# Notes on Gender Role Transition

By Anne Vitale Ph.D.

## Rethinking the Gender Identity Disorder Terminology in the Diagnostic and Statistical Manual of Mental Disorders IV

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The overwhelming success gender role transition has enjoyed world wide in the last four decades, leads me to believe that the current reference to gender issues in the DSM IV---as a subset of the sexual disorders---is inaccurate and should be revised.

As a basis for my argument, I will--

1. Briefly review the history of how gender issues have been handled in past editions of the DSM.

2. I will Elaborate on the evolving concept of gender variance.

3. Briefly review several studies that lead us closer to understanding the role biology plays in establishing gender identity.

4. I will discuss the sociological and political ramifications of the increased number of individuals who have undergone gender role transition.

5. I will conclude by proposing that instead of Gender Identity Disorder- future editions of the DSM consider a less stigmatizing and more accurate descriptor of the gender variant condition --namely Gender Expression Deprivation Anxiety Disorder.

As we gain in our understanding of how gender identity is formed, the potential of there being a naturally occurring partial-to-full-negative correlation between gender identity and biological sex --in a significant segment of the population--has led many clinicians to advocate for a major rethinking of how we address the issue in the DSM.

Those who wish to see changes in the DSM regarding gender identity issues generally fall into two camps.

--Some clinicians advocate the complete removal of any reference to gender issues in the next edition of the DSM.

-- Others advocate a nonpathologizing inclusion that recognizes gender variance as a naturally occurring

phenomenon requiring a combination of psychological and medical attention.

Members of the first group believe that the mere fact of inclusion in the DSM automatically induces psychological stigmatization encouraging cultural disapproval while the latter group worries that unless the issue is listed somewhere in a medical index of disorders, necessary medical procedures would then be deemed medically unnecessary especially in countries that have a National Health Service.

I side with those who feel that inclusion is beneficial, while advocating that the citation be moved from the sexual disorders to the anxiety disorders.

## HISTORY-DSM I through DSM IV-TR

The American Psychological Association has published four benchmark editions of the DSM. It has also published two "Revised" editions. DSM I was published in 1952. DSM II was published in 1968. DSM III was published in 1980 and revised in 1987. The latest benchmark edition of the DSM, DSM IV was published in 1994 and revised in 2000. It is referred to as DSM IV -TR. (1, 2, 3, 4, 5, 6)

Although both the DSM I and DSM II mention "Transvestism," neither manual addresses the issue of gender identity per se. Gender Identity as a separate issue does not appear until the third edition. In DSM III a new category of disorders entitled Psychosexual Disorders appears. It has four subsections: the Gender Identity Disorders, the Paraphilias, the Psychosexual Dysfunctions and Other Psychosexual Disorders, which includes the now-defunct, Ego-dystonic Homosexuality and Psychosexual Disorders Not Elsewhere Classified. The Gender Identity Disorders are further subdivided into three specific areas: Transsexualism, Gender Identity Disorder of Childhood, and Atypical Gender Identity Disorder.

### The Gender Identity Disorders in DSM III ---Transsexualism

DSM III characterizes the Gender Identity Disorders first as a whole and a series of subgroups. As a group the Gender Identity Disorders are described as follows:

The essential feature of the disorders included in this subclass is an incongruence between anatomic sex and gender identity. Gender identity is the sense of knowing to which sex one belongs, that is, the awareness that 'I am male' or 'I am female'. Gender identity is the private experience of gender role and gender role is the public expression of gender identity. Gender role can be defined as everything that one says and does, including sexual arousal, to indicate to others or to oneself the degree to which one is male or female.

On the whole I think this is a good definition.

They go on to include the following description of individuals with this condition.
• They usually complain that they are uncomfortable wearing the cloths of their own anatomic sex.
• They often choose to engage in activities that are generally associated with the other sex.
• They often find their genitals repugnant which may lead to persistent requests for sex reassignment by surgical or hormonal means.

• To varying degrees, their behavior, dress and mannerisms are those of the other sex.
• They have moderate to severe coexisting personality disturbances.
• They frequently experience considerable anxiety and depression.
• Without treatment, the course is chronic and unremitting.
• Their social and occupational functioning are often markedly impaired, depression is common and, in rare instances males may mutilate their genitals.

There is further sub-classification based on sexual preference. The sub-classifications are: *asexual, homosexual (same anatomic sex), heterosexual (other anatomic sex),* and *unspecified*.

**Gender Identity Disorder of Childhood**
In DSM III, Gender Identity Disorder of Childhood is defined, in part, as follows:

Paraphrasing high lights from the rest of the description:
• Girls with this disorder regularly have male peer groups, an avid interest in sports and rough-and-tumble play, and a lack of interest in playing with dolls.
• Boys with this disorder invariably are preoccupied with female stereotypical activities. They may have a preference for dressing in girl's or women's clothing, or may improvise such items when genuine articles are not available.
• Boys with this disorder have a compelling desire to participate in the games and pastimes of girls.
• Some children refuse to attend school because of teasing or pressure to dress in attire stereotypical of their sex.
• Most children with this disorder deny being disturbed by it except as it brings them into conflict with the expectations of their family or peers.
• Some of these children, particularly girls, show no signs of psychopathology. Others may display serious signs of disturbance such as phobias and persistent nightmares.

**DSM III-R**
In DSM III-R published seven years later, the category of Psychosexual Disorders was removed all together. Instead gender variant issues are covered under a heading of Gender Identity Disorders and it is listed alphabetically after the Eating Disorders. The definition of Gender Identity Disorders included in DSM III and noted above, is repeated, with Transsexualism given prominence in the body of the text.

**DSM IV**
In 1994, with the release of the DSM IV, the section entitled Gender Identity Disorders was replaced with the singular term, Gender Identity Disorder (GID) and subdivided into three, rather then four areas: Gender Identity Disorder in Children, Gender Identity Disorder in Adolescents and Adults, and Gender Identity Disorder Not Otherwise Specified.

The term "Transsexualism" was eliminated. Most importantly, perhaps is that GID was reclassified as being a sexual disorder rather then a psychological one. It is listed directly after Voyeurism and Paraphilia in the Sexual and Gender Identity Disorders section.

As a result of this change, a condition that was described in DSM III largely in terms of the psychological difficulties most gender variant individuals experience, became an abstract description of stereotypical cross-

gender behaviors and implied abnormal sexuality. Only passing mention is made of the psychosocial difficulties inherent in being gender variant.

The placement change was explained by the DSM IV Subcommittee on Gender Identity Disorders in its Interim Report (7) published in the *Archives of Sexual Behavior. They said:*
A basic issue considered by the subcommittee, but was one that was not in its jurisdiction to alter, was the diagnostic category in which gender identity disorders should be placed. In DSM III, Transsexualism and Gender Identity Disorder of Childhood were placed under the larger category entitled Psychosexual Disorders. In DSM III-R, the category Psychosexual Disorders was eliminated, with many of the former diagnoses placed under a new category termed Sexual Disorders.

Apparently, the members of the subcommittee were aware of the negative implications of placing gender identity issues back with the Sexual Disorders but for reasons not offered, did not petition for a less stigmatizing placement.

There are other problems with the DSM IV description. One of the most obvious is the listing of stereotypical cross-gender behaviors as "symptoms". No mention is made of the possibility that these cross-sex behaviors may be coping behaviors being used to relieve anxiety that experiencing a physical sex/gender discordance would naturally evoke. The authors of the DSM IV write about a preoccupation with cross-gender behavior as if the behavior is pathological.
For example;

• In boys, the cross-gender identification is manifested by a marked preoccupation with traditionally feminine activities.

• They may have a preference for dressing in girl's or women's clothes or may improvise such items when genuine article are unavailable. Towels, aprons and scarves are often used to represent long hair and skirts.

• There is a strong attraction for stereotypical games and pastimes of girls. They particularly enjoy playing house, drawing pictures of beautiful girls and princesses and watching videos of their favorite female characters.

• Stereotypical female -type dolls, such as Barbie, are often their favorite toys, and girls are their preferred playmates. When playing "house" these boys role-play female figures, most commonly, "mother roles" and often are quite occupied with female fantasy figures.

• They avoid rough-and-tumble play and competitive sports and have little interest in cars and trucks or other non aggressive but stereotypical boy's toys.
• They may insist on a wish to be a girl and assert that they will grow up to be a woman.

• They may insist on sitting to urinate and pretend not to have a penis by pushing it in between their legs.

• More rarely boys with Gender Identity Disorder may state that they find their penis or testes discussing, that they want to remove them, or that they have, or wish to have a vagina.

The following paragraph regarding girls reads similarly:

Girls with Gender Identity Disorder display intense negative reactions to parental expectations or attempts to have them wear dresses or other feminine attire. Some may refuse to attend school or events where such clothes may be required. They prefer boy's clothing and short hair, are often misidentified by strangers as boys, and may ask to be called by a boy's name. Their fantasy heroes are most often powerful male figures, such as Batman or Superman. These girls prefer boys as playmates with whom they share interest in contact sports, rough-and-tumble play, and traditional boyhood games. They show little interest in dolls or any form of feminine dress -up or role-play activity. A girl with this disorder may occasionally refuse to urinate in a sitting position. She may claim that she has or will grow a penis and may not want to grow breasts or to menstruate. She may assert that she will grow up to be a man. Such girls typically reveal marked cross-gender identification in role-play, dreams and fantasies.

The most disturbing aspects of these passages is that the description of childhood behaviors meant to describe an abnormal gender identity development, is not in fact representative of a majority of genetic male individuals who present in their adult years for gender reassignment assessment. At least 90 percent of the genetic male clients I have treated over the last 21 years have reported having what appeared to everyone else to be a normal boyhood.

At best it represents only those children brought into treatment centers by parents who disapprove of their child's gender expression. To the extent that some of these behaviors may be present to one degree or another, a child's own insistence regarding gender expression ought to be taken at its obvious face value, that is, as an indication that the child has at least in part the gender identity of the sex opposite to that assignment at birth.

Commenting on the DSM IV description, Katherine Winters (8) writes:

In the diagnostic criteria and supporting text of Gender Identity Disorder for Children, behaviors that would be ordinary or even exemplary for gender conforming girls and boys are presented as symptomatic of mental disorder for gender nonconforming children....It is unclear whether the intent of the DSM is to reflect such dated, narrow and sexist gender stereotypes or to enforce them.

## Gender Variant

In recent years, contrary to the idea of regarding gender identity problems as a mental disorder, many clinicians who regularly work with this population have come to think of this phenomenon--not as a pathology--but as a naturally occurring variation to the common, binary male/female understanding of gender. To help in depathologizing the phenomenon, the term "gender variant" is gaining in common usage. For example, at the 2001 HBIGDA conference held in Galveston Texas, Lin Fraser (9), whose psychotherapeutic practice is in San Francisco --arguably the center of the gender community in the United States--stated:

Who we see in practice is a mix of people, some are in the binary, very traditional system of gender and some are not. They are gender variant, gender different, they are members of the queer community or are otherwise non-binry. There is much variation here.

And this from psychotherapist Rebecca Auge (10), who also practices in the San Francisco Bay Area:

Transgender clients in the San Francisco Bay Area are a diverse bunch. In general, one finds more variation in gender display, than, say, ten years ago; this was evident this past June when the LGBT Pride Parade in SF included Muslim, Armenian and Chinese participants. The variations of gender identity and role encountered are not limited to a strict binary (or two box) gender system. As a result, clients are helping us map the gender terrain. What is emerging is a panorama of possible solutions to transgender issues.

## Developments since Publication of DSM IV

Along with a large number of papers noting the efficacy of hormone replacement therapy in treating the gender variant condition, there have been three major papers worth noting as having presented physiological data that propose that much of an individual's gender identity may depend on biological events outside of anyone's control.

In 1997 Zhou et al. (11) published a study wherein they examined the volume of the central subdivision of the bed nucleus of the stria terminalis (BSTc) of the brain of six male-to-female transsexuals. They found that a female-sized BSTc was found in all of the subjects. This led them to declare that a female brain structure exists in genetically male transsexuals, supporting the hypothesis that gender identity develops as a result of an interaction between the developing brain and sex hormones in utero. It follows, therefore, that the affected individual may have as a result, a partial to full sense of having a cross-sexed gender identity.

Krujver et al. (12), did a follow up study to that of Zhou. Krujver and his colleagues counted the number of somatostatin-expressing neurons in the BSTc of 42 subjects in relation to sex, sexual orientation, gender identity, and past or present hormonal status. They found, that regardless of sexual orientation, males had almost twice as many somatostatin neurons as females ($P < 0.006$). The number of neurons in the BSTc of male-to-female transsexuals was similar to that of the females ($P = 0.83$). In contrast, the neuron number of a female-to-male transsexual was found to be in the male range. By carefully chosen controls, they show that hormone treatment or sex hormone-level variations in adulthood did not seem to have influenced BSTc neuron numbers. The authors conclude: *"The present findings of somatostatin neuronal sex differences in the BSTc and its sex reversal in the transsexual brain clearly support the paradigm that in transsexuals sexual differentiation of the brain and genitals may go into opposite directions and point to a neurobiological basis of gender identity disorder."*

To add to this, we now have six relatively recent papers published in the *Proceedings of the National Academy of Sciences of the USA* describing a peri-natal process known as defeminization --or the loss of the ability to display female-type behaviors in males and male behaviors in females (13,14,15,16,17,18).

This ongoing area of research, done on rats and mice, is based primarily on the fact that neonatal males -- unlike neonatal females --produce androgens and estrodiol and that minute excess of either hormone present at a critical time of brain development, can disrupt the normal masculinization or feminization of the brain. In 2000 Auger et. al. reported:

*A central aspect of steroid-mediated differentiation of the brain is that, although testosterone secreted by the testis is the primary hormonal signal, once in the brain, it is metabolized into two principle ligands:*

*dihydrotestosterone by 5 alpha reductase or estradiol by aromatase. The subsequent activation of either androgen or estrogen receptors mediates distinct aspects of the differentiation process in [ ] rats. For example, increased estrogen receptor activation is responsible for defeminization whereas increased androgen receptor activation seems to be responsible for masculinization . Blocking the aromatization of testosterone into estradiol interferes with defeminization but not masculinization in male rats because androgen receptors are still being activated.*

Following the lead of Auger and others, Andrea Kudwa and her colleagues, after conducting a number of experiments on mice, confirmed that estrodiol was the priciple agent in the defeminization process. They report:

*The development of neural sex differences is initiated by estradiol, which activates two processes in male neonates; masculinization, the development of male-type behaviors, and defeminization, the loss of the ability to display female-type behaviors.*

The mere fact that there is a specific process of masculinization and defeminization in the brain of the developing fetus and that it is sensitive to environmental disturbance such as the accidental or purposeful introduction of exogenous hormones, [DES for example] gives added credence to the possibility of there being a gender variant condition in a significant number of the population.

**The "John/Joan," David Reimer case.**
Finally, it's helpful to review the well-known David Reimer(aka "John/Joan") case, as new developments have come to light. Here is a summery of the case.

In 1972, John Money(19, 20) and his colleagues at Johns Hopkins University reported that they had successfully reversed the sex of one of a set of 8-month-old genetic male twins who had suffered the ablation of his penis in a circumcision accident (Money, 1972, 1975). In keeping with the then widely held belief that individuals are psychosexually neutral at birth and that healthy psychosexual development is dependent on the appearance of the genitals and the sex of rearing, Money advised the parents to give the boy a female name and rear him as a girl. A bilateral orchiectomy and preliminary neovagina surgery was performed on the boy to facilitate feminization and to aid the child and the family in thinking of the child as a girl. Management was reinforced with yearly visits to Johns Hopkins Hospital, where the doctors examined the child's genitals and encouraged the child to play and act like a girl. In the literature the child was described as developing into a normal girl and accepting life as "Joan."

The mainstream press picked up on the "success" being reported by Money, noting that this case provided strong support that conventional patterns of masculine and feminine behaviors can be altered by the way a child is raised. (Time Magazine, January 8, 1973). Sociological, psychological and even women's studies texts began to reflect the notion that masculine and feminine behavior were more a factor of nurture then nature. We now know that, none of the so-called "success" of the case that the team at Johns Hopkins published and publicly reinforced over a period of 20 years were true.

The true facts of the John/Joan case came out in 1997 when Diamond and Sigmundson (21) published their paradigm-shifting paper, Sex reassignment at birth: Long term review and clinical implications, in the Archives of Adolescent Medicine. There they revealed that the long-watched gender-role-reversal case was in fact a tragic failure. The case was further reported at great length by John Colapinto (22) in his book, "As Nature Made Him: The Case of a Boy who was Raised as a Girl. The new knowledge about the gendered self

revealed by these reports should result in new thinking about gender variation in the next edition of the DSM, I will briefly state the true course of this case.

Despite being raised as a girl, being told all his life that he was a girl, having what appeared to be female genitalia that he could compare with his twin brother's penis (pointed out on their yearly visits to Johns Hopkins), and even after the administration of estrogen at puberty, David retained a strong sense of his male gendered self. Not only did he reject the concept of his being female, he also rejected the estrogen therapy soon after it was imposed on him. This is a clear and unrefutable example of what happens when an individual is deprived of his innate gender expression and forced to endure hormone replacement therapy. In an interview with Colapinto, David told him that the hormones made him "feel funny" and he detested the feminizing effect they had on his body. Please note: This is the exact opposite of what gender dysphoric males report when commencing into transition to the female gender role. When at the age of fourteen it became clear to David's parents that the experiment had gone woefully wrong, David was told what had happened. He immediately stopped taking estrogen and started testosterone treatments. Although he went on to get married as a man and serve as a step-father, he never really got over the trauma of his ordeal. He took his own life in May, 2004.

**Lessons from the Reimer Case: Phallic Inadequacy**.
Prior to the publication of DSM IV, it was standard practice sanctioned by the American Academy of Pediatrics (23) to suggest that doctors "normalize" the genitals in all cases of genetic male neonates born with cloacal exstrophy and ambiguous genitalia. Parents were routinely advised that in order to prevent severe psychosocial dysfunction it would be best to reassign their male child immediately to female and have the child undergo surgical bilateral orchiectomy and construction of a vulva. The parents were further advised never to tell anyone, especially the child, of the child's true genetic background. Three factors were dominant in this practice: the need for the parents to announce unequivocally the sex of their newborn; second, the fact that it is easier to fashion a vulva surgically out of the available material than it is to enlarge a micropenis; and third, since gender identity was believed to be a social construct, it was thought that the child would have a more satisfying life as a girl than a boy without a functioning penis.

With the revelations of the Reimer case and the publication of other cases where intersex children rejected their assigned sex, some members of the medical world began to rethink the advisability of reassigning male children as females simply because of what was deemed penile inadequacy.

One of the more important studies was recently conducted by Reiner and Gearhart (24). Until recently both doctors were associated with the departments of Psychiatry and Urology at Johns Hopkins University. They assessed all 16 genetic males in their cloacal exstrophy clinic, ranging in age at that time from 5 to 16 years. As neonates, 14 of the 16 subjects had undergone social, legal and surgical sex reassignment to females. The parents of the other two subjects refused the reassignment and the children were raised as boys.

Using detailed questionnaires, the authors evaluated the sexual role and identity of the subjects as defined by their "persistent declaration of their sex." They report that 8 of the 14 subjects assigned to the female sex had, over the course of the study, declared themselves to be male, whereas the 2 subjects assigned as male identified as male. They further note that *"All 16 subjects had moderate-to-marked interest and attitudes that were considered typical of males."* , and they conclude:*"Routine neonatal assignment of genetic males to female sex because of severe phallic inadequacy can result in unpredictable sexual identification. Clinical interventions in such children should be reexamined in light of these findings."*

These findings support the emerging thesis that despite the still too commonly held believe, the genitals are not the seat of a gendered self. Nor is sex of rearing especially effective in permanently establishing a sense of a gendered self. Indeed, Female-to-Male transsexual people also bear witness to the power of a masculine psyche, regarless of genital configuration.

As I said earlier, most male-to-female transsexuals are raised unremarkably as males. The successful treatment of thousands of individuals presenting with gender dysphoria and treated per the HBIGDA, Standards of Care reveal that cross-dressing and other cross-sex behaviors has been the client's way of coping with a sense of a gendered self other than what was assigned them at birth. In the end the most common way of treating this anomaly in a gender variant individual, is to encourage healthy cross-sex behaviors, not eliminate them.

By listing the gender variant condition as Gender Identity Disorder with the implication that the individual is confused and unable to determine their true gender, and by describing the symptoms primarily in terms of cross-gender behaviors, the DSM IV-TR continues to ignore what gender specialists routinely see when gender variant individuals present for treatment. If the situation is critical, the therapists often find themselves treating some combination of depression, anxiety, depersonalization, fear, anger, an overwhelming sense of guilt and a very real threat of suicide. These secondary symptoms appear to arise as a result of the decades of forced social pressure to conform to a gender expression they innately know is wrong and can no longer tolerate. The life of David Reimer and his tragic suicide surely attest to the potential damage to the psyche decades of forced gender expression deprivation can have.

**New thinking for DSM V**

As the DSM prepares the next update, I urge the authors to consider that the cross-gender behavior typical of gender variant people is neither a sexual disorder nor a gender identity disorder. Rather it is an anxiety disorder secondary to physical and sociological gender expression deprivation. Rather than referring to the cluster of behaviors as "Transsexualism" or "Gender Identity Disorder" I propose as I have elsewhere (25), that the condition be refereed to as Gender Expression Deprivation Anxiety Disorder (GEDAD).

Advantages in the terminology:

• GEDAD tacitly recognizes that gender expression is a critical element in all that makes us human.

• GEDAD tacitly recognizes that gender expression is a dictate of birth. It is not negotiable.

• GEDAD tacitly acknowledges that gender expression-- as defined by the individual-- is vital to good psychological health.

• GEDAD moves the locus of attention from the sexological to the psychological.

• Unlike GID, GEDAD does not connote disorder or confusion in someone presenting with gender issues. This should take away using the DSM to foster religious/political objections to gender role transition as part of the treatment plan.

• GEDAD describes what the presenting individual is actually experiencing.

• GEDAD can be posted in a directory of disorders allowing National Health Service or insurance coverage without the negativity Gender Identity Disorder currently incurs.

• GEDAD does not differentiate between adults, adolescents, children, MTFs, FTMs, Intersex, androphilic or autogynephilic gender variant people.

Reviews of the treatment outcomes of cases wherein an individual's secondary sexual characteristics have been changed to comply with their innate sense of gender identity and the subsequent success of the individual's life has shown that it is long past time for clinicians to accept that this is not a problem of confused identity but a problem of gender expression deprivation.

The long history of successfully treating gender issues has shown that a significant number of people who have a deep sense of a gender/sex discordance have profited from a treatment that accepts their sense of gender as being the critical unchangeable element in the matter. Despite the fact that the prescribed and highly effective Harry Benjamin International Gender Dysphoria Association's Standards of Care, triadic treatment plan leaves the individual's gender and chromosomal sex discordant, permanent relief is commonly achieved. The exogenous administration of cross sex hormones has shown repeatedly to have a profound, almost immediate stabilizing effect on the gender variant individual's psyche. The medication appears to resolve a hormonal imbalance in the brain that the individual's endocrine system cannot otherwise provide. Indeed the testes in pretreated male-to-female individuals and the ovaries in pretreated female-to-male individuals may be playing a role in exacerbating the problem. Further relief is attained with optional surgery and re-socialization into the new gender role, eliminating gender expression deprivation as an issue.

**We Can-and-Need to do much Better in DSM V.**

If we start with the premises that only the individual can know their gender, we must acknowledge that a gender variant individual, adult or child, is right and justified in experiencing difficulty trying to cope in an unvaried binary gendered system. Gender identity appears to have no other function in the human psyche than to impose masculine or feminine expression. To be forced to adopt a cross-sex gender expression as a way of being in the world in order to be accepted by friends, family and society at large has been shown to be unsustainable. What else can explain the large number of people who in mid-life have risked all that they know and love to resolve their sex/gender discontinuity by transitioning to the opposite gender role? Further more, how else to account for the overwhelming number of successful outcomes if in these cases these individuals were not "right" about their gendered sense of self?

At the 2003 American Psychological Association (APA) conference in San Francisco, participants discussed whether Gender Identity Disorder should be removed from the DSM altogether. Citing the current APA thinking that homosexuality is not a mental disorder, participants suggested that lacking proof otherwise, the gender variant condition may also be a regularly occurring condition in humans.

Karasic and Kohler (26) reported,"*There are a lot of problems with the way psychiatry has viewed transgender folks. In labeling an identity as a mental disorder, as opposed to identifying symptoms in the same way we do for, say, major depression, anxiety disorder or other disorders in the DSM, the consequence of this is pathologizing and really hurting our clients*."

After more than fifty years of treating gender issues hormonally, it is beyond dispute that despite some

possible negative physical side effects, the introduction of cross-sex hormones has proven to be the center piece of a successful treatment regimen for this population. (27, 28) When SSRIs are prescribed for depression they are commonly considered psychothropic medication. In a similar manner, when cross-sex hormones are prescribed to a gender variant individual, what they are receiving is, for them, psychothropic medication.

## Political Ramifications

In addition to the therapeutic concerns, there are political reasons to consider in this matter. As the transgender community has made gains in having their human rights acknowledged, the Christian Right in the USA has declared that helping people transition to their preferred gender role is immoral.

To add credence to their argument they note that the term Gender Identity Disorder comes from the DSM, a manual of mental disorders. They conclude, therefore, that since Gender Identity Disorder is a mental disorder, hormonal and surgical interventions leading to gender role transition should be replaced with long-term psychological care.

Here is one example of such writing from The Traditional Values Collation web site (29):

Our medical profession does no favors to sexually **confused** individuals by physically altering them so they can pretend to be something they will never be. Surgeons who mutilate men and women who suffer from a Gender Identity Disorder should be condemned by their medical associates.

.....Gender **confused** individuals need long-term counseling not approval for what is clearly a mental disorder."

Jerry Leach, who describes himself as having "an international ministry to those afflicted with gender identity confusion, homosexuality, and sexual addiction" writes on his site Realityresources.com (30).*"In transsexuality, not only is the sexual identity* **confused** *but there is also a gradually splitting off from one's God-given gender role. The end result being the total rejection of it and the taking on of a pseudo-feminine persona and role. "*

Robert Knight, the director of the Culture and Family Institute, an affiliate of Concerned Women for America, chimes in. "*Nobody is doing these poor* ***confused*** *people any favors by encouraging them to cultivate their disorder. We're talking serious dysfunction here*."

Finally, Traditional Values Coalition founder, Rev. Louis P.Sheldon (31) took the time to write to the U.S. Internal Revenue Service in December 2004 on behalf of 43,000 churches in the coalition to complain about the Internal Revenue Service granting a male-to-female transsexual's right to deduct sex reassignment surgery as a medically necessary, non-cosmetic medical procedure. Here is part of Rev. Sheldon's letter. *"The decision to give tax deductions for 'sex change' operations sends the wrong message to individuals who suffer from a Gender Identity Disorder. This is a mental condition, not one that needs surgery. In fact, by giving this tax deduction, your agency will be encouraging other mentally disturbed individuals to consider such surgery as an unneeded surgical procedure for what is a troubled mind."*

## Conclusion

In DSM IV and DSM IV-TR, placing the term "Gender Identity Disorder" in the Psychosexual Disorders, implies to some practitioners, that the individual with this condition has a psychosexual disorder; that is that people with this disorder refuse to accept the body based reality of their gender identity for sexual reasons. Recent research, however, has clearly shown that most people who present with severe gender dysphoria have a sound sense of a gendered self and are acutely aware of that gendered self being discordant with their biological sex.

Concomitant with a gendered self is a need for gender expression. To be denied gender expression in virtually every aspect of one's life typically leads to some combination of depression, anxiety, depersonalization, fear, anger, overwhelming guilt and a very real threat of suicide. Beyond this, the descriptive terminology used in DSM IV and DSM IV-TR, reinforces negative stereotypes of gender variant people. Moreover, despite strong evidence of the efficacy of hormonal and surgical interventions, the DSM IV and DSM IV-TR both fail to legitimize these interventions in cases where it may be the only logical treatment.

As an alternative, I purpose that in the next edition of the DSM, the dis-ease or dysphoria associated with being gender variant be moved from the Sexual Disorders category to its own heading as an anxiety disorder; specifically that it be termed, Gender Expression Deprivation Anxiety Disorder. The information listed thereunder would take for a basis that a person who has had a life-long struggle with gender dysphoria be accepted as being gender variant and a medical and psychological treatment plan be designed to alleviate their anxiety.

The authors of DSM IV-TR tell us' *"It must be noted that DSM IV reflects a consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication. New knowledge generated by research or clinical experience will undoubtedly lead to an increased understanding of the disorders included in DSM IV, to the identification of new disorders, and the removal of some disorders in future classifications."* The time has come to remove Gender Identity Disorder and replace it with a new classification: Gender Expression Deprivation Anxiety Disorder.

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