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# Gender Dysphoria: Two Steps Forward, One Step Back

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**Abstract** The long-awaited *DSM-5* has finally been published, generating controversy in many areas, including the revised diagnostic category of Gender Dysphoria. This commentary contextualizes the history and reform of the pathologization of diverse gender identities and expressions, within a larger perspective of examining psychological viewpoints on sexual minority persons, and the problems with continuing to label gender identities and expressions as pathological or disordered.

**Keywords** Transgender · Gender · Diagnosis · GID · Gender dysphoria · Gender identity · LGBT · Trans · LGBTQ

> Sexualities keep marching out of the Diagnostic and Statistical Manual and on to the pages of social history.
> Gayle Rubin 1984, p. 287.

*Clinical Social Work* has just celebrated its 40th anniversary, and this volume marks the first special issue devoted to lesbian, gay, bisexual, and transgender (LGBT) mental health and psychotherapy. The lives of LGBT people, people who are now reclaiming the word queer as a proud self-descriptor to encompass the term LGBTQ (Tilsen 2013), have changed dramatically in this same period of time. LGBTQ people were leading clandestine, marginalized lives, ostracized by family and friends, unable to have children (or retain custody of them), living with a constant threat of unemployment, creating false narratives about their social lives to appease others and protect their private lives. Now LGBTQ people have the potentiality of full lives—out, proud, married, with families, serving in the military, working for the government—with strong communities and federal laws that protect us against bias-related violence.

Forty years ago, I was a 15-year-old Jewish working-class adolescent, growing up in the tail end of 1960s counter-culture, and deeply in love with my best girlfriend. My journals were full of endless, painful monologues about her, about society, and about where I would fit into the grownup world I would soon be entering. I wasn't exactly closeted—I called myself bisexual—but I was filled with angst and confusion and drowning in myriad social messages of what it meant to be a lesbian (which in my journals I spelled "lesibean" because even simple access to seeing words that reflected my experiences in print was non-existent). I did not know how to talk with my mother, my friends, my boyfriend, my *girlfriend* about my emerging queer identity. What could be the future for a young dyke? Where could I find a home, a job, a lover, a life? And if I found my way to therapy, what would the psychotherapist say to me that would affirm my identity? What education did she have, what trainings had he attended, what journal articles could she/he have read to help her or him help me to grow to be a healthy secure and very queer adult?

In entering into this discourse with you, the reader, I must start with a moment of silence, for all that has not been said within the therapy professions, within social work and family therapy—the professional communities I call home—these past 40 years. The LGBTQ communities have been hard at work informing politics, changing policy, opening minds, indeed transforming the world in many ways—and our clinical communities have followed along, taking a mostly progressive, supportive stance on issues as they have arisen, incorporating a "gay-affirmative" approach into our clinical

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practices (Levy and Koff 2001), but as a social work community, I wonder if we have done enough (Levy and Koff 2001). Have we been at the vanguard of advocacy and progressive change, or have we merely followed the evolving trends (Hegarty 2009)? I hope that this inaugural issue heralds a change not just in direction, but in conceptualization, so that LGBTQ issues become not a "special issue," but are incorporated into the framework and organization of the journal. I was taught many years ago to always ask the questions "Who is not present at the table? Whose voice is not being heard?"

The challenge of fully incorporating LGBTQ clinical knowledge into the mainstream of clinical social work is to deconstruct heteronormative thinking, to queer the discourse. I will try in the words that follow to move this discussion past "gay-affirmative" therapy, and to imagine a more queer psychotherapy, one that truly challenges the pathologizing of LGBTQ lives, and heteronormativity of non-queer ones. I want to look at the role that diagnoses play in the development of identity, communities, and the therapeutic gaze. The context of this discussion is the change from Gender Identity Disorder to Gender Dysphoria in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association (APA) 2013), but it is by necessity a wider discourse about both sexual orientation and gender identity, the social and political context of the holding environment we call therapy, as well as an emerging queer sensibility that challenges the hegemony of pathological labeling. The shift in diagnostic nomenclature initiates a potential shift in clinical conceptualization from gender nonconformity as "other," "mentally ill," or "disordered" to understanding that gender, as a biological fact and as a social construct, can be variable, diverse, and changeable, and existing without the specter of pathology. De-centering the cisgender assumption that normal people remain in the natal sex (cis) and that disordered people change (trans) is at the root of debate regarding gender diagnoses in the *DSM* and the battle for their reform.

I became a social worker 25 years ago to work with what we then called the gay community. I fought and lost the battle as the Chair of the "Gay Issues Committee" of the New York State Chapter of the National Association of Social Workers (NASW) to change the name to the "Lesbian and Gay Issues Committee"; the word lesbian was still foreboden. Although this was over a decade after homosexuality had been removed from the *DSM*, "gay" issues were poorly integrated in my social work education. The only time I heard the word transsexual as a student (the word transgender had not yet been coined) was when a teacher said, "You know that some people want to change sex?! Really!" She leaned into the class and repeated in a loud incredulous whisper for emphasis, "Really!" When I became an adjunct professor (in the same Social Work program in the late 1980s) and I asked my colleagues how they addressed issues of sexual orientation in the curricula, I was met with blank stares. Was there really nothing to say about homosexuality now that it was no longer a diagnosis in the *DSM*? Really?!

However, despite the silence within training institutions, there have been many positive changes for LGB people socially and politically. In the past few decades lesbian and gay people have secured many civil rights. It is worth pondering whether these social changes would have happened if homosexuality had remained in the *DSM*. Do you think we would be seeing these massive social changes, like marriage equality? Throwing off the yoke and stigma of "pathology" allowed not only for the coming out of gay, lesbian, and bisexual people, but also allowed for legal, political, and *clinical* transformations that could never have been granted a "mentally ill" population. How would your psychotherapy practice look different than it currently does, if homosexuality was still a mental disorder? These questions are an important prelude to the discussion of Gender Dysphoria in the *DSM*.

The acronym LGBT has become a moniker, a catch-all expression meant to include a group of people who may not have all that much in common. It has become a practice of mine, whenever I receive new classroom textbooks, to look in the index for the phrase LGBT, and then see what the content reveals. Most of the time what is revealed is general information on lesbian and gay people. The B and T are too often silent. Although I mentioned above that I feel relatively secure that lesbians and gay men are receiving competent care when seeking therapy, I do not pretend to feel that trusting about the clinical treatment received when we toss in the unique issues bisexual people face in either heterosexual or same-sex partnerships (see Scherrer, this issue for an in-depth discussion regarding bisexual individuals). And what about the complex issues transgender, transsexual, and gender non-conforming people experience within the confines of the consulting room?

I began to work with transgender clients and their families in the mid-1980s. I had no training in understanding gender identity, gender expression, gender dysphoria, or the process of transitioning one's sex medically, legally, or psychologically. In my first sessions with a transwoman I will refer to as Krystal the Duchess, I was initially baffled, bringing to the sessions not much more than a compassionate heart, an open-mind, and deeply challenged feminist politic. Krystal arrived in therapy, presenting as a mild-mannered, disheveled and middle aged depressed man named Norman who lived at home with his mother. Norman could have easily been diagnosed with various personality disturbances, severe anxiety, and perhaps a mild psychotic disorder, and indeed would have been if diagnostics were the primary clinical lens I used. Krystal then revealed herself to me, bigger than life, a drag artist who traveled to New York City on the weekends to perform in Greenwich Village; a double-life she had lived

for decades. Krystal disclosed that this was no longer performance, she wanted to fully live as Krystal, but felt stuck, caught between two genders, two different worlds, and saw no way to actualize herself, to become Krystal. Frankly, neither did I.

At the same time, another client was referred to me, a young masculine female named Sam, who had come out as a lesbian when she was still a teenager, and received support from her parents, as well as a gay-affirmative social worker. She confided to me: "I'm not really a lesbian; I'm really a man." I asked her girlfriend what she thought of this statement, and she conferred, "Of course, she's a man. If she's not a man, then I would be a lesbian, and I am definitely not a lesbian!" I thought this was the worst case of internalized homophobia I had ever seen (and I'd seen plenty by then), if not a mutual delusion system. I was clearly in over my gay-affirmative head!

Both Krystal and Mel arrived in my office because they were told I was an "expert," but perhaps the only real expertise I had was realizing how little I really knew about sexuality, sexual orientation, and gender. Being a bibliophile, I spent the next 5 years reading everything there was to read on gender identity, transsexualism, Gender Identity Disorder, and the political analyses emerging from the burgeoning transgender liberation movement. Mix thoroughly, cook on a low heat, and my book *Transgender Emergence: Therapeutic Guidelines for Working with Gender-Variant People and Their Families* was born.

In the years that have followed, I have worked with hundreds of trans people, their partners, their children, and their extended families. I have worked with heterosexual, married men well into mid-life who had been secretly cross-dressing since they were small boys, and had never revealed this to anyone, until they told me, indeed until they *showed* me; I've heard this story more times than I can count. I worked with butch-identified lesbians who wanted to live as men, but their lesbian lovers didn't want to be with men—they wanted the particular masculinity that butch women exude. I have worked with 5-year-old children who were absolutely sure that they were girls, and having a penis did not in any way deter them from their convictions; as they matured, they are still 100 % sure of this. I have worked with many heterosexual couples trying to come to grips with whether to allow their teenagers to start hormone-blockers, giving them time to decide whether to begin puberty as a boy or as a girl. I have worked with young adults who eschew all pronouns, all genders, and call themselves queer with a fierce pride. I worked with a Roman Catholic priest, who lives full-time as a woman now. Transgender people represent an enormous diversity of humanity, crossing all racial, ethnic, class, and cultural populations, all ages, dis/abilities, and religions.

The word transition is used to describe the process of changing gender that Krystal and Sam and so many others since were describing; it is also a word used during the birth of a baby, when the head begins to crown. I have spent the last few decades witnessing this transition, the crowning, the birth, their *re-birth,* if I dare to use such a term. There is much that I have learned in this process, but one thing is perfectly clear, transgender people are more like the rest of us—cisgender people, those who do not challenge the sex binary—than they are like one another. For the most part they are mentally stable—no small task given what they face—and when they are not so stable, they are unstable in the ways the rest of us are: anxious, depressed, and sometimes struggling with deeper mental health issues. But their gender is not disordered (Lev 2005); indeed their gender is quite ordered, just not in conventional ways.

I live in awe of these transformations and the emotional cost of these journeys, but in the mid-1980s I was mostly just infuriated because one thing was blatantly clear reading clinical treatises on trans/gender—the entire field (small enough at the time that I likely read every tome ever written) was built on the exact same pathologizing narrative that had made homosexuality a viable diagnosis for nearly 100 years (Oosterhuis 1997). The story of Gender Identity Disorder, and the new diagnosis of Gender Dysphoria, is a narrative of an oppressed people and their liberation struggle, amid the psychobabble of gender conformity, mental illness, and medicalization of human diversity. Plummer (1981) has said that the "…realization that one was collectively oppressed rather than individually disturbed…" (p. 25) was the realization of gay and lesbian people in the 1960s, a realization that began to dawn on transgender people in the 1990s.

The diagnosis of homosexuality rested on simple heteronormative assumptions about what was "natural," "healthy," "functional," "common" (it is, after all the *Diagnostic and* ***Statistical*** *Manual*). Within the confines of western culture, same-sex love was obviously pathological, outside the expected boundaries of human behavior and experience. Based on those assumptions, psychological theories developed etiologies of "why" someone could be like "that." The answers, based initially in psychoanalytic ideology as well as the behavioral and cognitive theories of gender acquisition that developed later, led to theories of faulty child-rearing and mother-blame: homosexuality in men was caused by over-involved mothers and distant fathers, causing a disturbance in proper gender socialization (see Stoller 1966); (in classic pre-feminist psychoanalytic theory, there was a mostly silence about what caused lesbianism (Kitzinger 1993). Decades later these ideas seem anachronistic, as thousands of lesbian, gay, and bisexual people attest to coming from very different family

structures, most whose configuration does not resemble the suffocating mother/distant father dynamic (see LaSala, this issue for a detailed discussion of this topic). However, my review of the literature revealed that these same etiological theories were resurrected in the late twentieth century to explain transsexualism.

Few therapists today would treat a lesbian or gay client using a lens of causality, nor would they try to assist them in living a heterosexual life (and indeed, if they did so, they would be going against the ethical and moral standards of nearly every professional mental health organization, see Anastas, this issue). However, the field of transgendersim is only recently coming out (literally) from the shroud of etiology. What if gender transitions are a normative part of the diversity of human identity? Research from history, anthropology, and the biological sciences seem to show that non-binary gender identities, gender transformations and transpositions, are ubiquitous across human and non-human communities, throughout history and cross-culturally (see Lev 2004). What if there is nothing disordered, dysfunctional, odd, or unnatural about transgendering? If transgender is not pathological, then what is it that needs to be diagnosed?

Although Homosexuality was officially removed from the *DSM* in 1973, it was replaced in the *DSM-III* with an only somewhat less noxious diagnosis—Ego-Dystonic Homosexuality, which was not removed until 1980. Dystonic refers to the subjective experience of unhappiness and is contrasted with syntonic behavior, or one's comfort with their same-sex desires. The *DSM-III* stated that this diagnosis should only be used when the client had unwanted homosexual feelings and it also stated that "…distress resulting from a conflict between a homosexual and society should not be classified" (APA 1980, p. 282). It soon became clear that living in a homophobic and heterosexist culture left few "happy well-adjusted homosexuals," and given the complexities of internalizing a stigmatized minority status, the diagnosis was determined to be biased, and was removed.[1]

At about the same time that homosexuality was removed from the *DSM*, gender identity diagnoses were included. From a contemporary perspective, this appears confusing, especially when you realize it was the same men who developed the *DSM* diagnosis for gender identity who were the strongest advocates for both the removal of homosexuality from the *DSM* and also the early pioneers working with, and supportive of, transsexuals and their need for medical assistance in transition (see Drescher 2010; Zucker and Spitzer 2005). Why would they want to pathologize gender identity diversity while we were finally liberating homosexuality as a diagnosis? It was thought at the time that the inclusion of a diagnostic category would legitimize transgender identity and would assist in the development of treatment and professional attention for this invisible and vilified population. History has indeed shown some wisdom in this perspective. However, it has also left us 30 years later with a diagnostic category that pathologizes a minority community, and potentially interferes with their pleas for civil rights and acceptance within the human family.

A brief review of this process follows: In the *DSM-III* (APA 1980), two diagnoses were included for the first time, one called Transsexualism, to be used for adults and adolescents, and the second Gender Identity Disorder of Childhood. In *DSM-III-R* (APA 1987), a third diagnosis was added: Gender Identity Disorder of Adolescence and Adulthood, non-transsexual type, which was removed when the *DSM-IV* (APA 1994) was published.[2] Also in the *DSM-IV* the two previous diagnoses were conflated into one, Gender Identity Disorder (GID), with different criteria sets, one for adolescents and adults, and another for children (see pages 537–538). Additionally, the diagnosis of Transvestic Fetishism, a paraphilia, has undergone numerous changes in nomenclature and criteria during the revisions; all were included in the section on Sexual and Gender Identity Disorders.

For the past few years, there has been a fervent movement among both trans-activists and professionals to remove the gender diagnoses from the *DSM*, and in lieu of that, to at least reform them (see Lev et al. 2010; Winters 2008a). However, depathologizing gender identity in the *DSM* mirrors the slow process of change in removing homosexuality, incrementally through many versions of the *DSM*. As Winters (under pseudonym Wilson) noted back in 1997, "American psychiatric perceptions of transgender people are remarkably parallel to those for gay and lesbian people before the declassification of homosexuality as a mental disorder in 1973" (p. 15). Similar to the history of the removal of homosexuality from the *DSM*, some headway has been made in the construction of the *DSM-5*, and improvements are slowly evolving, in gradual stages, of what appears to be a positive direction.

[1] Many are not aware that a residual category for homosexuality remained in the DSM-IV under the category of Sexual Disorders Not Otherwise Specified [NOS]. This category includes three items, the last one was, "Persistent and marked distress about sexual orientation" (DSM-IV-TR. 2000, p. 582); ostensibly this could be used for anyone struggling with sexual orientation, though I suspect it was not often used for heterosexuals struggling with their straightness. This has been removed in the DSM-5.

[2] The phrase "non-transsexual type" referred primarily to male cross-dressers, but in some ways was a foreshadowing of the emergence of diverse gender expressions that might not involve a complete gender transition.

On December 1, 2012, the Board of Trustees for the APA approved the final draft of the *DSM-5,* published in May of 2013. The term Gender Dysphoria has replaced the Gender Identity Disorder diagnosis, and it has also been placed in a distinct chapter in the *DSM-5*. Numerous changes in *DSM-5* diagnostic criteria have toned-down sexist language, shifted the focus away from binary gender categories, and placed the onus of diagnosis on distress and dysphoria rather than gender nonconformity. The diagnosis is intended to be used when there is a marked incongruence between the individual's expressed or experienced gender and that which was assigned to the person at birth. This condition, consistent with other diagnoses, must causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Gender dysphoria is characterized by a strong desire to be treated as the "other" gender or to want to change one's sex characteristics, and a strong conviction that one has feelings that are typical of the "other" gender. These changes represent significant strides forward, both in the form of the changes, as well as the public discourse the process has fueled (discussed below). However, the inclusion of Gender Dysphoria in the *DSM-5—i.e., the inclusion in a diagnostic manual of psychopathology,* ensures that transgender people will continue to be labeled with a mental illness for decades to come. Like Ego-dystonic Homosexuality, Gender Dysphoria represents a battle only half won.

In addition to Gender Dysphoria, there is another diagnosis that addresses issues of gender diversity, which has been the focus of far less attention among professionals and in public forums, but is no less controversial. Transvestic Fetishism was listed as a paraphila in the *DSM-IV*, and the nomenclature has changed in the *DSM-5* to Transvestic Disorder, with the goal of distinguishing between non-pathological cross-dressing behavior and that which causes distress to the person or harm to others (Blanchard 2010). Historically, the diagnosis only included heterosexual men, surely an arbitrary and judgmental perspective, though it is unclear how expanding this to include other groups is a step forward. It is frankly questionable how crossdressing behavior can *ever* be "harmful," and surely it cannot be harmful to others! The diagnosis is primarily reflective of the work of Ray Blanchard, who was chair of the sub-committee on Paraphilias, and since his research has been viewed negatively by trans-activists for decades, the inclusion of this diagnosis is quite controversial (Winters 2008b).

We cannot minimize the power of diagnoses in the civil rights struggles of sexual and gender minorities. Richard Green (2004) has jested that, "On that fateful day in 1973 [when homosexuality was removed from the *DSM*], in America alone, several million mentally ill persons were cured." (p. 327). The conceptual trajectory from mental illness to human diversity is not a simple straight line (no pun intended); however, it is undeniable that diagnostic categories impact the social opinions of people with little knowledge or investment of the inner workings of psychological institutions that determine and define pathologies. As each of the changes have unfolded through various editions of the *DSM* (inclusion, revision, removal) for sexual and gender identity "disorders," these changes were incorporated in the years that followed by the World Health Organization and the International Classification of Diseases. Laura Brown (1994) has said, "The decision to call a cluster of behaviors a mental illness is responsive to many factors that have nothing to do with science but a great deal to do with the feelings, experiences, and epistemologies of those in power and dominance in mental health disciplines" (p. 135). I would add that the consequences of those acts impact the feelings, experiences, and epistemologies of average people, many of whom do not know the meaning of the word epistemologies.

The *DSM-5* has been under serious scrutiny on numerous issues from many sources, receiving much professional and public criticism. Allen Frances, who was chair of the DSM-IV Task Force, has been outspoken about many potential problems with the *DSM-5,* including criticism of the field trials, and objection to many new controversial diagnoses (see Francis 2013). Additionally, the Society for Humanistic Psychology (Division 32 of the American Psychological Association) disseminated an Open Letter to the *DSM-5 Task Force* stating criticisms about the lack of involvement of psychologists in the development of the *DSM*, a lowering of the threshold of many disorders, and the de-emphasis of sociocultural phenomena while highlighting theories of biological etiology, among other issues (Society for Humanistic Psychology 2011). This petition was signed by over 15,000 people including many other Divisions of the American Psychological Association, numerous international professional organizations and academic institutions. Notably NASW posted the petition on their website, but did not sign it, despite the fact that the petition speaks to many concerns familiar to social workers (i.e., the lack of involvement of social workers in the *DSM* development process, and the downplaying of the impact of the social environment on diagnostic processes, and the close relationship between the pharmaceutical industry and the APA) (Littrell and Lacasse 2012).

The workgroups for Sexual and Gender Identity Disorders have been under fire since they were first convened in 2008. The appointments of Drs. Kenneth Zucker and Raymond Blanchard of the Toronto Centre for Addiction and Mental Illness (CAMH) became the focus of a public outcry, and a petition requesting their removal from the *DSM* committees (see: http://www.thepetitionsite.com/2/

objection-to-dsm-v-committee-members-on-gender-identity-disorders). Zucker was chair of the Sexual and Gender Identity Disorders Work Group, and Blanchard was chair of the sub-committee on Paraphilias; both were also key authors in the *DSM-IV*. They are also both productive researchers and prolific writers whose ideas about transgender identity have been viewed with disdain for nearly two decades by those advocating de-pathologization of transgender people (see Lev 2004). These controversies are complex and nuanced, and can only be briefly stated here. Zucker has spent much of his career crafting clinical treatments that encourage gender-nonconforming young children to acclimate to their birth gender, which has been referred to by transgender community activists as "gender-reparative therapies," an accusation that Zucker denies with the backing of the American Psychiatric Association (APA 2008; Lostracco 2008; National Gay and Lesbian Task Force 2012). Blanchard has developed a construct mentioned earlier, called autogynephilia, which defines male-to-female transsexuals who are not exclusively attracted toward men as having a paraphilia defined by their sexual desire to be a woman (Blanchard 2010). Many transwomen find Blanchard's theories insulting, and his insistence that these are evidence-based scientific truths, has only further enraged both the professional and activist communities (Moser 2010; Wyndzen 2003). Zucker's treatments have been blamed for promoting "child abuse" (Burke 1996), and Blanchard has been scorned for "sexualizing" transwomen's desire for actualization (Winters 2008b). Sorting through the complexities of the social meaning and use of research, the power of data in the definition of identity development, and the political position of academics to develop nosologies that reflect the work of their own careers are larger topics than can be addressed in this essay.

However, what must be noted here is that numerous lay and professional groups spoke out publicly about these issues. For example, more than 7,000 people have signed an online petition, sponsored by the International Foundation for Gender Education (IFGE), calling for the removal of transvestic fetishism (see petition here: http://dsm.ifge.org/petition/). Additionally, *Professionals Concerned about Gender Diagnoses in the DSM,* an ad-hoc group of international professionals, expressed concern about the lack of diversity in clinical perspectives represented within the membership of these workgroups, especially gender specialists who are affirming of gender diversity and transgender people (Disclosure Statement #1: I am a founding member of this group). We made recommendations of potential additions to the workgroups and also made extensive feedback regarding the proposed diagnoses.

While these battles have raged there have been numerous other professional changes in regarding the clinical treatment of transgender people. In 2008, the American Medical Association passed a resolution for removing barriers to care for transgender people and stated support for public and private health insurance coverage for treatment of gender related concerns. The American Psychological Association released a transgender, gender identity, and gender expression non-discrimination statement in 2009, and in the same year NASW affirmed their transgender and gender identity issues statement. In 2012 the APA itself released a public policy statement affirming the medical necessity of hormonal and/or surgical transition care for transgender people as well as calling for civil rights protections and an end to gender-specific discrimination.

The World Professional Association for Transgender Health (WPATH), which is the leading international multidisciplinary organization promoting evidence-based clinical treatment, education, research, and advocacy for transgender people, released a statement in 2008 asserting that sex reassignment treatment is a *medical necessity* for treating people gender identity issues. In 2010, they issued a statement urging the de-psychopathologisation of gender variance worldwide. These public policy statements from the leading professional organizations are important to set policy and direction for clinical care, but it is the guidance set up by WPATH's Standards of Care (SOC) that is most essential for determining best practices (Disclosure Statement #2: I am a member of the Standards of Care Committee). The SOC state:

> Thus, transsexual, transgender, and gender-nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments (Coleman et al. 2011, p. 169).

The above statement, judiciously written, expresses the complexity and diversity of viewpoints, and the struggles with consensus regarding diagnosis and access to treatment within WPATH and among professional experts committed to transgender care. As Ehrbar (2010) said, "Addressing this lack of consensus was the first issue the WPATH Consensus Statement work groups faced" (p. 60). There are areas of agreement among professionals as well as areas of divergence regarding maintaining gender diagnoses in the *DSM*, and concerns about access to care if it were removed (DeCuypere et al. 2010; Ehrbar et al. 2009). Numerous papers were written by workgroups within WPATH responding to specific issues for children, adolescents, and adults examining potential problems with the gender identity disorders and the proposals for revision in the *DSM-5*. (Although space does not allow for a thorough

extrapolation of these issues, the papers are published in the *International Journal of Transgenderism—see* www.wpath.org).

Because trans people suffer bias, prejudice, and are denied basic civil justice because of stereotypes that are reinforced by labels of mental illness (Winter 2008a), most professionals support actions that depathologize and limit stigma associated with being gender nonconforming or transgender (DeCuypere et al. 2010). Additionally, most professionals agree that trans people should have access to medical and therapeutic care, which should be reimbursed by insurance companies, and that all discrimination against trans people in employment, housing, civil law, and in access to health care should end (Ehrbar et al. 2009; Lev et al. 2010). The writers of the *DSM-5* are themselves aware of this dilemma and state that they aim "to avoid stigma and ensure clinical care for individuals who see and feel themselves to be a different gender than their assigned gender" and that "gender nonconformity is not in itself a mental disorder" (APA 2013).

The question that everyone grapples with is whether one can best achieve these aims by maintaining a *DSM* diagnosis, or conversely whether one can best achieve these same aims by removing the diagnosis, that is, does the diagnosis cause and/or increase stigma, or does it facilitate access to health care? Perhaps what is most interesting in reviewing all the ideas published by gender specialists is that people came to completely different conclusions for the same reasons. More specifically, some people thought retaining the diagnosis would facilitate better medical care, and others thought it would weaken access to care; some thought it would decrease stigma to remove the diagnosis and others thought it would increase stigma (Ehrbar et al. 2009; Ehrbar 2010). In the end, the decision by the *DSM* Committee was to retain the diagnosis.

I have always taken a definitive position that removal of the diagnosis would be the best way to depathologize transgender people. Trans people deserve access to medical care, not because they are mentally ill and fit the criteria within a diagnostic manual, but rather precisely because they are sane and actualizing their authentic gender is their civil right. Having said that, I think that the change in nomenclature from the *DSM-IV* to the *DSM-5* is a step forward, that is, removing the concept of gender as the site of the disorder and placing the focus on issues of distress and dysphoria. The placement of the gender dysphoria diagnosis within its own section in the *DSM-5* helps to separate it from sexual dysfunctions and paraphilias. The new nomenclature is significantly less sexist, somewhat less cisgenderist, and helps to distinguish between gender nonconformity and gender dysphoria. Lastly, the new criterion assists in recognizing the existence of a broad array of gender identities and expressions, and attempts to step out of the linguistic limitations of binary gender categories. It will assist in providing medically necessary services for transgender people in the decades to come.

Conceptually I understand the fear that if gender diagnoses are removed from the *DSM* in future editions that insurance might not pay for treatment. However, increasing numbers of insurance companies have begun to cover transgender care for a number of clients in my practice. I am relatively sure that insurance companies do not cover hormones and surgery because I, a mental health professional, gave the client a mental health diagnosis; they cover the services because a physician to whom I referred the client gave the client a medical (*ICD*) diagnosis. All medications are prescribed because medical doctors and surgeons utilize medical diagnosis, not mental health diagnoses, for medical and surgical procedures. There is, however, a precedent for the provision of reimbursing medical care without any pathology, specifically, pregnancy; again an appropriate metaphor for the transition rebirthing process (Lev 2005).

Surely the *DSM-5* Sex and Gender Workgroup can be criticized about their politics, professional biases, and the lack of professional diversity of the committee itself, but given the task before them, the climate of hostility in which they worked, in the end I think they did a good job creating a diagnosis, though I will continue to affirm that none was necessary. In defense of the APA, the field trials[3] attempted to gather detailed demographic information to inform their research on transgender participants asking: "Sex/Gender (check all that apply)" with the options being, "Male/Female/Intersex/Transgender (Male to Female)/Transgender (Female to Male)/" (Disclosure Statement #3: I was part of the field trials for the *DSM-5*.) It is unfortunate that, after months of preparation, the APA halted their field studies barely a few weeks into the process. Although 5,000 clinicians signed up to participate and 195 completed the extensive training, only 70 enrolled any patients in trials (Greenberg 2013). My personal experience was feeling barely prepared, with an unrealistic time frame to complete an extensive field process. The APA had a goal of 10,000 participants in the field study; in the end, they only had 150, 2 of whom were mine.

The APA offered two periods of public feedback, inviting opinion and criticism, and although gender issues were only one area under review, they served as a lightening-rod for comment. Ken Zucker jokingly referred to this as the "*DSM-5* Olympics," and noted that the Sex and Gender Disorders Work group received a "bronze medal" for being the third largest category to receive input

[3] The DSM-5 Field Trials were designed to assess the feasibility, clinical utility, and reliability of the diagnostic criteria by testing it in clinical populations, including mental health clinics, general psychiatry clinics, general medical clinics and solo and small group practices.

(personal communication, February 27, 2010). I think, all things considered, the Sexual and Gender Identity Disorders Work Group and sub-committees listened to the massive influx of opinion from trans people who live with the consequences of this diagnosis, and the professionals in WPATH who worked so hard at coming to consensus on such challenging issues. I think they developed a diagnosis that identifies what should be the crux of all useful mental health diagnoses—human distress—and managed to discuss the issue of gender dysphoria in a relatively non-pathologizing, broadly inclusive manner. Although I still wish for ultimate removal—and remain convinced if live long enough I will see that come to be—the gender dysphoria diagnosis in the *DSM-5* is an improvement over the *DSM-IV* diagnostic category of Gender Identity Disorder, and the extensive public discourse has moved the agenda forward.

It will be a while before the T catches up with the LGB communities, but increasing numbers of people think that transgender people should have access to civil liberties and the medical services they require to live authentic lives. The simple binaries we have all been born to believe in based in male/female dichotomies, a world where opposites naturally attract, is slowly transforming into a complex world of multiple and queer ways of expressing gender and sexuality. How will this impact our clinical work? I encourage everyone to practice your therapy as if there was no *DSM-5* diagnosis for Gender Dysphoria, and at the same time I caution you to be very conscious of the reality of gender dysphoria. Krystal the Duchess and Sam had to forge a way into a new life that had no name 20 years ago. I did the best I could to help them. Clients in your office tomorrow will need to do the same. No diagnoses will ever capture the great diversity of gender expressions and identities available to humanity, and the distress some will experience transitioning will always require the midwife's loving hands.

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