Hijras*, who still exist on the Indian sub-continent. Nevertheless, in the West today this existential condition is to some extent shaped, and somehow even produced, by a series of *discourses*, which are first and foremost medical/psychiatric and define and mold its very nature. *Gender Dysphoria*, the clinical taxonomic category which the American Psychiatric Association has recently adopted to replace the existing *Gender Identity Disorder*, refers to an individual's affective/cognitive discontent with the assigned gender and the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender, which in many, but not all, cases also involves a somatic transition by cross-sex hormone treatment and genital surgery (*Sex Reassignment Surgery*). As Michel Foucault would have it, psychiatric knowledge molds bodies. In any case, the work of preparation and drafting of the recent edition of the DSM, the Diagnostic and Statistical Manual of Mental Disorders has been accompanied by a lively debate on whether or not it is legal to include the condition within the ranks of Mental Disorders. The result of this debate was to keep the condition in the manual, therefore interpreting it as a manifestation of a Mental Disorder. In the present paper, the authors will analyze the main historical stages of the process of inclusion of this condition within psychiatric knowledge. The authors will, therefore, discuss the main problems that this inclusion produces, questioning the very foundations of psychiatric knowledge. Moreover, the authors will consider the exact nature of this condition within the framework of a phenomenological/existential approach, beyond the simplistic diagnostic criteria proposed by the American manual.

Chapter 5 – Gender Dysphoria (GD) is a complex and most probably multifactorially caused condition and it is increasingly a matter of interest in the media and scientific literature. In particular, it is expressed by a significant discomfort that is usually associated with the incongruence between natal sex and gender identity and it represents a dimensional

phenomenon that can occur with different degrees of intensity. The most extreme form of GD is usually accompanied by a desire for gender reassignment (GR). GD can have an early onset, since preschool age, with extremely variable and hard to predict clinical outcomes. Etiopathogenic theories are still uncertain and no specific etiological factor determining atypical gender development has been found to date, but there seems to be an increasing evidence of a biologic and/or genetic component involved. Professionals that deal with this kind of issues need to be able to recognize gender variant youth in order to perform an early assessment, to support awareness and structuring of sexual identity dimensions, to prevent associated psychopathology (if present), and consequently to improve the quality of life. Despite international guidelines being available, treatment of gender dysphoric children and adolescents is still controversial and there is currently poor consensus on psychological and medical intervention. Specialized GD services appear to be important in order to prevent suffering and distress and ensure psychosocial wellbeing of gender variant children/adolescents and their families. Aim of this chapter is to deal with psychological, medical and ethic aspects related to GD in children and adolescents, and to provide an overview of current debates and clinical options available internationally.

Chapter 6 – Transsexualism is a gender identity disorder with a multifactorial etiology. Neurodevelopmental processes and genetic factors seem to be implicated.

The aim of this study was to investigate the association between the genotype and female-to-male (FtM) and male-to-female (MtF) transsexualism by performing a karyotype and molecular analysis of three variable regions of the genes *ER*β (estrogen receptor β), *AR* (androgen receptor) and *CYP19A1* (aromatase).

Methods: The authors carried out a cytogenetic and molecular analysis in 273 FtMs, 442 MtFs, 371 control females and 473 control males. The control groups were healthy, age- and geographical origin-matched. The karyotype was investigated by G-banding and by high-density (HD) array in the transsexual group. The molecular analysis involved three tandem variable regions of genes *ER*β (CA repeats in intron 5), *AR* (CAG repeats in exon 1) and *CYP19A1* (TTTA repeats in intron 4). The allele and genotype frequencies, after division into short (S) and long (L) alleles, were obtained.

Results: No karyotype aberration has been linked to transsexualism (FtM or MtF), and prevalence of aneuploidy (3%) appears to be slightly higher than in the general population (0.53%). Concerning the molecular study, FtMs differed significantly from control females with respect to the median repeat length polymorphism *ER*β ($P = 0.002$) but not to the length of the other two studied polymorphisms. The repeat numbers in *ER*β were significantly higher in FtMs than in the female control group, and the likelihood of developing transsexualism was higher (odds ratio: 2.001 [1.15–3.46]) in the subjects with the genotype homozygous for long alleles.

No significant difference in allelic or genotypic distribution of any gene examined was found between MtFs and control males. Moreover, molecular findings presented no evidence of an association between the sex hormone-related genes (*ER*β, *AR*, and *CYP19A1*) and MtF transsexualism.

Chapter 7 – Gender violence is a social problem that has a great impact in Spain. This complex process has also personal implications in women's health (physical and mental health) and social implications (laws or cultural constrains, among others) that affect interpersonal relationships. To analyze this phenomenon a wide range of variables should be taken into account. Two of these important variables are cultural level (culture of honor) and

individual level (gender identity). Their studies show that there is a relationship between gender identity and culture of honor. Specifically, individuals high in masculine gender identity give more importance to culture of honor whereas high feminine gender identity relates with a lower concern to honor affairs. In this book chapter for *Gender Identity: Disorders, Developmental Perspectives and Social Implications*, the authors analyze the role that this relation has on gender violence and their consequences and social implications. Specifically, the authors summarize a series of studies that examine gender identity, culture of honor and gender violence both in prisoners and in non prisoners' men and in general population. Their results would help to better understand gender violence and the role that gender identity has in this complex, personal and social, phenomenon.

Chapter 8 – Gender Identity Disorder (GID) is included in the ICD-10 among the Mental and Behavioural Disorders (so called F-Codes) (F64). The World Health Organization is currently preparing the eleventh version of the ICD, to be published in 2015 or 2017. Members of the WHO Working Group on the Classification of Sexual Disorders and Sexual Health propose the removal of GID from the Mental and Behavioural Disorders and its inclusion in a non-psychiatric category. One motion is to rename the condition 'Gender Incongruence', and place it within a new category called 'Certain conditions related to sexual health', thereby formalising the idea that whatever the condition is, it is not a disorder.

Retaining GID within the ICD is thought to facilitate access to publicly funded or otherwise subsidised medical treatment. Whereas removing GID from mental illnesses is certainly a step forward in the recognition of the diversity of individual gender and sexual orientations, it may be asked whether it is still too small a step. Why should gender differences be included at all in diagnostic manuals? On what grounds? This chapter explores the reasons for and against retention of the diagnostic category of GID in the ICD, and it discusses where it should eventually be placed.

It will conclude that, as proposed by some LGBT groups, gender variance could be enclosed within the so-called Z coded of the ICD. These are non-pathologising codes, currently listed under the "Factors influencing health status and contact with health services".

Chapter 9 – In the past few decades, the literature has addressed transsexual patients' quality of life, satisfaction and various other outcomes such as sexual functioning after sex reassignment surgery. Instead, the role of the cross-sex hormonal treatment alone in the well-being of transsexual patients has been the subject of very little differentiated investigation. Moreover, due to their cross-sectional design, previous studies did not demonstrate a direct effect of hormonal treatment in transsexual patients' distress. To their knowledge only three recent researches studied the transsexual patients' distress related to the hormonal treatment in a longitudinal study. In light of the importance of this information, this chapter discusses a review of these three perspective studies, two of whom were performed in partially overlapping samples from the same gender unit. Although transsexualism has been described as a diagnostic entity in its own right, not necessarily associated with severe comorbid psychiatric findings, for most patients transsexualism may be a stressful situation and may cause clinical distress or impairment in important areas of functioning. This review provides information on the prevalence and/or severity of psychobiological distress, mental distress and functional impairment in untreated transsexual patients. One of these three studies revealed that, despite the majority of transsexual patients do not suffer of a psychiatric disorder, the condition is associated with subthreshold anxiety/depression, psychological distress and functional impairment. Another of these three studies achieved the same results

on the psychological distress in untreated transsexual patients, using part of the methodology of the previous study in a different sample. The last study added information about the untreated transsexual patients' stress system dysregulation, revealing that these patients show hypothalamic-pituitary-adrenal (HPA) system dysregulation and appear to notably differ from normative samples in terms of mean levels of perceived stress. In particular, untreated transsexual patients showed elevated cortisol awakening response (CAR), with cortisol levels above the normal range, and elevated perceived stress. Moreover, this review reports the role of the hormonal treatment in reducing psychobiological and mental distress in transsexualism. Specifically, when treated with hormonal treatment transsexual patients reported less anxiety, depression, psychological distress and functional impairment. Also transsexual patients showed reduced cortisol awakening response (CAR) and perceived stress levels after the beginning of the cross-sex hormonal treatment. It should be added that in all the three studies the psychobiological and mental distress scores resembled those of a general population after cross-sex hormonal treatment was initiated. Finally, the review discusses the hypothesis of a direct relation versus an indirect relation between the hormone therapy itself and the patients' well-being, supporting a psycho-social meaning of the hormonal treatment (indirect relation) rather than a biological effect of sex hormones (direct relation).

Chapter 10 – The demands of gender dysphoria (GD) in children and adolescents are increasing in recent years in the Spanish public health system. The complexity of the process and its clinical approach requires providing treatment by specialized units with multidisciplinary teams. The legislation relating to children with GD is not homogeneous in Spain. It currently provides health care for this population in gender teams with a non-interventionist attitude in children, and recommending pubertal suppression for adolescents in Tanner Stage above 2, in most units. Integral care of the GD begins in the Spanish public health system in Andalusia (southern region) in 1999 (Andalusian-Gender-Team, AGT). The demand for minors has grown dramatically in recent years, having a fivefold increase in the number of applications since 2007, especially in the group of natal boys.

From 1999 through 2013, 165 subjects with a range of age (5 to 17 years) have been evaluated. 74,5% were natal males (male-to-female, MtF) and 25,5% female-to-male (FtM). 12%, were $\leq$ 12 years (childhood group), the rest had 12 to 17 years (adolescent group). 4 cases were excluded and 22 dropped out from the AGT. 3 boys regreted the GD in this period. Currently 136 subjetcs mantain follow up (42% in psychogical-evaluation-phase and 58% in cross-hormone-treatment, CHT). In 10 adolescents the puberty has been blocked. No alterations in the karyotype, ultrasound or analytical tests were found but basal bone mineral mass is decreased, especially in the group of MtF. During this period, at the legal age (18 years), sex-reassignment-surgeries have been indicated in 16% of the patients (female genitoplasty in 21 MtF and hysterooforectomies in 5 FtM). 24 cases have had breast surgeries (13 mamoplasties and 10 mastectomies). Most of the adolescents, or their parents, asked for intervention (psychological, endocrine, or surgical) at the first visit. Parents of children also requested intervention in most cases. The request at first visits in their Unit is significatively associated to the age group.

In recent years there has been an associative movement of patients and their families around social groups, which has led to increased demand for therapeutic procedures or deadlines that do not always agree with the recommendations of scientific societies. In the case of minors, sometimes these demands include not only early medical intervention, but full integration in schools according to their sexual identity. Therefore, it is essential to organize

care with transgender population through specialized interdisciplinary teams, in close collaboration with the family and educational environment.

Chapter 11 – Objective: The authors aim to study the relation between exposure to violence during childhood and adolescence and substance consumption in adulthood in a population of transsexuals.

Material and Methods: Descriptive study of 209 transsexual subjects, based on the ICD-10 diagnostic criteria (109 male-to-female, and 100 female-to-male), followed at the Transsexuality and Gender Identity Unit of the General University Hospital of Malaga (Spain). The Social-demographic structured questionnaire and Exposure to Violence Questionnaire (EVQ) were used during the psychological evaluation phase of the gender reassignment process.

Results: The highest score of direct violence experienced in childhood and adolescence was obtained from when the subjects were at school, the lowest score was obtained at home, and direct violence in the neighbourhood came second. The average score of the EVQ questionnaire (Violence in the neighbourhood) was significantly higher in those who had consumed cannabis in the past compared to those who hadn't ($p<0.05$). Differences were not observed either in the total direct score of EVQ nor in the other EVQ scores for active *cannabis* consumers. The average of the EVQ direct score in those who had consumed cocaine in the past ($p<0.05$) were higher. Specifically, higher scores of violence were experienced at home, both among current and past consumers of cocaine. The differences between consumers and non-consumers of designer drugs in the past were significant within the scores of exposure to violence at home ($p<0.05$) but not on the total questionnaire score.

Conclusions: In accordance with the data, violence experienced during childhood and adolescence may play a role in substance abuse in adult transsexuals. In addition, some characteristic patterns are observed between exposure to violence and the type of drug consumed. In an attempt to prevent early exposure to violence and its consequences on mental health and influence the psychosocial adjustment in transsexuals, early interventions are imperative.

Chapter 12 – This study aims to investigate how Physical Education (P.E.) teachers of elementary/middle schools from Municipal Education Foundation of Niterói (FME) represent the relationship between course content and the construction of gender identities. The study was developed in three stages: i) document research on the FME Curriculum; ii) a structured questionnaire with all 55 P.E. teachers from FME-Niterói to analyze their professional profiles; iii) ten structured interviews with teachers who have five or more years of experience in teaching P.E. in elementary/middle school. After documental analysis, general questions of gender were identified in the P.E. Curriculum of FME, leading us to the conclusion that FME teachers should be knowledgeable about this subject. Literature Research on the subject of gender was completed about gender identities, co-education and course content. The group of teachers interviewed was composed of 59% women, and 41% men, and the average age was 40 years old. Most of them (86%) were born in Rio de Janeiro. Regarding their higher education background, 79% came from public universities and 24% from private institutions. The average time experience teaching P.E. was 14 years. All teachers work in public schools, and four of them also teach in private schools. The Content Analysis of interviews resulted in six categories: "misunderstanding about the concept of gender identity"; "teacher's program versus FME curriculum"; "students' resistance to mixed gender classes"; "lack of knowledge about Co-Education"; "sports as a factor for gender

exclusion"; and "course content and identity". The authors concluded that most of the teachers don't know concepts about gender and Co-education, and don't follow the learning objectives related to the gender issues presented in the curriculum orientation of FME. The teachers interviewed have a tendency to teach the P.E. content in a gendered way, reproducing gender stereotypes and/or separating students by gender during the class activities. The authors believe that P.E. class is a moment of learning relevant questions related to diversity and gender, creating a sense of inclusion for every student. Teachers need to select their content that encourages gender-related discussions, allowing students to question their gender representations. In this way, they could recreate themselves in a non-stereotypical way, being free to construct their identities and participate in any activities in P.E. classes. To achieve this objective, teachers must be better prepared by the universities to face this important question. Unfortunately, in Brazil, universities rarely or poorly discuss gender topics in P.E. undergraduate courses.

Chapter 13 – Gender identity disorder is recognized as a rare disease. The prevalence of this disorder is different among regions and races. In Japan, the prevalence of female-to-male transsexual (FTM-TS) patients is estimated to be 1 in 12,500 women, which is approximately twice as many as male-to-female transsexual patients.

There are two interesting facts in association with FTM-TS: 1) the complication rate of polycystic ovary syndrome (PCOS) is high among FTM-TS patients; and 2) natal female patients with congenital adrenal hyperplasia (CAH) tend to have gender identity problems more often than the normal population. PCOS is a common disease and it affects 5–10% of women of reproductive age. PCOS is characterized by ovulation disorder, hyperandrogenism, and polycystic ovarian morphology. Additionally, PCOS is correlated with insulin resistance, and predisposes to type 2 diabetes mellitus, atherosclerosis, and metabolic syndrome. The etiology of PCOS is still obscure, but excess androgen exposure during the fetal period is considered to be a dominant hypothesis. CAH is an autosomal recessive disorder impairing adrenal steroid metabolism, which causes excess androgenemia from the fetal period. A review on 250 natal female cases with CAH showed that 13 (5.2%) of the patients had serious gender identity problems. Surprisingly, the occurrence of FTM-TS in CAH is extremely high. The pathogenesis of FTM-TS is still uncertain. However, excess androgen exposure may be related to FTM-TS according to the above-mentioned findings.

In humans, experimental androgen administration to women is impossible. However, cross-sex hormone administration to FTM-TS patients is not associated with any problems because it is a standard tactic for treatment. If excess androgen exposure is a cause of PCOS, androgen-treated FTM-TS patients may be a disease model of PCOS. Assessment of the effects of androgen administration on metabolic parameters is informative because FTM-TS patients with PCOS may have potent insulin resistance.

In this chapter, the authors discuss endocrinological aspects of FTM-TS, the effect of cross-sex hormones, and the hypothetical etiology in FTM and PCOS.

Chapter 14 – Transgender (TG) individuals who believe in the God of the three major faith traditions, Judiasm, Islam, and Christianity, and have an internal conflict surrounding their gender identity often say to themselves, "Where is God in all of this?" For the many people who wonder, "Why do I have these experiences?" there is no consensus for how to best answer that question. Experiencing these questions or conflicts and not having many solid answers may make lead TG persons of faith to feel confusion, frustration, or anger—this negative affect can be directed inward (toward themselves) or outward (toward their parents,

their religious institutions and leaders, and even to God). In this chapter the authors present some questions and results from preliminary research with TG persons of faith that might help clinicians and religious persons explore this area and find their own answers. Topics that are explored include the etiology of Gender Dysphoria and the potential conflict with any of the three major Abrahamic religions (Judaism, Christianity, and Islam), the pursuit of God for meaning and purpose for the TG individual, how TG persons of faith can live in the tension, and lastly, the authors give specific recommendations for both clinicians and TG individuals based on the limited existing research in this area.

Chapter 15 – This report presents the findings from an exploratory study of the experiences of 34 male-to-female transgender persons of faith. These findings are from a larger study on the experiences of transgender (TG) Christian. Some of the items discussed are ages/timeframes in which people begin to acknowledge for themselves that there is an apparent conflict between their birth sex and their sense of gender; when and what types of attributions are made to these experiences; when and with whom they disclosed their inner conflict; and if/when they began to transition. Additionally, questions are asked about the participants' experiences within their faith traditions, including such areas as church life, relationship with God, and understanding of Scripture. Granted this study is retrospective and subject to all the limitations of recall, but prior research on children whose gender dysphoria persists and desists, as well as milestone events in identify formation in other areas of study warrants some examination of typical timelines in which some of common life events generally occur.

CONTENTS

In: Gender Identity
Editor: Beverly L. Miller
ISBN: 978-1-63321-488-0

Chapter 1

GENDER IDENTITY AS A PERSONALITY PROCESS

Charlotte Tate
Department of Psychology, San Francisco State University, US

ABSTRACT

Within psychology and psychiatry, *gender identity* has developed at least two distinguishable meanings: awareness of anatomy (e.g., Stoller, 1974) and endorsing specific traits that are stereotypical of different gender groups (e.g., Bem, 1974; Wood & Eagly, 2010). However, neither existing approach has considered gender identity to be a self-categorization process that exists within personality science. In this chapter, I develop the argument that gender identity can be fruitfully explored as a personality process. I use both classic and modern personality process approaches to demonstrate that theorizing about gender identity from the personality perspective clarifies and complements—rather than eclipses—prior theorizing. Additionally, several unique insights are available to researchers when gender identity is approached as a personality process, and some of these insights are identified within this chapter.

GENDER IDENTITY AS A PERSONALITY PROCESS

Over the past 50 years in psychology and psychiatry, *gender identity* has developed at least two distinguishable meanings. One meaning is the sense of self that is little more than a person's anatomical awareness. This meaning is seen in Stoller's (1968/1974) original ideas about *core gender identity.* With modification through the years, Stoller's view has remained part of both the psychiatric and clinical psychology understanding of gender identity to the present. The other meaning of gender identity is the sense of self as endorsing specific traits that are stereotypical of different gender groups. This meaning is seen in Bem's (1974, 1981a) *gender schema theory*, Spence and colleagues (1975) *personal attributes* approach, and to the present in Eagly and Wood's (2010) approach to gender identity—all of which are found under the purview of social psychology. Yet, none of the current understandings has considered gender identity to be a self-categorization process that exists within modern personality psychology (also called personality science). The goal of this chapter is therefore

to detail an argument for gender identity as a personality process that is inclusive of all gender identity experiences and developmental profiles. Using classic personality process approaches (e.g., Kluckhohn & Murray, 1948), this chapter starts from the premise that gender identity, like any other personality process, at the broadest level covers all people in some way, at a second level constitutes the traditional individual difference (i.e., applies to some people differently than others), and, at a third level, becomes idiosyncratic for a specific person.

Using modern personality process approaches (e.g., Caspi, Roberts, & Shiner, 2005; Revelle, 1995), this chapter also starts from the premise that gender identity involves both self-perception and other-perception components as well as biological and social influences. The chapter then develops the case for measuring gender identity as self-categorization consistent with the personality trait approaches. Specifically, one part of the argumentation within this chapter is to show that the study of gender self-categorization would benefit from making explicit the supposition that one's internal sense of self is likely a process different from genital anatomy awareness—substantially revising the Stollerian view. With this supposition in mind one can unite the descriptive experiences of *cisgender individuals* (i.e., those whose current gender identity labels are the same as their birth-assigned category labels) and *transgender spectrum individuals* (i.e., those whose current gender identity labels are different from their birth-assigned category labels) to argue that each is emanating from a common source that is not awareness of genitals as ultimate or core identity. Additionally, one can view transgender spectrum experiences as providing an extremely useful and necessary lens on this common source of gender identity experience because these experiences are not as easily confused with additional information sources—namely, other people's perceptions of the self—as happens with cisgender experiences. I also argue that much of the social psychological view starts from a cisgender bias that focuses research attention primarily on the perception of the self by others, and only secondarily (if at all) on self-perception and self-categorization (see also Ansara & Hegarty, 2012). While also important, this social psychological view is not the whole of the story for gender identity.

Another part of the specific argumentation in this chapter is to show that gender self-categorization can be measured at different levels—not just the broadest level of checking a box that corresponds to one's current gender identity label. Self-categorization itself may imply a sense of strong overlap with, affinity to, or subsumption within any or none of the available gender categories in one's culture. Importantly, the argument for gender identity as a personality process does not eclipse prior theorizing about gender identity as involving a person's consideration of anatomy (at some level) and social schemas (at another level); instead, this new argument clarifies and complements the previous arguments. I argue that gender identity as a personality process exists within a bundle of gender-related constructs, and that specifying focus on this aspect allows researchers to more completely characterize the others.

In order to develop the arguments as clearly as possible, this chapter first details the early and current approaches to gender identity within various disciplines of psychology and psychiatry and then makes the argument for gender identity as a personality process within the context of the historical and current theorizing. Finally, the new insights that accompany theorizing about gender identity as a personality process are enumerated.