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Gender Dysphoric Disorder (GDD) in Adolescence: A Psycho-Social Issue for Faith-based Groups and Cultural Societies in Nigeria

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Abstract

There exists a dearth of literature on the psychosocial consequences of the "unusual" or atypical sexual practices and gender identity disorders on affected persons and there family members as many cases are either not documented or reported in clinical settings or treated on cultural and or religious grounds. There is also a general lack of professional and research attention drawn to the nature, prevalence and management of these disorders among mental health practitioners and scholars working in faith-based and cultural societies like Nigeria. Therefore, the true incidence of these disorders in Nigeria is at present undetermined. Thus, little is known about what may be done to help people with these disorders in culture bound societies like Nigeria. Hence, the need for this paper which adopted a descriptive and interpretive double hermeneutic phenomenological survey research design to examine the faith-based and cultural definitions and responses to gender dysphoria in Nigeria. A total of 200 subjects participated in the study, one hundred from the faith-based organizations and another one hundred from different cultural groups in Nigeria. The pre-tested *Faith-Based/ Cultural Definitions of Gender Dysphoric and Response Instrument*was administered to them in their natural setting.Five (5)research questions and three (3) hypotheses were raised and tested at 0.05 level of significance using both simple descriptive statistics and Kruskal Wallis test. The results which have implications for mental health practitioners, faith-based organizations and cultural societies indicated that sexual orientation played significant role in adolescents' religious beliefs and socio-cultural definitions and attitudes towards sexual deviations and gender dysphoria among adolescent boys and girls in Nigeria.

Keywords: Gender Adolescence; Cultural Societies; Dysphoric Disorder (GDD); Faith-based Groups and Psycho-Social Issue for

1. Introduction

Gender and anatomical sex are two distinct elements: each developing at different times in different parts of the body. They are central features of identity development in adolescence. When an adolescent's internal experience of gender and/or sexuality does not match his or her anatomical sex, it may result in gender dysphoric disorders (GDD). Gender dysphoria also known as gender identity disorders (GID) is a pervasive sense of discomfort and unhappiness with one's biological or chromosomal sex or its usual gender role, accompanied by strong identification with the opposite gender and a desire to live as or to become a member of the opposite gender.It referred to Cross-Gender Behavior Issues as indicated in the American Psychological Association's Diagnostic and Statistical Manual IV (1994).

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Examples are lesbianism, gay, bi-sexual, transgender, two-spirited, transsexual, queer and questioning individuals.Its occurrence has been classified as Gender dysphoria in Children, Gender dysphoria in Adolescents/Adults, and Unspecified Gender Dysphoria (A.P.A., 1994). Gender Dysphoria is essentially a pervasive expression of strong discomfort with one's biological sex that cannot be attributed to perceived societal advantages of the desired sex in a given culture (The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, [HBIGDA] 2001). For instance, a biological woman may feel disgusted that she is a woman and hate her secondary sex characteristics. A biological male may feel that he is a woman trapped inside a man's body (Okabe, Sato, Matsumoto, Ido, Terada, & Kuroda, 2008).

Developmentally, Gender Dysphoria may be experienced in childhood, adolescence and adulthood. In adolescence, GDD may be accompanied by depressed mood, anxiety, and behaviour problems, all of which can considerably heighten the adolescent's distress when going through puberty and developing features of their biological sex (de Vries, Cohen-Kettenis, &Delemarre-van de Waal, 2006). In the Western societies, adolescents with GDD often engage in cross-gender behavior and dress; some engage in self-mutilation and wound their sexual characteristics; a biological female may damage her breast, while a biological male may damage his penis (de Vries, Cohen-Kettenis, and Delemarre-van de Waal, 2006). These disturbances may cause such people to feel significant distress and/or be unable to function properly in life (de Vries, Cohen-Kettenis, and Delemarre-van de Waal, 2006).In adolescents/adults, Gender Dysphoria has 8 possible criteria, and 6 of them must be met in order to be diagnosed with Gender Dysphoria. Adolescents and adults are likely to fully understand the feelings they have, therefore, their criteria is often associated with emotional and behavioral problems as well as a high rate of psychiatric comorbidity. The Undefined Gender Dysphoria is apparently planned to mean something, but at preset has no existing criteria.

The literature is replete with varying categories and symptoms of GDD in adolescence, For instance, the International Classification of Diseases-10 (World Health Organization, 2011) has categorized GDD into four. First is 'transsexualism' (ICD-10 F64.0), which is a desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make one's body as congruent as possible with one's preferred sex through surgery and hormone treatment. The presence of the transsexual identity may occur for at least two years persistently. The disorder is not a symptom of another mental disorder, such as schizophrenia, or associated with chromosomal abnormality. Next is Dual-role transvestism (ICD-10 F64.1), which is wearing clothes of the opposite sex in order to experience temporary membership of the opposite sex; absence of any sexual motivation for the cross-dressing; and absence of any desire for a permanent change to the opposite sex. It also identifies Other gender identity Disorders (F64.8) and Gender Identity Disorder, Unspecified (F64.9). It identified no specific criteria for these diagnoses.

In addition to the ICD-10 F64.0 (World Health Organization, 2011) are the DSM-V (APA, 2012) criteria for the diagnosis of Gender dysphoria in adolescence and adulthood. According to the DSM-V criteria, this disturbance is manifested by symptoms such as exhibition of strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex); a stated desire to be the other sex; frequent passing as the other sex; desire to live or be treated as the other sex; or the conviction that he or she has the typical feelings and reactions of the other sex. It also includes persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex; as well as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex. The disturbance is not concurrent with a physical intersex condition; but may cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Essentially, the proposed criteria for Gender Dysphoria Symptoms in adolescents and adults for the upcoming DSM-V (APA, 2012) are (retrieved from http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=482):

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by 2 or more of the following indicators:

1. a marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
2. a strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender
3. a strong desire for the primary and/or secondary sex characteristics of the other gender
4. a strong desire to be of the other gender
5. a strong desire to be treated as the other gender
6. a strong conviction that one has the typical feelings and reactions of the other gender

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, or with a significantly increased risk of suffering, such as distress or disability (specifier) Subtypes

- With a disorder of sex development
- Without a disorder of sex development

Post-transition, i.e., the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is undergoing) at least one cross-sex medical procedure or treatment regimen, namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male, mastectomy, phalloplasty in a natal female). In clinical practice, an adolescent may experience a state of gender dysphoria at any point between strictly defined transvestism and transsexualism. Over a long time span there may be progress from the one to the other state. The transsexual state is more extreme than the matter of dress for the adolescent who may wish to lead life in the role of the opposite gender and, may requests medico-social help to be enabled to do so even though the cost may be high in terms of loss of esteem by others, financial security and the medical and surgical discomfort. Furthermore, in faith-based and culturally bound communities like Nigeria, affected individuals may strive, under perceived parental and societal pressures, to behave appropriately, but all the time wishes for the contrary: the adolescent boy may feel more comfortable in the company of girls and rejects typically masculine play activity such as football.

Conceptual Definition of Terms

- Gender Dysphoria: This is an individual's feeling of extreme discomfort with his or her biological sex.
- Gender identity disorder (GID): This implies gender identity crisis and role confusion. It contradict the usual binary gender construct
- Core Gender Identity: This term refers to an individual's innate sense of appropriateness of anatomical gender (Money &Ehrhardt, 1972).
- Gender Role Conflict: In psychological parlance, gender-role conflict is defined as social difficulty arising when individuals have internalized characteristics other than those traditionally ascribed to their sex (Wisniewski, Migeon, Meyer-Bahlburg, et al, 2000).
- Orientation of Sexual Drive: This is the hetero- or homosexual dimension
- Gendermaps: This is the entity, template, or schema within the mind and brain that codes masculinity and femininity and androgyny. This map or coding imprint is established very early in life through an interaction of nature and nurture. Because gendermap development is highly influenced by hormones emanating from the developing fetus, sex and gender identification are generally closely matched. But like most aspects of being human, there are no guarantees. As a result, as early as the age of four, an individual may notice that his gendermap is incongruous with his physical sex, and may react by either trying to suppress (in the face of his own instincts) or express (in the face of social disapproval) incongruities. It is also apparently possible for an individual to have no clear sense of gender whatsoever. Thus, the tension between social expectations, his gender identity and his own body may result in an identity crisis post-, mid- or even pre-adolescence.

Etiological Roots of Gender Identity Disorder and Faith-Based /Cultural Societies in Nigeria

The exact cause of Gender Dysphoric Disorder is highly debated (Tugnet, Goddard, Vickery, Khoosal, & Terry, 2007) and remains unknown even though many accounts of cross-gender behaviors (Homophobia, Biphobia and Transphobia) span classical and Hindu mythology, Western and Asian classical history, the Renaissance, and late nineteenth and early twentieth century studies of pre-literate cultures. Despite this, several theories have been presented on sexual deviancy.

These range from psychodynamic to faith-based and cultural perspective. Early pioneers of the study of sexual deviancy including Richard von Kraff-Ebing, Albert Moll, August Forel, Iwan Bloch, Magnus Hirschfield, Havelock Ellis, and Sigmund Freud held that the development and maintenance of gender dysphoric disorders is a multifactorial pathological process, in which individual psychological factors, nature (biological influences) and nurture (sociocultural or environmental influences) have a role. Psychologically, Freud postulated that fetishism, masochism, and sexual perversionsspring from an interaction of the individual's biological nature and his early life experiences. The psychodynamic theories postulate that GDD develops in biological males who had any overly close relationship with their mother growing up and whose fathers were absent or neglectful (Tugnet, et al.2007). Biological approaches are based on evidence of prenatal exposure to irregular amounts of hormones, especially androgens (Segal, 2006). Other studies have provided neuroscientific data that show a difference in brain anatomy in people with GDD. For instance, Zhou, Hofman, Gooren, and Swaab (1995) have found a reduced size of the bed nucleus of the striaterminalis (BSTc) brain region in male-to-female transsexuals. Twin studies also present with evidence etiological theories. Segal (2006) describes a case study of biologically female monozygotic twins, one of which has female-to-male Gender Identity Disorder. Segal describes that the twin who developed GID was abused by the mother and the other was not. This suggests that early childhood abuse may contribute to the development of the disorder. However, the authors suggest that this abuse may have been the mother's reaction to her child's cross-gendered behavior and not its cause. In turn, this abuse may have reinforced previously existing cross-gender identification.

These early investigators of sexual deviation provided an important principle: "Not only must the act be studied, but also the person" (Tugnet, et al.2007). In consequence, this study examined the faith-based/ cultural beliefs and responses to sexual deviation in Nigeria. From the faith-based angle, the Bible contains many statements and stories concerning sexual deviations such as paraphilias (Tugnet, et al.2007). Globally, the period of adolescence is a developmental phase fraught with anxiety and frustration. In the Western world, the arrival of adolescence increases the difficulties for children who are gender dysphoric. These difficulties for many adolescents are characterized by feelings of confusion, shame, guilt, and fear over an inability to handle gender identity problem and inability to control what they believe cultural societies and religion considers to being sexually perverse activities and gender identity problems.

In Nigeria, faith-based groups, whose members share common religious views, cultural societies and other spiritually-oriented groups have always played important roles in the secondary socialization and developmental processes of adolescents'sexualorientation and identity in Nigeria. Nigeria is one of the largest (923,768 km2) and most populous country of Africa(the population estimated at 110 million in 1990). Geographically, socially and culturally, Nigeria is the most diversifiedcountry in African countries. The country has over 250 identified cultural groups and ethnic societies. These hinges mostly on three very large ethno-linguistic entities: the Yoruba, the Ibo and the Hausa-Fulani. Others are the Niger-Congo [which include such languages as the Bariba, Birom, Busa, Chamba, Edo (including Bini and Urhobo), Efik (including Ibibio), Idoma, Ijo (Ijaw), Jukun, Kambari, Nupe, Tiv, and Vere], the Afro-Asiatic [which consists of Angas, Bachama, Bura, Higi, Mergi, Shuwa and others]and the Nilo-Saharan [which includes Dendi and Kanuri, among others]. Most people in Nigeria identify themselves as members of a religious or cultural community. Culture and religious beliefs are the very essence of Nigerian's individual and collective identities. Religious values and practices are deeply entwined in the fabric of their daily life.

Faith-based organizations (FBOs) can be defined as non-profit, voluntary organizations whose 'identity and mission are self-consciously derived from the teachings of one or more religious or spiritual traditions' and which seek to 'realize collectively articulated ideas about the public good at the national or international level' (Berger 2003: 16).

They are typically defined by three major characteristics: 1) an affiliation with and control by a denomination or other religious group; 2) dependence on religious entities for resources; and 3) a religious culture that creates a niche or space for agencies to pursue their religious values (Smith and Sosin 2001). Faith-based groups represent all religious traditions and denominations, from Roman Catholics and non-denominational Christians to Muslims and annimists. The faith-based groups in Nigeria are majorly Christians, Muslims and animist's organizations. Some of the Christian faith-based groups, such as Catholic Charities, and a number of the Muslim organizations such as the National Council of Muslim Youth Organizations (NACOMYO), Federation of Muslim Women's Association of Nigeria (FOMWAN), and Jama'atuIzalat al-Bid'ahWaIqamat al-Sunnah (JIBWIS) seek primarily to educate and provide various forms of social and community service.

Activities of cultural societies in Nigeria is to a large extent marked by tradition, and traditional forms of cultural events such as town's men meetings, festivals, exhibitions, performing, playing music and dancing in the open. The faith-based organizations and cultural societies are potential key partners in identification and management of gender identity disorders in Nigeria. They provide 50 per cent of the health and education services in poor communities. In sub-Saharan Africa, 40 per cent of the health-care infrastructure is operated by faith-basedgroups.

Faith-based and cultural accepted norms of sexual behavior and attitudes are influenced greatly by parents, faith-based practices as well as cultural norms and beliefs. A forbidding, puritanical rejection of physical affection, including touching, by a parent engenders guilt and shame in children and inhibits their capacity for enjoying sex and developing healthy intimate relationships as adults. Relations with parents may be damaged by excessive emotional distance, by disapproval and punitive behaviors, or by overt seductiveness and sexual exploitation. Children exposed to verbal and physical hostility, rejection, and cruelty are likely to develop considerable distress, impair sexual performance and emotional intimacy. For example, love and sexual arousal may become dissociated, so that although emotional bonds can be formed with people from the same social class or intellectual circle, sexual relationships can be formed only with those for whom there is no emotional intimacy (e.g. prostitutes, anonymous partners).

In most societal and cultural groups in Nigeria, adolescent girls and boys are usually exposed to various expectations in relation to gender roles (Coates, 1990; Zhou, Hofman , Gooren, Swaab, 1995; &Kipnis, Diamond, 1998), many of them conflicting (Meyer, 1982). Hill and Lynch, (1983) theorize that gender roles intensify at puberty as a result of social pressures from peers and parents (SeikowskiGollek, Harth, Reinhard, 2008). Physical maturity may provoke parental fears about premature sexuality and result in restrictions to adolescents' behaviour. Moreover, the earlier an adolescent develops a sexually mature appearance, the earlier he/she is met with confusing cultural messages regarding his/her sexuality (Wallien , Zucker , Steensma, Cohen-Kettenis,2008). Many homes, representing various ethnic and religious backgrounds, define certain behaviours as appropriate or inappropriate for young, boys and girls. In Nigeria, the adolescent often experience these norms as quite limiting (Gilmore, 1995). Adolescents exposed to contradictory societal and familial role expectations may find themselves with conflicting sexual orientations and desires (Coates , 1990; Zhou, Hofman , Gooren, Swaab, 1995; &Kipnis, Diamond, 1998).

Each of the tribal groups in Nigeria has both religious or cultural definitions and practices sustaining gender roles, gender identity disorders and or gender dysphoria. Religions and belief systems the world over uphold a common concern for human. Hence, this study examined the religious and cultural beliefs of Nigerians as well as their responses to sexual deviations. Five (5) research questions and three (3) hypotheses were raised and tested at 0.05 level of significance using both simple descriptive statistics and Kruskal Wallis test. The Kruskal-Wallis test (*H*-test) is an extension of the Wilcoxon test and a non-parametric analogue of a one-way ANOVA. It can be used to test the hypothesis that a number of unpaired samples originate from the same population.

Research Questions

1. What are the demographical variables of the study's respondents?
2. What types of sexual deviation and gender identity disorders are common among young people in Nigeria?
3. What are the religious beliefs and attitudes towards sexual deviation and gender identity disorder in Nigeria?
4. What are the cultural beliefs, definitions and attitudes towards sexual deviation and gender identity disorder among young people and adolescents?
5. What are the frequency distribution of respondents' sexual deviation and gender dysphoria by sexual orientation, by sex and by ethnicity?

Hypotheses

HO 1. There will be no significant difference in the respondents' faith-based and societal beliefs towards sexual deviation and gender dysphoria by sexual orientation

Ho 2.There will be no significant difference in the faith-based and cultural responses to sexual deviation among adolescents in Nigeria by sex

Ho 3. There will be no significant difference in the faith-based and cultural responses to gender dysphoria among adolescents in Nigeria by sex

Methodology

This study adopted a descriptive and interpretive double hermeneutic phenomenological survey research design to examine the faith-based and cultural definitions and responses to gender dysphoria in Nigeria. A phenomenological analysis does not aim to explain or discover causes. Instead, its goal is to clarify the meanings of phenomena from lived experiences. According to Giorgi (1997), a phenomenological psychologist, terms such as `consciousness', `intuition', `phenomena' and `intentionality' are essential element of phenomenological method. Consciousness refers to the presentation of phenomena to human experience through the process of intuition. Intuition refers to the way in which humans respond to objects. To intuit an object is to respond to it exactly as it is presented to consciousness with nothing added or deleted. Real phenomena are experienced exactly as they are presented to consciousness, and intentionality is the directing of the act of consciousnessto a phenomenon that transcends it' (Giorgi 1997, p. 238).

Sampling Techniques

A total of 200 (Male = 100, Female = 100) respondents participated in the study, one hundred from different faith-based organizations and another one hundred from different cultural groups in Nigeria. The pre-tested *Faith-Based/ Cultural Definitions of Gender Dysphoric and Response Instrument* was administered to them in their natural setting.

Instrumentation

The study employed the Faith-based/ Cultural Definitions of Gender Dysphoric and Response Instrument (Ilesanmi, 2012) which is a structured, clear and unambiguous questionnaire to assess people's beliefs, attitudes and responses to sexual deviance and gender dysphoria in Nigeria. The instrument is divided into three sections. Section one which sought demographic information about the respondents is made up of five items. Section two consisted of three items which tap information on the faith-based/ cultural definitions of and attitudes about sexual deviations and Gender dysphoria. Section three is a 30-item instrument which sought information on faith-based / Cultural responses to sexual deviation and gender dysphoria among young people in Nigeria. This instrument was validated by administering it to a sample of fifty faith-based respondents from different universities across the nation. To establish the reliability of the instrument, the split-half method was used to calculate the co-efficient of internal consistency and yielded an index of **0.77** which is administered to obtain demographic data of the respondents.

Results

1. What are the demographical variables of the study's respondents?

Table1: below presents the demographical data of the respondents by sex, age, religion, ethnicity and sexual orientation

Table 1: Demographical Variables						
	Male		Female		Not sure	
Sex	100 (50%)		100 (50%)		0 (0%)	
	12-17	18-25	26-39		40+	
Age	95 (47.5%)	98 (49%)	7 (3.5%)		0(0%)	
Faith-based	Christianity	Islam	Animism / Traditional			
	70 (35%)	71 (35.5%)	59 (29.5%)			
Cultural group/ Ethnicity	Yoruba	Hausa	Igbo	Edo		Others
	52 (26%)	48 (24%)	50 (25%)	50 (25%)	(-%)	0(0%)
Sexual orientation	men only	Women only	Both sex	Same sex	Autoeroticism	Group sex
	83 (41.5%)	92 (46%)	12 (6%)	7(3.5%)	0(0%)	5(2.5%)

2. What types of sexual deviation and gender dsyphoria are common among young people in Nigeria?
The table below presents the frequency distribution of some of the sexual deviation and gender dsyphoria known by the respondents in Nigeria:

Table 2: Frequency Distribution		
N	Types of Sexual Deviation and Gender Dysphoria	Frequencies
1.	Masturbation	135 (67.5%)
2.	homosexualism and lesbianism	159 (79.5%)
3.	extra-marital sex	165 (82.5%)
4.	Use of special objects like vibrator	123 (61.5%)
5.	voyeurism	147 (73.5%)
6.	sadomasochism	182 (91%)
7.	cybersex	118 (59%)
8.	peeping tongue	159 (79.5%)
9.	transexualism	127 (63.5%)
10.	paedophilic attitudes with under age kids	164 (82%)
11.	masochism	137 (68.5%)
12.	men to dogs	142 (71%)
13.	sadism	178 (89%)
14.	Total N	200

3. What are the religious beliefsand attitudes towards sexual deviation and gender dsyphoria in Nigeria?
The table below presents some of the religious beliefs and attitudes towardssexual deviation and gender dysphoria given by the respondents in Nigeria.

Table 3: Religious Beliefs and Attitudes Towards Sexual Deviation and GenderDsyphoria		
Christianity	Islam	Traditional
Seeks relationship with opposite sex Opposes same sex relationship Opposes sexual deviation and perversions Opposes gender dysphoria views desires for sex change as very wrong and ungodly, Views the body as the temple of God and of the Holy Ghost. Wrong and ungodly Alien to religious belief Totally unacceptable and unscriptural	Same sex relationship (homosexualism and lesbianism) is sinful as a man is not allowed to look at another man's awrah, a woman of a woman i.e. the area between his navel and his knees;A man is not allowed to go under one cloth with another man, nor a woman with another woman Homosexuality is sexual deviation Homosexuality is sexual perversion and it goes against the natural order Allah intended for mankind. Homosexuality is a corruption of man's sexuality and a crime against the opposite sex. Islam permits multiple sex partners through polygyny	Same sex relationship and paedophilia are ritualistic practices sex with owns mother, aged woman, mad person and dead woman are ritualistic

4. What are the cultural beliefs, definitions and attitudes towardssexual deviation and gender identity disorder among young people and adolescents?

Table 4: Cultural definitions and Explanations			
Yoruba	**Hausa**	**Igbo**	**Edo**
i. Unacceptable ii. Totally unacceptable iii. Frequent sexual activity with many partners and group sex is a sin iv. Extra-marital sexual intercourse is not encouraged. v. It supports polygamy-"*okunrin le layamefa"* *vi. What a man* vii. *enjoys in sexual intercourse with a woman is her countenance: the virgina of a madwoman is not different (Oju la n do: obo were o yato)* viii. it may result in sudden death. As *"Magun"* (lit. 'Don't climb'), the magical charm that the Yoruba use to control sexual incontinence may be prepared and used against the person. **ix.** Homosexuality is not acceptable because it is "counter-culture" or "counter-tradition in Yoruba land and there is no reference to it in the OduIfa	i. In Hausa-land, same sex relationship is unacceptable ii. polygyny is permitted iii. Homosexuals are called *'yandauda' (homosexual)* and *'dandauda' (homosexual 'wife')* in Hausa-land. iv. Hausa boys can enter into in courtship and sexual play (tsarance) with many girls who are younger than them	i. Alien to Nigerian Culture ii. Extra-marital sex and pedophilic affairs are serious taboos iii. any man who dresses like a woman is treated as have mental illness iv. Any married woman caught engaging in extramarital affairs will be publicly disgraced in a process called "orikp".	i. Same sex relationship is an abomination ii. any man who dresses like a woman is treated as have mental illness

5. What are the frequency distribution of respondents' sexual deviation and gender dysphoria by sexual orientation, by sex, by ethnicity and by religion?

Table 4: below present an analysis of the respondents' sexual deviation and gender dysphoria by sexual orientation

Table 5:Summary statistics table of Respondents gender Dysphoria and sexual deviation by sexual orientation										
	gender dsyphoria					sexual deviation				
sexual orientation	both sex	group sex	men only	same sex	women only	both sex	group sex	men only	same sex	women only
N	12	5	83	7	92	12	5	83	7	92
Mean	51.250	52.200	71.470	56.429	70.489	28.250	30.000	33.916	29.571	34.772
Variance	52.9318	17.2000	50.4960	122.9524	52.1427	16.3864	6.0000	27.8587	22.6190	24.8155
SD	7.2754	4.1473	7.1061	11.0884	7.2210	4.0480	2.4495	5.2781	4.7559	4.9815
Median	52.000	51.000	71.000	54.000	70.000	28.000	29.000	33.000	29.000	37.000
Normal Distr.	0.5719		0.0001		0.1229	0.0607		0.0823		0.0243

Table 5 below present an analysis of the respondents' sexual deviation and gender dysphoria by sex.

Table 6: Summary statistics table of Respondents gender Dysphoria and sexual deviation by sex				
	gender dsyphoria		sexual deviation	
sex	female	male	female	male
N	100	100	100	100
Mean	68.460	68.820	33.300	34.130
Variance	106.6752	76.0683	29.0000	26.5789
SD	10.3284	8.7217	5.3852	5.1555
Median	70.000	69.500	32.500	34.500
Normal Distr.	0.0014	0.0054	0.0757	0.0418

Table 6 below present an analysis of the respondents' sexual deviation and gender dysphoria by ethnicity

Table 7: Summary statistics table of the respondents' sexual deviation and gender dysphoria by ethnicity								
	gender dsyphoria				sexual deviation			
cultural group	edo	hausa	igbo	yoruba	edo	hausa	igbo	yoruba
N	50	48	50	52	50	48	50	52
Mean	68.740	67.854	68.060	69.827	33.360	34.021	33.280	34.192
Variance	119.1351	89.7868	70.0167	88.0283	27.8269	26.3187	30.6955	27.4525
SD	10.9149	9.4756	8.3676	9.3823	5.2751	5.1302	5.5404	5.2395
Median	70.500	68.500	69.500	70.500	33.000	33.000	32.500	34.500
Normal Distr.	0.0099	0.1490	0.0599	0.0057	0.1940	0.1528	0.1574	0.1306

Table 7 below present an analysis of the respondents' sexual deviation and gender dysphoria by religion

Table 8: Summary statistics table of the respondents' sexual deviation and gender dysphoria by religion						
	gender dsyphoria			sexual deviation		
Faith-based	christian	muslim	traditional	christian	muslim	traditional
N	70	71	59	70	71	59
Mean	68.100	67.183	71.034	34.171	32.873	34.186
Variance	105.0188	110.6089	44.8264	28.8398	27.5694	26.5336
SD	10.2479	10.5171	6.6953	5.3703	5.2507	5.1511
Median	70.000	69.000	70.000	36.500	32.000	33.000
Normal Distr.	0.0316	0.0228	0.2575	0.0682	0.1268	0.1117

Test of Hypotheses and Discussions

HO 1.There will be no significant difference in respondents' faith-based and societal beliefs towards sexual deviation and gender dysphoria by sexual orientation. Results of the Kruskal-Wallis test as indicated in the table below showed statistically significant difference (t.test value of 54.3797 is P< 0.0001) in the respondents' faith-based and societal beliefs towards sexual deviation and gender dysphoria by sexual orientation. The post hoc analysis .at (P<0.05) and Multiple comparison graph also indicated significant difference in respondents score by sexual orientation. The null-hypothesis is hereby rejected.

Table 9:*Showing respondents' faith-based and societal beliefs towards sexual deviation and gender dysphoria by sexual orientation*

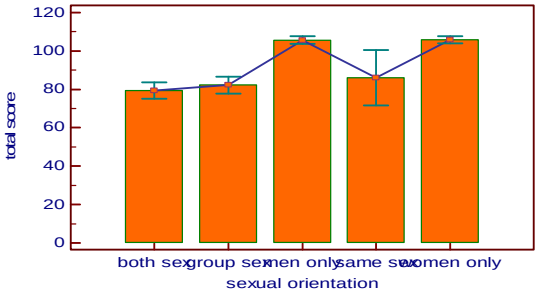
Data	*total_score total score*
Factor codes	*sexual_orientation sexual orientation*

Sample size	*199*
Test statistic	*54.3797*
Corrected for ties Ht	*54.5082*
Degrees of Freedom (DF)	*4*
Significance level	*P < 0.0001*

Table 10:*Presents the* Post-hoc analysis

Factor	n	Average Rank	Different(P<0.05) from factor nr
(1)BOTH SEX	12	11.25	(3)(5)
(2)GROUP SEX	5	13.90	(3)(5)
(3)MEN ONLY	83	110.86	(1)(2)(4)
(4)SAME SEX	7	37.43	(3)(5)
(5)WOMEN ONLY	92	111.22	(1)(2)(4)

Multiple comparison graph

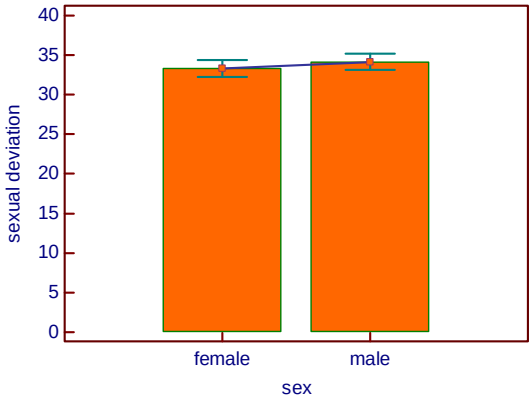


Ho2.There will be a significant difference in the faith-based and cultural responses to sexual deviation among adolescents in Nigeria by sex.

Results of the Kruskal-Wallis test as indicated in the table below showedno significant difference (t.test value of 0.7588 is P = 0.3800) in the faith-based and cultural responses of respondents. Thefactor analysis and Multiple comparison graph below also indicated no significant difference in respondents score by sexual orientation. The hypothesis is hereby accepted.

Table 11: *Presents the difference in the faith-based and cultural responses to sexual deviation among adolescents in Nigeria by sex*		
Data	sexual_deviation sexual deviation	
Factor codes	sex	
Sample size	200	
Test statistic	0.7588	
Corrected for ties Ht	0.7708	
Degrees of Freedom (DF)	1	
Significance level	P = 0.3800	
Factor	n	Average Rank
(1)FEMALE	100	96.93
(2)MALE	100	104.06

Multiple comparison graph

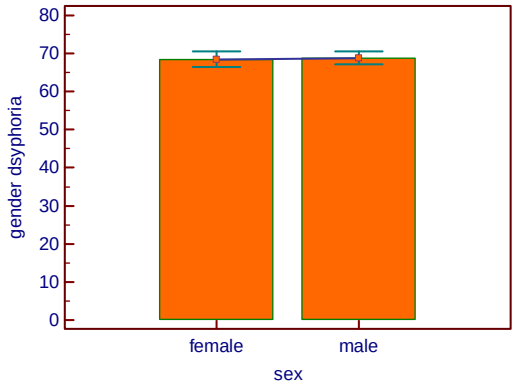


Ho 3.There will be no significant difference in the faith-based and cultural responses to gender dysphoria among adolescents in Nigeria by sex.

Results of the Kruskal-Wallis test as indicated in the table below show no statistically significant difference (t.test value of 0.1453 is P = 0.7023) in the faith-based and cultural responses of respondents. The multiple comparison graphbelow also indicated no significant difference in respondents score by sexual orientation. The hypothesis is hereby accepted.

Table 12: *Presents the difference in the faith-based and cultural responses to gender dysphoria among adolescents in Nigeria by sex*		
Data	gender_dsyphoria gender dsyphoria	
Factor codes	sex	
Sample size	200	
Test statistic	0.1453	
Corrected for ties Ht	0.1461	
Degrees of Freedom (DF)	1	
Significance level	P = 0.7023	
Factor	n	Average Rank
(1)FEMALE	100	102.06
(2)MALE	100	98.94

Multiple comparison graph



These results indicate that sexual orientation played significant role in adolescents' religious beliefs and socio-cultural definitions and attitudes towards sexual deviations and gender dsyphoria in Nigeria. In most societal and cultural groups in Nigeria, adolescent girls and boys are usually exposed to various expectations in relation to gender identity, gender roles and gender appropriate 1998), many of them conflicting (Meyer, 1982).

Huston and Alvarez (1990) noted that "Social pressures for sex-appropriate behavior are relatively benign during middle childhood, particularly for girls. With the onset of puberty for many adolescents in Nigeria, both psychological and social forces act to increase their awareness of gender roles and efforts to adhere to them. For some of the adolescents, the onset of pubescence may intensify their gender roles as a result of social pressures from peers and parents (SeikowskiGollek, Harth, Reinhard, 208). Physical maturity may provoke confusing cultural messages regarding the adolescent's sexuality (Wallien, Zucker, Steensma, Cohen-Kettenis, 2008). Many homes, representing various ethnic and religious backgrounds, define certain behaviours as appropriate or inappropriate for young, boys and girls. In Nigeria, the adolescent often experience these norms as quite limiting (Gilmore, 1995). Adolescents exposed to contradictory societal and familial role expectations may find themselves with conflicting sexual orientations and desires (Coates, 1990; Zhou, Hofman, Gooren, Swaab, 1995; &Kipnis, Diamond, 1998).

Clinical Implications and Recommendations for the Management of GDD in adolescence

Clinically,sexual deviations and Gender dysphoric disorders among adolescentsin Nigeria may result to inconsiderable degree of severe social isolation, suicidal ideation, suicide attempt, emotional stress and mental illness in the affected persons (and their parents), as well as with a high psychiatric comorbidity, especially disturbances of affective and social behavior that require treatment. Therefore, there is the urgent need for clinicians across Africa to explore sexual deviations and gender dsyphoria as potential contributors to risk in adolescents.

The course of sexual deviations and gender dsyphoria are highly variable and plastic. Gender dysphoric disorders are often the forerunner of a homosexual orientation. In adolescence, the main differential diagnoses are sexual maturation disorder (ICD-10 F66.0) and a rejected (repressed or denied) ego-dystonic homosexual orientation (ICD-10 F66.1), as well as fetishistic transvestism (ICD-10 F65.1), severe personality disorders, and—less commonly—psychotic disorders.The guiding principle for the treatment of adolescents with gender dysphoric disorder is strengthening the patient's feeling of belonging to the gender of birth without placing a negative value on his or her atypical gender-role behavior. The affected person's parentsmust be involved in the treatment, and any comorbid psychiatric disorders must be dealt with appropriately as well. The adolescents should be treated in a diagnostic and therapeutic process that is open to multiple outcomes, utilizing the concepts of adolescent psychiatry and sexual medicine. This will enable the affected adolescents to resolve their own identity conflicts. The treating physician should assess the degree of persistence of the desire for a gender transformation while paying special attention to other unresolved developmental tasks and/or conflicts aside from the specific problem of sexual deviation and GDD.

Many cultural societies and faith-based Institutions have existing organizational structures and communications systems that can be used to implement counseling and psychotherapy programs or transmit mental health messages relating to GDD.

The religious and cultural strong ethos, structure, events of all kinds, newsletters and bulletin boards, as well as religiously-oriented radio and television programs, could be used to disseminate information and foster discussion about the causes and consequences of GDD. These could also be used to create awareness about GDD as a multidimensional biopsychosocial disorders requiring spiritual, physical, psychological and social healing. Such structures could also be used to advocate for the participation of affected persons and families in psychotherapeutic management of GDD.

They could also be used for the organization of community-based psycho-educational programs on the nature, types and sources of available counseling and psychotherapy for GDD in Nigeria with special focus on the adolescents during the weekly, monthly and quarterly religious and cultural meetings of specific groups (Girls Guide, Boys Brigade, Muslim students Associations, singles, married, youth, men and women groups).The practicalities of these depends on a strong commitment from mental health practitioners, particularly counselors and psychotherapists, to initiative, foster and nurture long-standing and productive relationships with individual pastors, imams, traditional rulers, priests, lay leaders and communities' gate-keepers by demonstrating respect for cultural norms and religious tenets pertaining to GDD. Thus, mental health clinicians in Africa, and most especially Nigeria, ought to evolve faith-base and culturally sensitive approaches to the management of GDD.

Faith-based and cultural group's initiatives can be pivotal to the success of mental health programs directed towards the amelioration of gender dysphoric disorders of adolescence throughout the nation and across Africa.

There is therefore need for mental health practitioners in Nigeria to work closely with Christian, Muslim, and animists groups in the country. Religious institutions such as churches, mosques, temples, and synagogues are found in nearly all communities in Nigeria and have significant cultural, political, social, educational, and economic influence. Moreso, in Nigeria, faith-based institutions are the largest, most stable, and most extensively disbursed nongovernmental organizations. Most have resources, structures, and systems on which to build. They also possess the human, physical, technical, and financial resources needed to support and implement small and large-scale initiatives. Working with them can be very cost effective because they can leverage volunteer and other resources with minimal effort. For all of these reasons, it can be extremely helpful to involve faith-based groups in mental health initiatives towards the eradication of gender dysphoria in Nigeria.

The strengths and achievements of faith-based initiatives to date—including interdenominational action, high rates of volunteerism, and changes in church and health personnel toward a more holistic attitude—can be the building blocks for future coordination between faith-based organizations and multilateral, governmental, and nongovernmental efforts. Developing initiatives from a shared sense of compassion and a commitment to serving others can bring together even those who may be far apart in the other particulars of their beliefs and values—to the benefit of all. (culled from 'What Are Faith-Based Groups? eHow.com http://www.ehow.com/info_8579222_faithbased-groups.html#ixzz1ynJAaCUF').Dialogue with influential religious leaders should be carried out on an ongoing basis, rather than as a one-time pre-programming activity. This helps to build commitment and ensure common understanding of issues includingsexual deviations and gender dysphoric disorders.

Conclusion

In most societies and faith-based organizations, biological sex provides an organizing framework for how individuals are treated and how they are expected to behave (Rossi, 1985; Williams & Best, 1994). In adolescence, there is an intensification of gender-related socialization (Hill &Lynch, 1983). Empirical studies have shown that adolescent gender dysphoric disorders and sexual deviations do occur (Ruble & Martin, 1998), particularly when exposed to peer pressures and negative sexual orientation while parents hold traditional and faith-based views regarding gender (Arnett, 2001). Issues of religious beliefs and ethnicity or culture related to gender development may be coded but are often not included in the analyses.

For instance, Ruble and Martin (1998) as well as Lytton & Romney (1991) discussed the social construction of gender, but did not address issues of ethnicity or culture related to gender development in their analyses.Sexual deviations and gender dysphoric disorder are real and serious mental health issues that some individuals feel toward their assigned sex.

Their exact causes are unknown, but maybe connected with either a congenital irregularity, an irregularity that occurs in the first few years of childhood or some combination of the two. These may also alter an individual's sense of gender.In faith-based and culturally minded communities like Nigeria, mental health practitioners need to dedicate attention to understanding faith-based and ethnically diverse affected adolescents. This is because spirituality and cultural sensitivity are important issues in young people's moral identity and emotional developmental processes. Young people who attach deep value to religious and cultural beliefs and practices are less likely to manifest sexual deviation and gender dysphoria. In an effort to contribute to this goal, the current study provides novel information on the impact of sexual orientation, religious beliefs and social attitudes to the development and sustenance of sexual deviations and gender dusphoria among adolescents in Nigeria.

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Appendix 1

Faith-based / Cultural Definitions of Gender Dysphoria and Response Instrument

Dear Respondents,

This Instrument is designed to capture knowledge aboutlevels and patterns of gender dysphoric disorders,faith-based and culturally sensitive responses and approaches to gender dysphoric disorders. Information given will be used solely for research purposes and will not be divulged to unauthorized persons.

Section 1: Demographical Data of Respondents.

1. Sex: Male ---- Female ----- Not Sure ------
2. Age: (12- 17) ---- (18—25) ----- (26-39) ---- (40+) -----
3. Religion: Christian----- Muslims ----- Annimism/Traditional -----

4. Cultural Group/Ethnicity: Yoruba --- Hausa ------ Ibo ------
Others (Please specify): ----------
5. Sexual Orientation: Attracted to men only------- Attracted to womenonly-------

Attracted to both sex----------
Same-sex practice (homoeroticism -homosexual /lesbian affair) ---------
Autoeroticism (masturbation) ----------
Group sex ----------

Section 2: Faith-based/ Cultural Definitions of and Attitudes about Sexual Deviations and Gender Dysphoria

12. List the types of sexual deviation and gender identity disorders that you know among young people.
    a) ----------
    b) ----------

13. What is your religious beliefand attitude about sexual deviation and gender identity disorder?
    a) ----------
    ----
    b) ----------
    ----

14. What is your cultural beliefand attitude about sexual deviation and gender identity disorder among young people and adolescents?
    a) ----------
    ----
    b) ----------

Section 3: Faith-based / Cultural Responses to Sexual Deviation and Gender Dysphoria

S/N	Gender Dysphoria	Faith-based Response		Detailed Explanation	Cultural group Response		Detailed Explanation
A	Sexual Deviation	Acceptable = 1	Unacceptable = 2		Acceptable = 1	Unacceptable = 2	
	Compulsive Masturbation either in public or private						
	Same sex relationships (Homosexuality)						
	Frequent sexual activity with many partners, often involving anonymous or one-time-only encounters (Promiscuity)						
	Extramarital sex						
	Recurrent, intense, sexually arousing fantasies, urges, or behaviors that are distressing or disabling and that involve inanimate objects, children or other non-consenting adults, or suffering or humiliation of oneself or the partner (Paraphilias)						
	Achievement of sexual excitement through genital exposure, usually to an unsuspecting stranger (Exhibitionism)						
	Achievement of sexual arousal by observing people who are naked, disrobing, or engaging in sexual activity (Voyeurism)						
	Intentional participation in an activity that involves being humiliated, beaten, bound, or otherwise abused to experience sexual excitement (Masochism)						
	Infliction of physical or mental suffering (eg, humiliation, terror) on the sex partner to stimulate sexual excitement and orgasm (Sexual sadism)						
	Preference for sexual activity with prepubertal children (Pedophilia)						
B	Gender Identity Disorder						
	Heterosexual males who dress in women's clothing (Transvestic fetishism)						
	Desire to be the other sex						

	Persistent fantasies of being the other sex						
	Preference for cross-sex roles in play						
	preference for cross-dressing						
	An intense desire to participate in pastimes of the other sex						
	Strong preference for playmates of the other sex						
	Frequent passing as the other sex						
	Desire to live or be treated as the other sex						
	Strong conviction that the person has the typical feelings and reactions of the opposite sex						
	Persistent poor self-image and emotional distress						
	sense of inappropriateness in the gender role of one's sex						
	preoccupation with getting rid of primary and secondary sex characteristics						
	believe to be born with the wrong sex						
	significant distress or impairment in social, occupational, or other important areas of functioning						
	sexually attracted to same sex						
	great discomfort regarding his or her actual anatomic gender						
	may express a desire to alter their physical appearance through cosmetics, hormones and, in some cases, surgery						
	strong identification with the opposite sex						
	Poor interpersonal relationship and social isolation						

Scoring Manual for section 3:

1) **Sexual Deviation**: Acceptable = 1 Unacceptable = 2

A. **High Score:** Faith-Based category = 15-20 Socio-cultural category = 15-20

- **Total Score** = 30-40 (Implies non tolerance of sexual deviation)

B. **Low Score:** Faith-Based category = 10-14 Socio-cultural category = 10-14

- **Total Score** = 20-28 (Implies tolerance of sexual deviation)

2) **Gender Dsyphoria:** Acceptable = 1 Unacceptable = 2

C. **High Score:** Faith-Based category = 21-40 Socio-cultural category = 21-40

- **Total Score** = 42-80 (Implies non tolerance of gender dsyphoria)

D. **Low Score:** Faith-Based category = 10-20 Socio-cultural category = 10-20

- **Total Score** = 20-40 (Implies tolerance of gender dsyphoria)