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PSYCHOPATHOLOGY AND PSYCHODYNAMICS OF PARENTS OF BOYS WITH A GENDER IDENTITY DISORDER OF CHILDHOOD

by

SABRINA MARIE WOLFE

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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This is dedicated to Neil and Susan
whose support and guidance helped me
weather the many difficulties involved
in completing this study.

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CHAPTER 1

INTRODUCTION

In recent years there has been a burgeoning interest in severe boyhood effeminacy, which in DSM III-R nomenclature is referred to as a Gender Identity Disorder (GID) of Childhood. These children are researched for several reasons. First, studying children who suffer considerable gender dysphoria informs how we can best treat children with this disorder. Second, studying children with aberrant gender development furthers our understanding of the origins and evolution of gender in normal children. Third, tracking these children as they grow into adulthood has shown that 2/3 of these boys become homosexual (Green, 1987). Although only a small percentage of adult male homosexuals had a GID as children (Friedman, 1988; Saghir & Robbins, 1973), the correlation of severe boyhood effeminacy with adult homosexuality raises important questions about the influence of early gender identity on later sexual orientation and begins to elucidate one of the many possible routes which determines adult male homosexuality.

In most childhood disorders, as well as adult psychopathology, understanding the familial context in which the disorder developed is crucial to understanding the etiology of a particular syndrome. Identifying the psychodynamics and psychopathology of a child's parents is

critical to understanding his family environment. Another reason for studying family dynamics as etiological factors arises from the current lack of clear biological factors in this disorder. Although the biological contributions to GID are an area of ongoing research, these features have yet to be clearly identified. Thus far, studies have not yet identified genetic or morphological abnormalities in these boys (Green, 1976; Rekers, Crandall, Rosen, & Bentler, 1979). Converging data from several sources suggest that temperament may be a predisposing factor (Coates, 1990; Coates & Person, 1985; Ehrhardt & Meyer-Bahlberg, 1981). Coates (1990) observes that given these considerations a biopsychodevelopmental model is essential for understanding the etiology of a GID.

Thus far, investigations of the families of boys with GID have focused on the mothers, describing her pathological influence on her son's development (Coates, 1985, 1990; Coates & Person, 1985; Green, 1987; Marantz, 1984; Rainbow, 1986; Stoller, 1968, 1975, 1985). The only systematic study of maternal psychopathology was conducted by Marantz (1984) who found that mothers of boys with a GID had a greater incidence of depressive and borderline personality disorders than did mothers of masculine boys.

To date, fathers of boys with a GID have not been systematically investigated. In part, this reflects the fathers' physical absence in many families where there is a boy with a GID. For example, Green (1987) found that

fathers were not present in 25% of the 66 families he studied; similarly, 63% of the 20 families Coates (1985) studied constituted father-absent households. However, the exclusion of fathers from more systematic studies also reflects a general tendency to either omit or only cursorily involve the male parent in investigations, evaluations, or even treatment of his children (Ferholt & Gurwitt, 1982). Recent research has only begun to address the importance of the father's role in both normal and pathological development, his importance being noted as early as in neonatal development (Greenspan, 1982; Lamb, 1976; Nettelbladt, 1983; Parke, 1979; Yogman, 1982).

Although the psychopathology and psychodynamics of fathers of boys with a GID have not been systematically studied, the ample clinical literature on boyhood GID suggests that fathers may also have significant psychopathology (Coates, 1985, 1990; Green, 1974, 1987; Stoller 1985). This study aims to compare the psychopathology and psychodynamics of fathers of boys with a GID with the psychopathology and psychodynamics of mothers of boys with a GID.

CHAPTER 2

REVIEW OF THE LITERATURE

Description of the Disorder

The Diagnostic and Statistical Manual of Mental Disorders (3rd ed., DSM-III-R, American Psychiatric Association, 1987) criteria for a Gender Identity Disorder of Childhood (GID) in males is as follows:

A. Persistent and intense distress about being a boy and an intense desire to be a girl or, more rarely, insistence that he is a girl.

B. Either (1) or (2):
   (1) preoccupation with female stereotypical activities, as shown by a preference for either cross-dressing or simulating female attire, or by an intense desire to participate in the games and pastimes of girls and rejection of male stereotypical toys, games, and activities.
   (2) persistent repudiation of male anatomic structures, as indicated by at least one of the following repeated assertions:
      (a) that he will grow up to become a woman (not merely in role)
      (b) that his penis or testes are disgusting or will disappear
      (c) that it would be better not to have a penis or testes

C. The boy has not yet reached puberty.

A GID manifests itself early in the boy's development. Green (1987) found that all the boys in his sample were cross dressing by the age of 6 and slightly over 50% were cross-dressing before their third birthday. Coates (1985) similarly found that 80% of the boys expressed an intense interest in their mothers' clothes and were cross-dressing by age 3 and 50% displayed an interest in their mothers'

clothes by age 2. One of the fathers involved through the Roosevelt Hospital Gender Identity Unit described his son as wearing high heels, "almost as soon as he could walk."

Many different researchers have described the gender-specific characteristics observed in boys with a GID (Bates, Bentler, & Thompson, 1973; Bates, Skilbeck, & Smith, 1974; Coates, 1985, 1990; Coates & Person 1985; Coates & Zucker, 1988; Green, 1974, 1976, 1987; Zucker, 1982, 1985). Researchers consistently agree on the characteristics described below.

Boys with a GID often directly articulate that they hate being a boy and wish they were a girl. This is particularly true for younger boys who have not yet experienced extreme social disapproval for their feminine interests and preoccupations. One boy seen through the Roosevelt Unit awoke from a dream one night sobbing, "I hate being a boy. Why do I have to be a boy even in my dreams. I wish I was a girl."

Boys with a GID are preoccupied with female characters and feminine attributes. They indicate that Alice and Wonderland, Snow White, and Rapunzel are their favorite stories; they prefer Barbie, She-ra and "Ponies" (long-haired glittery horses) to male action figures. They typically assume the female role when play acting and will drape towels over their heads and around their waists pretending that they have long hair and are wearing skirts.

Boys with a GID are extremely interested in and attracted to women's clothing, hair, jewelry, and shoes. One 5-year-old boy seen through the Roosevelt Unit longingly told his therapist, "I think about long hair all the time." On a separate occasion, he responded to being given a calendar which indicated the days his therapist would be on vacation, by asking his therapist to draw what she would be wearing on each of the days shown on the calendar. These boys often cross-dress either by wearing their mothers' or sisters' clothing or by donning feminine apparel when allowed to play "dress up" in preschool. One boy's parents had bought him a kilt, trying to "masculinize" his feminine interests. Although his parents discussed the boy's Celtic ancestors who wore their kilts into battle, when interviewed, the child remarked how "some boys like to wear kilts because they pretend they are dresses."

Boys with a GID invariably prefer girls as playmates and often completely lack male friends. They are often fearful of typical boyish rough-and-tumble play and avoid any sort of rough housing or aggressive games. They are also quite fearful of ball games, often refusing to play because of their anxiety that they will be hurt. When the nursery school teacher of one of the boys seen through the Roosevelt Unit tried to coax the child into playing a ball game with the other children, the boy folded his arms and in a petulant, high-pitched voice, said, "I'm not going to

play because there is no reason for me to play."

Boys with a GID often dislike their penis. Many will push it between their legs and pretend either that they simply lack male genitals or that they actually have a vagina. Some will sit, rather than stand, when they urinate. A small subgroup of children with a GID become extremely frightened when they have erections and attempt to mutilate or amputate their genitals (Lothstein, 1985).

Although researchers agree on the gender related characteristics and behavior of boys with a GID, they differ considerably in their descriptions of the overall psychiatric profile of the children. Stoller (1968, 1975, 1985) and Green (1987) contend that GID is an isolated psychiatric finding that arises in otherwise psychically healthy boys. Stoller writes that the child's ego functions have not been crippled in general, "except in regard to this sense of femaleness" (Stoller, 1975, p.54). Although Green notes that these boys often develop secondary psychiatric difficulties due to their isolation and social ostracism, he concurs with Stoller that boys with a GID do not evidence other psychopathology. Notably, neither Stoller nor Green attempted to systematically evaluate psychopathology in their studies.

Studies conducted at the UCLA Gender Identity Unit, at the Child and Adolescent Gender Identity Clinic within the Clarke Institute of Psychiatry in Toronto, and at the Gender Identity Unit at the Roosevelt Hospital in New York,

have all produced findings which challenge Stoller's and Green's positions. Three different UCLA studies which used overlapping samples compared first, boys referred for gender problems with a control group of boys referred for nongender problems (Bates et al., 1974); second, boys with a GID with normal controls (Bates et al., 1973); and third, boys with a GID, normal controls and boys referred for conduct and personality disorder who did not have a GID (Bates, Bentler, & Thompson, 1979). The studies respectively concluded that boys with a GID demonstrate greater passivity, harm-avoidance, lack of assertiveness and compulsive neatness than boys referred for nongender problems; that boys with a GID showed significantly greater behavior and personality disturbance than normal controls (the disturbance encompassing many areas of functioning other than gender identity); and that boys with a GID and psychiatric referrals who lack gender disturbances exhibit similar levels of behavior disturbance.

Other studies have used parent rating scales such as the Behavior Problem Checklist of the Revised Child Behavior Profile (CBC) (Achenbach & Edelbrock, 1983) to assess the overall functioning of boys with a GID (Bradley, Doering, Zucker, Finegan, & Gonda, 1980; Coates & Person, 1985; Coates & Zucker, 1988; Zucker, 1985). Bradley et al. (1980) compared 15 children with a GID (12 boys and 3 girls) to their siblings and to psychiatric controls. They found that on the CBC children with a GID exhibited levels

of behavioral disturbance which were more similar to the psychiatric controls than to their siblings. Similarly, an ongoing study at the Roosevelt Hospital has shown that 84% of the boys with a GID studied fell within the clinical range on the CBC and a comparison of the CBC's of boys with GID and those of normal controls showed highly significant differences between the two groups (Coates & Person, 1985; Coates & Zucker, 1988). Notably, 50% of the boys with a GID scored in the clinical range on the depression subscale of the CBC. The Roosevelt Unit has also found that 60% of the boys studied also met the criteria for a DSM-III diagnosis of separation anxiety disorder, pointing to a strong association between GID and separation anxiety.

On psychological tests the boys with a GID, unlike normal boys, typically draw a woman when asked to draw a person on the Draw-A-Person Test (Coates, 1985; Green, Fuller, & Rutley, 1972; Skilbeck, Bates, & Bentler, 1975; Zucker, Finegan, Doering, & Bradley, 1983). In addition, the female they draw is usually larger and more detailed than their drawing of a male (Coates, 1985; Skilbeck et al., 1975). On the Rorschach, the boys frequently provide idealized, stereotypical female responses, such as ballerinas, cheerleaders and women in bridal or ball gowns; they have also been noted to produce an unusually high number of percepts involving pregnancy or birth (Tuber & Coates, 1985).

Several studies have used the Rorschach to compare the

object representations and the level of thought organization of boys with a GID and normal boys (Bradley et al., 1980; Coates & Tuber, 1988; Tuber & Coates, 1985, 1989). Bradley et al. in their study of 12 boys and 3 girls with a GID concluded that although the children were clearly not psychotic, they did have "poor reality contact as manifested in arbitrary responses and confused or bizarre thinking" and "poor internalized object relations" (Bradley et al., 1980, p. 563).

In a preliminary exploratory study, Tuber and Coates (1985) compared the Rorschachs of 14 boys with a GID with Rorschach data of normal children published by Ames, Metraux, Rodell and Walker (1974). The investigators concluded that, "The object representations and thought organizations of feminine boys do not resemble that of either normal boys or girls, but that of severely disturbed children" (Tuber & Coates, 1985, p. 261).

In a subsequent study, Tuber and Coates (1989) compared the object representations and thought organization of 26 boys with a GID with normal male controls. The mean age and I.Q. of the boys did not differ significantly between the two groups. The Urist Mutuality of Autonomy Scale (MOA), a seven point scoring system which measures a person's characteristic way of experiencing interactions with others (Urist, 1977), was used to measure the children's object representations. (This scale is described in detail in Chapter 4.) The study found that

although the groups did not differ significantly in their total number of MOA scores, the boys with a GID had over 1 1/2 times as many depictions of malevolent interactions per Rorschach when compared with the normal controls. Using a hierarchical scale which measures pathological thinking (Blatt & Berman, 1984; Blatt & Ritzler, 1974; Rapaport, Gill, & Schafer, 1945), the investigators further found that boys with a GID had significantly more disturbances in their thinking as measured by their greater number of thought-disordered responses on this scale. (This scale which is referred to in this study as the Blatt Thought Disorder Scale (BTD) is described in detail in Chapter 4.)

Similar results were reported in a study which used an overlapping data base to compare 19 boys with a separation anxiety disorder, 10 of whom were also diagnosed as having a GID, with 14 normal male controls (Goddard & Tuber, 1989). The study concluded that when compared to normal controls, boys with separation anxiety disorder (half of whom also had a GID) had more disrupted object relations scores as measured by the MOA and more disturbances in their thought processes as measured by the BTD.

In addition to the disturbances in object relations and thought organization, boys with a GID have been reported to manifest gender confusion in their responses (Tuber & Coates, 1985). Three types of gender confusion were found in their percepts. First, they provided responses which combined male and female elements into a

single response. Second, in other responses where they identified a single person, the gender of that person changed or was transformed. Third, some of the children were unable to decide whether a single percept was exclusively male or female.

Lozinski (1988) failed to replicate Tuber and Coates' (1985) findings in a study which compared the patterns of sex-typed responses in the Rorschachs of cross-gender-identified children (70 boys and 9 girls), their siblings, psychiatric controls, and normal controls. The study investigated the frequency of cross-sexed responses, e.g., the frequency with which boys identified females or strongly implied female representations, the frequency of same-sexed responses, and the frequency of gender confusion, birthing and sexual-romantic responses. As hypothesized, Lozinski found that gender-referred children identified significantly more cross-sex responses, whereas the normal and psychiatric controls identified significantly more same-sex type responses. (Interestingly, the siblings of the gender-referred children perceived more cross-sex typed responses, though the difference was not significant.) Contrary to Lozinski's predictions, the frequency of gender confusion, birthing and sexual-romantic responses did not differ among the four groups.

Lozinski's finding that gender-referred children did not produce more gender confusion and birthing responses

differs from the results of Tuber and Coates' (1985) investigation. Although objective comparisons between the two studies cannot be made because of the lack of qualitative results in Tuber and Coates' report, one notable methodological difference between the two studies may, however, have had a highly significant influence on the findings. The difference involves the inclusion criteria for the probands. In Lozinski's investigation children who manifested cross-gender identifications, but who did not meet the criteria for a GID were included in the study (44 children met the criteria; 35 did not), whereas all of the 14 boys included in Tuber and Coates' study met the criteria for the DSM-III diagnosis. This difference raises the question of whether Tuber and Coates were reporting on a more severely disturbed subgroup of cross-gender-identified children. The gender confusion they observed in their sample's Rorschachs may therefore reflect the effect of the greater degree of gender pathology in their population.

Epidemiology and Demographic Characteristics of Boys with a GID

Although a GID is generally considered to be a rare disorder, to date, epidemiological data are lacking. Green's investigation of the demographic characteristics of families of boys with a GID found that the presence of a GID is unrelated to ethnic background, age of parents at the time of the child's birth, number of siblings, birth

order, or the age difference between the boy with the GID's next oldest and next youngest sibling (Green, 1987). Similarly, Coates (1985) found that ethnic background, religion, birth order, and socioeconomic status as measured by the Hollingshead Revised Scale (1975) are not related to the presence of a GID.

Etiology

Although boys with a GID do not have abnormalities in morphology or karyeotyping (Green, 1976; Rekers et al., 1979), the investigation of possible biological contributions to the development of a GID is an area of ongoing research. Coates suggests that there may be a biological, constitutional predisposition for developing severe boyhood effeminacy that expresses itself as temperament (Coates, 1990; Coates & Person, 1985). Although the role of temperament has not yet been systematically studied, Coates has identified five temperamental characteristics as commonly observed in her sample. They include a predisposition to anxiety and/or depression; a predisposition to timidity which expresses itself as an experience of body fragility and vulnerability; an unusual capacity to emotionally connect with others; a variety of unusual sensitivities, including sensitivities to sound, color and texture; and an unusual ability to immitate. (Coates, 1990).

Since clear biological factors have yet to be identified in the etiology of GID, researchers have

looked to environmental influences, particularly family dynamics, to explain the development of the disorder. Those who regard a GID as an isolated phenomena in boys whose early development is otherwise normal posit that the disorder arises from either non-conflictual imprinting (Stoller, 1968, 1975, 1985) or from reinforcement (Green, 1974, 1987). In contrast, those who regard GID as arising in the context of pervasive psychopathology believe that the disorder is significantly influenced by conflicts which arise in the context of extreme family problems (Bradley et al., 1980; Coates, 1985, 1990; Coates & Person, 1985; Coates & Zucker, 1988).

Stoller concludes from his psychoanalytic treatment of several mothers of boys with a GID that five conditions produce the disorder. Briefly summarized, his position is as follows: A depressed woman who herself experiences gender dysphoria marries a passive and unavailable man and then gives birth to a physically beautiful boy. The mother keeps the child in a prolonged period of physical and emotional "blissful symbiosis" and during this time the father's physical or psychological absence permits the mother's femininity to be "imprinted " on the son (Stoller, 1968, 1975). Although Stoller later expanded his data base to include 15 families of effeminate boys, he concluded that the dynamics he observed in his analytic cases were

operative in all of the subsequent families he either interviewed or treated (Stoller, 1985).

Stoller's position has received several different criticisms. First, he has been been criticized by the Roosevelt group which found significant disruptions in the early mother-child relationship (Marantz, 1984; Coates, 1985, 1990; Coates & Person, 1985). Marantz (1984) conducted an extensive study of the child rearing practices and psychopathology of mothers of boys with a GID, comparing 16 of these mothers with a closely matched comparison group of mothers of normal boys. She found that mothers of boys with a GID had a greater incidence of depression (as measured by the Beck Depression Inventory) and borderline personality disorder (as measured by the Gunderson Diagnostic Interview for Borderlines) and concluded that their psychopathology seriously interfered with their mothering abilities.

Coates and Person (1985), when describing the early disruptions, indicate that 50% of the mothers of boys with a GID whom they interviewed reported significant mother-son separations early in the child's life. This finding has been reported elsewhere in the literature. Green found that 22% of the boys with GID that he studied (1974) had early hospitalizations and Bradley et al. (1980) reported a high frequency of mother-son separations which were either psychological separations because of severe maternal depression or actual physical separations because of

maternal illness. Green (1974) also found that there was no difference in the amount of time mothers of boys with a GID report having held their sons and the amount of time reported by mothers of normal boys and that mothers of boys with a GID report having spent less time with their sons than did mothers of normal boys.

Coates and Person (1985, Coates, 1985, 1990) have also reported that 45% of the mothers of boys with a GID whom they studied experienced traumatic events during the first three years of the child's life. These traumas included rape, serious physical injuries, and losses of loved ones. These experiences exacerbated maternal psychopathology and either increased or precipitated the mother's withdrawal from her son. For example, Coates describes a "mother (who) discovered that she was carrying a Down's syndrome child and had an abortion at five months. She reported enormous guilt over having "killed her daughter" whom she had already named. The baby was cremated and to this day the ashes are still in the mother's closet (Coates, 1990). The above findings are consistent with Person and Ovesey's report (1974) that adult transsexuals describe experiencing their mothers during their early childhood as being unempathic, distant and self-absorbed, not as overly involved in a "blissful" relationship.

Many who criticize Stoller (Limentani, 1979; Mahler, 1975; Marantz, 1984; Rainbow, 1986) argue that there is an inherent contradiction in stating that the mothers

dramatically impede any sense of separateness or autonomy in the child, yet do not in general interfere with the child's ego development (Stoller, 1975). Stoller (1985) seems to insufficiently address this argument when he counters Limentani's argument by stating that when one conjures forth the image of an adoring, warm mother enjoying prolonged periods of embracing her infant, a mother who encourages her son's physical, intellectual and artistic development, one cannot possibly regard the interaction as in any way traumatic.

The "blissful symbiosis" theory was also criticized by Mahler, who specifically in response to Stoller, argues that the "infant's innate maturational push insures that symbiosis does not continue to be blissful for the infant beyond the 4th or 5th month whether or not the mother wants it to remain so!" (1975, p. 246).

Green (1987) emphasizes the role of reinforcement in the development of a GID. The conditions whereby feminine behavior is reinforced in the child are as follows: 1) The mother views her son as unusually attractive; 2) she devotes considerable attention to him; 3) both father and mother regard his playing with feminine accouterments as "cute"; 4) the father is often absent physically or psychologically; 5) although the father anticipates a time when the son will play in masculine rough and tumble ways, the son seems unresponsive to such activities; 6) girls are primarily available as playmates; and 7) early

socialization of feminine skills interferes with the child's integration with same sex peers during school age years (1974). Green's position is challenged by Coates' observation that in her sample, although some of the families did not discourage the cross gender behavior, others harshly punished the behavior, trying to "stamp it out."

Researchers at both the Toronto and New York Gender Identity Units have argued that a GID arises as a solution to conflicts, which have developed in the context of significant family psychopathology. Bradley et al. (1980) concluded from the prevalence of parental psychopathology and from the parents' inability to effectively set limits on the child's cross-gender behavior, that the parents were fueling the child's belief that he could become a girl.

Based on her work with the families seen through the Roosevelt Gender Identity Unit, Coates (1985, 1990) explains the development of GID in boys as follows. A child with an at risk temperamental predisposition toward developing a GID is born to parents who themselves manifest significant psychopathology, usually including both affective and personality disorders. The mothers have either anxious and/or hostile, controlling and intrusive parenting styles which interfere with the child's ability to develop his own sense of autonomy and independence. In addition, the mothers have "gender role difficulties" which

are communicated to their sons. Specifically, the mothers often fear, denigrate, and devalue men; many express overt hostility and chronic anger towards men. The mothers also regard normal male assertiveness as tantamount to destructive aggression. This attitude colors their perception of normal boyish rough and tumble activity, which characterizes healthy male playground interactions. The mothers therefore represent this type of play as dangerous and violent, cautioning their sons that they will be hurt if they become involved in these activities. As these attitudes are transmitted to the sons, the fathers either reinforce the attitudes by displaying explosive tempers or by failing to provide a strong counter-experience for the boys because of either their physical or psychological absence. Then, during the first years of the boy's life, when gender identity is being formed, there is a significant stressor in the family's life. The stressor is often a trauma which causes the mother to precipitously withdraw her attention from her son. The child who is then primed by temperamental and familial factors then uses cross-gender identifications and behaviors in the service of creating a fantasy of "being mommy" to allay the profound separation anxiety he experiences as a result of his mother's withdrawal. This "reparative" fantasy, which represents a variation of an identification with the lost object, also serves as a solution to the child's conflicts about masculine assertiveness and about aggression, which

arose from the interplay of the child's temperament and the family's dynamics. Since the child regards his own aggression as dangerous and therefore threatening to his internal tie to his mother, he uses a specific form of splitting where his rage and aggression are projected entirely on to men. Men are then primitively devalued and women are primitively idealized. By identifying with women, he dissociates himself from his own aggression and thereby safeguards his internal tie to his mother.

Coates further writes that the symptoms were not only determined by temperament, family dynamics and environmental stressors, but also by the child's cognitive developmental level at the time of the stressors (Coates, 1990). Her studies have shown that the stress occurs during the first three years of the boy's life, a time during which a child's gender identity is being formed (Fast, 1984; Fagot, 1985). Since earlier studies have shown that a child's developing perception of their own gender is profoundly affected by environmental influences (Money & Ehrhardt, 1972), she writes that a boy who has been primed for gender difficulties by temperament, family, and environmental influences can develop disturbances in his gender identity, which were he older, he could not develop. In part, this occurs because prior to the age of 4, children have not yet attained either gender constancy or gender stability. (Gender constancy refers to the

understanding that gender does not change when one assumes the external accouterment of the opposite gender, e.g., a boy remains a boy when he wears a dress or grows long hair. Gender stability refers to the understanding that gender does not change over the course of one's life, e.g., a boy invariably grows up to be a man. A child normally attains gender constancy and gender stability between the ages of 4-6 years (Fagot, 1985).) Therefore, when these young children with the above characteristics are stressed by maternal withdrawal, they are in part able to develop the reparative fantasy of "becoming mommy" because for developmental reasons they have not yet acquired the understanding that gender cannot change. Interestingly, Coates has found that many of the boys with a GID whom she has studied have not attained gender stability or gender constancy, suggesting that these early disruptions delay the acquisition of these cognitive structures.

Studies of Mothers of Boys with a GID

Although Stoller provides descriptions of the prototypical mother of a boy with a GID (Stoller, 1968; 1975; 1985), he has not conducted a systematic study of these mothers. Instead, he initially formulated his description of these women from the analyses of several mothers of boys with a GID and later expanded the number of families of boys with a GID he has interviewed to include 15 cases. (It is significant that there is no report on

Stoller's interviews with the boys.) He describes mothers of boys with a GID as themselves having had troubled, unhappy childhoods. Their own mothers, i.e., the maternal grandmothers of the boy with the GID, are cold, harsh and rejecting; they hold little or no respect for their daughters; and they devalue femininity. In contrast, the fathers of these mothers, i.e., the maternal grandfathers of the boys with GID, are for several years involved in a close, loving relationship with their daughters and the young girls are routinely involved in masculine activities. Before the girl becomes pubertal, the father precipitously withdraws his attention and affection from her (because of death, separation, divorce, birth of a sibling, etc.). The girls respond to the loss by beginning to dress in boys' clothing, to prefer boys as playmates, to only participate in boys' activities, and to express the wish that they have a penis and become male. At puberty, when her femaleness becomes undeniable, the girl "stops waiting for maleness, becomes manifestly depressed and puts on a feminine facade" (Stoller, 1985, p. 29). When the woman eventually marries, she does so without heterosexual fantasies or attraction and she chooses a distant, passive man. According to Stoller, the organizing maternal characteristics which contribute to the development of her son's GID are therefore the mother's lifelong depression, her basic bisexual orientation, and her repressed hatred and envy of men.

In his 15 year long longitudinal study of 66 boys with a GID, Green (1987) evaluated the parents by having them complete questionnaires designed to elicit information about their attitudes toward the boy's behavior, their relationship to their son, their marital relationship and their own psychosexual background. Addressing Stoller's claims that the mothers of GID boys had a distant relationship with their own mothers, that they were essentially "bisexual," and that they did not date or have sexual experiences prior to marriage, Green found that the mothers of boys with a GID did, in fact, report more distant childhood relationships with their mothers and did have less premarital dating and sexual experiences, but that "they did not have early girlhood sex-typed behaviors that were different from those reported by the mothers of "masculine" boys" (1987, p. 68). His results therefore did not support Stoller's finding that mothers of boys with a GID engaged in masculine activities during their childhoods. Green did not assess the mothers for psychiatric disorders, nor did he administer psychological tests.

Several researchers have more systematically investigated the "hostile" attitude towards men that Stoller describes as characteristic of mothers of boys with a GID (Bradley et al. 1980; Coates & Person; 1985). Bradley et al. (1980) concluded that these women typically perceived men as ineffectual and often expressed overt

hostility towards them. Coates and Person (1985) noted that the mothers not only devalued and expressed contempt and anger towards men, but they were also often quite fearful of them and tended to confuse normal masculine assertiveness with out-of-control, destructive aggression. They also noted the related finding that these mothers took considerable pride in their boys' lack of rough-and-tumble rambunctiousness and that they clearly articulated the belief that their gentle, kind, sensitive boys were better than other boys whom they regarded as aggressive, insensitive bullies.

Several investigations of maternal psychopathology have also been conducted in recent years. Bradley et al. (1980) found that many of these mothers had significant depressive episodes during the child's first three years and that a significant percentage of the parents of boys with a GID had been treated for affective illness and for substance abuse. Rekers, Mead, Rosen, and Brigham (1983) found that 80% of the mothers had a history of mental health problems.

Marantz (1984), working with the Roosevelt group, conducted the first systematic study of psychopathology in mothers. She used systematic measurements to compare the psychopathology and child rearing practices of mothers of boys with a GID with mothers of normal boys who were matched for age and intellectual level of the son, presence or absence of father prior to age 4, race,

religion, and socio-economic status. She compared 16 mothers of boys with a GID with 17 mothers of boys who did not have significant psychopathology. All the mothers were administered the following: 1) The Gunderson Diagnostic Interview for Borderlines (DIB); 2) Beck Depression Inventory (BDI); 3) Summers and Walsh Interview for the Measurement of Symbiosis; 4) Block Child Rearing Practices Report; 5) an interview designed to elicit information about the mother's life circumstances during the first three years of the son's life; 6) an interview about the mother's childhood; and 7) the Rorschach.

From the above measures Marantz drew the following conclusions: 1) None of the control mothers had a borderline personality disorder, whereas 25% of the mothers of boys with a GID received this diagnosis. The proband mothers who did not have the personality disorder did manifest significantly more borderline psychopathology than did the controls. The probands specifically differed from the controls on the DIB in their unstable interpersonal relationships; their intensely experienced feelings of depression, emptiness, loneliness, anger and entitlement; and their tendency to have transient psychotic experiences. 2) Mothers of boys with a GID evinced greater depression both on the BDI and in their treatment histories than did control mothers. On the BDI mothers of boys with a GID scored

in the upper end of the mildly depressed range of the scale whereas the control mothers scored in the non-depressed range of the scale. 3) Although mothers of boys with a GID did not differ from control mothers in child rearing practices (as measured by the Block Q-sort), on the Summers and Walsh Interview for the Measurement of Symbiosis they identified themselves as more enmeshed with their son. On this scale they further differed from controls in their being more dependent on their child, more controlling of him, more disapproving of the boy's relationships with others, less differentiated and less able to separate from the child.

Both groups were also administered the Rorschach, which was scored with the Urist Mutuality of Autonomy scale (MOA). The MOA measures the extent to which a person experiences interactions as benign, reciprocal and autonomous verses dependent and enmeshed verses destructive and completely violating one's autonomy. (A detailed description of this scale is included in chapter 4.) Although the mean scores did not differ significantly, the modal scores differed as follows: 1) 36% of the probands obtained modal scores in the normal-neurotic range of object relations pathology compared to 85% of the controls; 2) 29% of the mothers of boys with a GID obtained modal scores which fell in the range of narcissistic pathology as compared to 15% of the control

mothers; and 3) 36% of the mothers of boys with a GID and none of the control mothers had modal scores which fell within the more pathological end of the scale. This end of the scale has been thought to measure borderline psychopathology and is commonly accepted among users of the scale to reflect a person's tendency to experience interpersonal relationships as threatening to one's basic autonomy, as malevolently controlling, or as overtly destructive.

Rainbow (1986) compared 5 boys with a GID and their mothers, 5 separation anxious boys and their mothers, and 5 normal boys and their mothers. She found that although the mothers in the two clinical groups showed greater personality disturbance than mothers in the control group, only mothers of boys with a GID had a borderline personality organization. Mothers of boys with GID also experienced greater losses and more mother-son separation during their sons' first years than did the other mothers. Also, although the mothers of boys with a GID and the mothers of separation anxious boys equally experienced traumatic stress during this period, mothers of boys with a GID responded in a more psychologically debilitating manner than did mothers of separation anxious boys; specifically, mothers of boys with a GID were reported to be less emotionally accessible than mothers of separation anxious boys. Finally, she found that mothers of boys with a GID held

"rigidly fixed" negative representations of males, whereas the mothers of separation anxious boys had a more integrated, balanced view of males. Significantly, when fathers were absent from the household, mothers of the separation anxious boys, unlike mothers of boys with a GID, found "surrogate fathers" who adopted a positive paternal role with the boys.

Studies of Fathers of Boys with a GID

To date fathers of boys with a GID have not been systematically studied. However, most researchers who have in any way studied families of boys with a GID agree that the fathers, like the mothers, have significant psychopathology. As mentioned earlier, Bradley et al. (1980) found a high rate of previous treatment for affective disorders, alcoholism, and drug abuse in both mothers and fathers of boys with a GID. Rekers (1983) found that 45% of the fathers had previous mental health problems. Coates (1985, 1990) observed that in her study "none of the gender disturbed boys had a father who was appropriately involved (with the boy)." She further notes that the fathers fear intimacy with women and are as angry with women as the mothers are with men. Most researchers have also found a high incidence of either physical or psychological absence of the fathers in the households of boys with GID (Bradley et al., 1980; Coates, 1985; Coates & Zucker, 1988; Green, 1974; Rosen & Teague, 1974; Stoller, 1985).

Rosen and Teague (1974) report case histories of fathers of four boys with gender disorders. They drew the following conclusions about these four men: 1) The fathers were physically present, but psychologically absent. They had many interests outside the home, though they were not highly masculine interests. 2) The fathers had doubts about their own gender identity, which they had managed by repressing the concerns. Many had histories of feminine interests and were at the time of the interviews described as "soft and effeminate." 3) The fathers were uncomfortable with emotional intimacy and they tended to repress their emotional reactions until they exploded in "isolated, unpredictable ... violent and explosive outbursts of anger and frustration." Rosen and Teague conclude that because of these characteristics, the fathers of boys with gender disturbance do not provide a model for their son's masculinity and, in fact, would regard a highly masculine son as a "visible threat to his own masculinity."

Stoller (1979, 1985) has cursorily investigated the fathers of GID boys. In Presentations of Gender he includes quotes from 9 of the 15 families of boys with a GID with whom he had contact. It is noteworthy that of the 9 cases he presents, only 3 actually include quotations from the fathers themselves. The other 6 cases included the mothers' descriptions of the fathers. Stoller explains

that, "The fathers usually failed to come in for evaluation interviews. Then when we recommended that the fathers participate in the treatment, not a single one was able to cooperate (1985, page 46)." (Significantly, every father who was asked to participate in the evaluation of their son through the Roosevelt Unit agreed to do so.) From this paucity of data, Stoller concluded that mothers of boys with a GID choose an ineffective, passive man who is as "good as castrated." She chooses a man "who will not interfere and who as time passes, will not be present to serve as a model for masculinity; she is left free to help create the femininity we then see" (1985, p. 56). The boy then fails to develop an adequate representation of a father because of the father's physical and emotional absence and in fantasy the boy experiences his father as either an absence or an "unmovable inadequate presence."

Green used the same questionnaire with the fathers that he used with the mothers. With the fathers, he particularly focused on the amount of time spent with the child, the father's attitudes towards a child's sexuality, and the father's own childhood play interests. He found a "very weak trend" in the difference in the amount of time fathers of boys with GID report having spent with their sons in the first year compared to fathers of "masculine" boys, with the fathers of boys with a GID having spent slightly less time with their sons. However, there was a significant difference in the amount of reported father-son

time during the second year and the difference became greater in years three to five. Green also found that these fathers spent less time with their "prefeminine" sons than with their "premasculine" sons during the sons' second year, demonstrating a strong preference for their masculine son. Green further found a correlation between the amount of time fathers spent with their sons and the extent to which the father reported wanting to have a boy during the pregnancy; the more the father wanted a girl, the less time he spent with his son. Green's description of the fathers' psychosexual development was extremely brief. In the four lines he devoted to this issue, he concludes that fathers who were less conventionally masculine during their childhood (meaning less interested in rough-and-tumble play and sports) had a more positive reaction to their sons' early expressions of feminine behavior than to their sons' early masculine behavior.

Although Rainbow's (1986) study focused on the mothers of boys with a GID, she did find that fathers of the boys with a GID whom she studied were described by the mothers as present, but negative influences on their sons. This contrasted with the fathers of separation anxious boys who were either absent or were present and described as providing a positive influence.

Although the Roosevelt group has not yet systematically assessed fathers, Coates writes that her initial impressions are that the fathers, like the

mothers have chronic character pathology and affect disorders (Coates, 1985, 1990). She has observed that the mothers in her study describe their husbands as "remote, violent, and sometimes alternatingly remote and violent." She quotes one middle class father who when questioned about whether his son had tantrums answered, "No, I have the tantrums. If he had one, I'd drown him in the pool." Several of the fathers of boys with a GID whom she studied were abusive/harsh disciplinarians. For example, one man would throw his son against the wall and another would destroy the child's toys to discipline him. She noted that other fathers were uninvolved with their families, either because of work commitments, extramarital affairs, or a professed aversion to a child whom they said they knew was going to be homosexual. This is consistent with Marantz's (1984) finding that 56% of the mothers of boys with a GID as compared to 24% of the controls described their husbands as having extramarital affairs during the boy's early years.

CHAPTER THREE

INTRODUCTION TO EMPIRICAL STUDY AND HYPOTHESES

Since parental psychopathology and psychodynamics are thought to play an important role in the etiology of GID in boys, systematic investigations of these aspects of parental functioning are critical to advancing our understanding of the disorder and informing how we can effectively treat boys with a GID. To date, there has been one systematic study of maternal psychopathology. Systematic studies of paternal psychopathology have yet to be conducted, although clinical reports suggest that the fathers, like the mothers, have psychiatric disorders, notably affect disorders. This study will compare the psychopathology of the mothers of boys with a GID to the psychopathology of the fathers of these children to determine whether the fathers, like the mothers, do indeed have psychiatric disturbances. A comparison of the mothers and fathers will also elucidate whether one group exhibits significantly more psychopathology than the other group or whether the type of psychopathology characteristically seen in the mothers differs from that observed in the fathers.

Although Marantz's (1984) study was extremely important in demonstrating the prevalence of depression and borderline psychopathology in the mothers, her investigation did not assess the presence or absence of other psychiatric syndromes. The measures she used do not

differentiate among the different types of depressive disorders, nor are other types of psychopathology, including other personality disorders, queried for. (The BDI measures current depression on a scale ranging from 0-63 and depending on the numerical score a person is rated as "not depressed," or "mildly," "moderately," or "severely" depressed. The DIB reflects the criteria used to make the diagnosis of a borderline personality disorder in DSM-III, but does not rule out the possibility of a subject having another personality disorder.) This study will employ a more comprehensive structured clinical interview which queries for many types of Axis I psychiatric disorders, as well as Axis II personality disturbances, to provide a more comprehensive assessment of the overall rates of psychopathology in the mothers and the fathers.

Marantz's study did indicate that when compared with normal controls mothers of boys with a GID had greater disturbances in their concepts of interpersonal relations. From the results obtained on the DIB, she also concluded that these mothers have disturbances in their thought processes which are characteristic of borderline psychopathology. These particular aspects of parental functioning will also be investigated in this study, again, to compare the rate of disturbance in the object representations and thought organization of mothers and fathers of boys with a GID.

Although the clinical descriptions suggest that the rate and extent of psychopathology in mothers and fathers is similar, the one paper which actually reports rates of psychiatric disturbances in mothers and fathers indicates that the percentage of mothers who have mental health problems is higher than the percentage of fathers with psychopathology (Rekers et al., 1983). Although the method used to elicit the data is unclear from their report, Rekers et al. found that 80% of the mothers and 45% of the fathers had histories of "psychological problems or had reported being under the care of a psychiatrist, psychologist or counselor." Given this finding and the finding that higher rates of psychopathology are associated with greater disturbances in object representations and thought organization (Blatt & Berman, 1985; Blatt & Ritzler, 1974; Coates & Tuber, 1988; Goddard & Tuber, 1989; Harder, Greenwald, Wechsler, & Ritzler, 1984; Spear & Sugarman, 1984; Tuber & Coates, 1989), the following hypotheses were developed.

HYPOTHESIS 1. Mothers of boys with a GID will exhibit Axis I diagnoses more frequently than fathers of boys with a GID on the Structured Clinical Interview for DSM-III-R.

HYPOTHESIS II. Mothers of boys with a GID will exhibit Axis II diagnoses more frequently than fathers of boys with a GID on the Structured Clinical Interview for DSM-III-R Personality Disorders.

HYPOTHESIS III. Mothers of boys with a GID will exhibit disturbances in their concepts of interpersonal relationships more frequently than fathers of boys with a GID on Urist's Mutuality of Autonomy Scale applied to Rorschach protocols.

HYPOTHESIS IV. Mothers of boys with a GID will exhibit greater disturbances in their thought processes than do fathers of boys with a GID as measured by the Blatt Thought Disorder Scale applied to Rorschach protocols.

Understanding parental psychodynamics, as well as parental psychopathology, may further explain the etiology of GID in boys. Therefore, in addition to the above hypotheses, this study will address two exploratory questions, which involve parental psychodynamics, in order to generate additional hypotheses which could direct future research. The two issues which will be explored are characteristics which have been reported in the boys with GID. First, in fantasy and on projective tests boys with a GID have been reported to exhibit gender confusion, that is, they have difficulty deciding on the gender of a character, they see gender as mutable, or they fuse male and female characteristics into a single male/female hybrid (Tuber & Coates, 1985).

Secondly, boys with a GID experience significant body anxiety; they regard their bodies as being fragile and

easily damaged and they are overly fearful about being hurt (Bates et al., 1979; Coates, 1985, 1990). Using Rorschach scales which measure gender confusion and experiences of body vulnerability, these aspects of parental functioning will be investigated in the mothers and fathers of boys with a GID. Coates' descriptions (1990) of the mothers' concerns about assertiveness and aggression and of mothers' gender role difficulties and Rosen and Teague's descriptions (1974) of fathers' (based on interviews with four men) body anxiety, lack of highly masculine interests, and doubts about their own gender identity suggest that this would be a useful line of inquiry.

The exploratory questions therefore being asked are:

1) Is there evidence in the mothers' and fathers' Rorschachs of their experiencing their bodies as fragile and vulnerable?

2) Is there evidence of gender confusion in the mothers' and fathers' Rorschachs?

CHAPTER FOUR

METHODOLOGY

Subject Population

Inclusion Criteria: 1. Parents of boys with a GID whose GID son is between 4-12 years of age. (See page 4 for DSM-III-R criteria for GID.)

Exclusion Criteria: 2. Parents of boys with a GID whose GID son is either retarded or psychotic.

The subjects for this study were 11 mothers and 12 fathers of boys with a GID. The population was comprised of 9 married couples, 2 divorced couples and one father whose wife was not recruited for the study for reasons described below. The subjects came primarily from upper-middle to upper class families. Their mean Hollingshead (1975) socioeconomic score was 53.4. Although race was not a selection criteria, nor was it being controlled for, all parents who participated in the study were white. The mean age of the fathers was 39 years and the mean age of the mothers was 38.2 years.

The age of the subjects' sons ranged from 4-12 years (M = 5.6 years) and all were diagnosed as having a GID. The boys had either been referred to the Childhood Gender Identity Disorder Unit at the St. Luke's/Roosevelt Hospital or privately to Susan Coates, Ph.D. for a thorough psychiatric and psychological evaluation of cross-gender preoccupations and behavior.

Recruiting Procedures

Parents were recruited two ways. First, three sets of parents who were currently being seen through the Childhood Gender Identity Unit, and one who was in recent communication with the unit, were contacted and asked if they would like to participate in this study. All other subjects were consecutive referrals to the Childhood Gender Identity Unit, with the exception of one out of town referral.

All parents who were asked, agreed to participate in the study. In one couple, the father was asked to participate in an investigation of fathers before the study was conceptualized as including both parents. This father agreed and did participate. However, by the time that the study began recruiting mothers, this couple had left the clinic because of their disappointment and anger upon hearing their concerns confirmed that their son had a GID.

Parents were informed that they were free to withdraw from the study at any time and that all material would be kept confidential. They were asked to sign a consent form (see Appendix 1) and were given an opportunity to ask any questions they had about the study. Each parent was seen either at the Roosevelt Hospital or Dr. Coates' private office for 2-6 hours, with the average time being approximately 4 hours. Sessions were scheduled according to parents' personal needs.

Measures

Measures for this study include: 1) Structured Clinical Interview for DSM-III-R (SCID); 2) Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II); 3) Urist Mutuality of Autonomy Scale (MOA) applied to the Rorschach; 4) Blatt Thought Disorder Scale (BTD) applied to the Rorschach; 5) Tuber and Coates' categorization for gender confusion applied to the Rorschach; and 6) Fisher and Cleveland Body Image (FCBI) Scale applied to the Rorschach.

1. Structured Clinical Interview for DSM-III-R (Spitzer, Williams & Gibbon, 1987)

The SCID is a detailed structured clinical interview which is designed to generate Axis I diagnoses based on the diagnostic criteria outlined in DSM-III-R (APA, 1987). To address the needs of different populations, three versions of the instrument were designed. The SCID-P (patient version) was developed for use with psychiatric inpatients who often require detailed questioning about psychotic symptoms. The SCID-OP (outpatient version) was designed for use with psychiatric outpatients who are not expected to have psychotic disorders, but who should be queried about the problems which caused them to seek treatment, i.e., their "chief complaint." The SCID-NP (nonpatient version) was developed to use with patients who are not identified as psychiatric patients. The SCID-NP lacks a detailed assessment of psychotic symptoms and inquires

about history of possible psychiatric disorders, rather than about the "chief complaint."

The SCID-NP was used in this study because the literature on the psychopathology of parents of boys with a GID did not suggest that these parents comprised a population with psychotic disorders and because, although some of the parents may be in treatment, it was expected that many would not be (Gibbon, personal communication, 1989). The SCID-NP includes the following modules:

SCID-NP Summary Score Sheet
SCID-NP Overview
A. Mood Syndromes
B/C. Psychotic Screening
D. Mood Disorders
E. Psychoactive Substance Use Disorders
F. Anxiety Disorders
G. Somatoform Disorders
H. Eating Disorders
I. Adjustment Disorders

The SCID-NP Summary Score Sheet is completed after the interview has been conducted and scored and indicates which disorders a patient does and does not have, and which "subthreshold," disorders a patient may have, i.e., the disorders where a subject has many, but not all of the symptoms required to warrant a diagnosis. In situations where the interviewer diagnoses the subject as having a disorder that is not included within the SCID, this diagnosis should be included in the summary. The summary also includes a Global Assessment of Functioning Scale which is a numerical rating ranging from 1-90 of the subject's lowest level of functioning. The interviewer is asked to consider the subject's worst week in the month

immediately preceding the interview when making the rating. The assessment is made by the interviewer at the interview's conclusion.

The SCID-NP Overview obtains demographic data from the subject and asks general questions about previous psychopathology, treatment history, and overall functioning during the past month.

Modules A. through I. inquire about specific disorders. Each module begins with general screening questions which allow an interviewer to "skip-out" of a particular module if it is clear that the person does not have, or with disorders where past history is also obtained, has never had, a particular disorder. Questions are based on the DSM-III-R criteria for the different disorders, i.e., the diagnostic criteria are included within the interview itself and the sequence of questions is similar to the DSM-III-R decision trees. The interview contains many open-ended questions designed to have subjects describe their symptoms in detail, rather than merely agreeing or disagreeing about a symptom's presence. Although most modules assess whether a subject has ever had a particular disorder, i.e., "lifetime prevalence," the past history of several disorders is not elicited. The disorders where only current psychopathology is diagnosed are: dysthymia, generalized anxiety disorder, somatoform disorders and adjustment disorders.

The SCID instructs an interviewer to use all sources

of available information to make the final diagnosis, including referral notes, treatment records and consultations with other professionals. (This was relevant for several parents included in this study who had either been in treatment through the Roosevelt Childhood Gender Identity Unit or where additional, relevant parental information had been elicited during the evaluation of their son.) The SCID further instructs an interviewer that although he/she is asking structured questions, the ratings are for diagnostic criteria, which may or may not correspond to the subject's answer to the question. An interviewer is cautioned to use clinical judgment about whether the diagnostic criteria are actually met or not. For example, at times, a subject adamantly denies a particular symptom which he, through other responses, has clearly indicated as present; in such situations, the symptom would be coded.

Although the SCID is a detailed interview which elicits diagnostic information about many of the DSM-III-R Axis I disorders, questions are not asked about all possible diagnoses. For example, the interview does not include questions about sexual disorders, sleep disorders, and many impulse control disorders.

Although data has been collected on the reliability of the SCID, the results have not yet been published. Gibbon, who is involved in the compilation of this data at the New York State Psychiatric Institute indicated (personal

communication, 1990) that the interrater reliability is between that of the Diagnostic Interview Schedule (DIS) test-retest study and that obtained for the Schedule for Affective Disorders and Schizophrenia (SADS). (The DIS test-retest study had a chance-corrected concordance of .60 or better for 8 of the 11 diagnoses included in the interview (Helzer, Robins, McEnvoy, Spitznagel, Stoltzman, Farmer, & Brockington, 1987) and the reliability on the SADS ranged from .66 to 1.00 for all but one diagnosis (Spitzer, Endicott, & Robins, 1978).)

Riskind, Beck, Berchnick, Brown, and Steer (1987) examined the interrater reliability for diagnosing generalized anxiety disorder and major depressive disorder using the SCID and demonstrated .72 and .79 reliability, respectively. From their study, they concluded that the SCID reliably differentiates generalized anxiety disorder and major depressive disorder.

As yet, validity studies of the SCID Axis I diagnoses have not been conducted.

2. Structured Clinical Interview for DSM-III-R Personality Disorders (Spitzer, et al. 1987)

The SCID-II is often preceded by the SCID Personality Questionnaire which was designed to expedite the administration of the SCID-II. The SCID Personality Questionnaire is a written questionnaire which is comprised of 120 yes/no questions about a subject's personality, The questions correspond to the 120 questions on the SCID-II,

which are based on the criteria used for diagnosing different personality disorders. The questionnaire itself is based on the assumption that if, on this screening instrument a subject indicates that a certain statement does not characterize him/her, then the interviewer need not inquire about that characteristic during the structured interview.

Once the questionnaire is completed, the interviewer then administers the SCID-II. The SCID-II includes the following sections:

SCID-II Summary Score Sheet
SCID-II Overview
Personality Disorders

The SCID-II Summary Score Sheet is the Axis II version of the SCID Summary Score Sheet described above. The SCID-II Overview asks 8 general questions about a subject's personality. The questions include: "How do you describe yourself as a person?" and "If you could change your personality in some ways, how would you want to be different?"

The questions which comprise the Personality Disorders section of the SCID-II are based on the same design as the questions in the SCID. Prior to beginning this section, a subject is told that he/she will be asked about the questions to which he/she answered "yes" on the questionnaire (since question #1 on the questionnaire corresponds to question #1 on the SCID-II, etc.). The inquiry during the interview determines whether the items

which the subject identified on the questionnaire as characteristic of him or herself, are actually clinical symptoms. This is often accomplished by using probes such as, "Give me the most extreme example " or "Do you think you are more this way than most people?"

The SCID-II evaluates the presence of the 11 personality disorders described in DSM-III-R. A twelfth, personality disorder not otherwise specified, which is included in the DSM-III-R can be scored with the SCID-II. A thirteenth disorder, self-defeating personality disorder, which is included in Appendix A of the DSM-III-R was included in the SCID-II because it was considered to be the focus of many current research projects (Spitzer et al., 1988).

Preliminary data compiled by the New York State Psychiatric Institute on the reliability of the SCID II indicate that the reliability of the SCID II is similar to the reliability of other personality disorder instruments, such as the Personality Disorder Examination (SCID Newsletter, 1988; Lorenger, Susman, & Oldham, 1987).

Skodol, Rosnick, Kellman, Oldham, and Hyler (1988) have conducted the only validity study of the SCID II. In their study, SCID II diagnoses were compared with observations of maladaptive personality traits in psychiatric inpatients which were made over the course of a long-term hospitalization. They found that the diagnoses of disorders which have behaviorally defined

psychopathology, such as antisocial and schizotypal personality disorders are more accurate than those which require the interviewer to make inferences about the subject, such as with narcissistic and self-defeating personality disorders. They found a high false positive rate and no false negatives for avoidant and obsessive compulsive personality disorders and concluded that the SCID II criteria are too easily met for these disorders. They were unable to accurately assess the validity of borderline and schizoid personality disorders.

Rorschach Administration

The Rorschach was administered according to the method outlined by Klopfer and Davidson (1962). However, Klopfer's method of inquiry was slightly revised according to the method prescribed by Tuber to facilitate using the MOA scoring system (Tuber, 1984).

3. Urist Mutuality of Autonomy Scale (Urist, 1977)

The Urist Mutuality of Autonomy (MOA) Scale is a seven point scale which measures a person's characteristic way of experiencing interpersonal interactions. When the scale is applied to the Rorschach, any percept which either specifies an interaction between two figures (animate or inanimate), or strongly implies an interaction, receives a MOA score. The scale measures a continuum of possible object representations ranging from mutual, empathic, autonomous interactions to interactions which are

characterized by overpowering control, malevolence and destruction. Urist conceptualized the scale as reflecting a developmental progression towards greater autonomy and mutuality in relationships. He writes that the seven points along the scale correspond to "developmentally significant gradations in the individual's capacity to experience the self and other as mutually autonomous within a relationship " (Urist, 1977, p. 4).

A scale point of 1 is indicative of the highest level of object relations. Such responses highlight the mutual, autonomous, reciprocating quality of an interaction. "Two people laughing together, playing patti-cake with one another" is an example of a scale point of 1. A scale point of 2 refers to interactions where mutuality is not stressed, such as in parallel activity; although the autonomy of the two figures has not in any way been compromised, these responses do not depict interactions where the figures mutually acknowledge one another's separateness. "Two people washing clothes" would be an example of scale point 2. Scale point 3 describes an emerging loss of autonomy between the two figures, where one or many figures require an external source of support. An example of scale point 3 would be "two animals leaning against a bush." Scale point 4 involves an even greater loss of autonomy in the interaction as one figure is seen as the reflection or imprint of another. "An animal and his reflection" would be an example of such a response.

Scale points 5, 6 and 7 reflect both the decreasing capacity for a separate, autonomous interaction, but also the increasing malevolence and destructiveness of one figure towards another. A response where one figure is adversely influencing or controlling another is scored 5, an example being, "A witch casting a spell over these two animals." When one figure seriously harms or destroys the other as in "A monster killing a rabbit" a 6 is scored. Finally, when a figure is overpowered by an extremely destructive, "larger-than-life" force, a scale point of 7 is scored. "A tornado destroying everything in its path" is an example of a 7.

Tuber (1984) believes that the scale can be used to measure levels of object relations which are characteristic of different degrees of psychopathology. He regards scores of 1-2 as indicating normal or neurotic organization; scores of 3-4 as indicative of narcissistic character organization; scores of 5-6 as characteristic of borderline psychopathology; and scores of 7 as reflective of psychosis. He further notes that failure to generate any Urist scores is often pathognomonic and should therefore be indicated in any summary of scores.

High levels of inter-rater reliability have been demonstrated with the percentage of exact agreement in scoring ranging from 70-90% and with 85% or greater agreement within one scale point (Blatt, Tuber, & Auerbach, in press). The Urist MOA has been used with both adult and

child and both clinical and normal populations. Using independent assessments of interpersonal behavior, social interactions and psychiatric disorders, a variety of studies have demonstrated the scale's validity (Harder, Greenwald, Wechsler, & Ritzler, 1984; Kavanaugh, 1985; Ryan, Avery, & Grolnick, 1985; Spear & Sugarman, 1984; Tuber, 1983; Urist, 1977; Urist & Schill, 1982).

4. Blatt Thought Disorder Scale

Rapaport et al. (1945) developed a system for measuring different levels of cognitive boundary disturbances in Rorschach responses. The scale is based on the premise that a subject's inability to maintain boundaries between independent objects and between self and non-self on the Rorschach reflects disturbances in the person's thought processes. The original scale measured three basic types of thought disorder in Rorschach responses and three milder, variations of these basic categories. The scale was later refined by Blatt and Berman (1984) to include seven categories. An eighth category, which also represents a finer tuning of the original system, rather than an introduction of a "new" type of thought disorder response, has been used by several investigators (Blatt, Tuber, & Auerbach, in press; Goddard & Tuber, 1989, Tuber, 1983).

Rapaport et al. (1945) identified three types of responses which reflect disturbances in a subject's thought

processes. The most severe is a "contamination," which involves a fusion of two independent percepts or concepts into a single, distorted response, which completely violates the usual boundaries of the identified figures. An example would be a "rabbit hand" where the separate images of a rabbit and a hand are fused into a single response. "Confabulations" reflect a subject's difficulty differentiating the boundary between what he sees in the inkblot and his own inner associations, fantasies, and reactions. The percept, which may be "well-seen," is embellished with extensive, unrealistic and personalized associations. The following is a confabulation. "Looks like twins on the bottom. It looks spiritual or something, like the beginning of the world. The division line in the middle is the difference between them, heaven or earth or something." A "fabulized combination" is the least serious of these three types of responses and includes precepts which link together separate, but spatially contiguous figures in an implausible, illogical relationship. "Prairie dogs standing on a butterfly" would be an example of a fabulized combination.

Rapaport et al. (1945) and Allison, Blatt, and Zimet (1968) also discuss milder versions of each of the above types of thought disturbances, which are referred to as "tendencies." A tendency is scored either when the response is less extensive (as in confabulations) or includes only part of the percept (as in contaminations). A tendency is

also scored when the subject in some way criticizes or qualifies his response, indicating that he recognizes the unrealistic nature of what he has identified and is able to assume a critical distance from the contamination, confabulation, or fabulized combination.

Blatt and Berman (1984) discuss the need to clearly distinguish responses where two separate figures are seen in an implausible relationship (fabulized combinations) and responses where the percepts are joined together, though not completely merged (as they would be in contaminations). To differentiate these responses, Blatt and Berman categorized the original fabulized combination, as exemplified by the "prairie dogs standing on a butterfly" response, as "fabulized combination (regular)." The responses where the subject blends disparate parts of separate figures into a hybrid which contains the discrete parts, e.g., the "bear with a rabbit's head," represents a more serious boundary disturbance and in the revised system these responses are "fabulized combinations (serious)."

Several papers and studies (Blatt, Tuber, & Auerbach, in press; Goddard & Tuber, 1989; Tuber, 1983) have further distinguished confabulation tendencies, differentiating those responses where the subject criticizes or qualifies his response and those which are less extensive, less personalized, that is, "milder" confabulations. In these studies, the former continue to be called "confabulation tendencies" and the later are categorized as "fabulized to

confabulation."

Both Blatt and Ritzler (1974) and Blatt and Berman (1984) have emphasized that the scale is a hierarchical scale which measures levels of severity of thought disturbance and have ascribed numerical values to the different categories in order to compare Rorschach protocols. Blatt and Berman (1984) rated the categories from most to least severe as follows: contamination (6), contamination tendency (5), fabulized combination (serious) (5), confabulation (4), confabulation tendency (3), fabulized combination (regular) (2), and fabulized combination tendency (1).

Inter-rater reliability on the Blatt scale has ranged from .76 to .96 (Blatt & Berman, 1984; Blatt & Ritzler, 1974). Several studies have demonstrated the validity of the scale with adult psychiatric populations (Blatt & Berman, 1984; Blatt & Ritzler, 1974; Goldfried, Stricker, & Weiner, 1971; Harder & Ritzler, 1979). Blatt and Ritzler (1974) found that the level of thought disorder measured by the scale correlated with other measures of hospitalized psychiatric patients' boundary disturbances and with the extent of their psychopathology. Blatt and Berman (1985) found that the scale successfully differentiated opiate addicts and psychiatric in-patients.

Although norms for nonpatient adults have not been published for the Blatt scale, the scale is based on the premise that any scored response is inherently an indicator

of psychopathology in adults. (This is not true for children.) Rapaport et al. write that "fabulized combinations occur, though rarely in the records of normal and fairly well-organized neurotic subjects. But these subjects will usually seem startled when such a response possibility comes into their minds; they will give the response with a smile, with some apologetic explanation of the fact that 'it just struck me that way' " (1945, p. 433). This suggests that in normal controls one does occasionally see fabulized combination responses, but they are more likely to be fabulized combination tendencies, than fabulized combination regular or serious responses. They further write, "Among neurotics, we should expect to find no confabulations and few fabulized combinations."

Rapaport et al.'s observations are corroborated by norms published by other investigators. Although these norms are not derived using the Blatt scale, they are derived either from using some of the Blatt categories or differently named equivalents. Friedman (1952) designed a scoring system to measure a subject's developmental level. Fabulized combinations, which correspond to Blatt's fabulized combination regular, serious, and tendency, and contaminations, which seem to include contamination tendencies, are included in this scoring system. When 30 normal adult males were assessed using this system, Friedman found that the median of the fabulized combination and contamination responses was zero and that only 3% of

the normal subjects had one or more of these responses. Goldfried, Stricker, and Weiner (1971) indicated identical findings were reported by Frank (1952) in "neurotic" subjects.

Exner (1986) has collected norms on the frequency of "inappropriate" responses in 600 nonpatient adults. He found that normal adults produced a mean of .54 "incongruous combinations" (which are identical to Blatt's fabulized combination serious), a mean of .18 fabulized combination responses (which are identical to fabulized combination regular) and a mean of .01 contamination responses (which are identical to Blatt's contamination responses).

5. Tuber and Coates' Categories for Scoring Gender Confusion (1985)

Tuber and Coates (1985) have noted that boys with a GID manifest overt gender confusion in their Rorschach responses. They observe that the confusion is expressed in three different types of responses. First, in some responses the child is unable to decide whether a single percept is exclusively male or female. An example of such a response is "If it's a girl then the hair goes up... or if it's a boy, it needs a haircut." Second, in a single percept, the gender changes, such as in "It looks like a lady, looks like a man, turning into a Superman." Third, in some responses the child fuses male and female elements into a single percept. " This looks like a fat man naked

with lady's shoes on" is an example of this third type of response. The first type of response is the least serious type of gender confusion, whereas as the third type of response is the most serious, and in fact, is often scored as a thought disorder response as well as a gender confused response.

For the purposes of this study, a brief description of the three categories of responses, which included examples of each type of gender confusion was developed in order to train a rater in how to score for gender confusion in Rorschach responses. (See Appendix 2.)

Thus far, neither reliability nor validity studies have been conducted using this scoring system. However, Coates believes that overt gender confusion on the Rorschach is a "highly specific" indicator of gender disturbance (Coates & Zucker, 1988).

6. Fisher and Cleveland Body Image Scale

Fisher considers body image to be quite complex and multidimensional. As an example of the complexity of body image, he describes how at any given moment a person may be simultaneously attending to his position in space, the integrity of his body boundaries, his body's salience and prominence in his total perceptual field, etc., all of which may or may not be correlated with one another. (Fisher, 1986). In 1958 Fisher and Cleveland published a scale to measure one dimension of body image, which they refer to as "the body-image boundary dimension." Their

interest in measuring a person's experience of the boundaries of his body arose from their studies of patients with medical illnesses, which are conventionally regarded as having psychosomatic determinants, e.g., rheumatoid arthritis, stomach disturbance, and neurodermititis. They observed that these patients expressed considerable concerns about their bodies, which were reflected in their Rorschach responses. Patients whose disorders were located in the exterior of their body, such as in arthritis and neurodermatitis, typically gave Rorschach responses which emphasized the containing, protective, boundary-defining qualities of the periphery of a percept, as in "a knight with armor." Patients whose symptoms were located on the interior of their body, such as in stomach disorders or ulcerative colitis, gave a preponderance of responses which emphasized the permeability, weakness, or actual destruction of a percept, as in " a broken-up butterfly."

Their observations led to a two-category scale which measures a person's perception of his body boundaries and reflects the extent to which people experience these boundaries as "definite and firm verses indefinite and vague." One score (Barrier) represents the positive assertion of definite boundaries where the body is experienced as functionally protective, whereas the other score (Penetration of Boundary) measures experiences of body boundary breakdown and fragility, where the body exterior is unable to be protective and is easily damaged.

Barrier responses involve percepts where the surface is characterized as having protective, enclosing, decorative, or concealing qualities and include references to clothing, animals with unusual skins, buildings, vehicles, and enclosing geographical formations. Penetration responses emphasize the weakness, lack of substance, and penetrability of persons and objects and include references to openings, degenerative processes, and insubstantial states (e.g., ghost, shadows).

Normal subjects have both Barrier and Penetration responses in their Rorschachs and the ratio of Barrier to Penetration responses is roughly 2:1 (Fisher, 1986; Fisher & Cleveland, 1968). Although Barrier responses carry a positive connotation, in excess they represent over-concern with one's body boundaries, and a rigid, compulsive need to shield oneself from the outer world and to constrict and contain the contents of one's inner world. Similarly, although Penetration responses generally connote experiencing one's boundaries as fragile and easily disrupted, they also represent a readiness for certain kinds of healthy boundary interactions such as taking in new experiences or having intimate relationships.

Fisher (1970) summarized many studies which indicate that the reliability of the scale ranged from the high .80s to the .90s. Fisher (1986) also states that many studies have investigated the scale's validity. From these studies he concluded that "the inkblot responses (as scored for

Barrier and Penetration) reflect the relative perceptual prominence of the body surface as compared to the body interior in the body schema; intensity of concern about the vulnerability of the body exterior; and the distribution of psychosomatic symptoms of the body exterior verses interior sectors of the body" (1986, p. 331).

Validity studies focused on investigating whether the scale differentiates between groups who are presumed to have differences in their experience of their body boundaries. Researchers have found that the scale does distinguish individuals who have illnesses involving the exterior of their body. e.g., arthritis, skin problems, and breast cancer, and those whose illnesses are internal, e.g., ulcer and cancer of the cervix (Cleveland & Johnson, 1962; Fisher & Cleveland, 1955, 1956; Williams & Krasnoff, 1964). Similarly, researchers have found that the scale distinguishes people who manifest high exterior reactivity on physiological measures, e.g., on galvanic skin response, from those who manifest high interior reactivity, e.g., pulse rate and cardiac output (Davis, 1960; Fisher, 1959); it also distinguishes among people who have varying degrees of muscle tension (Shipman, Oken, Grinker, Goldstein, & Heath, 1964). The scale has also been found to differentiate people with varying personality characteristics, most notably, differences in people's "self-steering behavior" (Fisher, 1956, 1958; Funkenstein, King, & Drolette, 1959; Steisel, 1952; Ware, Fisher, &

Cleveland, 1957). (Self-steering behavior refers to the extent to which a person is independent, has defined standards and goals, and has assertive ways of approaching tasks and problems.) Surprisingly few studies have used the scale to differentiate groups of psychiatric patients and those which have been conducted, have produced conflicting findings (Fisher, Boyd, Walker, & Sheer, 1959; Fisher & Cleveland, 1968; Jaskar & Reed, 1963).

Fisher has noted (1986) that it is difficult to specify norms for the Barrier and Penetration scores because data has been collected under such varying circumstances. Some of the data was collected using the Rorschach; other using the Holtzman Inkbot Test; some was collected during individual test administration; other during group inkblot administration. At times subjects were allowed unlimited time to give their response and other times the time available for each response was strictly controlled. Given these variations, Fisher cites a range of means, rather than specific means. The mean for normal subjects who have a total of 25 responses is between 7 - 9 Barrier responses and 3.5 - 5.5 Penetration responses. Barrier scores are normally distributed, whereas Penetration scores tend to be positively skewed. (Positive skew refers to a markedly asymmetric distribution of scores where many people receive low scores and some people receive high scores. This is in contrast with a normal distribution where people equally receive low and high

scores.) Fisher does not explain why Penetration scores tend to be positively skewed in contrast with Barrier scores which are normally distributed. Given that one would expect the highest and the lowest scores of both Barrier and Penetration to equally represent disturbances in body boundary image and therefore to deviate with equal frequency from the range of normal scores, the significance of this is not readily discernible.

Fisher further notes that although the extent of verbal output per response does not significantly influence total scores, it is imperative to control for response totals when computing mean Barrier and Penetration responses (Fisher, 1970, 1986; Fisher & Cleveland, 1968). Several methods were developed for controlling for response total including: 1) eliminating all Rorschach records with less than 15 responses and reducing all records with more than 25 responses to 25 responses; or 2) only drawing conclusions concerning differences between groups in body image scores when the groups did not differ significantly in response total.

For the purposes of this study several decisions were made. First, the amended mode of inquiry may alter the normal ratio of Barrier to Penetration responses, rendering comparisons between the ratio of responses produced by parents of boys with a GID and Fisher's norms invalid. (One could hypothesize that asking "as if" would not generate a Barrier or Penetration response when one is eliciting

information about Mutuality of Autonomy responses 1-2-3-4; however, asking "as if" about a 5 or 6 could elicit a Penetration score in many cases where Penetration responses had not initially been scored.) However, were the inquiry excluded from the scoring and only the free response used to tally Barrier and Penetration responses, the total scored responses would certainly be lowered and the normal ratio may also be altered. Because of these difficulties, the mean scores obtained from the mothers and the fathers of GID boys will not be statistically compared to the established norms. Rather, descriptive comparisons will be made to determine whether they differ in any obvious way from normal subjects. If they are obviously different, then hypotheses, rather than conclusions can be drawn about the parents' experience of their body boundaries. Normal controls who were administered the Rorschach using the amended form of inquiry would then need to be obtained to verify these hypotheses.

Second, since the total number of responses provided by the mothers and fathers did not differ significantly ($\underline{M}$ fathers = 21.5; $\underline{M}$ mothers = 26.2, $t = 1.41$, n.s.), response productivity was not controlled for using the method outlined by Fisher and Cleveland (1968). Furthermore, had this method been used, six couples, i.e., over half of the subjects, would have been excluded from the data analysis.

CHAPTER 5

RESULTS

Parents' Axis I Psychopathology as Measured by the SCID

The hypothesis that mothers of boys with a GID will exhibit Axis I diagnoses more frequently than fathers of boys with a GID was not confirmed. All of the mothers and all of the fathers received an Axis I diagnosis for either a current or past disorder. Four out of the 11 mothers (36%) and 8 out of the 12 fathers (67%) were diagnosed as having current psychiatric disorders; the remainder of the parents either were effectively being pharmocologically treated for what otherwise would have received a current diagnosis and/or described a past history of psychiatric illness.

From most to least frequent, parents were diagnosed as having mood disorders, psychoactive substance abuse disorders, anxiety disorders, hypochondriasis, and bulimia nervosa. (See Table 1 for the frequencies of different Axis I diagnoses and Table 2 for a listing of each parent's diagnoses.) Of particular interest was the frequency of mood, psychoactive substance use and anxiety disorders in both groups of parents.

Mood Disorders in Parents of Boys with a GID

Ten out of the 11 mothers (91%) and 7 out of the 12 (58%) fathers had either a past history of a mood disorder or received a diagnosis for a current mood disorder. Mood

disorders therefore tended to occur more frequently in mothers than in fathers. (The difference in the frequency of mood disorder in the parents was not significant at the .05 level, chi-square = 3.16, 1 df, $p < .10$.)

Four of the mothers (36%) had a history of a major depression. Another 36% had a history of depression not otherwise specified. The later group of mothers had experienced distinct, lasting and debilitating depressive episodes which included several vegetative symptoms but fell one or two symptoms short of the requisite number for warranting this diagnosis. One mother met the criteria for a current dysthymic disorder and another had a past history of bipolar illness II, meaning that she had had one hypomanic and one major depressive episode.

Four of the fathers (33%) also had a history of a major depressive illness and another 2 (17%) had a history of depressive episodes not otherwise specified, the depressions of the later group being very similar to those described above for the mothers. One father had a history of bipolar illness, for which he was currently being medicated, and interestingly, he had been married to the one mother who had the Bipolar II disorder.

Psychoactive Substance Abuse Disorders in Parents of Boys with a GID

Nine of the fathers (75%) and 4 of the mothers (36%) had either a current or past substance abuse disorder. Six of the fathers (50%) and 3 of the mothers

(27%) reported that they had at some point not only abused drugs or alcohol, but that they had been dependent on the substance. Psychoactive substance use disorders tended to occur more frequently in fathers than in mothers. (The difference in the frequency of psychoactive substance use disorder in the parents was not significant at the .05 level, chi-square = 3.49, 1 df, $p < .10$.)

Five of the fathers (42%) and none of the mothers reported current substance abuse problems. Of those fathers who acknowledged current problems, all were either abusing or were dependent on alcohol. The actual percentage of fathers who were currently abusing alcohol, however, may have been somewhat higher, since some seemed to be denying that their regularly excessive drinking caused problems. For example, one father said that weekly he went out and drank "7 hard drinks," yet denied doing anything dangerous while drunk and denied having any problems which resulted from this excessive drinking. He therefore was not diagnosed as having a current disorder, although it is likely that were he not denying possible problems, he would have meet the criteria for alcohol abuse.

Lifelong, 8 of the fathers (67%) and 3 of the mothers (27%) had abused or been dependent on alcohol. Several fathers described having quite serious and prolonged drinking problems, which they eventually were able to control through participating in Alcoholics Anonymous.

Although alcohol was the most frequently abused

substance by both groups of parents, both groups of parents did exhibit other types of abuse or dependence. Two of the mothers (18%) and 4 of the fathers (33%) had abused cannabis. Two mothers and 2 fathers had abused substances other than alcohol or cannabis. Interestingly, this group was comprised of two couples, though in only one couple did the abuse antedate the marriage. The other substances abused included stimulants, cocaine, and heroin.

Anxiety Disorders in Parents of Boys with a GID

Five of the mothers (45%) and 3 of the fathers (25%) reported having had an anxiety disorder at some point in their lives. Three of the mothers (27%) and 2 of the fathers (17%) received the diagnosis for a current anxiety disorder. Another mother who did not receive a current diagnosis was being pharmocologically treated for anxiety with moderate symptom relief. Notable differences in the rates of anxiety disorders were not observed between the mothers and fathers. (The difference between the frequency with which parents exhibited anxiety disorders was not significant at the .05 level, chi-square = 1.06, 1 df, $p < .50$.)

Three of the mothers (27%) had social phobias. Two of the mothers (18%) had simple phobias, specifically, a fear of heights which they felt interfered with their lives. Another 2 of the mothers (18%) reported a past history of panic disorders; these mothers had sought treatment and the

panic attacks remitted. Two of the fathers had a panic disorder and one had an obsessive compulsive disorder.

Other Psychiatric Disorders in Parents of Boys with a GID

Only three parents exhibited psychiatric disturbances other than mood, substance abuse or anxiety disorders. One mother had a history of bulimia nervosa and has continued to struggle with lifelong issues around her eating, her weight and her body image. This mother also had a past history of depressive illness. One father, since adolescence, had hypochondriasis; this father also had a history of major depression and currently had an obsessive compulsive disorder. Although the SCID does not inquire for this disorder, one other father described having the symptoms of an attention deficit-hyperactivity disorder. He was being medicated with stimulants for his attentional problems and distractibility and felt significantly helped by medication. This father also had a past history of major depression.

Co-morbidity of Mood, Substance Abuse and Anxiety Disorder

Six of the mothers (55%) and 6 of the fathers (50%) had more than one Axis I diagnosis. Four of the fathers (33%) and 2 of the mothers (18%) had both mood and substance abuse disorders. Four of the mothers (36%) and one father (8%) had both a mood and anxiety disorder. Three of the fathers (25%) and 2 of the mothers (18%) had a mood, substance abuse and anxiety disorder. Of related

significance, all of the mothers had either anxiety or mood disorders and although only 7 of the fathers (58%) had either a mood or anxiety disorder, all of the fathers had either a mood or substance abuse disorder.

Parents' Axis II Psychopathology as Measured by the SCID II

The hypothesis that mothers would exhibit Axis II diagnoses more frequently than fathers was also not confirmed. In fact, fathers tended to receive an Axis II diagnosis more often than mothers. (The difference was not significant at the .05 level of significance, chi-square = 3.569, 1 df, $p < .10$.) Eight fathers (67%) and three mothers (27%) received a diagnosis of one or more personality disorders on the SCID II.

In addition to tending to have a greater frequency of Axis II psychopathology, fathers also tended to have more clearly differentiated personality disorders. The three mothers who received an Axis II diagnosis were all diagnosed as having a personality disorder not otherwise specified. They were given this diagnosis because: 1) they did exhibit some symptoms of different personality disorders, but did not meet the full criteria for any one disorder; and 2) therapists who had been involved in treating these mothers clearly indicated that the mothers' functioning, most notably as parents, had been impaired by these symptoms. These criteria are based on the criteria established in the DSM-III-R (APA, 1987) for diagnosing personality disorder not otherwise specified. Although 3

fathers were also diagnosed as having a personality disorder not otherwise specified for the same reasons, 5 (42%) of the fathers clearly met the criteria for other personality disorders.

Four of the fathers (33%) exhibited a paranoid personality disorder and 3 (25%) exhibited a narcissistic personality disorder. Two fathers received more than one Axis II diagnosis. One father received diagnoses of paranoid, narcissistic and dependent personality disorders and another father received the following five diagnoses: passive aggressive, self-defeating, paranoid, schizotypal and narcissistic personality disorders.

The SCID II also measures "subthreshold" disorders, i.e. disorders where a subject clearly manifests significant clinical symptoms, but does not meet the full criteria. To date, a clear convention for scoring subthreshold disorders has not been established and researchers have been advised to develop their own internally consistent criteria for rating subthreshold disorders (Gibbon, personal communication, 1989). (See Table 3 for criteria used in this study for scoring subthreshold disorders and for the frequency of subthreshold disorders in mothers and fathers). Using the criteria established for this study, both mothers and fathers received subthreshold diagnoses. When the rates of subthreshold diagnoses are tallied along with the other Axis II diagnoses, the rate of personality disturbance in

fathers remains 67% (8 out of 12 fathers); however, the rate in mothers increases from 27% to 64% (from 3 out of 11 to 7 out of 11 mothers). This suggests that although mothers often do not meet the criteria to warrant the diagnosis of an Axis II personality disorder, they do frequently have personality disturbances which interfere with their functioning. Mothers most frequently evidence subthreshold features of self-defeating and narcissistic personality disorders, whereas fathers most frequently exhibited features of histrionic and narcissistic personality disorders.

Although none of the mothers received the Axis II diagnosis of a self-defeating personality disorder, 4 of the mothers (36%) received subthreshold diagnoses of this disturbance. Similarly, although none of the fathers received the diagnosis of a histrionic personality disorder, 4 fathers (33%) exhibited a subthreshold disturbance.

Narcissistic disturbances notably figured in the fathers and to a lesser extent, also in the mothers. Combining the subthreshold and clinical diagnoses, 6 of the fathers (50%) exhibited narcissistic disturbances and although only 2 of the mothers (18%) had a subthreshold narcissistic disturbance (none had an actual disorder), mothers reported symptoms of a narcissistic disorder more frequently than symptoms of any other disorder. (This was also true for the fathers.)

When the subthreshold and clinical diagnoses are combined, 5 of the fathers (42%) had paranoid personality disturbances (4 fathers had received the Axis II diagnosis). None of the mothers exhibited either subthreshold or diagnosed paranoid personality disturbances.

Neither group of parents exhibited significant borderline psychopathology. None of the parents received the diagnosis of a borderline personality disorder and only one mother and 2 fathers exhibited subthreshold borderline disturbances.

Summary of Results on SCID I and SCID II

All of the parents exhibited Axis I psychopathology. There were notable trends in the differences between the frequency of the different disorders, suggesting that the rates of particular types of psychopathology differ between the two groups. Specifically, mothers tended to have a higher frequency of mood disorders and fathers tended to have higher frequencies of substance abuse and personality disorders. Most likely the differences between the mothers and the fathers in this study were only significant at the .10 level because the sample was quite small; were the study repeated with more subjects, the tendencies observed in this investigation would probably reach statistical significance.

Rorschachs of Parents of Boys with a GID

Reliability

Rorschachs were scored by a doctoral level psychology extern who was blind to the purposes of the study and by this investigator. Disputed scores were resolved by a senior psychologist. Acceptable levels of interrater reliability were obtained for all four Rorschach scales. On the MOA, 83% exact agreement was obtained and agreement within one scale point was 88%. On the BTD, 79% agreement was reached about whether or not a response was scored for any type of thought disorder. 90% exact agreement was obtained on the FCBI. 89% exact agreement was obtained when rating the Rorschachs for gender confusion.

The total number of Rorschach responses did not differ significantly between the two groups. (M fathers = 21.5, SD = 12.7; M mothers = 26.2, SD = 10.11, t = 1.41, N.S.) The means for both groups were comparable to those published by Exner (1985) for 600 nonpatient adults (M = 22.57).

Response productivity was not controlled for the following reasons. First, the total number of responses did not differ between the two groups which were being compared to one another. Fisher and Cleveland have indicated that when using their scale it is acceptable to draw comparisons between groups without controlling for response productivity when the response total of the groups does not differ significantly (Fisher, 1986; Fisher & Cleveland,

1968). Second, other studies which have used the method described by Kalter and Marsden (1970) have found that the Rorschach productivity did not affect either the Urist Mutuality of Autonomy or the Blatt Thought Disorder Scores (Goddard & Tuber, 1989; Tuber & Coates, 1989).

The prediction that mothers would have greater disturbances in their concepts of interpersonal relationships as measured by the Urist Mutuality of Autonomy Scale was not confirmed. In fact, fathers' Rorschach responses reflected disturbances in their object relations, whereas mothers' did not. Although the mean Urist score obtained by mothers and fathers did not differ significantly between the two groups (M mothers = 3.29; M fathers = 3.06; using Wilcoxon matched-pairs signed ranks test z = 1.24, NS), there were quite striking differences in the frequencies and the modes of the groups' responses, although the differences were not in the predicted direction. (See Table 4 for distribution and modes.) The distribution and modes of the responses were calculated and compared for the following two reasons. First, the mean scores earned by both groups were quite similar to those obtained by Marantz (1984) for both the mothers of GID boys and the normal controls and Marantz had found more meaningful differences between her two groups when she compared modes. Second, several other investigators have noted that the distribution of responses and the modes meaningfully distinguish groups and point to pathological

inner representations, which at times are not reflected in the mean responses (Goddard & Tuber, 1989; Rainbow, 1986; Tuber & Coates; 1989).

The modal response when all the fathers' responses were pooled was a scale point of 5 and for the mothers' was a scale point of 2. When the modes of the separate records were compared, the most common mode for the mothers remained a scale point of 2; however, fathers exhibited a bimodal distribution of 2 and 5. When the frequencies of the seven scale points were compared, mothers had significantly more "2" responses (chi-square = 4.02, 1 df, $p < .05$) and fathers had significantly more "5" responses (chi-square = 6.5, 1df, $p < .05$). The frequency with which other scale points occurred did not differ significantly between the groups.

The hypothesis that mothers would exhibit greater disturbances in their thought processes than do fathers, as measured by the Blatt Thought Disorder Scale, was not confirmed. Fathers had a mean of 5.8 thought disorder responses per Rorschach and mothers had a mean of 3.5 thought disorder responses. Fathers produced significantly more thought disorder responses than did the mothers (using Wilcoxon matched-pairs signed ranks test, $z = 1.96$, $p < .05$). (See Table 5 for the frequency of the numbers of thought disorder responses.) Ten of the fathers (83%) and 8 of the mothers (73%) had at least one scored response. Both the percentages of parents who received at least one

scored response and the mean number of responses per parent are high relative to the normative data published by Friedman (1952) and Exner (1986). Although direct comparisons cannot be made because of differences in the scoring systems, both fathers and mothers of boys with a GID appeared to produce more thought disorder responses than are reported in normal subjects.

Using Tuber and Coates' categorization for gender confusion, both fathers and mothers evidenced gender confusion in their Rorschach responses. Three of the fathers and 3 of the mothers produced scored responses. Fathers produced a total of four responses with gender confusion and mothers produced five scored responses. Statistical comparisons could not be made because there were too few subjects who produced scored responses.

Neither mothers, nor fathers evinced body vulnerability and fragility in their Rorschach responses as measured by the FCBI. Neither mothers nor fathers had Penetration scores which were much greater than the range of mean Penetration scores produced by normal subjects.

Fathers had a mean Barrier score of 7.73 and a mean Penetration score of 4.73. Mothers had a mean Barrier score of 10.36 and a mean Penetration score of 6.09. The fathers mean scores fell within the range of norms obtained from normal subjects. The mothers' mean scores fell slightly outside of this range of norms. Since the mothers mean scores appear to be only somewhat higher, they would

need to be compared to means obtained from normal controls who were administered the Rorschach using the amended inquiry in order to determine whether this difference is significant and meaningful.

Mothers had significantly more Barrier and Penetration responses than did the fathers. (For Barrier, using t-test, $t = 2.81$, 10 df, $p < .02$. For Penetration, using Wilcoxon matched-pairs signed ranks test $z = 4.59$, $p < .01$). (T-test was used to compare Barrier scores because Barrier scores are normally distributed; since Penetration scores are positively skewed the Wilcoxon matched-pairs signed ranks test, a nonparametric statistic, was used.) The ratio of Barrier to Penetration scores in both mothers and fathers appears to be similar to that obtained from normal subjects.

Summary of Parents' Rorschach Responses

In sum, fathers most typically exhibited disturbed concepts of interpersonal relationships; mothers did not. Both fathers and mothers evidenced disturbances in their thought processes, fathers exhibiting significantly more thought disturbance on the measure used in this study. Both fathers and mothers produced gender confusion in their Rorschach responses; the number of mothers and fathers who produced gender confused responses did not differ. Neither mothers nor fathers appeared to differ notably from normal subjects in their representation of body boundaries as

measured in Rorschach responses; fathers and mothers did however differ significantly from one another, as mothers had both more responses which emphasized the body's protective boundaries and more responses which depicted the body as fragile and permeable.

CHAPTER 6

DISCUSSION

The results from the SCID are consistent with the reports in the literature that parents of boys with a GID themselves have psychopathology (Bradley et al., 1980; Coates, 1985, 1990; Coates & Zucker, 1988; Marantz, 1984; Rainbow, 1986; Rekers et al., 1983). However, it is somewhat surprising that all of the parents received Axis I diagnoses. The figures are therefore slightly higher for mothers and notably higher for fathers than the rates observed by Rekers et al. (1983), who found that 80% of the mothers and 45% of the fathers had histories of mental health problems. The frequency of psychopathology measured in this study was also higher than that reported by Bradley et al. (1980) who noted that 73% of the parents of boys with a GID had documented psychiatric problems.

Mood Disorders in Parents of Boys with a GID

As described earlier, both mothers and fathers exhibited mood disorders on the SCID. The most prevalent mood disturbance for both mothers and fathers was a depressive disorder. The results of this study suggest that depressive disorders occur somewhat more frequently in the mothers than in the fathers, a finding which is reflected in the adult population in general (APA, 1987). This difference, however, reflects pooling all of the parents' depressive disorders together, i.e., dysthymia,

major depression, and depression not otherwise specified are all being considered together in this analysis. It is interesting to note that when major depression is isolated from other types of depression, the same number of fathers and mothers had lifetime histories of major depressive illness. This finding diverges from sex ratios found in the general population, where major depression occurs twice as often in females as in males (APA, 1987). Also of note, the frequency of major depression in both groups of parents is higher than the lifetime prevalence in the general population. (Studies indicate that the rate of major depression in women ranges from 9% to 26% and from 5% to 12% for men (APA, 1987).)

In general, parents described their depressive illnesses as intense and debilitating. Several parents had thought of suicide; one mother commented that she "came to understand why people want to die" and how "no one can live with this amount of pain." Another mother made several suicide attempts. Two fathers and none of the mothers had been hospitalized for major depressive episodes. The following vignettes illustrate parents' experience of their depression.

> From a mother: "I felt like a cloud was over my head and my eyes were heavy. I was always on the verge of crying."
>
> From a mother: "I couldn't focus on anything because there was this terrible black cloud looming in the future -- it was like my life would be over. I would just lay on the couch and cry "Oh, God, what am I going to do?"

> From a father: "Every couple of years I get into something where I cannot handle the stress ... 3 months before going into the hospital for the second time I was unable to do anything. I couldn't get out of bed and then I just wanted to die ... Now it seems like life is so complicated that I'm not sure it's worth hanging out for ... I feel like I'm being thrown out by them (his wife and children)."

Several mothers and several fathers linked their depressive episodes to the break-up of relationships or to worries about their children, suggesting that both have particularly intense reactions to separations or loss. Several fathers described becoming clinically depressed when they were not in a relationship with a woman. The following are examples of descriptions present in many of the parents' interviews.

> A mother's description of an episode of major depression which occurred after she brought her son for an evaluation of his gender disorder: "I remember blaming myself. I just kept thinking about what I had done to cause it. Like did I hold him too much. I couldn't eat, sleep or concentrate. I found myself wishing I could curl up in a ball and go to sleep and wake up and it (her son's gender disorder) would all be over."

> From a mother: "I broke up with a boy friend to go out with another man who I sort of knew was gay, but I dismissed it as unimportant. We started going out and it was not very fulfilling and it got me very very depressed." During this time this mother was frequently tearful, had low energy, gained weight and had trouble concentrating.

> From a father who had a depressive episode where he previously experienced several significant vegetative symptoms as well as a depressed mood: "The big problem I was having then, I couldn't meet any girls. I didn't have any dates -- that was the main thing depressing me."

> From a father who had left his baby son with relatives and was vacationing with his wife: "I kept having the feeling that something would go terribly wrong -- a feeling of dread, impending doom. I felt that

> something bad was going to happen to R. (his son) and I would never see him again." For several weeks this father was depressed, unable to enjoy himself, and unable to sleep or concentrate.
>
> From a father who described having clinically depressive episodes whenever relationships ended: "I felt a sense of loss. I put this investment of time and love and it had come to naught. I felt full and complete and happy when around these women and without them I felt less complete."

The high incidence of depressive disorders observed in this sample of mothers is consistent with Marantz's (1984) finding that mothers of boys with a GID had lifelong histories of depressive illness and that 44% had received psychiatric treatment for depression. Marantz also observed that as a group the mothers scored on the upper end of the mildly depressed range of the Beck scale which measures current depression. In this study, only one mother meet the criteria for a current depression. The difference may reflect a difference in the measures; on the SCID one either receives a diagnosis or not, whereas the Beck scale measures depression along a continuum. Certainly many of the mothers who did not receive a diagnosis indicated that they currently had some depressive symptoms, most notably depressed mood and low self esteem. The rate of depression has not previously been described in the fathers.

Psychoactive Substance Abuse Disorders in Parents of Boys with a GID

The finding that fathers tend to abuse or become dependent on drugs or alcohol more frequently than the

mothers is consistent with epidemiological studies which report that psychoactive substance use disorders are diagnosed more frequently in males than in females (APA, 1987). The rate of alcohol abuse and dependence found in parents of boys with a GID is higher than is reported for the general population; this is particularly dramatic for the fathers of boys with a GID. Epidemiological studies conducted from 1981-1983 in the United States indicated that approximately 13% of the adult population had alcohol disorders at some point in their lives (APA, 1987). Similarly, Robins et al. (1984) found a lifetime prevalence of alcohol abuse or dependence in household samples from three U.S. cities as ranging from 12%-16%.

Parents also reported abusing cannabis, stimulants, cocaine, and heroin. The one parent who was actually dependent on heroin clearly stated that he had used it for "medicinal purposes." (This was the parent who had had two psychiatric hospitalizations for major depressive disorders.) Similarly, one of the two mothers who was dependent on stimulants described using amphetamines to alleviate her depression. This mother indicated that although she had not taken stimulants for several years, to this day she keeps a shoe box filled with amphetamines in her closet because she fears she may again become debilitatingly depressed and need to resort to taking the pills.

Substance abuse disorders in parents of boys with a

GID have not been systematically investigated. Though rates of substance abuse were not specifically reported, Bradley et al. (1980) did note that 67% of the families in their study had chronic sexual problems or alcohol or drug abuse, a finding which is consistent with the results of this study.

Anxiety Disorders

The anxiety disorders reported by parents in this study included panic disorders, simple phobias, and social phobias. In addition, one parent had an obsessive compulsive disorder. Since social phobias, simple phobias, and panic attacks are all reported to be fairly common and since the exact lifetime prevalence is not clearly known (APA, 1987), the extent to which parents of boys with a GID manifest specific anxiety disorders more frequently than the general population cannot be described. However, given that almost half of the mothers and one quarter of the fathers have histories of anxiety disorders, it is likely that these disorders occur more frequently in these parents than in the general population. One father (8%) and 3 of the mothers (27%) were diagnosed as having a current anxiety disorder. This exceeds what Weiss and Rosenberg (1985) report as the 2% - 4% expected rate in the general population.

Parents described the symptoms of their anxiety disorders as intense and quite detrimental to their functioning. Three of the mothers had social phobias and

each of the mothers described experiencing extreme anxiety when they had to speak or read aloud in front of other people. One mother described being unable to stand and introduce her class of children during a Sunday school performance. Another mother must routinely give oral presentations for her job and finds it excruciatingly painful. This mother described, "I just get so panicky. I can't breathe, I can't think and I'm convinced I'll burst out crying and run from the room. Even as I start to talk, I think these people will hate me. They'll think I'm a fool. If I could get help with this it would mean more to me than almost anything--just because it is so terrifying."

Two of the fathers and 2 of the mothers reported having had panic attacks. One of the fathers who had panic attacks began having the attacks after he stopped drinking. He described, "I was really experiencing life sober for the first time and being more in touch with reality. Because I had gone for so long sedating myself, there was a lot of stuff going on that was new and uncomfortable." Another father described having lifelong panic attacks, which had recently diminished since he began taking an antidepressant. Interestingly, 3 of the 4 of the parents who reported having panic attacks also had a past history of alcohol dependence; like the father described above, they all may have been self medicating.

One father had had a moderately severe obsessive compulsive disorder since adolescence. He described

currently having repetitive thoughts about "how vulnerable C. (his son with the GID) is--as a baby--even now--how vulnerable a baby's body is--I could just drop him. I find myself thinking horrible thoughts towards other people. It's scary when they're towards people I care for." This father is also extremely fearful of germs and of developing fatal illnesses. Since adolescence he has had rituals, such as tapping his knee in a particular way 100 times, which he feels will safeguard him when he fears he will contract a disease.

Anxiety disorders have not previously been systematically investigated in parents of boys with a GID. The presence of anxiety disorders is consistent with the clinical reports that have indicated that the mothers have many fears, particularly about being separated from their sons, about what they imagine to be their son's physical vulnerability, and about male assertiveness and male aggression in general (Coates, 1990; Coates & Zucker, 1988; Marantz, 1984). Coates and Zucker (1988) have specifically observed that "these mothers have a phobic orientation to the world." Although it is clear that these descriptions are characterizing maternal psychodynamics, the findings of this study suggest that these psychodynamic issues exist against the background of diagnosed anxiety disorders, disorders which are currently thought to have physiological determinants.

Parents' Axis II Psychopathology

As described earlier, fathers tended to exhibit personality disorders more frequently than mothers. This difference is consistent with what has been reported in the literature. Torgersen (1988) using the SCID and SCID II with an outpatient population found that personality disorders occur significantly more frequently in men and that men in particular are significantly more frequently diagnosed as having passive-aggressive, compulsive, schizotypal, paranoid and narcissistic disorders. As stated earlier, the differences between the mothers and fathers in this study were most likely not significant because the sample was quite small and in a larger sample, the tendencies observed in this study would probably reach statistical significance.

Notably, the fathers who received the multiple Axis II diagnoses were among the fathers who received the most Axis I diagnoses, suggesting that the many personality disorders were reflecting global, pervasive psychopathology. This is consistent with findings that hospitalized psychiatric patients, (Skodol, et al., 1988) have a mean of 4.6 SCID II diagnoses per patient and in an out-patient population females had a mean of 1.9 and males had a mean of 2.3 SCID II diagnoses (Torgersen, 1988), i.e., the more disturbed, impaired patients receive more personality diagnoses when assessed by the SCID II.

The prevalence of subthreshold personality disorders

is consistent with the clinical descriptions of mothers of boys with a GID, which identify the mothers as having trait psychopathology, i.e. personality disturbances (Bradley et al., 1980; Coates, 1985, 1990; Coates & Zucker, 1988 Marantz, 1984).

Over one third of the mothers received a subthreshold diagnosis of a self-defeating personality disorder. These mothers typically described themselves as feeling depressed or guilty following positive personal events and seldom able to enjoy what should be pleasurable situations. Similarly, one third of the fathers received a diagnosis of a subthreshold histrionic personality disturbance. Over half of the fathers in this study identified themselves as constantly seeking reassurance, approval or praise, a trait which is common to this disorder.

Narcissistic disturbances figured significantly in the fathers and to a lesser extent, also in the mothers. Fathers typically identified themselves as being overly sensitive to criticism, as preoccupied with fantasies of unlimited success, power, brilliance, or beauty, and as requiring constant attention. Over 1/3 of the mothers described themselves similarly. Many parents also indicated that they were preoccupied with feelings of envy. Below are parents' descriptions of themselves:

> From a father: "I'm envious ... if anybody is doing something, doing a certain job, displayed a certain emotion in a personal relationship or has something material that I think is admirable, I'm envious and I look to do that same thing, have that same thing or have that same feeling. I'm just constantly comparing

and contrasting my own possessions and financial status."

From a father: "I'm a great day dreamer. It's been that way my whole life ... I could watch a baseball game and then a tennis match, then a rock concert and immediately day dream about being a great baseball player a great tennis player or a great rock n' roll star. It's the idea of being the center of attention--the top of the heap."

From a father: "I can remember for years criticisms of me."

From a mother: "I'm an actress -- that's what I've chosen to be and that's what turns me on. I need to be doing things where I'm around people and I'm admired ... I feel particularly turned on when the attention is on me ... I want to see my name in lights."

From a mother: " I just need to be noticed -- to do things that stand out as different has always been important to me -- that my kids be cuter -- that I dress nicer -- that I be funnier -- that I stand out in some way. It's very important that I look attractive."

From a mother: "I can't stop thinking about it if I've been criticized ... I feel like it's a put down of me even when it's constructive criticism, it'll keep going around and around in my head."

Many of the fathers exhibited subthreshold or diagnosed paranoid personality disturbances. (One third received the Axis II diagnosis.) Half of all the fathers identified themselves as reluctant to allow people to get to know them because of an unwarranted fear that this knowledge would be used to harm them. Over half of the fathers described themselves as bearing grudges or as being unforgiving of insults or injuries and a third indicated that they were very "thin skinned." Below are excerpts from fathers' descriptions of themselves.

"I think my nature is that I feel people can't be trusted, that people will screw around if it's to their advantage ... it makes me vulnerable if they (people)

know a lot about me. They might be able to hurt me."

"I carry a grudge -- I'll get someone back if it's 10 years later ... In many ways, I let people know nothing about me ... every time someone does get a psychological profile (on me) whether it be right or wrong, they'll try to use it against me as a weapon."

"I have had feelings of paranoia -- it centers around my relationship with authority figures. Just that they were trying to hurt me and be nasty ... I feel I'm so needy with regards to approval that when people are disapproving I take things out of context."

Interestingly, neither group of parents exhibited significant borderline psychopathology. None of the parents received the diagnosis of a borderline personality disorder and only one mother and 2 fathers exhibited subthreshold borderline disturbances. This result is somewhat surprising given Marantz's (1984) finding on the Diagnostic Interview for Borderlines that 25% of the mothers obtained scores in the borderline range of psychopathology. She specifically found that the mothers had long standing difficulties in their interpersonal interactions and their affect regulation and that they tended to have transient psychotic features, such depersonalization. As a group, mothers in this study did not describe their interpersonal relationships as intense and stormy or as vacillating between extremes of overidealization and devaluation. Although they did evidence significant difficulties with depressive episodes, they denied affective instability and few reported having ever had any psychotic-like experiences.

Two differences between this study and Marantz's

investigation could account for the different results. First, the DIB is a comprehensive 123 question interview for borderline psychopathology, whereas the SCID II has an 18 question section for diagnosing this disorder. It is therefore possible that the DIB is more sensitive to diagnosing borderline psychopathology than is the SCID II. Significantly, the only investigators who have conducted a study assessing the validity of the SCID II concluded that they were unable to assess the validity of the borderline disorders (Skodol et al., 1988), whereas numerous studies have demonstrated the validity of the DIB (Gunderson & Kolb, 1978; Kolb & Gunderson, 1980; Soloff, 1981; Soloff & Ulrich, 1981). Second, there was a significant difference between the socio-economic status of mothers in Marantz's study and the parents who participated in this investigation; Marantz's group was comprised of subjects who came primarily from the lower-middle class families, in contrast with parents in this study who came primarily from upper-middle to upper class families. Future investigations will need to ascertain whether borderline psychopathology is more prevalent in parents of boys with a GID from lower socioeconomic groups.

Parental Psychopathology and Psychodynamics as Evidenced in Their Rorschach Responses

Parents' Object Relations

When the Urist scale is divided into the four ranges described by Tuber (1984), the following results were

obtained: 36% of the fathers and 83% of the mothers had modes which fell in the normal-neurotic range of pathology in object relations; 27% of the fathers and none of the mothers had modes in the narcissistic range of pathology in object relations; 36% of the fathers and 18% of the mothers had modes which are thought to reflect borderline personality organization; and neither group produced modes in the range of psychotic object relations.

These findings, together with the findings about the parents' modal responses, indicate that in this sample, fathers exhibit greater disturbance in their object relations than do the mothers. Interestingly, the mothers' modal responses are quite similar to those obtained by Marantz's normal controls, whereas the fathers' modal responses were almost identical to those obtained by the mothers of GID boys in Marantz's sample (1984) and to those obtained by Tuber and Coates (1989) in their study of boys with a GID. In this study fathers, much more often than mothers, experience interpersonal interactions as characterized by domination, control and threat of destruction or malevolence. It was a father who produced the only "7" response out of the entire 524 Rorschach responses. The response was "...a mushroom cloud over Hiroshima ... the atomic bomb dropped on Hiroshima and may have been causing a mushroom cloud" (Card VII). (In fact, 3 fathers and none of the mothers identified mushroom clouds or atom bomb tests.)

Mothers, much more often than fathers, typically experience interactions as benign, although mothers' typical experience is not that of the highest level of functioning where interactions are experienced as mutual, reciprocating and autonomous. Several features of the Urist MOA scores are worth highlighting. Although as a group, fathers typically experience interactions as controlling and malevolent, 8 out of the 12 fathers (67%) also had responses which were scored a scale point of "1," suggesting that they are capable of experiencing interactions not only as benign, but as mutual and reciprocating. As described earlier, when the individual modes are pooled, the group is split between those who typically experience interactions as benign, though parallel, i.e., who had a modal score of "2" and those who experience interactions as threatening and harmfully controlling, i.e., who had a modal score of "5." For example, one father who had a mode of 5 and produced such "5" responses as " a spider devouring a green insect ... it's like "Blue Velvet ... deep within the grass all these forces are fighting, chewing on each other" (Card X), also produced the following "1" response " 2 ladies sitting on a bench ... talking to each other ... they're enjoying each other -- a little one-up-manship going on, but they've been doing that for years and would not like to be any place else."

Also of note, although none of the mothers had modes

in the narcissistic range, the frequency with which fathers and mothers obtained 3s or 4s did not differ. Therefore, though it may not be any given mother's most typical way of experiencing interactions, mothers and fathers equally represent interactions as dependent or narcissistically oriented. Of clinical interest, both mothers and fathers produced 3s and 4s where the percepts involved children or mothers and children. The responses included a fetus with an umbilical cord (from a father), children hanging on to a merry-go-round so they don't fall off (from a mother), and the following response " 2 manta rays ... one superimposed on the other ... this one being though rather unfinished, but with a more defined nose and the second one being within the other. Perhaps it's a baby on the back of a mother." (Father's response to Card II.)

Finally, although mothers obtained significantly less 5s than did the fathers, fathers and mothers did not differ in the frequency with which they scored a "6", suggesting that although fathers more often see interactions as malevolently controlling, fathers and mothers do not differ in the frequency with which they portray the interactions as more overtly harmful or destructive. For example, one mother whose mode was a "2" gave the following "6" response, " 2 figures falling into an abyss--just falling into nothingness ... they're going to Hell maybe" (Card III).

The mothers' modal Urist scores differ significantly

from those obtained by Marantz (1984) in her study. This difference is consistent with the finding that unlike the mothers in Marantz's study, the mothers in this study do not evidence borderline psychopathology, since a hallmark of borderline psychopathology is disturbed object relations. Although the meaning of this difference is unclear, it suggests that there may be subgroups among the parents of boys with a GID.

Thought Disorder in Parents' Rorschach Responses

Although norms for nonpatient adults have not been published for the Blatt Scale, comparing the results of this study to the findings of Rapaport, et al. (1945), Friedman (1952) and Exner (1985) described above, strongly indicates that parents of boys with a GID have far more thought disordered responses than do normal adults. As described earlier, the mean number of thought disorder responses per Rorschach was 5.8 for the fathers and 3.5 for mothers. These findings suggest that both groups of parents at least at times exhibit unrealistic thinking and have rich elaborated fantasy worlds which at times interfere with their ability to maintain accurate interpretations of what they are observing and experiencing. Although the frequencies of the different types of thought disorder responses are not being computed or formally considered in this study it is important to note that in all of the Rorschachs there were not any contamination responses and only one contamination

tendency, which was produced by a father. This suggests that although parents of boys with a GID manifest disruptions in their thinking, they uniformly do not produce the most serious type of thought disorder response.

Fathers produced significantly more thought disorder responses than did the mothers, suggesting that although both evidence disruptions in their thinking, the extent of the disruption is greater in the fathers and is therefore more likely to interfere with daily functioning than in the mothers.

Although formal comparisons were not made about the different types of thought disorder responses, it is important to note that both fathers and mothers produced responses which combined separate concepts in an implausible or illogical way because of the spatial contiguity of the figures (fabulized combination -- tendency, regular and serious, and contamination tendency and contamination) and responses which included highly elaborated personal associations or fantasies (fabulized to confabulation, confabulation tendency, and confabulation). Interestingly, mothers produced approximately equal numbers of both types of responses, whereas the fathers produced 2 1/2 times more of the affectively elaborated, personalized responses than of the implausible combination responses. Mothers and fathers produced similar numbers of the implausible combination responses and fathers produced 2 1/2 times more of the affectively elaborated, personalized

responses than did the mothers. (These results need to be interpreted with caution. Although acceptable reliability was obtained for whether or not a response should be scored for thought disorder, acceptable reliability was not obtained for differentiating the 8 different types of thought disorder responses. Exact agreement only occurred only 66% of the time.)

The following are examples of clinically rich thought disorder responses provided by fathers and mothers.

Mothers (Each response came from a different mother):

> "A bear skin rug -- this would be the head -- it looks like a snake head ... but I guess they call it a pelt when they skin it and hang it on the wall ... it would be a pretty strange animal that was skinned" (Card VI).
>
> "This is a tree with eyes and this 11 the feet of a person trapped inside of the tree ... if the person wasn't so scared he could probably get away because the legs are so far apart. It looks like the person inside the tree could be saying you could get out, but the person can't" (Card IV).
>
> "Somebody up on point. It looks like a fat beast -- something insect like about the head ... that looks like the toe shoes ... I saw these eyes as sort of elongated and these pointed ears and the antenna like projections here ... it's up in ballet shoes up on point" (Card II).

Fathers (Each response came from a different father):

> "Things that are half animal and half plant ... like this looks like an insect with a flower head" (Card X).
>
> "Cannibals ... see they have a pot cooking, so the red has to be sort of blood or something. See like this little butterfly could be like the soul flying away as the person is cooked ... The splotches of red means there is some kind of butchery going on. Something all together unpleasant" (Card III).
>
> "Strange, in the middle I see a conductor -- a symphonic conductor and in front of him I see two

> dancers with hoods sort of twirling around. It reminds me of the film "Amadeus" It was the part after his father dies, he does this really intense opera and this guy comes through the wall ... " Don Giovanni"... he wrote the opera to purge his soul of his father ... They are dancing -- not a joyous dance -- a scary dance. This is a scary picture ... I even have a title for this one, "Dance of Death." That's nice. That's a happy thought. I would say that the hooded robed figures are scary. Sorry -- maybe it's left over from being around nuns at an early age. I'm convinced that nuns dressed that way to scare kids. Ah ha kids! Halloween comes every day!" (Card I).

Gender Confusion in Parents' Rorschachs

Both mothers and fathers produced responses which were scored for gender confusion using the categorization developed by Tuber and Coates (1985). Specifically, both parents gave responses which were scored as "inability to decide" and "combined." Fathers produced the following responses (the responses are from different fathers) :

> " either a penis or a vagina" (Same area on Card II, scored as "inability to decide").

> "It's an absolute monster ... the monster is approaching and I am laying down. The monster is in an extremely threatening position ... It's as if I'm trapped under glass and he's standing up over top of me looking down on me ... The head on the monster looks like a woman's vulva and this is the lips and the outer part is the whole 9 yards. I guess it's my frame of reference. See my wife and I are having serious marital problems and at this point in time it's appropriate that I see vulva as a monster because I'm not getting a lot. It's as if pussy can be a real bitch. ... That's the tail and his very large feet" (Card IV, scored as "combined").

Mothers produced the following responses (the responses are from different mothers):

> "Almost like the diagrams in text books -- see there's the Fallopian tubes and there's the uterus and or whatever ... I'm so bad -- I can't remember if that's the inside of a man or a woman, but I think these were

> ovaries or something like that -- I don't really know" (Card III, scored as "inability to decide").
>
> "When I look at this more, it seems hermaphroditic to me ... the head looked masculine and ... because of the bra that part looked feminine" (Card X, scored as "combined").

It is interesting to note that the mother who provided this last example immediately followed this response with the following percept which seems to express the criticism and confusion she experiences with regard to her feelings and fantasies about gender. "And those look like eyes with scowling eye brows and this looks like a mustache. The eyes are scowling (as if) Confused. Yeah, confused."

As responses were scored for gender confusion, it became apparent that mothers and fathers were producing another type of response which seemed to express gender confusion. These types of responses appear to be developmentally more advanced than the other types of responses and therefore may not have been present in the children's records. The responses involved identifying percepts of one gender and describing the percept as wearing clothing or having features which typically belong to the opposite gender, but which in certain situations can legitimately be sported by the originally identified gender. Examples from different mothers' records include, " Monks ... wearing a robe ... they have little pig tails" (Card II) and "a mandarin chinese man ... this is his kimono" (Card X). Examples from different fathers' records include, " men ... they're dressed kind of formal -- like

dancers are dressed in black tights" (Card III) and "a face ... this looks like the mustache, This is long hair. I have a whole feeling of John Lennon here ... the walrus mustache, you know, long hair, which he often parted down the middle. It would come down this way, sort of in 2 equal waves" (Card X). These responses involve portraying one clearly specified gender (in these records this only occurred with responses involving male percepts) as having clothing or features which create a sense of androgyny about the figure. These responses may be "less serious" indicators of gender confusion. Four of the fathers (36%) and 3 of the mothers (27%) had these types of responses. If these responses are included along with the other types of scored responses, 5 of the fathers (42%) and 4 of the mothers (36%) exhibit gender confusion in their Rorschach responses. To validate whether these "androgynous" responses are clinically significant one would need to score the Rorschachs of normal controls to determine how frequently one sees these responses in a nonclinical population.

Although a systematic study of the prevalence of any type of gender confusion responses in normal adults has not been conducted, in the 16 Rorschachs obtained from Marantz's control group, gender confusion, as defined by the Tuber and Coates' categorization system did not appear in the free response or inquiry of any of the mothers (Coates, unpublished findings). This suggests that overt

gender confusion in Rorschach responses is unusual and, perhaps, as Coates and Zucker (1988) have suggested with regard to the children's protocols, the presence of such responses is a highly specific indicator of disturbances in gender identity.

Parents' Experience of Body Boundaries as Reflected by Rorschach Responses

Mothers produced significantly more Barrier and Penetration responses than did fathers. Although a recent review of 20 studies involving male and female adults indicated that in 50% of the cases females have greater boundary definiteness, as manifested by higher Barrier scores, the difference was only significant in a few of the cases (Fisher, 1986). This suggests that the significant differences between the mothers and fathers in this study are meaningful. The meaning of these differences is, however, somewhat unclear, since the mean number of Barrier and Penetration scores either fell within or very close to the normal range for both groups and since the ratio of parents' Barrier to Penetration responses were also similar to those observed in normal adults. One possible interpretation is that the mothers may be slightly more concerned than the fathers about body boundaries. They may simultaneously have a greater awareness of their body as a protective, definite boundary between the inner and outer world and a more frequent experience of these boundaries as being easily permeated or violated.

Although there were notable sex differences, neither mothers not fathers evidenced body vulnerability when their Rorschachs were scored with the FCBI. However, both groups produced a significant number of anatomy responses (described below), which is often interpreted as signifying bodily concerns and preoccupations. This finding suggests that the FCBI may not be a useful measure for investigating feelings of body vulnerability and fragility in the parents and subsequent studies should utilize different methods for assessing this aspect of parental functioning.

Other Characteristics of Parents' Rorschachs

In addition to the findings described above, there were several other notable features about the Rorschachs of both the mothers and the fathers. Many of the protocols included elaborate and often quite vivid responses which were consistently found in either one or both groups. Characteristics which were common to the protocols of both the mothers and the fathers included: 1) many anatomy responses; 2) many responses identifying primary sexual features; 3) frequent references to birth imagery; 4) many responses involving children or references to children's stories; 5) many food responses or references to eating; and 6) frequent references to clothing.

Anatomy Responses

As a group, parents of boys with a GID frequently identified anatomy responses on the Rorschach. These

responses include "parts of the human body or concepts dealing with the human body in the anatomical sense (such as x-rays)" (Klopfer, 1962). Six of the mothers (54%) and 4 of the fathers (33%) produced two or more anatomy responses in their records. (The mean number of anatomy responses produced by mothers was 1.5 per Rorschach and the mean number produced by fathers was 1.0.)

The literature reporting the rates with which normal subjects produce anatomy responses is somewhat inconsistent. Although Rapaport et al. (1945) observed that one or 2 anatomy responses in a Rorschach record of 20-25 responses "carries no pathological weight," Exner found that the mean number of anatomy and x-ray responses combined is .6 per record for nonpatient subjects, whereas the mean for an out-patient psychiatric group is 1.6. (Beck, Beck, Levitt, and Molish (1961) reported an Average of 1.5 anatomy response per record. Phillips and Smith (1953) report that normal subjects produce an average of one anatomy response.)

If the frequency of anatomy responses is compared with Exner's norms, which are derived from 600 nonpatient adults, then over one half of the mothers and one third of the fathers produced these responses more frequently than nonpatient subjects. However, given the discrepancies in the literature, normal controls would need to be obtained to determine whether the apparent preponderance of anatomy responses actually exceeds what is found in normal records.

Rapaport et al. (1945) suggest that a multitude of anatomy responses may signify any of the following: 1) feelings of intellectual inadequacy; 2) bodily preoccupations; 3) generalized anxiety; and 4) extreme blocking which may even lead to perseveration of anatomy responses. Phillips and Smith (1953) indicate that anatomy responses represent a sensitivity to and concern with the expression of destructive impulses. They further note that subjects who act out their destructive impulses do not produce anatomy responses; rather, it is subjects who experience these impulses, without directly acting upon them who tend to identify these percepts. Allison, Blatt and Zimet (1968) state that a high number of anatomy, sexual, blood and x-ray responses "is often associated with a predominant preoccupation with bodily intactness."

An examination of the Axis I diagnoses of the subjects who produced an apparently high number of anatomy responses suggests that these Rorschach responses are reflecting both anxiety and bodily preoccupations. Specifically, many of the subjects who produced two or more anatomy responses also received an Axis I diagnosis of an anxiety disorder. Also of note, the one father who received a diagnosis of hypochondriasis and the one mother who had a history of bulimia nervosa, i.e., disorders involving bodily preoccupations, respectively had two and five of these responses. Interestingly, two of the fathers who gave several anatomy responses included responses whose content

specifically referred to concerns about bodily deterioration. One of the fathers described "intestines ... maybe a stomach, maybe more like a growth ... more like a cancer" (Card IX). Another father described "the lungs of a heavy smoker -- darkened -- blackened" (Card X).

Although the following is a speculative conclusion, the finding that a slightly higher percentage of mothers may have more than an expected number of anatomy responses may be reflecting the same features that are being measured by the mothers slightly higher Barrier and Penetration scores on the FCBI Scale. As stated earlier, one possible hypothesis is that mothers in general have more concerns about their bodies than do the fathers.

Sex Responses

An extremely high percentage of both mothers and fathers included sex responses in their Rorschachs. Eight of the fathers (67%) and 9 of the mothers (82%) produced at least one sex response. Four of the fathers (33%) and 5 of the mothers (45%) had two or more of these responses. The total number of sex responses per record ranged from no responses to seven responses. The responses varied from unelaborated descriptions of a penis or vagina to more detailed percepts involving sexual activity.

The literature on the significance of sex responses suggests that they are usually pathological indicators, though they can at times appear in the protocols of uninhibited, professional or recently psychoanalyzed people

(Exner, 1986; Klopfer, 1962; Phillips & Smith, 1953; Rapaport, et al., 1945). Rapaport et al. (1945) further note that sex responses are usually pathognomic because talking about sexuality with a relative stranger, as in a testing situation, is socially taboo. They suggest that sex responses in neurotics most often reflect a sexual preoccupation or a case where the presenting symptom is a sexual disturbance. Some researchers have argued that males who emphasize sex content display inadequate sexual adjustment (Phillips & Smith, 1953).

An examination of the specific content of the parents' sex responses suggests that the responses reflect both sexual preoccupations and worries and concerns about procreation and birth. As one father described on Card VII, "Someone is showing their vagina. It's one of two things. One as if ready to give birth or two, ready to have sex."

Images which suggest concerns about sexuality were present in both the Rorschachs of fathers and of mothers. The following responses were produced by different mothers:

> " A skin graft ... from those pictures I saw in my father's magazines--you know the pins that hold the skin and the incision (Anything else make it look like a skin graft?) Well, it's all the same -- I always see -- it's the same thing -- it looks like a vagina -- a woman with her legs spread open. It's the same scenario. You have the incision or the -- your crack or whatever and then everything is open, so it's kind of the same" (Card VIII).

> "The red looks like blood to me ... It's dripping or splattering a little bit. It makes me think of a woman's period. I don't see anything violent" (Card

II).

"Looks like something dropped on a hospital floor ... It looks like some type of chemical interacting with blood or something else that was on the floor -- or acid ... It doesn't look any more ominous than blood on a Kotex or something like that" (Card IX).

"2 things coming together ... mating ... they are just meshing together. When I say mating, it's almost like they are animal, not people" (Card 1).

The mothers' responses suggest that they may have conflicts about their femininity and sexuality, particularly about menstruation and intercourse, and that they experience themselves as quite vulnerable with regards to their sexuality.

The following are responses produced by fathers:

"Two African women -- nude. Looks like a typical image you might see in a "National Geographic" or in one of those old movies -- big breasts ... something you would see in a picture of an African princess type" (Card III).

"A pelvic examination ... with perhaps an ovarian structure ... You often see in medical magazines or in any magazine this sort of an x-ray with one or more organs or one or more problems superimposed on them ... perhaps this is a zeroing in on a problem area" (Card III).

"A cherubic creature with arms outstretched ... pleading ... It seems to have a testicle and 2 penises hanging down ... (It's) pleading for mercy -- an imploring gesture. A bit like when you see the form of a shoulder emerging from a tunnel or house and he throws down his weapon and gives up -- and outstretched gesture of surrender and vulnerability" (Card I).

"A female sexual organ sort of exploding in orgasm and this up here looks like a penis. The penis is not exploding unfortunately" (Card II).

"A serious face with dangerous teeth about to ... take a bite out of its (an animal's) rump or penis. It would rather not have its rear end tasted by anything at all, but particularly not by a mouth as repulsive as that. And there are sexual aspects of it. Penis into

> vaginas. Well, with all those teeth there this particular vagina looks dangerous to that penis" (two consecutive responses to Card VIII).

The fathers' responses suggest that they have concerns about their own sexual competence and about the normalcy of their sexuality. Fathers at times portray females as "sexual objects" and other times portray female sexuality as either abberant and damaged, or as potentially damaging to them.

Both fathers and mothers produced responses which included references to procreation or birth. (In the couples interviewed only one had recently had a baby. None were expectant.) The responses included pregnant women, an episiotomy line, and babies in uteruses. One father identified a fetus with an umbilical cord on Card II stating, "This is how I sort of picture a fetus situated in the woman, in the mother." A mother who gave five separate responses referring to the reproductive system burst into tears after she identified, "the cervix is here and maybe the uterus and the baby is in here (Card VII)." Testing was then interrupted for 45 minutes as she sobbed about how much she wanted another child, but had opted to only have one because of her son's many psychiatric problems. The prevalence of birth responses is consistent with Tuber and Coates' (1985) observation that these types of responses are frequently seen in the Rorschachs of boys with a GID.

Children Responses

Both mothers and fathers gave responses where they

either identified children or identified characters from children's stories, fairy tales or cartoons. (Four of the fathers (33%) and 9 of the mothers (82%) gave these responses.) Children were either seen in playful activity as in "Two children on a see-saw ... they are playing--like they are friends" (Card VII) or, in several protocols, they were seen with mothers. The significance of this is most likely multiply determined. The responses may reflect in part that the population is comprised of parents with young children; they may also reflect childishness or immaturity; and finally, they may reflect a defensive distancing from the parents' own concerns.

When mothers or mother figures and children were seen together, the mothers were represented by both mothers and fathers as either protective and enveloping or as critical, angry and/or destructive. The following response which expresses the destructive anger these parents at times feel towards their children was produced by a mother:

> "Romulus and Remus drinking from the cow ... drinking from the breast ...(next response) An antelope spitting out something ... it's falling on the babies. The animal is mad ... the babies look vulnerable and having something on them like that looks like it might hurt them" (Card IX).

Food Responses

Food responses occurred much more frequently than would be expected. Four of the mothers (36%) and 5 of the fathers (42%) produced either food or eating responses. (According to Phillips and Smith, 1953, one food response

occurs in approximately 1 of 10 normal protocols.) There were five food responses in the 12 fathers' protocols and four food responses in the 11 mothers' protocols. Food content is thought to signify dependency needs (Phillips & Smith, 1953) the desire for nurturance (Klopfer, 1962) and affective deprivation (Exner, 1986). The following response provided by a father suggests that for at least some of the parents these are valid interpretations. "Crab or insect ... kind of crawling along ... looking for crumbs of bread dropped from the table above" (Card III).

Clothing Responses

Both fathers and mothers produced an unusually high number of clothing responses. (Nine of the mothers (82%) and 9 of the fathers (83%) had clothing responses. Six of the mothers (54%) produced two or more clothing responses. Five of the fathers (42%) produced two or more clothing responses.) Phillips and Smith (1953) indicate that it is quite rare for records to have more than one clothing response, although people of superior intelligence sometimes produce two clothing responses. Clothing responses are thought to signify 1) sensitivity to external social conventions or 2) concern over sexual differences and unresolved conflicts and problems with sexual role. The second interpretation suggests that the preponderance of clothing responses is consistent with the presence of gender confusion responses and sex responses.

Parents Representations of Men and Women in Rorschach Responses

Both mothers and fathers produced human responses; both produced males and female responses. The following conclusions were drawn from all human or human-like responses, such as witches or human-like monsters, etc. Giants and monsters were only included if specific features were stressed, such as their friendliness or their being destructive or frightening. Animals or animals in human-like activity were not included.

Fathers portrayed men as either powerful and threatening or destructive, or as diminutive and devalued. (Half identified destructive males and 5 of the 12 (42%) had diminutive, devalued responses.) The following are examples of powerful, threatening, destructive representations of men:

> "Pagan priest ... he has one arm outstretched ... about to cast a spell, release you from sin or send you to hell" (Card I).
>
> "A Russian Cossack ... sitting on a horse -- I don't think they were nice characters -- looks like he's ready for action -- this guy, he's not happy" (Card IV).
>
> "Darth Vader ... sinister, tramping down, coming towards me" (Card IV).

Devalued male representations included male clowns with "funny chins," " impish" pot-bellied Tolkein creatures with "strange" noses, a plastic "Santi Claus (sic)" figure on a pole, and the following to Card X:

> "Very pretty ... very Pop Art ... a mustache on a beady

> eyed man with fluffy cotton candy-like ... real fluffy white pinkish hair."

In contrast, only one mother produced a powerful and destructive male response, though 7 (64%) included diminutive, devalued, male representations. The mothers, more frequently than the fathers, described the men as "caricatured," as wearing "funny" clothes, or as being "funny looking." At times mothers specifically identified the phallic aspects of the percept as aberrant. Examples include:

> "A monster with ... drippy hands and this enormous body (speaking of center "tail" on the blot) ... I don't know what it is. Monsters just have extra parts ... It looks as if he's holding his hands very limply" (Card IV).

> "Peter Pan looking in the mirror with his little feather in his little cap and his little monkey nose" (Card VII).

Other examples include an unctuous "jowly" record producer, a "mutated" troll, and a "fat beast on point... it's a nonhuman creature. It seems masculine. "

None of the fathers produced male responses where males were portrayed as benignly powerful or where men interacted nonaggressively. Several of the mothers did produce these types of responses, but interestingly each of the responses involved androgynous features. One mother saw male dancers, another identified kneeling monks in robes with pigtails, and a third mother described a Biblical and "angelly (man) in a flowing kind of robe."

Two of the fathers and none of the mothers portrayed powerful malevolent females. One father identified female

cannibals and another gave the following response:

> "A powerful supernatural woman ... her power is coming out of her ... and these 2 guys down here are mice-like creatures and they are reacting to her presence -- like Oh God, protect us. They recognized how powerful she is and they want want to be a part of her" (Card X).

This last response suggests that, at least this father, at times identifies with women to stave off his anxiety about how powerful and destructive he experiences women as being, this identification therefore representing an identification with the aggressor.

Mothers more often than fathers portrayed women as benignly interacting. (Seven of the mothers (64%) in contrast with 3 of the fathers (25%) produced these kinds of responses.) Mothers' responses depicted women as either childish, nurturant and protective, or as sexually provocative. Examples included girls playing, ladies cooking, Mary Poppins, and "tartish" "flirty" Bistro ladies. Fathers' responses emphasized women as being intimate and interdependent and included pregnant ladies, women sharing secrets, and women "having trouble separating." Only one mother and none of the fathers produced a diminutive, devalued woman.

Significant Strengths in Parents of Boys with a GID

Although this study focused on the psychopathology and psychodynamics of parents of boys with a GID, many notable and quite striking strengths emerged in these parents during the course of the interviews. First, the parents

were extremely open and articulate and quite self-revealing about their difficulties and life histories. Second, many had a great deal of insight into how they may have inadvertently contributed to their sons' problems. Third, and perhaps most significantly, they were profoundly committed to their children and they not only expressed a quite poignant desire to "do whatever it takes" to help their child, but many altruistically said that they were glad to participate in the research in order to aid the investigator in understanding how to help other children and parents who were struggling with a GID.

Summary and Conclusions about Results

The results of this study indicate that fathers and mothers of boys with a GID have significant psychopathology and that the psychopathology and psychodynamics of the fathers and mothers are similar. All of the parents exhibited Axis I psychopathology and the prevalence of mood, substance use, and anxiety disorders was higher for both fathers and mothers than in the general population. Over half of the mothers and fathers exhibited personality disturbances. (The rate of diagnosed personality disorders was lower in the mothers.) On the Rorschach, both fathers and mothers evidenced disruptions in their thinking and both mothers and fathers produced responses suggestive of conflicts and concerns about their gender identity and sexuality. Although both groups did not differ

from normal subjects on a scale measuring a person's experience of their body boundaries, a content analysis of their Rorschach responses strongly suggests that both groups experience body anxiety and bodily preoccupations.

Although fathers and mothers exhibited similar psychopathology and psychodynamics, there were significant trends in the differences between the prevalence of different disturbances in the mothers and the fathers. Some of the variations in the prevalence of Axis I and Axis II psychopathology reflect what has been found in epidemiological studies, i.e., depressive disorders are more frequent in females and substance use and personality disorders are more common in men. However, although the variations reflect known sex differences, the results of the SCID and SCID II, together with the results garnered from the Rorschach scores, indicate that in this sample, fathers of boys with a GID had more pervasive and extensive psychopathology than did the mothers. Although the frequency of all types of depressive disorders and the extent of body anxiety and concerns were greater in the mothers, fathers not only exhibited equal rates of major depression and more frequent substance use and personality disorders, but they also exhibited greater disturbances in their object relations and more frequent disruptions in their thought processes.

The finding that parents of boys with a GID exhibit mood, anxiety and substance abuse disorders is consistent

with the literature describing parents of children with mood and anxiety disorders. Given the high rates of depression and anxiety disorders in boys with a GID, the results of these investigations are particularly relevant to understanding the findings of this study. Although most of the research on the familial aggregation of depression and anxiety has involved looking at the offspring of parents with diagnosed disorders or obtaining information about the adult relatives of adult patients, several studies have examined the relationship between the childhood disorder and parental psychopathology. Strober (1984) found higher than expected rates of affective and alcohol disorders in relatives of depressed adolescents. Puig-Antich, Goetz, and Davies (in press) similarly found a higher incidence of depression and alcoholism in relatives of depressed prepubertal children than in a normal control group. Mitchell, McCauley, Burke, Calderon, and Schloredt (1989) compared the mothers and fathers of depressed children and adolescents with parents of offspring with nondepressive psychiatric disorders. They found a high rate of major depression in parents of both the depressed and nondepressed juveniles; depression therefore did not distinguish between the two groups. However, maternal histories of anxiety disorders and substance abuse did differentiate between the groups, as both occurred significantly more often in mothers of the depressed children and adolescents than in mothers of nondepressed

psychiatrically diagnosed juveniles. Although fathers also had histories of anxiety disorders and alcoholism, there were not significant differences in the rates of these disorders between the two groups.

The specific finding that parents of boys with a GID have mood, substance use and anxiety disorders is therefore consistent with the findings of Strober, Puig-Antich, and Mitchell et al. Interestingly, Mitchell et al. (1989) also observed the same sex differences found in this study, i.e., they found that depression occurred more frequently in the mothers and there was a greater prevalence of alcoholism in the fathers. Of note, they also found that anxiety disorders occurred significantly more often in mothers, suggesting that although the difference in the anxiety disorders in this sample were far from being significant, with a larger sample, differences between the groups may become more apparent.

Parents of boys with a GID are therefore diagnostically quite similar to parents of depressed children. This similarity raises questions about which factors distinguish parents of boys with a GID from parents of children with affective disorders. Given that 50% of the boys with a GID in Coates' sample scored in the clinical range on the depression subscale of the Child Behavior Checklist (Coates, 1985, 1990; Coates & Person, 1985; Coates & Zucker, 1988), one could argue that these findings reflect the characteristics of parents of

depressed children, rather than specific features of parents of boys with a GID. To more clearly distinguish parents of boys with a GID from parents of depressed children one would need to compare three groups: the parents of boys with a GID and depression; parents of boys with a GID without depression; and parents of depressed boys.

One current finding which may distinguish this group of parents from parents of depressed children (and parents of children with other psychiatric disorders) is the parents' concerns about their own gender identity and sexuality. In this study, the presence of gender confusion and the preponderance of sex responses in the parents' Rorschachs suggested that the parents were more concerned with gender and with sexuality than normal subjects. It can be hypothesized that parents of boys with a GID have subclinical gender conflicts and concerns and sexual anxieties which would distinguish them from parents of children with other disorders, most notably anxiety and depressive disorders.

A serious challenge to this hypothesis would be the argument that the Rorschach findings are reflecting the parents' anxiety and concern about their son's gender identity disorder. The parents' responses may not be indicative of their own conflicts, but reflective of expectable concerns about their son's gender problems and of their worries about his future sexual orientation.

Although these parents do clearly seem to be more concerned with gender and sexuality, the argument can be made that these concerns are secondary to their son's problems. Although further research using more robust measures of adults' experiences of gender identity and sexuality would be needed to counter this argument, several of the parents in this study spontaneously discussed concerns about their sexuality or gender identity. Three of the mothers and four of the fathers described concerns about their gender identity, their sexuality, or their sexual orientation during either the SCID or during history gathering interviews which preceded the research protocol. Below is an excerpt from the SCID of a mother who was answering questions about previous depressive episodes.

> "I was very upset about my own sexuality because I was so fearful ... I even had doubts about my own sexuality, whether I might be gay or not. I just didn't know about myself. I went to college in the 60's when everyone was screwing all over the place and I was the only one who didn't."

The parents' unsolicited descriptions of sexual and gender concerns suggest that the Rorschach responses are measuring parental conflicts which antedate their son's gender disorder.

In sum, the prevalence and sex differences of mood, psychoactive substance use, and anxiety disorders found in this study are consistent with what has been found about parents of depressed children. The presence of personality disturbances in both parents is consistent with the clinical descriptions of parents of boys with a GID and the

finding that fathers have a greater frequency of personality disorders is consistent with epidemiological data on clinical samples. The gender and sexual conflicts which appear in both groups of parents of boys with a GID have not been reported in the descriptions of parents of children with depression or anxiety disorders suggesting that this may be a specific factor which distinguishes parents of boys with a GID from parents of children with depression or anxiety.

Implications of Results for Theories of Etiology

When considering parental psychopathology and psychodynamics as etiological factors in the development of a GID, one implicitly raises the question of the extent to which each parent is contributing to the development of the disorder. The question is raised both in terms of a parent genetically passing on certain disorders, such as depression, anxiety disorders or psychoactive substance abuse problems and in terms of parental psychodynamics, which may be pathogenic influences in the mother-son or father-son relationships.

The results of this study overwhelmingly suggest that boys with a GID were, because of their parents' psychopathology, genetically at risk for developing a psychiatric disorder. The rate of parental psychopathology for both mothers and fathers was 100%. In 7 out of the 11 couples (64%) both parents had histories of depressive

illness. Weissman et al. (1984) have found that the risk for one child developing an Axis I disorder increases linearly if both parents are psychiatrically ill, from the risk if only one or if neither parent has psychopathology. In 6 out of the 11 couples (54%) the dyad had both anxiety and mood disorders (meaning that either or both the mother and/or the father had a mood disorder and either or both also had an anxiety disorder). In 4 out of the 11 couples (36%) both parents had histories of depression and additionally, at least one of the two depressed parents also had an anxiety disorder. Leckman, Weissman, Merikangas, Pauls, and Prusoff (1983) found that relatives of individuals who have both major depression and an anxiety disorder are at greater risk for both depressive and anxiety disorders. Weissman, Leckman, Merikangas, Gammon, and Prusoff (1984) additionally found that if a parent has a panic disorder a child has a threefold chance of developing separation anxiety. Panic disorder occurred in 4 out of the 11 couples (36%). Given the evidence from twin and adoption studies of the genetic transmission of mood, anxiety, and psychoactive substance abuse disorder (Blehar, Weissman, Gershon, & Hirschfeld, 1988; Cadoret, Troughton, O'Gorman, & Heywoood, 1986; Goodwin, 1985; Kendler, Heath, Martin, & Eaves, 1986; Wender, Kety, Rosenthal, Schulsinger, Ortmann, & Lunde, 1986) and given the results of this study, children who develop a GID are at considerable biological risk for developing both

depressive and anxiety disorders, most significantly, separation anxiety.

In addition to creating a biological risk, the psychopathology in mothers and fathers significantly influences their ability to adequately parent. Weissman and Paykel (1974) identified depressed mothers as more irritable and resentful of their children, as well as less affectionate and involved with them. They also found that the depressed woman's problems with her children persisted after her depression remitted. Weissman and Paykel's finding together with the findings of this study suggest that the mother's significant psychopathology interfered with the early mother-child relationship. Rather than being involved in a prolonged period of blissful symbiosis as suggested by Stoller (1968, 1975, 1985), it was likely that these mothers were at times quite emotionally unavailable to their offspring. This maternal unavailability most likely created anxiety and insecurity in the child's attachment to his mother, rather than a comfortable feeling of uninterrupted merger and enmeshment as Stoller suggests. Radke-Yarrow, Cummings, Kuczynski and Chapman (1985) have reported findings which support this hypotheses. They investigated the patterns of attachment in two-and three-year olds in normal families and families with parental depression and found insecure patterns of attachment in children of mothers with a major depression much more frequently than in children of normal mothers.

The interviews with the mothers in this study did however afford an insight into one of the ways Stoller may have been led to spurious conclusions about the early mother-child relationship. The interviewed mothers were, as a group extremely likable, articulate people who expressed considerable love and concern for their child. All were either working or going to school and at first glance appeared to be quite high functioning. It was only through the systematic measures used during this interview that the extent of parental psychopathology could be fully apprehended. Neither Stoller nor Green (1987) used such measures.

Children with a GID have been described as being quite fearful of aggressive situations; similarly, mothers have been described as regarding any aggressive interchange as invariably leading to out-of control destruction (Coates, 1985, 1990). Kochanska, Kuczynski, Radke-Yarrow, and Welsh (1987) have produced findings that suggest that this attitude not only reflects maternal psychodynamics which are passed along to the child, but it may also be being reinforced by the mother's depression. When they compared normal and affectively ill mothers, they found that affectively ill mothers avoided confrontation and conflict with their child, and they speculated that this then disrupts the child's socialization and development of autonomous functioning. This finding also suggests that the child is not learning from his mother, because of his

mother's depression as well as from her psychodynamics, how to resolve conflicts, and that for many reasons, the child is receiving the message that confrontations are to be avoided. This may also have ramifications in terms of mothers' responses to their sons' cross gender behavior. Rather than setting limits on the behavior, which would result in a confrontation, the mothers avoid the situation and allow the boys to persist in the effeminate behaviors. The mothers' tendencies to avoid confrontations about the boys' cross gender behavior may be compounded by an overall sense of helplessness about their children. Kochanska, Radke-Yarrow, Kucyznski and Friedman (1987) found that affectively ill mothers when compared with normal controls expressed a greater degree of helplessness about their children and were more likely to feel that their child's development would be determined by uncontrollable factors.

Although the effects of paternal psychopathology on fathers' parenting has been underinvestigated, one can speculate that, like the mothers, fathers who have significant psychopathology are less available to their children. Since the 1970's the importance of the father's specific involvement in a child's development has received increasing attention. Studies have focused both on the father's indirect influence as he facilitates maternal competence (Belsky, 1981; Lamb, Chase, Lansdale, & Owen, 1979; Pederson, Anderson, & Cain, 1977) and on his direct influence on his child's personality (Abelin, 1971, 1975;

Greenspan, 1982; Henderson, 1982; Mahler, Pine, & Bergman, 1975), moral (Biller, 1974), and gender identity and sex role development (Abelin, 1980; Biller, 1974; Greenspan, 1968; Kogel & Schilling, 1975). Paternal involvement has also been identified as important to the development of a child's capacity to modulate aggression (Herzog, 1980, 1982; Ross & Herzog, 1985).

The extremely high rate of paternal psychopathology suggests that the father's ability to foster his son's development in the above ways would be impaired. Due to his own disturbances, the father would not be able to facilitate maternal competence, nor would he be available as a "healthier" parent when the mother's psychiatric problems compromise her mothering.

The high rate of substance abuse and depression raises the question of whether fathers are intermittently violent and explosive, because of their substance abuse, and then withdrawn and unavailable due to their depressions. If this were the case, then the father's unpredicatble outbursts would interfere with the boys's ability to utilize his relationship with his father to learn how to manage aggression.

Parents' Axis II psychopathology may also be factors in the etiology of a GID. When subthreshold and diagnosed disorders are considered together, over 1/2 of the fathers and over 1/2 of the mothers exhibit personality disturbances. As a group, parents evinced narcissistic

personality disturbances and described themselves as sensitive to criticism; as preoccupied with fantasies of unlimited power, brilliance, and beauty; as preoccupied with feelings of envy; and as requiring constant attention. These personality traits suggest that the parents' availability to their children is compromised by their narcissism and that the child would often be used to gratify the parents' needs. The parents' narcissism would therefore impede the child's ability to develop a strong sense of self as the child focused on anticipating and meeting parental needs and on anticipating and fulfilling parental expectations in order to secure parental love, rather than focusing on his own burgeoning identity.

The presence of thought disorder in both the fathers' and the mothers' Rorschachs suggests that both groups have boundary disturbances which could further impair their ability to distinguish between their fantasies about their child and what the child may actually be wanting, feeling and experiencing. Fathers produced affectively elaborated, highly personalized thought disorder responses 2 1/2 times more frequently than they produced the other types of thought disorder responses, suggesting that they are particularly prone to elaborate their observations with their own fantasies and feelings and that they are therefore particularly prone to misinterpreting situtions.

In addition to exhibiting narcissistic disturbances, almost half of the fathers also exhibited paranoid

features. They described themselves as reluctant to let people get to know them (because they fear people would use the information to harm them), as bearing grudges, as unforgiving of insults and injuries, and as thin skinned. These paranoid features, together with fathers' narcissism and tendency to project their own fantasies and feelings support the supposition that fathers of boys who develop a GID are impaired in their ability to develop an appropriate relationship with their sons. These fathers are particularly susceptible to feeling rejected and criticized and they are extremely needy. One can speculate that these characteristics render the father particularly vulnerable to feeling "left out" and rejected by their sons. One could imagine a father reacting with intense envy to the closeness of the early mother-child interactions and his retreating from the new baby, rather than developing a bond with his son. One could similarly imagine a father feeling implicitly criticized and rejected if the baby boy does not immediately smile and engage with him when he approaches the boy and the father then recoiling in hurt and anger and becoming increasingly reluctant to re-approach the child as he feels "left out" and excluded from the mother-child interactions and as he misinterprets the child's normal fussiness as rejection. These personality disturbances could therefore be hypothesized to contribute to an estrangement between the fathers and their children.

The prevalence of disturbances in the fathers' object

relations as measured by the MOA further suggest impairments in their interpersonal relationships. Fathers specifically tended to perceive interactions as overpowering and malevolent which would both adversely affect their capacity to have a mutually, autonomous relationship with their child, and would further compromise their ability to serve as a model for how one manages aggression in interpersonal interactions. Interestingly, although mothers characteristically represented interactions as benign, they also portrayed interactions as malevolent and overtly destructive as often as the fathers did, suggesting that they, like the fathers, have concerns about the safety of close interpersonal relationships and that they, along with the fathers, communicate these beliefs to their children.

Coates (1985, 1990) has described how mothers transmit their anxiety about aggression and rough-and-tumble play to their sons and thereby contribute to the boy feeling that if he engages in typical boyish playground activities he will be harmed. Ross and Herzog (1985) see the father, unlike the mother, as engaging in "large motor" (nonhostile aggression) play with the child. This play serves to "organize and modulate the child's aggressive repertoire" and provides the basis for the child's later comfort with rough-and-tumble play. They note that this is particularly important for sons since the male's appropriate modulation of aggression "fuels man's capacities for vigorous play and

reasonable discipline." Although fathers responses did not seem to differ from the results obtained from normal subjects on the FCBI, they, like the mothers did produce a seemingly high number of anatomy responses on the Rorschach. Given that these responses are often interpreted as indices of body anxiety and body preoccupations, one could raise the question of whether these fathers do indeed engage in this type of "large motor play" or whether because of their own body anxiety they refrain from these types of interactions with their children. It can be postulated then that lacking a model for the management of aggression and being sensitve to his mother's attitudes toward assertiveness and aggresssion, the boy also comes to regard aggression as unmanagable and destructive and to be avoided.

The previously discussed findings suggest nonspecific factors in the etiology of a GID, factors which contribute to distrubances in the child's development of a sense of self, in his capacity to manage aggression and in his ability to perceive interpersonal interactions as benign and reciprocating. There were also findings in this study which may represent specific etiological factors and which may distinguish this group of parents from parents of depressed and anxious children who do not have gender problems.

First, the findings in this study suggest that the parents themselves have gender conflicts. These conflicts

may influence their parenting both in their inadvertently encouraging cross gender behavior and in their inability to present consistent representations of conventionally defined gender role stereotypes, e.g., this is what boys do and do not do, this is what boys wear and what they do not wear, etc. Second, this investigation also found that mothers' representations of men as depicted in Rorschach responses were consistent with reports that mothers of boys with a GID devalue men (Bradley et al., 1980; Coates, 1985, 1990; Coates & Zucker, 1988). Interestingly, the fathers' Rorschach responses suggest that they also have negative representations of men. Specifically, fathers either represented men as powerful and threatening or as devalued. This suggests that the fathers of GID boys are also communicating negative representations of males to their sons.

The above speculations are quite consistent with Coates' model for the etiology of GID (1985, 1990). Briefly restated, she describes the development of a GID as follows. A child with an at risk temperament is born to parents who themselves manifest both state and trait psychopathology. Mothers have anxious, hostile parenting styles which interfere with the child's ability to develop his own sense of autonomy and independence. Mothers denigrate and devalue men and regard normal male assertiveness as tantamount to destructive aggression; fathers reinforce these attitudes either by displaying

explosive tempers or by failing to provide a strong counter-example. During the first few years of the boy's life, during which gender identity is being formed, there is a significant stressor in the family's life during which the mother precipitously withdraws from her son. The child who is primed by temperamental and familial factors then uses cross-gender identifications and behaviors in the service of creating a fantasy of "being mommy" to allay the anxiety he feels as a result of her withdrawal. This fantasy also serves as a solution to the child's conflicts about assertiveness and aggression.

Based on the results of this study one could posit the following as further hypotheses about the etiology of GID. Boys with a GID are born to parents who have a combination of mood, anxiety and substance abuse disorders, which creates a biological vulnerability to depression and anxiety in the child. Parents' Axis I psychopathology, together with their personality disturbances compromise their parenting style. Both parents may be less emotionally available to their sons and both may use the child to gratify their own narcissistic needs. Fathers' personality disturbances may render them particularly vulnerable to feeling excluded and rejected by their sons and they react to situations where these feelings are elicited, however erroneously, by withdrawing. This withdrawal, coupled with fathers' anxiety about their own bodies and also, possibly with intermittent explosiveness

caused by their substance abuse problems, interferes with the fathers' ability to serve as a model for the regulation of aggression. Both fathers and mothers devalue men and have conflicts about their own sexuality and gender identity. These gender specific conflicts may cause parents to inadvertently encourage cross gender behavior and may interfere with their providing their sons with clear representations about what constitutes conventionally defined gender role behavior. This formulation elaborates on the contributions of parental psychopatholgy and psychodynamics to the etiology of a GID; further study is needed to refute, refine, or substantiate what has been suggested by the results of this investigation.

Limitations of Current Study and Implications for Future Research

The current study is limited by several significant factors. First, the lack of normal controls weakens the conclusions drawn about how parents of boys with a GID differ from the general population. Although the results were interpreted in the context of epidemiological data on the rates and sex differences of relevant psychopathology, and although the Rorschach data was similarly compared to results obtained from nonclinical subjects, the study needs to be repeated with normal controls to base these conclusions on more solid methodological grounds.

Secondly, given the ubiquitous finding that children with psychopathology have parents with psychopathology, the

study needs to be repeated with clinical controls to more clearly identify which features differentiate parents of boys with a GID from parents of boys with other types of psychopathology. The findings of this study suggest two ways of investigating this issue. First, to more clearly differentiate parents of boys with a GID from parents of depressed children, parents of boys with a GID without depression should be compared to parents of boys with a GID and depression and parents of boys with depression alone. Second, parents of boys with a GID should be compared to parents of boys with anxiety disorders and with parents of depressed boys.

Third, the sample size in this study was extremely small. Several seemingly meaningful trends were noted which may have reached statistical significance if the study were repeated with a larger number of subjects. A larger sample would also allow for the control of certain probably significant variables. One notable variable which was not systematically investigated or controlled for was the parents' treatment history, which could obviously significantly influence the results. For example, one would expect different rates of current psychopathology from the many parents who were in treatment or who had previously received many years of treatment than from parents who had never sought treatment.

Finally, this study was not blind. The investigator conducted and rated all of the structured interviews and

administered all of the Rorschachs. The study should therefore be repeated with blind interviewers and blind ratings.

In sum, this study should be regarded as strong pilot data which would justify the resources needed to repeat the investigation with a larger sample, with normal and clinical controls and with blind interviews and blind SCID ratings. As pilot data, the study raises the following important questions which could be addressed in future research: 1) When compared to clinical controls, which configurations of parental psychopathology are correlated with a GID in a child, i.e., which are the specific and which are the nonspecific factors in the mother-father dyad? 2) When compared with clinical controls, which aspects of the mothers' and which aspects of the fathers' psychopathology and psychodynamics are associated with a GID in their offspring and which are not? (This question would be particularly important to answer given Mitchell et al.'s (1989) finding that it was particular types of maternal psychopathology and not paternal psychopathology which distinguished depressed from nondepressed psychiatrically diagnosed juveniles.) 3) Do parents exhibit gender and sexual conflicts when more robust measures are used, such as structured interviews about an adults' sexuality, and do these features distinguish parents of boys with a GID from parents of boys with other types of psychopathology? 4) Are there subgroups among the parents?

The mothers in this study share some of the features of the mothers studied by Marantz, but they do not have the borderline psychopathology or the disturbances in their object relations noted by Marantz. What accounts for these differences? 5) If there are subgroups of parents, do they co-vary with different subgroups of boys with a GID, e.g., boys who also have depression verses those with anxiety disorders verses those with other behavioral disturbances etc.?

The results from this study therefore stand as strong pilot data. The findings raise both specific questions about the features which distinguish these parents from parents of children with other disorders and about the features which distinguish the mothers and fathers of boys with a GID from one another. The clinically significant results obtained from this study suggest that it would be valuable to repeat the study with the methodological rigor described above.

Table 1

Frequency of Axis I Diagnoses Observed in Parents of Boys with a GID

Axis I Diagnosis	Mothers		Fathers	
	N	%	N	%
Major Depression	4	36%	4	33%
Depression NOS	4	36%	2	17%
Bipolar Disorders	1	9%	1	8%
Dysthymia	1	9%	0	-
Any Mood Disorder	10	91%	7	58%
Panic Disorder	2	18%	2	17%
Simple Phobia	2	18%	0	-
Social Phobia	3	27%	0	-
Obsessive Compulsive	0	-	1	8%
Any Anxiety Disorder	5	45%	3	25%
Alcohol Abuse	1	9%	3	25%
Alcohol Dependence	2	18%	5	42%
Drug Abuse	2	18%	5	42%
Drug Dependence	2	18%	0	-
Any Substance Abuse	4	36%	9	75%
Hypochondriasis	0	-	1	8%
Bulimia Nervosa	1	9%	0	-

Table 2

Axis I and Axis II Diagnoses Observed in Parents of Boys with a GID

Psychopathology in Fathers

Couple	Axis I	Axis II
#1	Alcohol Abuse Drug Abuse	None
#2	Alcohol Dependence	None
#3	Major Depression Attention Deficit-hyperactivity Disorder	Personality Disorder NOS
#4	Drug Abuse	Narcissistic
#5	Major Depression Alcohol Dependence	Paranoid
#6	Bipolar Disorder Panic Disorder Alcohol Dependence Drug Abuse	Paranoid Narcissistic Dependent
#7	Alcohol Dependence Panic Disorder Depression NOS	Paranoid
#8	Major Depression Obsessive-Compulsive Hypochondriasis	Personality Disorder NOS
#9	Alcohol Abuse Drug Abuse	None
#10	Major Depression Drug Abuse Alcohol Dependence	Passive Aggressive Self-defeating Paranoid Narcissistic Schizotypal
#11	Alcohol Abuse	None
#12	Depression NOS	Personality Disorder NOS

Psychopathology in Mothers

Couple	Axis I	Axis II
#1	Social Phobia	None
#2	Major Depression	None
#3	Depression NOS Bulimia Nervosa	Personality Disorder NOS
#4	Not included in study	
#5	Depression NOS	None
#6	Bipolar II Drug Abuse (cannabis) Drug Dependence (stimulants)	Personality Disorder NOS
#7	Depression NOS	None
#8	Dysthymia Simple Phobia	Personality Disorder NOS
#9	Depression NOS Panic Disorder Social Phobia	None
#10	Major Depression Social Phobia Simple Phobia Alcohol Dependence Drug Abuse (cannabis) Drug Dependence (stimulants)	None
#11	Major Depression Alcohol Abuse	None
#12	Major Depression Alcohol Dependence Panic Disorder	None

Table 3

Frequency of Personality Disorders Observed in Parents of Boys with a GID

	Axis II Diagnoses		Subthreshold *	
	Mothers	Fathers	Mothers	Fathers
Personality Disorder				
Avoidant	0	0	0	1
Dependent	0	1	0	0
Obsessive-Compulsive	0	0	0	1
Passive Aggressive	0	1	0	2
Self-Defeating	0	1	4	1
Paranoid	0	4	0	1
Schizotypal	0	1	0	0
Schizoid	0	0	0	1
Histrionic	0	0	1	4
Narcissistic	0	3	2	3
Borderline	0	0	1	2
Antisocial	0	0	0	0
NOS	3	3		

* A subthreshold diagnosis was scored if either:

1) All but one of the required number of symptoms were met

2) The number of symptoms which fell in the clinical range and the number of symptoms which fell in the subthreshold range totaled the number of symptoms required for a diagnosis

Table 4

Distribution of Urist MOA Scores in Rorschachs of Parents of Boys with a GID

	Number of Responses	
MOA Scale Point	Mothers	Fathers
1	21	22
2	32 *	21
3	10	11
4	4	4
5	16	33 *
6	16	13
7	0	1

* modes

Table 5

Distribution of Thought Disorder Responses in Rorschachs of Parents of Boys with a GID

# of Thought Disorder Responses	Mothers	Fathers
0	3	2
1	2	2
2	0	2
3	1	1
4	1	1
5	2	0
6	0	0
7	0	1
8	1	0
9	0	0
10	0	0
11	1	0
12	0	0
13	0	1
31	0	1

APPENDIX 1

ST. LUKE'S\ROOSEVELT
Hospital Center

428 West 59th Street, New York, New York 10019

CONSENT FORM

The Roosevelt Hospital
St. Luke's Hospital
Woman's Hospital

1. I, _____ give my consent for my son _____ and myself to participate in the project which has been approved by the Research Committee of St. Luke's/Roosevelt Hospital.

2. The project has been described to me. I understand that it will consist of in-depth interviewing of both myself and my son. My son will receive psychological testing and I will be given the choice to participate in similar testing.

3. I understand my son will be given a comprehensive psychological evaluation, the results of which will be discussed fully with me. If the outcome of this evaluation suggests that he needs psychological help of any kind, the project will, if I wish, assist in helping to obtain appropriate treatment services.

4. I understand that all the results will be coded and kept strictly confidential.

5. I understand that the results of this study may be described in medical and psychological journals. I have been told that it will not be possible to identify me or my son through any information so published.

6. My questions about the study have been answered and I understand that I am free to ask any questions in the future and to withdraw from the study at any time.

Witness _____ Signed _____
(to be signed by the parent or guardian of the child)

Witness _____ Date _____

Susan Coates, Ph.D.
Principle Investigator - Child and Adolescent Psychiatry

Richard C. Friedman, M.D.
Co-investigator - Child and Adolescent Psychiatry

APPENDIX 2

GENDER CONFUSION IN RORSCHACH RESPONSES (from Tuber and Coates, 1985)

COMBINED MALE/FEMALE RESPONSE: Male and female elements are combined into a single response.

e.g. "this looks like a fat lady, no, looks like a fat man naked with lady's shoes on." (Card IV)

"this could be a man with breasts...a hermaphrodite"

TRANSFORMED MALE/FEMALE RESPONSE: In a single percept, gender is changed or transformed from one to the other.

e.g. "It looks like a lady, looks like a man, turning into a Superman..." (Card V)

"this is a little girl playing patti-cake, actually it's more like boys doing high five after winning a game"

This includes shifts in pronouns, deliberate or otherwise.

e.g. " A monster--he's going to eat someone. She's very hungry."

ARTICULATED INABILITY TO DECIDE ON GENDER OF PERCEPT: A marked inability to decide whether a single percept is exclusively male or female. This differs from the other two in that the subject resolves the gender confusion in the other two by either fusing the male and female attributes or by transforming the gender of the percept. In this case, the gender is not ever definitely specified.

e.g. "If it's a girl his (sic) hair goes up...or if it's a boy, it needs a haircut" (Card VII)

"This could be a man--this is his penis or it could be a woman and those are her breasts"

Score responses where there is an inability to decide on a body part which is obviously linked to gender, e.g., penis, vagina, breasts

e.g. "This could be a penis or actually maybe it's a vagina"

Do not score elaborations where something which is not specific to one gender is described as belonging to either one or the other

e.g. "This is a crown--like what a king or a queen would wear"

The following would however be scored as an Inability to Decide response:

> " This is a king see his beard or maybe it's a queen because of the long dress, I'm not sure, either a king or a queen"

SCORE ONLY ONCE PER RESPONSE. IF A RESPONSE SEEMS TO MEET THE CRITERIA FOR MORE THAN ONE SCORE, ASSIGN THE "MOST SERIOUS" SCORE POSSIBLE. FOR EXAMPLE, "COMBINED" TAKES PRECEDENCE OVER "TRANSFORMED" WHICH TAKES PRECEDENCE OVER "INABILITY TO DECIDE."

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