

Revision Suggestions for Gender Related Diagnoses in the DSM and ICD¹

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Introduction

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association (APA), defines mental disorder, medically and socially, in North America. It strongly influences mental disorders listed in the The International Statistical Classification of Diseases and Related Health Problems (ICD), published by the World Health Association (WHO) and used worldwide. The current psychiatric classifications of Gender Identity Disorder (GID) and Transvestic Fetishism (TF) in the Fourth Edition Text Revision of the DSM (APA 2000, DSM-IV-TR) have drawn a great deal of concern within the trans² community and among medical care providers and civil rights advocates (Winters and Ehrbar 2009). At issue, trans and gender nonconforming³ people suffer prejudice, intolerance and denial of civil justice that result from false stereotypes of sexual deviance and mental illness. At the same time, access to hormonal and/or surgical transition⁴ care is a medical necessity for some transsexual⁵ individuals. There is a need for diagnostic nomenclature and coding that is respectful of gender diversity and congruent with medical transition to lower barriers to this care. A third issue is that trans and gender nonconforming people, especially youth, are subjected to harmful psychiatric gender identity conversion “treatments,” intended to enforce conformity to assigned birth sex and suppress gender variant identities and expressions into the closet. As the APA prepares the Fifth Edition of the DSM (DSM-V) for publication in 2013, psychiatric policymakers have an opportunity for diagnostic reform to address these issues.

We three authors approach issues of gender diversity in psychiatric nomenclature from different backgrounds: Dr. Ehrbar, a clinical psychologist; Dr. Winters, a writer and policy consultant; and Dr. Gorton, a physician. Like many within the diverse trans community, we struggle with questions of what shape if any a diagnosis should take for

¹ This is a version of a presentation to the XXI Biennial Symposium of the World Professional Association for Transgender Health, held in Oslo in June 2009.

²Transgender or Trans describe a wide diversity of people who differ in gender identity or gender expression from expectations of assigned birth sex. Not all people in various categories of gender diversity socially identify as members of the Transgender Community.

³Those whose gender expression differ from expectations of assigned birth sex. The majority of gender nonconforming people have gender identities congruent with birth sex.

⁴Changes to social gender expression or physical sex characteristic to gain congruence with inner gender identity.

⁵Those whose gender identities are incongruent with their born physical sex characteristics. Many transsexual individuals seek medical treatments to bring their bodies into harmony with their gender identities, though not all are able or choose to do so. Some regard Transsexual identity as transitional and refer to it in the past tense after surgical transition.

those who transition in their social gender role or physical sex characteristics. Despite our differing viewpoints, we agree about fundamental principles of human dignity, civil rights, and the right to medical treatment for trans people.

We began with significant differences in how we thought diagnostic policy should reflect our views of gender diversity, mental pathology, psychiatric diagnosis and its impact on civil justice:

- According to Winters, individuals whose gender identity or expression differ from assigned birth-sex are labeled mentally disordered in the DSM-IV-TR, inflicting both harmful social stigma and barriers to medical transition care.
- Ehrbar concludes that diagnosis is needed for access to medical transition care and that, conceptually, it makes sense to categorize the distress of gender dysphoria as a mental health disorder.
- Gorton asserts that GID (perhaps by another name) belongs in DSM-V and that diagnosis can facilitate insurance coverage and disability protections. He feels that improvements on the current diagnosis can foster acceptance among consumers without compromising scientific accuracy.

In working together, however, we discovered that we shared many common principles and views about the utility of diagnostic coding in enabling access to medical transition care. Our shared values are summarized in the following vision statements:

- We call for an end to discrimination on the basis of gender identity and expression.
- Gender identity and expression that differ from assigned birth sex do not, in themselves, constitute a mental disorder or an impairment in competence
- Hormonal, surgical and/or mental health care to relieve gender dysphoria are medically necessary.
- Public and private health insurance must include medically necessary transition treatment.
- Legal recognition/documentation for all people that is consistent with their gender identity and expression is a basic civil and human right.
- Reform should consider the needs of the full breadth of the transgender community, but as a social justice movement we must weigh more heavily the needs of those least enfranchised.

The following narratives reflect our individual views on issues of access to medical care and social stigma in the current DSM nomenclature. They also describe our collaborative proposal to reform the GID diagnosis and remove the Transvestic Fetishism category in the pending DSM-V.

Nick Gorton: The Purpose of Diagnostic Nosology

The primary reasons for medical and mental health diagnostic nomenclature is to offer safe and effective treatments to individual patients. Diagnostic nomenclature also serves

to describe and better understand conditions that we treat. Because people tend to have the same sorts of illnesses, it can be useful to know what treatments are effective for people with a similar illness as a group instead of starting fresh with every individual. As a society we also believe that people should have access to medically necessary health care. However in one form or another payment for care is restricted to care that is necessary and that treats an illness or significantly promotes health. Thus we also use diagnoses as a standardized way to delineate significant health problems. An example of this is the ICD, which helps us understand what conditions are diseases and provides a means for insurance payers to determine and describe what they cover. In addition, a consistent diagnostic nosology facilitates epidemiological and medical research, by defining diseases and disease populations.

The use of a formal diagnosis is often important in offering relief, providing health insurance coverage, and guiding research to provide more effective future treatments *WPATH Standards of Care* (Meyer, et al. 2001)

Competing issues of barriers to access and payment for medical, surgical, and mental health care, and barriers to social justice and equality arising from stigma of mental illness, pose a conundrum for health care providers, policymakers and consumers when discussing what form a diagnosis for transgender people should take:

The transcommunity and care providers have long been polarized by fear that we must choose between stigma of mental illness and sexual deviance or lose access to hormonal and surgical procedures as well as disability protections. (Winters 2004)

The trans community is deeply divided on questions of which, if any, trans people should be classified as having a disease. This is one of the major points where the authors lack consensus. One argument states that a diagnosis is necessary to gain access to health care services and disability protections. This viewpoint considers that a diagnostic nomenclature will help insurers understand that people who need access to medical transition have a condition for which there are effective and necessary treatments and help guarantee disability protections for those who need them. The counter-viewpoint considers that there is an inherent harm in accepting the illness (and disability) label and that such labels are used to deny access to health care and legal protections for all trans people.

Wherever one lies along the spectrum of this discourse, it is very important for us to remember that when talking about the stigma and negative consequences for people with disabilities we must refrain from using language that itself perpetuates the stigma for the broader community of people with illness and disabilities. As a social justice movement it is imperative that we do not, in seeking to remove stigma from our community,

either overtly stigmatize other communities ourselves or tacitly approve of the stigmatization of those other communities by others.

I come from a people who gave the Ten Commandments to the world. Time has come to strengthen them by three additional ones, which we ought to adopt and commit ourselves to: thou shall not be a perpetrator; thou shall not be a victim; and thou shall never, but never, be a bystander
-Yehuda Bauer (2006), Professor of Holocaust Studies Hebrew University of Jerusalem

This quote is important to consider. Even if we believe that trans people have no mental illness or any illness whatsoever, it is important that we not be bystanders while others are subject to the very discrimination that we believe may be erroneously be applied to the transgender community.

Kelley Winters: Barriers to Both Civil Liberties and Medical Care Access

The current diagnostic nomenclature of Gender Identity Disorder and Fetishistic Transvestism label those who do not conform to their assigned birth sex, either by inner identity or outer social expression, as mentally disordered, with harmful consequences (Winters 2008, pp. 2-4; Cohen-Ketennis and Pfafflin 2009), to both civil justice and access to medical transition services. It is not a question of either/or; not of one versus the other; it is a failure on both issues.

The current diagnostic criteria for Gender Identity Disorder for children, adolescents and adults, lack clarity on who should be diagnosed and who should not. Ambiguous language, preoccupation with antiquated sex stereotypes, and incongruence with the definition of mental disorder have confused care providers, medical policymakers, and insurers, posing barriers to access to transition care.

While the DSM is intended as a diagnostic reference and not a treatment guide, the efficacy of all medical and mental treatments are measured according to symptoms defined by the diagnosed condition (Winters and Ehrbar 2009). The specific diagnostic criteria and supporting text of the current GID category contradict transition care and implicitly support the opposite approach: punitive gender identity conversion or gender-reparative treatments intended to shame or suppress gender identity and expression which differ from assigned birth sex roles.

Supportive care providers need better diagnostic coding to make transition procedures available to individuals who require them. We believe it is possible to revise GID nomenclature in the DSM-V to address both issues of social stigma and access to transition care: reducing unfair stigma of mental illness and sexual deviance while at the same time supporting rather than contradicting social and/or medical transition.

The current GID and Transvestic Fetishism categories have reinforced harmful false stereotypes of mental disease and perversion for transwomen (Winters and Lev 2003). These stereotypes were exemplified in a full-page newspaper ad campaign by Focus on the Family (2008), a political and religious extremist group opposed to civil rights for trans people in Colorado, U.S. A transwoman was depicted in a photo as a disheveled

suspicious male in dirty work boots, lurking in a women's restroom as a little girl stepped out of a stall. The ad contained the headline, "Colorado Just Opened Its Bathrooms to Either Sex!" and the phrase, "sexual predator."

Political extremists opposed to transgender equality cite the American Psychiatric Association directly in defaming gender variant people. For example, a Maryland group waged an internet campaign against transgender civil rights, specifically referencing the DSM to promote false stereotypes of mental illness and sexual deviance (Maryland Citizens for a Responsible Government 2007). It stated,

'Gender Identity Disorder' is classified as a mental disorder by the American Psychiatric Association. Legal protection against discrimination based on mental illness is not provided for any other disorder, and there is no rational explanation why it should be offered for this one. Those who wish to assume a 'gender identity' contrary to their biological sex are in need of mental health treatment to overcome such disturbed thinking, not legislation to affirm it.

While diagnostic coding of some form is necessary to facilitate access to transition care, the current categories of GID and Transvestic Fetishism have failed in this role. Transition related medical, surgical and mental health care remain largely excluded from coverage by healthcare plans (AMA 2008). Moreover, the GID and TF diagnoses have played a direct role in limiting access to transition care. For example, Dr. Paul McHugh (2004), former psychiatrist-in-chief at Johns Hopkins Hospital, used DSM classification to justify terminating gender confirming surgeries there. He said,

I concluded that to provide a surgical alteration to the body of these unfortunate people was to collaborate with a mental disorder rather than to treat it.

Dr. Paul Fedoroff (2000) of the Toronto CAMH center (formerly the Clarke Institute of Psychiatry) exploited mental illness classification to call for elimination of gender confirming surgeries in Ontario. He stated,

TS [transsexualism, in reference to the GID diagnosis] is also unique for being the only psychiatric disorder in which the defining symptom is facilitated, rather than ameliorated, by the 'treatment.' ... It is the only psychiatric disorder in which no attempt is made to alter the presenting core symptom.

In contrast, the American Medical Association (AMA; 2008), the American Psychological Association (2008), and the World Professional Association for Transgender Health (WPATH ; 2008) have issued public statements clarifying the medical necessity of hormonal and/or surgical transition treatments for those who suffer distress caused by deprivation of physical characteristics congruent with their gender identity:

RESOLVED, That the AMA support public and private health insurance coverage for treatment of gender identity disorder; and be it further

RESOLVED, That the AMA oppose categorical exclusions of coverage for treatment of gender identity disorder when prescribed by a physician
--American Medical Association Policy H-185.950

Moreover, these professional organizations have opposed healthcare and insurance exclusion of trans and transitioning individuals. This is the model, the new standard, that we hope the American Psychiatric Association will follow in the DSM-V and in their own public position statements.

Randall Ehrbar: Recommendations for Harm Reduction of the GID Diagnosis in the DSM-V

The DSM-V will likely impact public acceptance, civil rights, social justice and medical care of gender variant people through the end of the 2020s. There will almost definitely be a diagnosis in the DSM V and the ICD-11. Therefore, the immediate issue is to improve the diagnosis so that it better reflects the experience of trans people and is more useful in supporting access to care and civil rights of trans people rather than undermining them.

We recommend that the focus of pathology in the current GID diagnosis be on the distress of gender dysphoria rather than on gender identities and expressions that differ from assigned birth sex. We define **gender dysphoria** as:

- **Distress with current**
 - **physical sex characteristics, (including anticipated pubertal changes for youth)**

AND/OR

- **ascribed gender role that is incongruent with persistent gender identity**

There are two separate but related aspects of gender dysphoria—distress with sexed aspects of the body, that is primary or secondary sex characteristics, and distress related to social gender role. Distress with physical sex characteristics also includes anticipated development of secondary sex characteristics, for example in puberty. This is especially important for natal males who may undergo distressing masculinization if the surge in testosterone production at puberty is not suppressed.

The conceptual center of the diagnosis should be gender dysphoria, and the criteria for GID in the DSM as well as Transsexualism in the ICD should be modified to reflect this. It is clear from the experience of trans people that their gender identity is not “the problem,” nor is degree of gender conformity “the problem.” Unfortunately, the current diagnostic criteria are overly broad and also treat gender identity different from that assigned at birth and gender non-conforming behavior as if they were pathological, and actions taken by the individual to resolve gender dysphoria as if they were symptoms.

This distress should be conceptualized as relative to the current situation—the current state of the body and social gender role, not the gender role assigned at birth or the body prior to modification. People who have been able to access physical interventions and are now happy with their body no longer have anatomic gender dysphoria. Similarly, people who have successfully been able to shift to a social gender role congruent with their gender identity no longer have social gender dysphoria.

The clinical significance criterion in the current GID diagnosis is ambiguous and may cause false positive diagnosis of trans people because they have suffered societal discrimination or intolerance. We recommend that that a replacement diagnosis:

- **Clarify impairment in the clinical significance criterion to exclude sequelae of societal intolerance, prejudice and discrimination.**
- **Distinguish distress of gender dysphoria, with physical sex characteristics or ascribed social gender role, from distress caused externally by societal or family intolerance.**

The DSM should never imply that to be a victim of prejudice is to be mentally disordered. While it can be difficult to distinguish between internal distress and distress which is influenced by stigma or minority stress, if a person is happy with his/her/hir social gender role and physical body, that person should not carry this active diagnosis. Someone who is facing anti-trans discrimination may not need any diagnosis—certainly being in a group which is subject to discrimination is not diagnosable *per se*. A diagnosis in another diagnostic category may be appropriate for people experiencing a significant level of distress. Examples include adjustment disorder, depression, anxiety, or even PTSD in cases of extreme mistreatment. This is similar to how we would handle diagnosis of someone who is being subject to discrimination for any other reason such as homophobia, classism, racism, sizism, etc.

Diagnoses often capture diverse groups of clients who share a conceptually central presenting concern. It is clear that there are a variety of meaningful categories into which trans-people can be divided. At a basic level, transmen and transwomen are different from one another. However, it is not necessary to have separate diagnostic categories for each identifiable subgroup of people with different identities or gender expressions as the ICD currently attempts to do with different diagnostic categories of Transsexualism and Dual Role Transvestism. For clinical and epidemiological utility we only need to ask: does this person experience gender dysphoria?

Diagnosis is also distinct from treatment. One of the problems with the current GID diagnosis is that it is worded in such a way as to imply that treatment which facilitates transition is inferior to treatment which encourages conforming with gender assignment at birth. The conceptual *why* of treatment should hinge upon the central concept of the diagnosis—in this case gender dysphoria. If treatment helps to resolve gender dysphoria, that treatment is successful. If it does not, it is not. For example in the case of children, because the current diagnostic criteria include a lot of criteria which reflect gender role conformity, a provider working with a child to behave in gender role

conforming ways can say “this treatment was successful—the child no longer meets the diagnostic criteria.” Under a gender dysphoria based diagnosis a clinician who believes that working with a child to be more successful in behaving in a gender appropriate way will resolve the gender dysphoria the child experiences could still use that treatment. However if such treatment did not resolve the gender dysphoria even if the child behaved in a gender normative way would not be considered successful. Given this focus on gender dysphoria the list of possible therapies doesn’t necessarily change. However the measure of whether the treatment is successful does change: the measure of success becomes not is the child gender conforming, but does the child experience gender dysphoria?

The current diagnostic criteria for Gender Identity Disorder of Children are especially troubling (Ehrbar, et al. 2008) and should be rewritten to center upon gender dysphoria rather than gender nonconformity. They should:

- **Reduce stigma of psychosexual pathology for gender expression differing from assigned birth-sex role.**
- **Reduce false positive diagnosis of gender nonconforming children who were never gender dysphoric.**
- **Remove all reference to gender nonconforming expression in diagnostic criteria and supporting text.**
- **Remove archaic “aversion” clauses in diagnostic criteria regarding “rough and tumble play” and “normative feminine clothing”**

A boy can enjoy activities which are stereotypically feminine and still feel confident that he is a boy and be happy with his body. He should not receive this diagnosis as he does not have gender dysphoria. If he is happy with himself and functioning well he does not have a mental illness at all. If he is suffering due to relationship problems with family or peers, another diagnostic category would be more appropriate. This would be analogous to a boy suffering because he is ridiculed on some other grounds, such as weight or religion. It can be useful in diagnoses describing children to provide behavior examples as children may not be able to verbalize their inner states as well as adolescents or adults. However those examples should be centered upon gender dysphoria rather than behavior that adults label as 'male typical' or 'female typical.' Examples should include behaviors typical of a natal female who is distressed by lack of a penis or a natal male who is distressed by the presence of one. The current criteria seem to equate the dislike of rough and tumble play in a natal male to distress because a natal male wishes his penis would disappear, and this equation is conceptually unsound. While it may be common for natal males who experience gender dysphoria to dislike rough and tumble play, this is not in and of itself an expression of gender dysphoria.

Kelley Winters: Appropriate Diagnostic Inclusion:

In the Story of Goldilocks and the Three Bears (Southey 1837), a young protagonist seeks that which is “just right” in her journey of burglary and criminal trespass: not too hard, not too soft, not too hot or cold, but just right. Psychiatric diagnosis should

similarly fit the needs of the patients and society: not inappropriately over-inclusive, not exclusive of those who need care, but just right.

Diagnostic nomenclature should be inclusive enough to meet the needs of those who need care. We recommend that criteria clarify the anatomical component of gender dysphoria to include clinically significant distress with current sex characteristics that are incongruent with gender identity, including distress caused by deprivation of characteristics that are congruent with inner identity. These should encompass anticipated sex characteristics for gender dysphoric youth approaching puberty as well.

Diagnostic criteria and supporting text should respect a diverse spectrum of gender identities and expression that are beyond stereotypical binary sex stereotypes. We suggest that dichotomous language such as “cross-gender,” “other sex” and “opposite sex” be removed from the diagnostic criteria, along with pathological descriptions of transition. It is more accurate and respectful to describe roles and behaviors corresponding to assigned birth sex or to experienced gender identity.

The current GID criteria promote false-positive diagnosis of people who meet no definition of mental disorder and suffer no distress or impairment with their bodies or ascribed roles. This tendency toward false positives is most striking with children who may be diagnosed with GID strictly on the basis of gender role nonconformity with no evidence of distress with their current physical attributes or assigned role. We recommend that all references to atypical or nonconforming gender expression be removed from the diagnostic criteria. The diagnostic focus should be on distress of gender dysphoria, not gender non-conformity. We recommend that a revised diagnosis in the DSM-V:

- **Remove gender expression stereotypes from diagnosis**
- **Exclude gender non-conforming children who are not distressed by anatomy or birth assignment**

Furthermore, there is no exit clause to the GID diagnosis for those who have transitioned and gained relief from gender dysphoria, regardless whether or not they currently suffer from any adverse mental health symptoms at all (Winters 1998). Post-transition individuals permanently meet Criteria A and B, because of language of nonconformity to assigned birth sex. For example, Criterion A describes transition itself as symptomatic of mental illness, where “other sex” means, other than assigned birth sex:

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 (APA 2000, p. 577)

These assertions would remain true for all happy, ego-syntonic individuals who have transitioned, who for the rest of their lives would meet Criterion A.

Criterion B described gender dysphoria in previous editions of the DSM. However,

gender dysphoria is rendered moot in the current DSM by the clause, “belief that he or she was born the wrong sex.” Virtually all well adjusted post-transition people will always believe that they were born or assigned the wrong sex and will therefore always meet Criterion B. Clauses describing beliefs and convictions as defining a pathological state should be removed from a revised diagnosis in the DSM-V.

The scope of gender dysphoria for diagnostic purposes is an important issue for discussion. Should it be limited to anatomical dysphoria as just described, or should it also include social gender dysphoria, that is distress with ascribed or assigned gender role? While no clinical assessment is necessary for social gender role transition for many individuals, access to medical transition procedures, such as hormones or for Female to Male (FTM) individuals chest reconstruction, is prerequisite to social transition for others. For this reason, we include both anatomic and social gender dysphoria in our recommendation for diagnostic criteria.

We also suggest that an In Remission specifier (described below) may be necessary in a revised diagnosis for GID. This specifier would apply to individuals who previously met the diagnostic criteria, whose dysphoria has been successfully ameliorated, but who also require ongoing access to medical or mental health care to remain in remission. The supporting text should clarify when the diagnosis and specifier situations where the diagnosis would no longer apply to an individual such as a person who previously met the criteria and whose treatment successfully reduced their gender dysphoria below the clinical threshold and who no longer need any ongoing care to maintain their remission.

A second problematic gender diagnosis, Transvestic Fetishism (TF), mis-characterizes crossdressing and social expression of femininity by birth-assigned males as a sexual paraphilia. TF is grouped with pedophilia, exhibitionism, and voyeurism in the current DSM and subjects transwomen to the stigma associated with these disorders (Serano 2007). Ambiguous language in Criteria A and B may implicate all transwomen, including transsexual women, who are birth-assigned male, attracted to women, wear clothing that is typical or ordinary for cisgender (non-transgender) women, and are distressed by social prejudice as perpetually diagnosable. In fact, the *DSM-IV Casebook*, edited by Robert Spitzer (1994), recommends a diagnosis of Transvestic Fetishism for a male whose cross-dressing is not necessarily sexually motivated and whose only impairment is an intolerant spouse.

Dr. Ray Blanchard (2009), chair of the Paraphilias Subcommittee of the DSM-V Workgroup for Sexual and Gender Identity Disorders, has proposed to retain these flawed diagnostic criteria and add the label of “autogynephilia” to the diagnosis, as a specifier for transsexual women. Adding that label which is often used pejoratively and is a source of significant distress for many transgender women who may perceive it as negatively as the term 'faggot' is neither useful or likely to improve patient outcomes.

In our view, the TF diagnosis is of no clinical use and yet potentially inflicts harm on all who do not conform to a male birth-assignment. Moreover adding the label autogynephilia takes a flawed diagnosis and further exacerbates its negative

consequences. **We urge that the Transvestic Fetishism diagnosis be removed entirely from the DSM-V.**

Nick Gorton: Harm Reduction of Gender Nomenclature in the DSM-V

All three authors agree that placement of a gender dysphoria diagnosis in the Sexual and Gender Identity disorders section is neither clinically accurate nor palatable to most people in the transgender community. The Sexuality and Gender Identity Disorders section is comprised of a number of different classes of sexual disorders. GID is currently located in this section, despite gender identity not being specifically related to sexuality, sexual function, or sexual preferences. We also agree that there are three possible places that Gender Dysphoria (GD) could go and that any of these would be an improvement on the current placement. However we disagree on which is the best and most accurate location. Possible classification is 1) in a separate category including the diagnosis in adults, children, and adolescence as well as other possible conditions relating to ones gender identity, 2) Disorders usually first diagnosed in infancy, childhood, or adolescence, and 3) Anxiety disorders.

A separate category would eliminate concerns about drawing connections to other diagnoses in that group (much as transgender people now object to being in the group containing pedophilia). However a separate class under Axis I might appear awkward and might eliminate scientific and research accuracy and utility by failing to draw valid connections to other disorders in a class. For example the vast majority of transgender people report awareness of their gender identity was present in childhood or adolescence. In addition transgender people often experience significant trauma making PTSD and anxiety disorders in some ways related.

Classification in disorders first diagnosed in infancy, childhood or adolescence could be nosologically helpful given that the vast majority of transgender people understood on some level their gender identity before adulthood. Additionally this location would be less objectionable to many in the transgender and medical community than classing it with Sexual Disorders. However similar objections could be raised by people who object to describing transgender people as a form of developmental delay or aberration.

Classification within anxiety disorders could facilitate understanding that many of the adverse mental health symptoms transgender people experience stem from the trauma that patients experience either due to sublimating their gender identity or due to the discrimination to which they are subject as a gender non-conforming person. However, this might also suggest a connection with OCD (Obsessive Compulsive Disorder), which might lead clinicians and researchers to misconstrue that patients seeking transition related care are obsessed. (This could be particularly problematic because patients who have been deprived of transition related care may have behaviors surrounding gaining access to that care that could be mis-interpreted, not as a normal reaction to a lack of a vital health care need, but as obsessive preoccupation.) This misunderstanding may further suggest that proper treatment might be to end the

obsession-compulsion cycle with medication or therapy aimed at changing a patient's core gender identity.

With regard to location within the DSM, all three authors would accept its location in a separate Axis I category. Ehrbar and Gorton would also accept it being in disorders commonly diagnosed in childhood and infancy. However we all agree that any of the possibilities is better than the current classification of Sexual and Gender Identity Disorders (APA 2000, Code 302).

In addition to problems with location within the DSM-V, there are also two primary problems in gender nomenclature and terminology in the current DSM-IV-TR: the name of the diagnosis and the pronouns and description of the sexual orientation of transgender people. Even those in the transgender community who agree that GID is a reasonable (albeit improvable) term still object quite vehemently to the practice of referring to individuals with incorrect and disrespectful pronouns or describing their sexual orientation in reference to their birth-assigned gender. The academic tradition of using pronouns and describing sexual orientation in reference to gender as assigned at birth is hurtful to individuals, increases the conflict between the medical and transgender communities, and is inaccurate and confusing to people not well versed in the transgender literature. For example a male to female (MTF) patient whose partner is male would be seen not only by herself but by others who perceive her as a woman as a heterosexual because she is a woman whose sexual preference is for men. If we describe her as a “homosexual male transsexual” that is not only disrespectful to the individual patient and her lived experience, but also confusing to many clinicians and the larger society. Moreover even in the academic community there no longer exists a common standard adding to the confusion in the literature. The majority of publications in recent years describe MTF patients as transgender women and using pronouns and descriptions of sexual orientation that reflect the patients gender identity such that a MTF patient with a sexual preference for women would be a lesbian transgender woman. The supporting information in any revision should set the academic nomenclature so that it is consistent and respectful of transgender identities and facilitates a consistent and logical standard for academic discourse and publication.

We should use the system that is most logical and understandable by everyone who accesses the literature whether they are scientists, clinicians, or laymen from within or outside of the transgender community. Transgender people should be referred to in terms of their affirmed gender. In cases where such identity is not known, gender neutral terms should be appropriate.

In addition, Autogynephilia has become such a diffuse term encompassing definitions including discreet experiences, etiological theory about transgender women, or a formal diagnosis such as Dr. Ray Blanchard's proposed modification for transvestic fetishism that it has really lost much of its utility. Moreover terminology that is disrespectful or discriminatory should be avoided – especially when creating new official nomenclature. Therefore, we feel that transgender patients and the understanding of gender diversity would be best served by not elevating this divisive term to the status of diagnostic nomenclature.

This respectfulness and awareness of the power of labels in medicine and society is not unusual in medicine or science. For example the first medical term for people born with trisomy 21 was 'mongolism' (referring to the typical faces of patients with trisomy 21 appearing somewhat Asian.) This racially charged diagnostic label was replaced by Downs' Syndrome named after the English Pediatrician who first described it. However, recently there has been greater realization that Downs was actually a racist and eugenicist who believed that patients with trisomy 21 were 'devolutions' of the superior caucasian race to an inferior 'mongoloid' form. Because of this many in the medical community advocate avoiding this eponym and simply referring to it with the more accurate and less historically charged term trisomy 21 (Gould 1981).

Therefore, we recommend that respectful affirming language be used to describe gender variant and transgendered individuals in the DSM-V:

- **Socially transitioned individuals should be described with pronouns and terms of their affirmed gender rather than gender assigned at birth.**
- **Gender neutral terms should be used to describe people where transition status is not known or who themselves use gender neutral pronouns.**
- **“Autogynephilia” has multiple ambiguous meanings, many of which are maligning and offensive to many transsexual women. Usage is not constructive in the DSM.**

Finally, the current title of Gender Identity Disorder, implies that gender identity itself is the pathology and is especially troubling. We propose changing the name of the diagnostic category to reflect a focus on dysphoria rather than identity as the defining characteristic of a disorder. Two proposed names that we could agree on are Gender Dysphoria or Gender Dissonance (Vanderburgh 2001, Winters 2005) with or without an 'incongruent' modifier. Gender dysphoria is particularly useful because it is a term already used in the art and diagnostic language. It is also quite descriptive if we wish to better focus on the dysphoria and treatment aimed at relieving it.

Summary: Proposed Changes for DSM-V

Given the different backgrounds, premises, and understandings of the transgender experience among we three authors, it seems surprising that we were able to come up with a single proposal for the revision of GID and removal of TF for the DSM-V. However, the basic core ideals that we share, such as social justice, the innate value of gender diversity, healthcare access as a civil right, and self-determination of identity as a human right, make our consensus less surprising. We agree that it is possible for a diagnosis and diagnostic nomenclature to be respectful of the patients it serves without sacrificing clinical or research utility.

We propose changing the name of GID in the DSM to Gender Dysphoria (GD). Further we propose two criteria for adult and adolescent gender dysphoria, both of which must be met in order for the diagnosis to be present:

A: Strong and persistent distress with physical sex characteristics, or ascribed social gender role, that is incongruent with persistent gender identity.

B: The distress is clinically significant or causes impairment in social, occupational, or other important areas of functioning, when this distress or impairment is not solely due to external prejudice or discrimination.

We hope that these criteria will address many of the concerns of people across the spectrum of beliefs about pathology and utility of the diagnosis.

We also feel that a specifier for GD in remission should be included. When any disease is 'in remission,' that implies that it no longer causes symptoms or problems but it would likely re-manifest if treatment were stopped. A cured disease is one that one does not expect to return even without continued treatment.

The utility of an in remission specifier is two fold. First it has pragmatic utility. A trans person might no longer manifest or experience any clinically significant dysphoria, but that does not mean that treatments can be safely stopped. We do not want to give insurers or health care systems the opportunity to justify such a cessation, because this could set transgender people up on a cycle where they resolve their dysphoria, are deprived of further treatment, then become dysphoric again and thus re-qualify for treatment. Additionally, an ongoing diagnosis, even if in remission, could allow transgender people to continued access to certain disability protections and accommodations.

Moreover an 'in remission' specifier is more diagnostically accurate. For example a transgender man who has successfully transitioned physically and socially to the full extent that is appropriate for him who is for some reason deprived of ongoing hormonal treatment may or may not experience a return of gender dysphoria. For example if he has not had hysterectomy and oophorectomy, cessation of hormones could result in resumption of menstrual cycles. This may cause a return of symptoms, whereas if he had undergone a hysterectomy/oophorectomy he might have menopausal symptoms but not a return of dysphoria.

We propose the in remission specifier would state:

- **Patient previously met the diagnostic criteria for GD (whether or not he or she received a formal dx), AND**
- **Patient no longer has symptoms sufficient to merit a mental health diagnosis, AND**
- **Patient has ongoing need for GD specific health care in order to maintain remission**

The 3rd qualifier – that ongoing treatment be necessary to maintain remission actually makes room for the 'exit clause' for which many people in the transgender community

advocate. With this specifier, it would be the case if an individual not only lacked distress but also had no real risk for the return of distress without ongoing treatment no diagnosis would be applicable at all. In order to make this explicit, the supporting text could specify that:

Individuals felt by both themselves and a mental health provider to not likely have a recurrence of GD qualifying symptoms if deprived of future medical, surgical, or mental health care would not meet the criteria for either GD or GD in Remission and would no longer be considered to have a mental health condition.

Regardless of our initial viewpoint, we share common principles of what gender diagnostic nomenclature should look like. Our main recommendations in reforming the gender diagnoses in the DSM-V are: 1) gender dysphoria is the conceptual center of the diagnosis, 2) use respectful language in nomenclature and description of individuals, 3) include those who are in need of inclusion, do not include those who should not be, 4) move the diagnosis out of the sexual and gender identity disorders chapter, and 5) remove transvestic fetishism.

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