What Can the Samoan "Fa'afafine" Teach Us about the Western Concept of Gender Identity Disorder in Childhood?

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What Can the Samoan "Fa'afafine" Teach Us About the Western Concept of Gender Identity Disorder in Childhood?

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ABSTRACT This article examines whether gender identity disorder in childhood (GIDC) constitutes a mental disorder as outlined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV-TR). Data were collected in Samoa, a culture that is characterized by a high degree of social tolerance towards feminine males who are known locally as *fa'afafine*. The study location was chosen because, unlike Western locales, it afforded the opportunity to examine whether gender-atypical behavior, gender-atypical identity, and sex-atypical identity, in and of themselves, cause distress in sex/gender variant individuals, while simultaneously controlling for the confounding effects of extreme societal intolerance towards such individuals. Because of our focus on the DSM-IV-TR's diagnosis of GIDC, we were specifically interested in ascertaining whether adult *fa'afafine* recalled a strong and persistent cross-gender identification

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in childhood, a sense of inappropriateness in the male-typical gender role, a discomfort with their sex, or distress associated with any of the above. In addition, we sought to determine whether parental encouragement or discouragement of cross-gender behaviors influence feelings of distress in relation to the behaviors in question. Based on the cross-cultural information presented here, we conclude that the diagnostic category of GIDC should not occur in its current form in future editions of the DSM, as there is no compelling evidence that cross-gender behaviors or identities, in and of themselves, cause distress in the individual.

First author: In my country [Canada], baby boys and girls traditionally wear different colored clothing; baby girls wear pink, but baby boys wear blue.

Fa'afafine *participant:* Really? *We don't have that problem in our culture.*

THE WORD *SEX* IS COMMONLY USED to refer to an individual's biological status as male or female. In contrast, *gender* commonly refers to the social roles expected for males and females within a given culture. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision (DSM-IV-TR; APA 2000) instructs psychological professionals to diagnose children with a mental disorder called gender identity disorder in children (GIDC) if they exhibit a strong and persistent cross-gender identification. This can manifest as a repeatedly stated desire to be, or insistence that one is, the other sex ("cross-sex wishes/identification") and/or as a strong and persistent desire to engage in activities typical of the other sex ("cross-gender behaviors"). Furthermore, individuals must exhibit a sense of inappropriateness in the gender role associated with their sex ("cross-gender identification") or a discomfort with their biological sex. In addition, a criterion for this disorder is that the condition must cause clinically significant distress or impairment in important areas of functioning. Estimates of the prevalence of GIDC range from 0.003% to 3% for boys, and 0.001% to 1.5% for girls (APA 1994; Green 1995; Zucker 1990).

Many people are generally intolerant towards, and rejecting of, children with GIDC, especially boys (Coates and Person 1985; Green 1974; Rofes 1993–94). Research shows that adolescents and adults with GIDC are at increased risk for physical and sexual victimization, increased psychopathology, homelessness, substance abuse, prostitution, AIDS, poverty, and school drop-out (Cochran et al. 2002; Nameste 2000; Seil 1996). In addition, adult transsexuals often go through enormous amounts of extremely invasive surgery and hormone therapy to bring their bodies into alignment with their sex/gender identities. For these reasons, many clinicians consider transsexualism a developmental outcome that should be avoided. (Obviously, many transsexual adults and their allies would question the validity of this claim [Burke 1996; Scholinski 1998; Wilchins 1997].)

Children diagnosed with GIDC are given various types of treatment in clinical settings aimed at improving their relationships with same-sex peers and decreasing their sex or gender dysphoria (Zucker and Bradley 1995). These sorts of treatments are believed to decrease the likelihood that children with GIDC will

go on to become transsexual in adulthood, although outcome data in support of this claim are lacking at present.

WHAT IS A MENTAL DISORDER?

Despite the inclusion of GIDC in the DSM-IV-TR, its status as a mental disorder is the subject of heated debate (Bartlett, Vasey, and Bukowski 2000, 2003; Richardson 1996, 1999; Wilson, Griffen, and Wren 2002; Zucker 1999). Part of that debate rests on the question of what should count as a "mental disorder." The DSM-IV-TR itself defines "mental disorders" as follows:

> Each of the mental disorders is conceptualised as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. . . . Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction *in* the individual, as described above. (DSM-IV-TR, pp. xxxi, emphasis added)

While we recognize that any comprehensive analysis of the concept of "mental disorder" must bear in mind that distress, disability, dysfunction, and deviance can be interrelated phenomena, we will focus specifically on the issues of distress and deviance. Surprisingly, the DSM-IV-TR provides no definition of "deviance." For the purposes of this essay, we follow the *Penguin Dictionary of Psychology* definition: "Generally, any pattern of behavior that is markedly different from the accepted standards within society. The connotation is always that moral or ethical issues are involved and, in use, the term is typically qualified to note the specific form, such as sexual deviance" (Reber 1985, p. 196).

The criteria specific to the diagnosis of GIDC require not simply that the syndrome is *associated* with present distress or disability (impairment), as outlined above, but that "the disturbance *causes* clinically significant distress or impairment" (DSM-IV-TR, p. 581, emphasis added). In other words, an individual cannot be diagnosed with GIDC (and, by extension, with a mental disorder) if distress is merely associated with the condition as a result, for example, of social censure for "deviant" gender-atypical behavior. Rather, distress must actually be caused by the GIDC itself and thus stem from *within* the individual (Bartlett, Vasey, and Bukowski 2000; Wakefield 1992). With this in mind, critics of the diagnosis argue that children diagnosed with GIDC are not inherently disordered. Rather, any distress, disability, and other negative outcomes that they experience are secondary, stemming from the social disapproval and rejection expe-

rienced as a result of their failure to conform to culturally prescribed gender role expectations. As such, the gender-variant child is not in need of treatment; rather, the target for intervention should be society's intolerance for gender variance. Indeed, some critics charge that GIDC, in and of itself, is not a disordered outcome, and that current treatment protocols produce iatrogenic outcomes; that is, they create the very symptoms of disorder that they are trying to alleviate, by exacerbating feelings of depression, anxiety, and worthlessness (Bartlett, Vasey, and Bukowski 2000, 2003; Burke 1996; Richardson 1996, 1999; Scholinski 1998; Wilchins 1997; Wilson, Griffen, and Wren 2002). In an effort to examine this critique, we have worked with a population that allows us to examine to what extent gender-atypical behavior, gender-atypical identity, and sex-atypical identity cause inherent distress.

Samoan "Fa'afafine": An Alternative Gender Role for Biological Males

In Independent Samoa, androphilic males (males sexually attracted to men) are referred to as *fa'afafine*. Translated literally, *fa'afafine* means "in the manner of a woman." Although the term implies that the members of this category are uniformly very feminine, they are, in fact, a heterogeneous group in many ways (Bartlett and Vasey 2006; Besnier 2000; Schmidt 2003). Most self-identify as *fa'afafine*, not as men. A minority self-identify as women, even though they recognize, as do all Samoans, that they differ physically and socially from biological women. In appearance and mannerisms, although most would be considered effeminate, they range from strikingly feminine to unremarkably masculine, although instances of the latter are rare. Despite this heterogeneity in gender role presentation, *fa'afafine* are, with very few exceptions, exclusively androphilic. Despite the fact that almost all *fa'afafine* are exclusively androphilic, they do not engage in sexual activity with each other. Instead, *fa'afafine* are attracted to, and engage in sexual interactions with, males who self-identify as "straight men" (Bartlett and Vasey 2006; Danielsson, Danielsson, and Pierson 1978).

In a Samoan cultural context, "straight men" are those who self-identify as men and are masculine in terms of their gender role presentation. Inclusion in this category is not contingent on exclusive sexual activity with women. Most self-identified straight men are gynephilic (sexually attracted to women), but may engage in sexual activity with *fa'afafine* or other straight men on a temporary basis, particularly if female sexual partners are unavailable. Our participants informed us that most straight men in Samoa have engaged in sexual interactions with *fa'afafine* at least once in their lives (also see *Paradise Bent* 1999).

In Independent Samoa, the categories "gay" or "homosexual" are *not* terms that androphilic males employ to construct their identities. In fact, the majority of *fa'afafine* are quite resolute in their assertion that Samoan "gays" and "homosexuals" do not exist (Bartlett and Vasey 2006).

HOW CAN "FA'AFAFINE" INFORM DEBATES ABOUT GIDC?

Fa'afafine live in a culture that is remarkably tolerant toward feminine males. As a result, they experience relatively little social censure for their sex/gender-atypicality relative to their counterparts in Euro-American cultures (Bartlett and Vasey 2006; Mageo 1992; *Paradise Bent* 1999; Vasey, Pocock, and VanderLaan 2007). Thus, *fa'afafine* furnish an opportunity to examine whether gender-atypical behavior, gender atypical identity, and sex-atypical identity, in and of themselves, cause distress, while simultaneously controlling for the confounding effects of extreme societal intolerance towards such individuals, like that often found in Western cultures.

To address these issues, we traveled to Independent Samoa in May 2003 and 2004 and conducted interviews with 53 adult *fa'afafine* (median age ± SD = 31.4 ± 7.7 years), 27 control men (26.1 ± 6.8 years), and 24 control women (30.1 ± 10.4 years) about their behaviors and identity in childhood, using a standardized questionnaire, the Childhood Gender Identity Scale (Bartlett and Vasey 2006). Because we sought to examine the validity of the DSM's categorization of GIDC as a mental disorder, we were specifically interested in ascertaining whether adult *fa'afafine* recalled: (1) a strong and persistent cross-gender identification in childhood; (2) a sense of inappropriateness in the male-typical gender role; (3) a discomfort with their sex; or (4) distress associated with any of the above. In addition, we sought to determine whether parental encouragement or discouragement of cross-gender behaviors influence feelings of distress in relation to the behaviors in question.

Cross-Gender Identification in Childhood

We asked the study participants about the frequency with which they engaged in six female-typical behaviors: (1) playing with girls; (2) playing with girls' toys and girls' games; (3) taking the female role in pretend play, such as when playing house or when imitating popular characters; (4) putting on makeup, girls' accessories, or girls' clothes; (5) talking and acting like a girl; and (6) doing girls' chores. The adult *fa'afafine* and women we interviewed recalled that they engaged in these female-typical behaviors in childhood significantly more frequently than did men (Bartlett and Vasey 2006). Interestingly, *fa'afafine* actually recalled playing with girls' toys and games significantly more than did the women ($p < .05$).

There was no evidence that *fa'afafine* experienced distress in relation to their cross-gender behaviors. Rather, when asked how they felt about participating in the female-typical behaviors outlined above, the modal response they gave was "I loved it." Women, on the other hand, tended to say they merely "liked" engaging in female-typical behaviors. In contrast, men were significantly more likely to recall negative feelings in relation to engaging in female-typical behaviors, compared to *fa'afafine* and women ($p < .001$).

Cross-gendered behaviors aside, a number of the *fa'afafine* who participated in our study told us that when they were children they believed they really were girls. In contrast, not one of the men we interviewed remembered having such beliefs as a child. We found no evidence that *fa'afafine* experienced distress in direct relation to this sort of cross-gender identity. When asked how they felt about publicly expressing the belief that they were girls, most *fa'afafine* simply said "I didn't really think about it."

Sense of Inappropriateness in the Male-Typical Gender Role

We asked the study participants about the frequency with which they engaged in five male-typical behaviors: (1) playing with boys; (2) playing with boys' toys and boys' games; (3) taking the male role in pretend play, such as when playing house or when imitating popular characters; (4) playing rough games and sports; and (4) doing boys' chores. The adult *fa'afafine* and women we interviewed reported that they engaged in these male-typical behaviors in childhood significantly less often than did men (Bartlett and Vasey 2006). Interestingly, the *fa'afafine* recalled playing rough games and sports even less than did women ($p < .05$).

The DSM-IV-TR lists aversion to rough-and-tumble play as one of the key diagnostic criteria for GIDC in boys. Consequently, we asked participants how they felt about engaging in rough-and-tumble play during childhood. *Fa'afafine* reported significantly more negative feelings associated with rough-and-tumble play in childhood compared to both men ($p < .001$) and women ($p < .001$). Indeed, most *fa'afafine* did not hesitate to state "I hated it."

When asked how they felt about being a boy, *fa'afafine* recalled significantly more negative feelings than did men. If men recalled any negative feelings at all about being a boy, it tended to be because they disliked the hard manual labor that members of their sex were sometimes expected to perform. For example, some of the men we interviewed stated that, when they were boys, they did not enjoy certain chores such as constructing the *umu*, a stone oven that is built into the ground and used for cooking feasts on Sundays and holidays. In contrast, *fa'afafines*' negative feelings about being a boy tended to be more generalized and applied to a greater range of masculine gender role expectations above and beyond chores, including clothing and play preferences. Very few, if any, men ever expressed dissatisfaction with these additional aspects of their gender roles.

Discomfort with Their Sex

Some of the *fa'afafine* we interviewed recalled that, as children, they experienced negative feelings about their genitals. A minority went so far as to say that, as children, they "hated" their genitals. In contrast, all of the men we interviewed recalled that, as children, they had nothing but positive feelings about their genitals. Not all of the *fa'afafine* who participated in our study recalled negative feelings about their genitalia, but as a group, they differed significantly in this regard compared to men.

Parental Attempts to Curb Cross-Gender Behavior

Overall, 20% of *fa'afafine* we interviewed reported that their parents tried to stop their cross-gender behavior at least sometimes, and of these, 95% stated that parental attempts to curb their cross-gender behaviors upset them. In reference to parental attempts to stop cross-gender behavior, one *fa'afafine* participant stated: "It made me confused because I wanted to do it and they stopped me. I didn't see any problem, so I don't know why it was a problem for them. I couldn't wait to go back to Savai'i [one of the islands of Independent Samoa] with my Auntie because she did not stop me. I could just be myself. This is *my* life!"

WHAT CAN SAMOAN "FA'AFAFINE" TEACH US ABOUT THE WESTERN CONCEPT OF GIDC?

Most of the *fa'afafine* we interviewed recalled that they frequently engaged in cross-gender behaviors in childhood, and some actually adopted cross-gender identities, believing they really were girls. In addition, it was very common for the *fa'afafine* participants to tell us that, as children, they hated engaging in male-typical activities such as rough-and-tumble play. It also was not unusual for the *fa'afafine* to say that they experienced negative feelings about being a boy. A minority even stated that they disliked or even hated their genitals in childhood. On the basis of this evidence, and in keeping with the DSM-IV-TR's guidelines, it seems reasonable to assume that some Western clinicians would conclude that many of the *fa'afafine* had GIDC.

That being said, we wish to stress that Samoans do *not* conceptualize femininity in males as indicative of mental disorder. Thus, when it comes to sex and gender diversity, what counts as mentally disordered in one culture is conceptualized as benign behavioral variation in another. It would be an overstatement to say that *fa'afafine* never experience *any* discrimination as a result of gender-atypicality or atypical sex- identities. Nevertheless, the level of societal acceptance they enjoy, the manner in which they are integrated into the quotidian fabric of Samoan life, and their highly public presence, stand in stark contrast to their Western counterparts, for whom widespread discrimination is, unfortunately, the norm.

The *fa'afafine* we interviewed did not recall distress as a direct result of their cross-gender behaviors and cross-gender identities. Rather, they often cited these behaviors and feelings as the sources of intense personal joy. On the other hand, parents' reactions to cross-gendered behaviors in their *fa'afafine* sons vary considerably (Bartlett and Vasey 2006). Many parents are extremely accepting, and some even facilitate the expression of cross-gender expression by dressing their *fa'afafine* sons in feminine clothing. A smaller proportion of parents react in a more negative manner, chastising their *fa'afafine* sons for cross-gender behavior. The *fa'afafine* we spoke to remembered being upset when their parents tried to stop them from engaging in cross-gender behaviors or when their parents tried

to force them to conform to masculine gender role expectations, such as playing rough sports like rugby.

Taken together, these results suggest that distress is not *caused* by cross-gender behavior and identity, but rather exists as a secondary product of social condemnation. As such, we believe that distress associated with gender-atypicality will vary both within and between cultures. It seems likely that in more accommodating cultures such as Samoa, gender-atypical children will experience relatively little secondary distress in relation to their cross-gender behavior and identity, because gender-atypicality is less socially problematic within such cultures. In more punitive societies, however, such as those in the West, gender-atypical children will often experience a great deal of secondary distress as a result of censure from peers, family members, and teachers. Moreover, that secondary distress will likely become worse with age, due to the harmful additive influence of being exposed to social ostracism over time, a process known as the "chronicity effect" (Zucker 1990).

The *fa'afafine* data raise the questions as to whether GIDC causes "distress" and, as such, whether GIDC is a mental disorder. In keeping with the DSM-IV-TR's guidelines, we have argued that only distress that is *in* the individual and directly *caused* by GIDC, should be taken as indicative of a mental disorder (Bartlett, Vasey, and Bukowski 2000, 2003). This interpretation is consistent with the DSM-IV-TR's own criterion that a mental disorder must not merely reflect a conflict between the individual and society. In Western cultures, the diagnosis of gender-variant children with GIDC would seem to be a prime example of a conflict between the individual and the society in which he or she lives. In such instances, the child deviates from culturally prescribed gender role expectations, and the society, in turn, seeks to police those gender role expectations by labeling the child with a mental disorder and then "treating" the child to eliminate the deviant behaviors.

As our interviews with the *fa'afafine* show, there is no compelling evidence that cross-gender behaviors or identities cause distress in children. But what about individuals who experience a sense of discomfort with their biological sex, per se? Discomfort with one's biological sex would certainly seem to be indicative of an inherent unease with how an individual experiences his or her body. Nevertheless, it is possible that distress with one's sexed body is also influenced by societal gender role expectations. For example, if one lives in a culture that conceptualizes the gender category "girl" as including only those individuals who do not have penises, then "feeling like a girl" might lead to feelings of distress about one's penis. In cultures like Samoa, where having a penis is not seen as incompatible with living socially "in the manner of a woman," many *fa'afafine* may "feel like girls or women" but experience no discomfort with their sexed bodies.

All this being said, a minority of the *fa'afafine* we interviewed stated that they *did* recall disliking, or even hating, their genitals in childhood. It is telling that these individuals experienced such negative feelings about their genitals, even

though they were raised in a society that was remarkably accepting of gender-atypicality in males. These data suggest that, among some cross-sex identified individuals, discomfort with one's sexed body—and the distress that one experiences as a result of that discomfort—exists *independent* of societal attitudes towards cross-gender behavior and identity. It is unlikely that the distress experienced by such children in relation to their bodies would be lessened even if they were raised in the most gender-tolerant of cultures. Thus, those relatively few cross-sex identified children who do experience discomfort with their bodies appear to meet the "distress" criteria for GIDC and for mental disorder. Whether such children would meet the "disability" and "dysfunction" criteria consistent with a complete diagnosis of GIDC (and thus, a GIDC specific mental disorder) is uncertain, but deserving of future investigation (for further discussion, see Bartlett, Vasey, and Bukowski 2000, 2003). In light of the information on *fa'afafine* presented here, we conclude that the diagnostic category of GIDC should not occur in its current form in future editions of the DSM, because there is no sound evidence that cross-*gender* behaviors or identities, per se, cause distress.

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