GID Reform Advocates

Issues of GID Diagnosis for Transsexual Women and Men
-- Kelley Winters, Ph.D.

Gender Identity Disorder in Adolescents or Adults, 302.85
Section: Sexual and Gender Identity Disorders
SubSection: Gender Identity Disorders

"Gender Identity Disorder" (GID) is a diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association (APA, 1994). The DSM is regarded as the medical and social definition of mental disorder throughout North America and strongly influences the *The International Statistical Classification of Diseases and Related Health Problems* (ICD) published by the World Health Organization. GID currently includes a broad array of gender variant adults and children who may or may not be transsexual and may or may not be distressed or impaired. GID literally implies a *"disordered"* gender identity.

Diagnostic Criteria (APA 2000, p 581)

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In adolescents and adults, the disturbance is manifested by symptoms such as 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.
B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In adolescents and adults, the disturbance is manifested by symptoms such 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.
C. The disturbance is not concurrent with a physical intersex condition.
D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if (for sexually mature individuals) Sexually Attracted to Males, ... Females,... Both, ... Neither.

Thirty-four years after the American Psychiatric Association (APA) voted to delete homosexuality as a mental disorder, the diagnostic categories of "gender identity disorder" and "transvestic fetishism" in the *Diagnostic and Statistical Manual of Mental Disorders* continue to raise questions of consistency, validity, and fairness. Recent revisions of the DSM have made these diagnostic categories increasingly ambiguous, conflicted and overinclusive. They reinforce false, negative stereotypes of gender variant people and at the same time fail to legitimize the medical necessity of sex reassignment surgeries (SRS) and procedures for transsexual women and men who urgently need them. The result is that a widening segment of gender non-conforming youth and adults are potentially subject to diagnosis of psychosexual disorder, stigma and loss of civil liberty.

A Question of Legitimacy.

The very name, Gender Identity Disorder, suggests that cross-gender identity is itself disordered or deficient. It implies that gender identities held by diagnosable people are not legitimate, in the sense that more ordinary gender identities are, but represent perversion, delusion or immature development. This message is reinforced in the diagnostic criteria and supporting text that emphasize difference from cultural norms over distress for those born in incongruent bodies or forced to live in wrong gender roles.

Under the premise of "disordered" gender identity, self-identified trans-women and trans-men lose any rightful claim to acceptance as women and men, but are reduced to mentally ill men and women respectively.

Maligning Terminology.

Of the disrespectful language faced by gender variant people in North America, none is more damaging or hurtful than that which disregards their experienced gender identities, denies the affirmed gender roles of those who have transitioned full time and relegates them to their assigned birth sex. Throughout the diagnostic criteria and supporting text, the affirmed gender identities and social role for transsexual individuals is termed "other sex." In the supporting text, subjects are offensively labeled by birth sex and not their experienced affirmed gender. Transsexual women are repeatedly termed "males," and "he." For example,

> For some <u>males</u> …, the individual's sexual activity with a woman is accompanied by the fantasy of being lesbian lovers or that <u>his</u> partner is a man and <u>he</u> is a woman. (APA, 2000, p. 577, emphasis noted by underline)

Perhaps most disturbing, the term "autogynephilia" was introduced in the supporting text of the DSM-IV-TR to demean lesbian transsexual women:

> Adult <u>males</u> who are sexually attracted to females, … usually report a history of erotic arousal associated with the thought or image of oneself as a woman (termed <u>*autogynephilia*</u>). (p. 578, emphasis noted by underline)

The implication is that all lesbian transsexual women are incapable of genuine affection for other female partners but are instead obsessed with narcissistic paraphilia. The fact that most ordinary natal women possess images of themselves as women within their erotic relationships and fantasies is conspicuously overlooked in the supporting text.

Medically Necessary Treatment of Gender Dysphoria.

Gender Dysphoria is defined in the DSM-IV-TR as:

> A persistent aversion toward some or all of those physical characteristics or social roles that connote one's own biological sex (APA, 2000, p. 823).

The focus of medical treatment described by the current World Professional Association for

Transgender Health Standards of Care is on relieving the distress of gender dysphoria and not on attempting to change one's gender identity (WPATH, 2001). Yet, the DSM-IV-TR emphasizes cross-gender identity and expression rather than the distress of gender dysphoria as the basis for mental disorder. While criterion B of Gender Identity Disorder may imply gender dysphoria, it is not limited to ego-dystonic subjects suffering distress with their born sex or its associated role. Ego-syntonic subjects who do not need medical treatment may also be ambiguously implicated. In failing to distinguish gender diversity from gender distress, the APA has undermined the medical necessity of sex reassignment procedures for transsexuals who need them. It is little wonder that the province of Ontario and virtually all insurers and HMOs in the U.S. and have denied or dropped coverage for sex reassignment surgery (SRS) procedures. Since gender dysphoria is not explicitly classified as a treatable medical condition, surgeries that relieve its distress are easily dismissed as "cosmetic" by insurers, governments and employers.

The transgender community and civil rights advocates have long been polarized by fear that access to SRS procedures would be lost if the GID classification were revised. In truth, however, transsexuals are poorly served by a diagnosis that stigmatizes them unconditionally as mentally deficient and at the same time fails to establish the medical necessity of procedures proven to relieve their distress.

Overinclusive Diagnosis.

Distress and impairment became central to the definition of mental disorder in the DSM-IV (1994, p. xxi), where a generic clinical significance criterion was added to most diagnostic categories, including criterion D of Gender Identity Disorder. Ironically, while the scope of mental disorder was narrowed in the DSM-IV, Gender Identity Disorder was broadened from the classification of Transsexualism in prior DSM revisions and combined with Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT) from the DSM-III-R (1987, pp. 74-77).

Unfortunately, no specific definition of distress and impairment is given in the GID diagnosis. The supporting text in the DSM-IV-TR lists relationship difficulties and impaired function at work or school as examples of distress and disability (2000, p. 577) with no reference to the role of societal prejudice as the cause. Prostitution, HIV risk, suicide attempts and substance abuse are described as associated features of GID, when they are in truth consequences of discrimination and undeserved shame. The DSM does not acknowledge the existence of many healthy, well-adjusted transsexual or gender variant people or differentiate them from those who could benefit from medical treatment. These are left to the interpretation of the reader. Tolerant clinicians may infer that transgender identity or expression is not inherently impairing, but that societal intolerance and prejudice are to blame for the distress and internalized shame that transpeople often suffer (Brown, 1995). Intolerant clinicians are free to infer the opposite: that cross-gender identity or expression by definition constitutes impairment, regardless of the individual's happiness or well-being. Therefore, the GID diagnosis is not limited to ego-dystonic subjects; it makes no distinction between the distress of gender dysphoria and that caused by prejudice and discrimination. Moreover, the current DSM has no clear exit clause for transitioned or post-operative transsexuals, however well adjusted. It lists postsurgical complications as "associated physical examination findings" of GID (2000, p. 579).

Pathologization of Ordinary Behaviors.

Conflicting and ambiguous language in the DSM serves to confuse cultural nonconformity with mental illness and pathologize ordinary behaviors as symptomatic. The Introduction to the DSM-IV-TR (2000, p. xxxi) states:

> Neither deviant behavior ... nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of dysfunction...

However, it is contradicted in the Gender Identity Disorder section (p. 580):

> Gender Identity Disorder can be distinguished from simple nonconformity to stereotypical sex role behavior by the extent and pervasiveness of the cross-gender wishes, interests, and activities.

The second statement implies that one may deviate from social expectation without a diagnostic label, but not too much. Conflicting language in the DSM serves the agendas of intolerant relatives and employers and their medical expert witnesses who seek to deny transgender individuals their civil liberties, children and jobs.

In the supporting text of the Gender Identity Disorder diagnosis, behaviors that would be ordinary or even exemplary for ordinary women and men are presented as symptomatic of mental disorder on a presumption of incongruence with born genitalia. These include passing, living and a desire to be treated as ordinary members of the preferred gender. For example, shaving legs for adolescent biological males is described as symptomatic, even though it is common among males involved in certain athletics. Adopting ordinary behaviors, dress and mannerisms of the preferred gender is described as a manifestation of preoccupation for adults. It is not clear how these behaviors can be pathological for one group of people and not for another.

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About the Author

Kelley Winters, Ph.D., formerly under pen-name Katherine Wilson, is a writer on issues of transgender medical policy, founder of GID Reform Advocates (www.gidreform.org) and an Advisory Board Member for the Matthew Shepard Foundation. She has presented papers on the psychiatric classification of gender diversity at the annual conventions of the American Psychiatric Association, the American Counseling Association and the Association of Women in Psychology. Her most recent work appears in *Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM), A Reevaluation* , edited by Dan Karasic and Jack Drescher (2005).