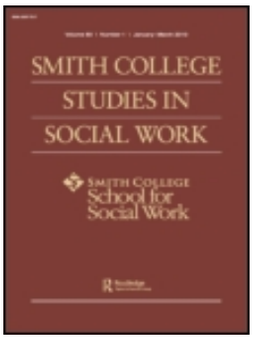

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Erin R. Markman

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Gender Identity Disorder, the Gender Binary, and Transgender Oppression: Implications for Ethical Social Work

ERIN R. MARKMAN
Hunter College School of Social Work, New York, New York, USA

This article argues that social workers are ethically obligated to serve as allies of transgender and gender-nonconforming communities and, thus, should critically examine the diagnosis of gender identity disorder and the oppression inherent in pathologizing gender nonconformity. Social workers should also consider the oppression inherent in the socially constructed gender binary that is the root of the perceived psychosis in gender nonconformance and should fight against this oppression and, therefore, against that binary. This article proposes several action steps that social workers can take to advocate for the transgender and gender-nonconforming communities.

KEYWORDS transgender, gender identity, oppression, social work, ethics, diagnostic and statistical manual of mental disorders

INTRODUCTION AND THE AUTHOR'S RELATIONSHIP TO THE COMMUNITY

In this article I intend to display that social workers, as ethically obligated allies of transgender and gender-nonconforming individuals, should be aware of and active in the discussion around the inclusion of gender identity disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*) (American Psychiatric Association [APA], 1994) and the proposed inclusion of gender incongruence in the *DSM-V* (APA, 2010b). It is the ethical responsibility of social workers to explore and advocate for the

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Address correspondence to Erin R. Markman, 81 8th Avenue, #6, Brooklyn, NY 11215, USA. E-mail: Markman.Erin@gmail.com

possibility of eliminating such psychiatric diagnoses in favor of a nonpsychiatric medical diagnosis in the *International Statistical Classification of Diseases and Related Health Problems* (World Health Organization, 2007) that would allow transgender and gender-nonconforming individuals access to health care and medical procedures without labeling their identity as pathological, as does the psychiatric diagnosis. Social workers should also consider the oppression inherent in the socially constructed male/female gender binary and should fight against this oppression, and therefore against that binary (Burdge, 2007). I propose several action steps that social workers can take to advocate for the transgender and gender nonconforming communities.

Those most directly affected by the diagnosis of gender identity disorder (GID)—transgender and gender-nonconforming individuals—are the experts in their own experience. I take guidance from materials generated by community members, and by individuals who seem to me, from their research and practice history, to be respectful, accountable allies. I hope to add to the literature with an ally's eye—listening, learning, and challenging internalized transphobia.

I identify as a cisgender woman—*cisgender* being a relatively newly coined term that derives from the Latin *cis* for "on the same side as"; that is, my gender identity is on the same side as the sex I was assigned at birth. Using the term *cisgender* is a way of distinguishing people who do not identify themselves as transgender without the implications of normalcy and determinism that come from terms like "biological woman" or the power implied in assuming that when one says simply "woman" that one means a nontransgender woman (Stryker, 2008). The gender binary affects all people, as all people have gender identities shaped and constrained by social constructs. It is also important to note that as a white[2] and economically privileged person, who is citing from a largely white body of academic literature, and maintaining a particular focus on the medical establishment, which takes economic resources to access, I do not sufficiently address issues of racism and classism in body of this article. Readers are directed to the final section of Stryker and Whittle's (2006) compilation for several pieces addressing racism in the discourse around transgender identity, as well as to organizations such as the Audre Lorde Project and the Sylvia Rivera Law Project, which are explicit and intentional in highlighting the marginalization of low income individuals and people of color.

AN ETHICAL OBLIGATION

Issues of transgender oppression—in general and as they relate to GID—should be of paramount concern to social workers, not only because social workers are involved with the diagnoses and treatment of individuals, but also because social workers are governed by a set of ethical guidelines that

draw attention to transgender oppression. Social workers, as stipulated in the National Association for Social Workers (NASW; 2008) *Code of Ethics*, "should obtain education about and seek to understand the nature of social diversity and oppression with respect to ... gender identity or expression" ("Cultural Competence," para. 3), should not "practice, condone, facilitate, or collaborate with any form of discrimination on the basis of ... gender identity or expression" ("Discrimination," para. 1), and should "act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis" thereof ("Social and Political Action," para. 4).

Social workers who engage clients' personal lives and the communities in which they live are thus ethically obligated and uniquely situated to become educated about and work to eliminate issues of oppression faced by the transgender and gender-nonconforming communities (Burdge, 2007; Burgess, 2009).

TERMINOLOGY

I will borrow from Zandvliet (2000) to define *gender* "as the sum of a person's non-physical and non-biological characteristics that determine their sense of being male, female or neither or any combination" (p. 181). Gender is an identity that exists separate from the constraints of physical sex characteristics and the dictates of a binary that our society has imposed (Nagoshi & Burzuzy, 2010).

The term *transgender* is a broad category (Elliot, 2001; Meyerowitz, 2002). In this article it will serve (unless being quoted by someone who sees fit to use it otherwise) as a broad umbrella term that includes the behaviors but rejects the pathological implications in the terminology of terms such as transvestism (dressing like a gender other than the one that person was ascribed at birth, for any number of reasons), transsexualism (having the desire to alter physical sex characteristics to change one's gender) (Stryker, 2008), and any other presentation seen as gender-nonconformance by a society that operates with an untenable binary that does not make space for the lived experience of gender. Note that a political use of language occurs above. *Transsexual* is a medical term. Representatives of the transgender community have reclaimed and altered it to read *transexual* as a sign of ownership and affirmation (Davis, 2009; Meyerowitz, 2002). The double *s* is used here because reference is made to a diagnostic category created using potentially oppressive language.

The use of *transgender* is not intended to label any particular individual before that individual has the opportunity to self-identify. The term *transgender* is intended to be mutable and broad and must ultimately be chosen and owned by those to whom it applies. If a gender-nonconforming individual chooses to identify as transgender, then that individual is. If that individual chooses instead to identify as genderqueer, two spirit, queer, aggressive (AG), or anything else, then that is that individual's proper

referent. One may use multiple identity terms, and identities may shift over time. I use the phrase *transgender and gender-nonconforming communities* in this article to emphasize that, though the term *transgender* is intended to be inclusive, there is a multiplicity of identities that should not be neglected.

There is a tendency in the literature (see, e.g., Pleak, 2009) to include highly charged and potentially vicious words like "tranny" in the umbrella of transgender without reference to these words' historical and present-day meanings and politics. I do not include such a list, as these terms are defamatory ones reclaimed by certain community members who have the right to use them if they choose. My privilege as an out-group member infuses them with violence. There is no desire to erase these labels and the communities they represent, but the language has little utility here. Davis (2009) has an extensive list of self-ascribed labels from gender-nonconforming communities that can be referenced as necessary.

I view transgender and gender-nonconforming identities as normal and valid. Transgender identity is a point in a constellation of lived gender identities—like my cisgender identity. The socially constructed male/female binary that is strictly imposed in this society simply fails to reflect that.

THE GENDER BINARY

The pervasive concept of male/female binary gender governs our lived experiences. As DeCrescenzo and Mallon (2000) articulated, "[s]trict boundaries have historically regulated gender in Western society, therefore, when one is defined by traditional theories and environmental expectations, no acceptable ways are currently available to achieve full status as a person who identifies as transgender" (p. viii). A binary sex and gender system, with concrete male/female dualities and no fluidity, is simply not a coherent way to make sense of the lived identity experiences that actually exist in the world (Bockting, 2008).

Positing the gender binary as oppressive does not mean that all people who identify as transgender reject that binary. Certainly not all transgender individuals share precisely the same idea of gender and gender fluidity (Nagoshi & Burzuzy, 2010). Nor, as Elliot (2001) stated, is "gender irrelevant or dispensable for transsexuals" just because they were failed by "gender norms" (p. 309). And the truth of sexism that arises from the binary is not to be dismissed by the assertion that gender is a social construction. But the fact that the societal definition of *gender* as binary leaves no space for transgender experience to be considered normal and does not reflect the lived experience of gender within society is problematic and oppressive. The result of the strict enforcement of the binary is that the individual who feels gender nonconforming and thus generates friction against the construct of gender is the one who is pathologized, instead of the critique being focused on the idea of gender in its current pervasive conception as being overly

rigid. Too often the locus of the problem is seen as situated within the individual who does not conform to societal expectations, rather than with the societal expectations themselves.

Social workers can actively pursue theoretical modalities that facilitate a challenge of the gender binary. Nagoshi and Burzuzy (2010), for example, advanced a transgender theory that subverts the binary. Spade (2006) applied Foucalt's theories of power to the medical model and the binary. Malpas (2006) identified that a deconstructive theoretical approach to gender allows clinicians to view gender as socially constructed and relationally defined, and to move beyond binary thinking to best serve clients, while still meeting clients wherever they are in their conceptions of gender.

The idea of eradicating, subverting, or progressing beyond binary gender is a contentious and idealistic goal. I hold it as an ultimate desired future. A world in which many genders are recognized as healthy—without the male/female—would be a world in which everyone's gender, no matter how they choose to perform it, and no matter their genitals, would be accepted as part of the human experience.

HISTORICAL FOUNDATIONS OF GENDER IDENTITY DISORDER: A BRIEF HISTORY

Medical and mental health sciences have long been the loci of labeling, classifying, and regulating the lives of transgender and gender-nonconforming people. Some transgender and gender-nonconforming people feel it necessary to have medical intervention (hormone therapy and/or surgeries) to actualize their gender appropriately. In the early and mid-1900s, much of the discourse on issues of gender identity was new to those in the medical profession, and access to surgical options for reconstructing or reconfiguring gender was limited (Meyerowitz, 2002; Stryker, 2008). At the beginning of the 1970s, after an extended period of often-heated debate over issues of gender identity, the medical community began to use the terminology of *gender dysphoria syndrome* (which soon become *gender identity disorder*) as an umbrella term that was then lauded by advocates as a step that liberalized rigid diagnostic categories that stood in the way of gender-modifying operations for transgender and gender-nonconforming individuals (Meyerowitz, 2002).

However progressive these steps, the oppression of transgender and gender-nonconforming individuals and the adamant adherence to a gender binary prevailed. The pursuit of medical treatment by those transgender and gender-nonconforming individuals who felt they needed medical intervention "became entangled with a socially conservative attempt to maintain traditional gender, in which changing sex was grudgingly permitted for the few of those seeking to do so, to the extent that the practice did not trouble the gender binary for the many" (Stryker, 2008, p. 94). There was

evident discrimination by the medical establishment against those (among the subset who sought medical intervention) whose desired presentation presented a challenge to the binary, and a preference for those who were more "repressed and depressed" (Meyerowitz, 2002, p.197) and conformed more strictly to gender norms. Perhaps to preserve the viability of their practices in the public eye, and almost certainly because of personal biases, many "doctors rejected candidates who would not conform after surgery to the dominant conventions of gender and sexuality" (Meyerowitz, 2002, p.225). This is the foundational history from which present-day diagnosis and treatment has arisen, a history essential to consider because, though there are reforms, mental health science builds on itself, and the inequities of its legacy influence its present-day iterations (Cosgrove, 2005; Reich, Pinkard, & Davidson, 2008). Despite the activism of transgender and gender-nonconforming individuals and the compassion of some medical and psychiatric professionals, discrimination, oppression, and an unrealistic gender binary have prevailed.

In 1980, the American Psychiatric Association included transsexualism and gender identity disorder of childhood in *DSM-III-R* (APA, 1980; Meyerowitz, 2002). It was not until publication of the *DSM-IV* that the diagnosis GID as applied to adults was codified (APA, 1994).

It is important to note that GID was added to the *DSM* the same year that homosexuality was removed, and some believe it may have been intended as, and is currently in use as, a diagnosis in children that functions to predict and attempt to prevent homosexuality (Lev, 2004; Mallon & DeCrescenzo, 2009). The authors of the *DSM-IV* (APA, 1994) still include language to indicate that "about three-quarters of boys who had a childhood history of Gender Identity Disorder report a homosexual or bisexual orientation, but without concurrent Gender Identity Disorder" (p. 536). There is concern that this information is being used as predictive indicator by those who want to "cure" homosexuality, and the use of the literature by groups like the National Association for Research and Therapy of Homosexuality (NARTH) (York, 2008) that promotes so-called treatment to help people get rid of unwanted homosexuality is a disturbing corroboration of these fears.

GENDER IDENTITY DISORDER: REIFYING THE GENDER BINARY AND ATTRIBUTING THE EFFECTS OF A SOCIETAL PROBLEM TO THE PERCEIVED PATHOLOGY OF AN INDIVIDUAL

The World Professional Association for Transgender Health, formerly known as the Harry Benjamin International Gender Dysphoria Association, has, since 1979 published a set of clinical guidelines for use by medical practitioners treating transgender individuals (World Professional Association for Transgender Health, 2011, para. 1). The Harry Benjamin Standards of Care,

as these guidelines are called, are widely utilized by medical professionals when considering treatment of transgender individuals (Bockting, 2008). These standards, and a legacy of professional tradition, dictate that people who wish to have access to medical treatment to modify their gender (hormone therapy, reconstructive surgeries, etc.) must have a diagnosis of GID (Meyer et al., 2001).

As a result of the wide acceptance of these standards, transgender and gender-nonconforming people wishing to access gender-specific medical procedures must pursue the GID diagnosis—which reifies the idea that the dissonance between the gender performance of an individual and the expectations of society are the result of a psychological problem within the individual rather than a societal problem with defining gender.

Currently, to be diagnosed with GID a person must exhibit "[a] strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex)" and "[p]ersistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex," and must also experience "clinically significant distress or impairment in social, occupational, or other important areas of functioning," all without having "a physical intersex condition"(APA, 1994, pp. 537–538).[1] The required "persistent discomfort" for adolescents and adults "is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics . . . or the belief that he or she was born the wrong sex" (APA, 1994, p. 538).

The authors of the *DSM-IV* (APA, 1994) clearly stated that "[n]either deviant behavior (e.g. political, religious, or sexual) *nor conflicts between the individual and society* are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual" (p. xxii, italics added). Yet in the GID definition, what is diagnosed as GID is a conflict between the identity of an individual and the views of a society for which, counter to the philosophy of the *DSM-IV*'s authors, the individual is held pathologically responsible.

The diagnosis is mandated social conformity to a structure of gender that is artificial and improperly reflective of actual lived gender experience. DeCrescenzo and Mallon (2000) put it well in their discussion of transgender youth: "[t]he biological and psychological distress of transgender youth are often symptomatic of pressures created from the macro and mezzo social systems surrounding these young people" (p. 8). It is not their identity that is causing these children pain, it is their identity in a culture of oppression, fear, and misinformation.

The impairment in social, occupational, and other areas of life experienced by those diagnosed with GID is indeed problematic, but it is due largely to the fact that those realms of life are often intolerant and hostile to transgender and gender-nonconforming people. Pervasive discrimination and acts of emotional and physical violence are perpetrated

against the transgender and gender-nonconforming communities—ranging from demonstrably discriminatory hiring practices at stores (Pearson, 2010), to, tragically often, physical assault and murder (Smith, 2010**)**. The fact that transgender individuals may experience a range of negative psychosocial consequences resultant from those forces is not the fault of some individual pathology. These are problems generated by the society and the failure of the gender binary, not by gender-nonconforming individuals. The distress experienced by transgender and gender variant people is a result of societal ignorance, prejudice, and bigotry, and not of an individual pathology. As Lev (2005) said,

> [i]t is worth noting that in other areas where children are routinely bullied, for example racial or ethnic discrimination and physical or mental disabilities, the focus of intervention has been policy directed toward changing the social conditions that maintain abuse, not changing children to better fit in to oppressive circumstances. (p. 49)

What is needed is not an individual intervention, but a social one.

GENDER LABELS IN THE *DSM-IV*

In addition to the problems inherent in the diagnosis itself, there is also a troubling and persistent misuse of gender labels in the *DSM-IV* (APA, 1994). In the *DSM-IV* (APA, 1994) individuals are consistently referred to by the gender label they were assigned at birth, despite the fact that this is, given they are transgender, likely not the label they would select for themselves. The text refers to "males" who undergo electrolysis and hormone treatment and "cross-dressing" as part of "passing convincingly as the other sex" (p. 533). There is no mention made in the text of the fact that a person who has gone to such lengths to pass as a woman would almost certainly not choose to be identified as "male." Operating under the ethical principle of respect for "the inherent dignity and worth of the person" outlined in the NASW *Code of Ethics* (NASW, 2002) and the APA ethical principle of providing "competent medical care with compassion and respect for human dignity and rights" (APA, 2009, p. 3), it is reasonable to assert that an individual must be referred to by his or her pronoun of choice. That is, if a person tells you he uses the pronoun "he" then that is the proper pronoun to use, regardless of what you know about his genital composition at birth. Improper gender labels and pronoun use can also be seen in the literature. See for example Pleak (2009) who used "he" to refer to a female-identified client in transition. Labeling theory and stigma theory (Yang et al., 2007) point toward the fact that the misuse of pronouns is not only disrespectful, reinforcing of pathology, and confusing, but can likely cause actual

psychosocial damage to individuals. Unfortunately the APA, which publishes the *DSM*, has a code of ethics which does not explicitly protect individuals from exclusion, segregation, or demeaning treatment on the basis of gender identity (APA, 2009). Patients are explicitly protected from this type of discrimination based on "ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation" (APA, 2009, p. 3). The APA should revise the language of this document.

THE *DSM-V*

The proposed revision in terminology from GID in the *DSM-IV* to gender incongruence (GI) in the *DSM-V*, the authors profess, is an attempt to adopt a "term that better reflects the core of the problem: an incongruence between, on the one hand, what identity one experiences and/or expresses and, on the other hand, how one is expected to live based on one's assigned gender (usually at birth)" (APA, 2010b, 'Rationale' endnote 1). This seems an apt description of the problem at hand: that gender as it is currently defined does not reflect gender as it is actually experienced. However, the substance of the diagnosis remains largely the same as in the *DSM-IV*. The new diagnosis still locates the source of dissonance between the experiences of transgender people and the expectations of society as within the individual and as the result of pathology.

The chair and psychologist in chief of the working group assembled to handle sexual and gender identity disorders for the *DSM-V* is Kenneth Zucker (APA, 2010a) who is a well-established voice in the literature, and a voice that neither affirms transgender and gender-variant identities nor challenges the gender binary (Zucker, 1999). Zucker has defended in print the initial GID diagnoses (Zucker, 1999) despite objections from the community that they were pathologizing a nondisordered state of being. Zucker advocates for so-called restorative therapy in which the intended goal is for a child not to transition (National Public Radio [NPR], 2008). In a 2008 interview on NPR, Zucker was critical of therapeutic practices that support early transitions in children and spoke of children's thoughts about transition as "a 'fantasy solution,' that being the other sex will make them happy." That Zucker is the chair of the group evaluating GI for the *DSM-V* seems illustrative of the fact that little of substance has changed in the organization's approach to transgender identity.

Options, Obligations, and Precedent for Change

The *DSM* is a mutable document. Organized populations of people such as women and the gay community have successfully organized and pressured

the psychiatric establishment to revise or remove diagnoses that stigmatized and oppressed them (Lev, 2005; Stryker, 2008). Transgender and gender-nonconforming communities have a long legacy of successful self- advocacy and organizing (Stryker, 2008). The sad fact that the double bind of diagnosis means that transgender individuals must have some kind of diagnosis to access appropriate health care, but don't want one that pathologizes them, is a difficult, but by no means insurmountable burden to successful organizing.

One potential action step is to entirely remove the diagnosis from the *DSM* and to instead rely on an amended version of the diagnosis of transsexualism already present in the *International Statistical Classification of Diseases and Related Health Problems* (World Health Organization, 2007) to demonstrate that transgender individuals who require and desire treatment are entitled to it based on a medical (Axis III) condition (Lev, 2005). The diagnosis in the *ICD* has its own set of problems, but removing the patholigization of a psychiatric diagnosis would be powerful. Any mental health issues that the person might experience can then be recorded as such, without undo reference to gender identity, as Axis I or II diagnosis. Depathologizing the identity and treating any actual mental illnesses as they arise (either as a result of oppression and discrimination, or for other reasons) is a viable, achievable, and justice-oriented action step. But it is only a step. The depatholigization of transgender and gender-nonconforming individuals by removal of diagnoses from the *DSM-V* is not sufficient to address gender binary bias and transphobia in the social work and psychiatric communities. There are many advocacy groups active in the fight against oppression of transgender and gender-nonconforming people. I intend to support and augment, and not to occlude, the voices of those within the community who have successfully, consistently, and persistently organized to advocate for the systemic and societal changes they feel they need and deserve. Groups such as the GLOBE project of Make the Road New York, The Transgender Law and Policy Institute, FTM International, The Intersex Society of North America, The International Foundation for Gender Education, and many more.

Social workers, given their ethical obligation to become allies to the transgender and gender-nonconforming communities, should utilize the feedback processes in place to communicate to the authors and committees of the *DSM-V* regarding transgender oppression. Individuals can register on the *DSM-V* website (www.dsm5.org) to send feedback about proposed diagnostic revisions. In addition to continued attention to the *DSM-V* diagnosis, social workers can take responsibility in their professional roles for advancing the rights of these groups who they are ethically obligated to defend.

Social workers can advocate for immediate change in their agencies in the following areas (in no particular order):

- Encourage education about and dialogue around gender identity within agencies and schools. Sharing literature, community-vetted websites, or inviting transgender sensitivity trainers to an agency can be a valuable way to start a dialogue and promote competent, respectful practice (Forshee, 2007).
- Amend agency intake forms, charts, and other material to reflect a gender continuum. The common practice of requiring staff and clients to check a box for "male" or for "female" reinforces the gender binary and ignores transgender and gender nonconforming identities (Davis, 2009). Leaving a blank space for clients to fill in their own gender is an easy and empowering solution.
- Encourage and institutionalize the practice of asking for preferred gender pronouns, and the use of modeling by practitioners to provide safety and affirmation around this practice ("My name is Erin. My preferred gender pronouns are 'she' and 'her' and I also use 'they'"). This allows people to self-identify and reminds all of us that our pronouns are socially constructed and ascribed. Gender-neutral pronouns like "they" used in the singular, "hir," "sie," and "zhe" can be used by those who do not feel "him" or "her" fit them well.
- Change agency bathrooms as necessary to be gender neutral. Male/female-gendered bathrooms can be a source of discomfort, confusion, and violence for transgender and gender-nonconforming individuals. Creating gender neutral or "all-gender" bathrooms cultivates safety for all people, regardless of their gender identity. If there are concerns in the agency, covering or blocking off the urinals and asking all people to use only stalls is a way to increase comfort. Put a sign on the bathroom door saying why gender neutrality and a safe space are important. Ideally, have one or more multistall all gender bathrooms and one or more single-stall bathrooms with locking doors to ensure that everyone can choose a situation in which they feel safe.
- Revise agency and organizational codes of ethics (including that of the APA) to include gender orientation and identity in all sections about protection against discrimination (DeCrescenzo & Mallon, 2000).
- Enforce social work ethics and challenge the gender binary. Use a deconstructive approach (Malpas, 2006) to view gender as socially constructed, relational, and fluid and as an identity we should examine in ourselves, as clinicians, to best serve our clients. Promote the idea (as articulated by Burdge, 2007) that it is ethically incumbent on social workers to deconstruct and challenge the gender binary.

Simultaneous to the fight for the removal of GID and GI from the *DSM-V*, and the implementation of basic transfriendly policies, there is an overarching and ultimate need for a revision of the idea of gender. As Zandvliet (2000) put it, a concept of "queer" that includes a broad range

of genders and sexual orientations paves the way for "a creative validation of ambiguity" (p. 179). Embracing ambiguity in this way would enable social workers and other helping professionals to treat their clients with greater respect and would fulfill their ethical obligation to find and fight oppression. Ultimately, it is ethically incumbent on social workers to deconstruct and challenge the gender binary (Burdge, 2007). The ultimate goal should be a revised concept of gender itself.

NOTES

1. There is much beyond the scope of this article to be said about the historical and modern-day fight of the intersex community. Chase (1998) offers an excellent overview of issues such as the pervasive practice of operating on the genitals of infants to ascribe a socially acceptable gender.

2. The lowercase 'w' is used here, as recommended by McIntyre (2008), to challenge historically constructed beliefs about control and power and a legacy of oppression that the uppercase "White" can connote.

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