Gender Dissonance: Diagnostic Reform of Gender Identity Disorder for Adults

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SUMMARY. Since its appearance in 1980, the diagnostic category "gender identity disorder" (GID) in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) has sparked concern among gender variant people and their advocates that it contributes to hurtful stigma and social barriers faced by gender variant individuals, while at the same time it contradicts the medical legitimacy of sex reassignment for the treatment of gender dysphoria. This paper examines the GID diagnosis of adults and adolescents and the social and medical consequences posed by its implication of "disordered" gender identity. Parallels are drawn to the removal of homosexuality and ego dystonic homosexuality

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from the DSM in the 1970s and '80s. At issue is the label of mental illness for behaviors that are otherwise ordinary or even exemplary based only on natal anatomical sex. Finally, a path forward is proposed to replace GID with a new diagnosis unambiguously defined by chronic distress rather than social nonconformity.

KEYWORDS. Diagnosis, Diagnostic and Statistical Manual, gender, gender identity, Gender Identity Disorder, psychiatry, stigma, transgender, transsexual

INTRODUCTION

More than thirty years after the American Psychiatric Association's board of trustees voted to remove homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (APA 1996), the diagnostic category "gender identity disorder" (GID) in adolescents and adults remains a concern to many gender variant people and civil rights advocates.

The Gender Identity Disorder diagnosis has divided the transgender community and mental health professions alike, on the premise that relief of social stigma associated with psychosexual diagnosis must inevitably be traded against access to sex reassignment procedures for those who require them. In truth, the current GID category fails transgender, and especially transitioning transsexual individuals, on both counts. Gender variant people face barriers to social legitimacy and civil rights under medical policy that terms their gender identity as mental disorder and labels ordinary gender expressions as sexual deviance. At the same time, transsexual individuals who suffer gender dysphoria, that is distress with their physical sex characteristics or their associated social roles, face obstacles to sex reassignment treatment posed by a diagnosis of *disordered* gender identity. By labeling a person's identity, which is discordant with her or his natal sex, as *disordered*, GID implies that identity and not the body is that which needs be fixed. By its title and diagnostic criteria, the diagnosis contradicts treatment goals that correct the body.

These shortcomings could be addressed by replacing GID with a new diagnosis unambiguously defined by chronic distress rather than social nonconformity. This would both reduce the harm of unnecessary stigma and help to support the medical necessity of sex reassignment procedures for those who require them.

The purpose of diagnosis of gender variant individuals, according to the Harry Benjamin International Gender Dysphoria (HBIGDA) "Standards of Care for Gender Identity Disorders," is to guide treatment and research:

> 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." The SOC notes that "diagnoses are based more on clinical reasoning than on scientific investigation," where mental disorder is in this context requires "a behavioral pattern that result in significant adaptive disadvantage to the person or cause mental suffering. (HBIGDA 2001)

However, if the purpose of GID for adults is to guide treatment and establish medical necessity for insurance coverage of sex reassignment procedures (Pauly 1992, Bolin 1988), then key questions arise: Is the current diagnosis consistent with treatment goals and procedures described in the Standard of Care? Is the diagnosis relevant to the distress and impairment that are relieved by sex reassignment procedures? Is it congruent with recognized definitions of mental disorder? Does the diagnosis differentiate gender variant individuals who require treatment from those who do not, or from those who have successfully completed treatment? What constitutes successful treatment with respect to the diagnosis? Is the diagnosis limited to those for whom it serves a therapeutic purpose? Are there unintended consequences of the diagnosis that undermine the treatment goals?

GENDER IDENTITY DISORDER IN THE DSM

Gender identity disorders first appeared as a subclass in the class of Psychosexual Disorders in the *DSM-III* (APA 1980, p. 261). They included two diagnostic categories, Transsexualism, 301.5x, a term coined by Magnus Hirschfeld (1923), and Gender Identity Disorder of Childhood, 302.6. Transsexualism was defined by a persistent sense of discomfort and inappropriateness about one's anatomic sex and a per-

sistent wish to be rid of one's genitals and to live as a member of the opposite sex for a period of at least two years (p. 263). A separate childhood category, with onset before puberty, was characterized by a strong and persistent stated desire to be or insistence that one is of the other sex and for natal males by nonconformity to male behavioral stereotypes (p. 265).

In DSM revision III-R (APA 1987), Gender Identity Disorders were moved to the class of Disorders Usually First Evident in Infancy, Childhood or Adolescence (p. 71), recognizing that "symptoms" of transsexuality almost always begin in childhood (p. 424). The diagnostic criteria for GID of Childhood, 302.60, were broadened to include gender role nonconformity for natal girls: "persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing . . . " (p. 73). While issues of diagnosis of gender variant children are beyond the scope of this article, this change illustrated an increased emphasis on social nonconformity in the diagnostic criteria that continued through the *DSM-IV* and *IV-TR*. Most important, Gender Identity Disorders in the *DSM-III* were expanded to implicate a wide range of gender variant individuals with a new category, Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT), 302.85 (p. 76). GIDAANT was defined by persistent or recurrent discomfort about one's assigned sex and cross-dressing in the role of the other sex, either in fantasy or actuality (p. 77). The diagnostic criteria excluded transsexual individuals wishing to be rid of their born sex characteristics and cross-dressers where sexual excitement was presumed the motivation. The latter were diagnosed with Transvestic Fetishism, 302.30, which remained in the DSM in the Paraphilias subclass of Sexual Disorders (p. 288). Transgender individuals who were not transsexual or distressed by their genitalia, however comfortable and well adjusted in a cross-sex role full time or part time, became diagnosable as mentally disordered in the *DSM-III-R*. By an unintended oversight in the diagnostic criteria, gender dysphoric subjects thought to be aroused by cross-dressing were precluded from diagnosis of Transsexualism, GIDAANT or Transvestic Fetishism, leading to an excessive number of cases classified as Gender Identity Disorder Not Otherwise Specified (GIDNOS) (Bradley et al. 1991).

In the *DSM-IV* (APA 1994), Gender Identity Disorders were returned to the class of sexual disorders, which was renamed Sexual and Gender Identity Disorders (p. 493). The *DSM-III* categories of Transsexualism, Gender Identity Disorder of Childhood and GIDAANT were subsumed by an expanded category, Gender Identity Disorder (GID), coded

302.85 for adults and adolescents and 302.6 for children (p. 538). The diagnostic criteria for adults are listed in Table 1.

Unlike prior revisions, the *DSM-IV* allowed concurrent diagnoses of GID and Transvestic Fetishism (APA 1994, p. 536). Individuals with intersex conditions were excluded from GID diagnosis. Diagnostic criteria for children were broadened to place a greater emphasis on nonconformity to social sex stereotypes (Wilson 1998) and to implicate children who never stated a desire to be, or insisted being, the other sex as mentally disordered (APA 1994, p. 537, Bradley et al. 1991, p. 337).

Perhaps the most significant change in the *DSM-IV* was the clinical significance criterion, which was added to many diagnoses in the DSM and at criterion D of the GID category. It required clinically significant distress or impairment for diagnosis of mental disorder (APA 1994, p. 7) and helped establish a threshold for diagnosis to delineate what meets the definition of mental disorder (p. xxi) from what does not. While some clinicians hailed this as acknowledgement by the APA that gender variant identity or expression are not inherently pathological (Brown 1995), the dominant psychiatric view of gender variance as intrinsically disordered persists. The clinical significance criterion was controversial among those who felt it redundant to the existing criteria for some diagnoses and insufficient to demark disorder in others (Spitzer & Wakefield 1999). In this context, some members of the *DSM-IV* Subcommittee on Gender Identity Disorders have dismissed the clinical significance criterion, at

TABLE 1. GID Diagnostic Criteria (APA 2000, p. 581)

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.
B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.
C. The disturbance is not concurrent with a physical intersex condition.
D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Specify if (for sexually mature individuals) Sexually Attracted to Males, . . . Females, . . . Both, . . . Neither.

least in the case of Transvestic Fetishism, as "muddled" and having "little import" (Zucker & Blanchard 1995, p. 258).

The most recent Text Revision to the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV-TR*) was published in August, 2000. The purpose of this revision was to correct, update and enhance the educational value of the 1994 *DSM-IV*. Most changes were limited to the descriptive text sections and not the diagnostic criteria, hence the title, *Text Revision*. The diagnostic criteria for GID were unchanged in revision TR (APA 2000, p. 581). However, the supporting text was expanded to further emphasize subtypes based on sexual orientation (pp. 578-579) as well as the controversial nomenclature of "autogynephilia".

> Adult males who are sexually attracted to females, to both males and females, or to neither sex usually report a history of erotic arousal associated with the thought or image of oneself as a woman (termed autogynephilia). (APA 2000, p. 578)

Blanchard (1989) defined autogynephilia as "love of oneself as a woman," to describe a phenomenon termed earlier by Hirschfeld as automonosexualism. Blanchard asserted that:

> All gender dysphoric males who are not sexually oriented toward men are instead sexually oriented toward the thought or image of themselves as women. (p. 322)

This characterization of "all" lesbian and bisexual transsexual women (male-to-female transsexual individuals attracted to other women or to both women and men) as pathologically attracted to themselves raised concern among transgender advocates (Wilson 2000). Wyndzen (2004) questioned Blanchard's findings (1989b) on grounds that they had not been replicated, excluded control groups of typically-gendered women, and presumed causality from correlated data.

Autogynephilia is listed as an "associated feature and disorder" of GID with no explanation of the relevance of sexual orientation to the definition of mental illness: distress, impairment or dysfunction. While a critique of the theory of autogynephilia is beyond the scope of this paper, its inclusion in the *DSM-IV-TR* illustrates emphasis in recent revisions on portraying behaviors and expressions as pathological that would be considered normal for those born with different genitalia.

Successive revisions of the DSM since 1980 have broadened the definition of Gender Identity Disorders for adults beyond gender dysphoria, where diagnosis serves a clear therapeutic purpose, to emphasize gender role nonconformity. The consequential social stigma and incongruence of the GID diagnosis with the definition of mental disorder are discussed in the following sections.

THE STIGMA OF "DISORDERED" GENDER IDENTITY

The diagnostic title itself, *Gender Identity Disorder*, implies that cross-gender identity is intrinsically disordered or deficient (Wilson 2002). It follows that gender identities held by diagnosable people, however ego-syntonic and highly functional in their preferred gender role, are not legitimate but represent perversion, confusion or defective development. This message is reinforced in the diagnostic criteria and supporting text that emphasize difference from cultural norms over distress and impairment. In fact, subjects are referenced in the GID supporting text by their natal sex (for example, transgender women are called "male" and "he"), discrediting their experienced gender identities (APA 2000, pp. 577-581). Under the premise of "disordered" gender identity, transgender women lose any claim to acceptance as *women* but are reduced to mentally ill "*men*." Transgender *men* are similarly marginalized as confused or disordered "*women*."

The view that cross gender identity and gender role nonconformity represent inherent mental pathology persists within the psychiatric and psychological professions. The wish to be the opposite sex is termed a "fantasy solution to internal conflict" (Zucker 1999a, p. 7, 1999b, p. 40). Zucker and Bradley advocate therapeutic intervention in gender nonconforming children to enforce traditional gender roles (1995, p. 280-281) even though:

> there are simply no formal empirical studies demonstrating that therapeutic intervention in childhood alters the developmental path toward either transsexualism or homosexuality. (p. 270)

Clinical interventions intended to change sexual orientation are known as "reparative" or "conversion" therapies and are opposed by the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers and the American Academy of Pediatrics (APA 1998).

At the 2003 Annual Meeting of the American Psychiatric Association, Robert Spitzer defended the view of inherent pathology, describing a failure to identify with one's natal gender as "a disorder." "Transsexualism," agreed former APA president Paul Fink at the same APA workshop, "is not a normal sexual variant" (Housman 2003).

The classification of gender variant identities and expressions as mental disorder has worsened the stigma that transgender people suffer (Bolin 1988, Wilson 1997). Among countless examples of consequent intolerance and discrimination is the following recent statement by the Congregation for the Doctrine of the Faith on behalf of the Vatican,

> Transsexuals suffer from "mental pathologies," are ineligible for admission to Roman Catholic religious orders and should be expelled if they have already entered the priesthood or religious life, the Vatican says in new directives. (AP 2003)

Notably, the Vatican distinguished transsexual people from intersex people in an apparent reference to criterion C of the Gender Identity Disorder diagnosis. (AP 2003)

Psychiatric diagnosis has a long unfortunate history of misuse in marginalizing human diversity around race, ethnicity, sex, gender, class, disability, and sexual orientation (Lev 2004). Issues of stigma associated with overly broad classification of gender variance as mental illness are remarkably parallel to those of same sex orientation over thirty years ago (Wilson 1998). The following statement by Robert Spitzer at the 1973 annual meeting of the American Psychiatric Association remains as true today for transgender people as it was for gay and lesbian people then:

> In the past, homosexuals have been denied civil rights in many areas of life on the ground that because they suffer from a "mental illness" the burden of proof is on them to demonstrate their competence, reliability, or mental stability. (Spitzer 1973)

The current GID diagnosis places a similar burden of proof upon a broad spectrum of gender variant individuals to demonstrate their competence, with a consequence of social stigma and denied civil rights. Ultimately, it harms those it was intended to help.

A QUESTION OF PATHOLOGY

Questions of legitimacy or pathology of gender variant identities ultimately turn on the definition of mental disorder. For minorities

marginalized by stigma of mental infirmary and sexual deviance, a cogent and unbiased definition of mental disorder takes on added significance. Distress and impairment became central to the definition of mental disorder in the *DSM-IV* (APA 1994, p. xxi), and to a generic clinical significance criterion which was added to most diagnostic categories, including criterion D of Gender Identity Disorder. The clinical significance criterion was not without controversy. Spitzer and Wakefield (1999) argued that it was redundant to other diagnostic criteria in some cases and too restrictive in others. They underscored the role of behavioral, psychological or biological dysfunction in the definition of disorder (APA 2000, p. xxi), which was not explicit in the clinical significance criterion.

While the scope of mental disorder was narrowed in the *DSM-IV*, Gender Identity Disorder was broadened from the prior classification of Transsexualism to place greater emphasis on gender role nonconformity. As a consequence, a wider spectrum of gender variant individuals today may be labeled mentally disordered. This could include people who are highly functional, well adjusted, or who have successfully completed treatment for gender dysphoria or never required it. Zucker (2005) recently stated, "The clinical research literature has paid very little attention to reliability of diagnosis for GID." On the merits of reason, the diagnostic criteria appear to implicate gender nonconforming (relative to their natal sex) subjects who may not be gender dysphoric and may not meet the distress, impairment or dysfunction criteria that define mental disorder in the DSM.

For example, consider a non-operative transgender woman, born male bodied, whose gender identity is profoundly feminine, and whose gender dysphoria extends insofar as her assigned male birth role and not to her natal physical sex characteristics. If this person were to transition full time to a female role and be happy, well adjusted and highly functional in that role without hormones or surgery, she could still be diagnosed as mentally disordered under the current GID diagnosis. She would meet criterion A because she frequently (full time) passes as the other sex, desires to live or be treated as the other sex, and has the conviction that she has the typical feelings and reactions of the other sex. She would meet criterion B because of her belief that she was born the wrong sex. She does not have a physical intersex condition and therefore meets criterion C. Although her gender dysphoria was ameliorated by her gender role transition, her external social and legal barriers that result from prejudice or intolerance may be construed as "impairment in

social, occupational or other important areas of functioning" (APA 2000, p. 581), meeting criterion D, the clinical significance criterion.

Unfortunately, no specific definition of distress and impairment is given in the GID diagnosis. There is no clarification to distinguish distress with one's physical sex characteristics from distress with assigned gender role. Bartlett and Vasey (2000) argue that

> Discomfort with one's biological sex and discomfort with the gender roles ascribed to this category are very different phenomena; equating them confuses, rather than clarifies, the distinction between them. This confusion seriously challenges the validity of this set of items as a diagnostic criterion.

Moreover, these elements of internal gender dysphoria are not distinguished from distress or impairment caused externally by prejudice and discrimination. The supporting text in the *DSM-IV-TR* lists relationship difficulties and impaired function at work or school as examples of distress and disability (APA 2000, p. 577) with no reference to the role of societal prejudice as the actual cause. Prostitution, HIV risk, and substance abuse are described as associated features of GID, rather than as sequelae of social intolerance and shame. As a consequence, gender variant victims of prejudice and discrimination are incorrectly cast as inherently mentally ill, much as gay and lesbian individuals were before 1973.

This lack of clarity in the clinical significance criterion for GID has been explained by the fact that it appears in most *DSM-IV* diagnoses and is not unique to GID (Zucker 2005). However, the clinical significance criteria in most paraphilia disorders, including exhibitionism, frotteurism, pedophilia, sexual sadism and voyeurism, were significantly revised in the *DSM-IV-TR* (APA 2000, pp. 569-575, 840) from the *DSM-IV* to clarify their intent. For example, criterion B for sexual sadism was changed to specify that acting on these sexual urges with a nonconsenting person meets the definition of clinical significance. The APA has offered no explanation for why ambiguities in the clinical significance criterion for these diagnoses were addressed, while those for GID were not.

Conflicting language in the DSM serves to conflate cultural nonconformity with mental illness and pathologize ordinary behaviors as symptomatic. The Introduction to the *DSM-IV-TR* states:

> Neither deviant behavior . . . nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of dysfunction. (APA 2000, p. xxxi)

However, it is contradicted in the Gender Identity Disorder section:

> Gender Identity Disorder can be distinguished from simple nonconformity to stereotypical sex role behavior by the extent and pervasiveness of the cross-gender wishes, interests, and activities. (p. 580)

Behaviors that would be ordinary or even exemplary for natal women and men are presented in Criterion A as symptomatic of mental disorder for the gender variant (Wilson 2002). For adults and adolescents, these include passing, living and a desire to be treated as ordinary members of the preferred gender. Adopting very commonplace behaviors, dress and mannerisms of one's own experienced gender is termed "preoccupation." It defies logic that these same behaviors can be pathological for one group of people and normal for another.

By implicating gender variant people who do not necessarily meet the DSM definition of mental illness as pathological, GID fails to acknowledge the existence of many healthy, well-adjusted transsexual or gender variant people or differentiate them from those who suffer gender dysphoria and could benefit from medical treatment (Wilson 1998). Professor Lynn Conway (2005a,b) has compiled an extensive list and gallery of transsexual women and men who have overcome formidable social obstacles and quietly lived successful lives that are congruent with their experienced gender identities. Overlooked by scholarly research focused on clinical populations, the narratives of these men and women provide powerful, albeit anecdotal, counterexamples to the psychiatric stereotype of "disordered" gender identity.

THE PURPOSE AND NECESSITY OF SEX REASSIGNMENT

The focus of treatment for transsexual individuals described by the current Harry Benjamin International Gender Dysphoria Association Standards of Care is on congruence with one's gender identity or "gendered self," not on attempting to change one's experienced gender identity:

> The general goal of psychotherapeutic, endocrine, or surgical therapy for persons with gender identity disorders is lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment. (HBIGDA 2001)

However, the language of the *DSM-IV-TR* lacks congruence with this treatment goal by labeling "gender identity" as the disorder, rather than the disjunction between somatic sex and experienced gender identity, and by diagnostic criteria that emphasize social role nonconformity over the distress of gender dysphoria. The GID diagnosis also lacks clarity in describing the problem to be treated. For example, gender dysphoria is defined in Appendix C as:

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

"Discomfort" and "aversion" seem euphemistic in describing the distress and pain that transsexual people commonly experience with their born genitalia or associated social roles. Therefore, Gender dysphoria is defined here in less ambiguous terms as *a persistent, chronic distress with one's physical sex characteristics or their associated social roles*.

While GID and gender dysphoria are often used synonymously, gender dysphoria is obfuscated by broad language in Criterion B that is not limited to ego-dystonic subjects. Criterion B states:

> Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. (p. 581)

"His or her sex" fails to distinguish birth sex from present somatic sex, so that a postoperative transsexual individual comfortable with her or his present sex characteristics ambiguously meets the criterion. Moreover, ego-syntonic people who are not gender dysphoric, do not meet the definition of mental illness or have successfully completed gender role or sex reassignment remain permanently implicated by the phrase, "belief that he or she was born the wrong sex" (p. 581). In other words, a gender variant person may be presumed distressed under criterion B on the basis of her or his beliefs, in the absence of actual distress.

The most successful achievement of sex reassignment treatment goals would not necessarily release a subject from the current GID diagnosis. It has no clear exit clause, even for post-operative transsexual in-

dividuals, however well adjusted. Consider a second example of a post-operative transsexual man, born female bodied, whose gender identity is profoundly masculine, and whose gender dysphoria was ameliorated by his social role transition, hormonal treatment and surgical procedures. If this person is happy, well adjusted and highly functional in a male role, he could remain inappropriately diagnosed as mentally disordered under the current GID diagnosis. As in the first example, he could meet criterion A because he passes full time as the "other" sex (which may be inferred in reference to one's born sex). He also desires to live or be treated as the other sex, and his conviction of "typical feelings and reactions of the other sex" (APA 2000, p. 581), is enhanced and not diminished by transition and surgical reassignment. He would also meet criterion B because of his belief that he was born the wrong sex. Lacking a physical intersex condition he would meet criterion C. Although he is no longer gender dysphoric, he could be presumed to meet criterion D, the clinical significance criterion, if he experiences discrimination at work or within his family. Furthermore, the current GID diagnosis is described as having a "chronic course" (p. 581) The supporting text lists *postsurgical complications* as "associated physical examination findings" of GID (p. 579). This implies that preoperative, postoperative and non-operative transsexual people may be irrevocably diagnosable, regardless of successful treatment outcome or their lack of actual impairment, distress or dysfunction.

This ambiguity concerning the mental illness of individuals whose gender dysphoria was successfully treated with hormones or surgeries contradicts the efficacy of those treatments. This ambiguity, combined with a label that implies "disordered" gender identity and diagnostic criteria that emphasize nonconformity over distress, undermine the legitimacy and medical necessity of sex reassignment for severely gender dysphoric individuals. Under the current GID diagnostic criteria and supporting text, the core symptoms are not improved by hormones and SRS but worsened. For example, Paul Fedoroff, of the Centre for Addiction and Mental Health, cites the GID diagnosis in arguing for the elimination of sex reassignment surgeries:

> TS 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. (Fedoroff 2000)

Consequently, medical coverage for sex reassignment surgery (SRS) procedures remains rare in the U.S. (Hong 2002). The current GID diagnosis provides a convenient excuse for by insurers, governments, HMOs and employers to dismiss hormonal and surgical treatment of gender dysphoria as cosmetic and elective.

DISTRESS BASED DIAGNOSIS: A PROPOSAL FOR REFORM

In the 1990s, new culturally competent treatment approaches emerged that rejected a presumption of inherent mental illness for gender variant identity or expression (Israel and Tarver 1997). The Tom Waddell Health Center, San Francisco Department of Public Health, developed a new protocol for the treatment of gender dysphoria for homeless individuals based on a model of informed consent and harm reduction. It did not require documentation attesting to transgender status to initiate hormonal therapy (Scanlon et al. 2002, Flaherty et al. 2001). This approach was adopted by the Denver based Colorado Coalition for the Homeless Stout Street Clinic in 1999, which rejected a requirement of psychiatric diagnosis for hormonal treatment:

> This approach excludes the widely-held belief that transgender (TG) identity equals mental illness, and utilizes the practice of informed consent and the rationale of harm reduction. The usual requirement of psychiatric approval prior to initiating hormone therapy for cross-gender living is eliminated. Thorough informed consent including an explanation of the risks and the limits of benefits of hormonal therapy replaces this requirement. By removing the requirement of psychiatric approval, a barrier to the access of health care is also removed for our TG clients, decreasing the likelihood that potentially harmful "street" hormones will be used. Furthermore, and perhaps most importantly, it avoids sending the message that people with a TG identity are mentally ill. (Stout Street Clinic 2001)

While these protocols have only been applied to hormonal therapies so far, they serve as examples of a non-pathologizing approach to the treatment of gender dysphoria embodying the following principles (Scanlon 2001):

- Assumes that most TG people are sane and responsible
- Recognizes cultural/social factors that affect care

- Promotes a respectful, nonpathologizing approach
- Rejects labeling of TG Identity as sexual perversion
- Adopts a model of informed consent and harm reduction for treatment

This approach is focused on reduction of distress and of barriers to treatment in a manner that does not cause further harm by contributing to social stigma and negative stereotypes of gender diversity.

In light of the issues raised here, it is proposed that Gender Identity Disorder be replaced in the DSM with a new diagnosis defined as chronic distress rather than social nonconformity and embodying the following principles:

- Defined unambiguously by distress with physical sex characteristics or their associated social roles
- Excludes social gender nonconformity and ordinary, normal behaviors and expressions as symptomatic
- Excludes consequences of societal prejudice or intolerance as symptomatic
- Excludes reference to sexual orientation as pathological
- Clearly differentiates those who are diagnosable and meet the DSM definition of mental disorder from those who are not
- Clearly differentiates those who have successfully completed treatment from those who have not

While development of new diagnostic criteria are beyond the scope of this paper, some general suggestions for revision are given here as a starting point for dialogue. As described previously, Criterion A in the current GID diagnosis is problematic in listing ordinary behaviors and expressions of gender as pathological, confusing gender dysphoria with social role nonconformity. Zucker (2005, p. 17.9), in reference to childhood GID, suggested several revision strategies, including:

> A more radical reform would be to relegate the indicators of extreme cross gender role behavior (A2-A5) to the text description of GID, with an explanation that they may not be sufficient, on their own, to indicate the presence of gender dysphoria.

Zucker concluded,

> . . . perhaps this would allay concerns that children with extreme gender nonconformity, but who are not truly gender dysphoric, are being inappropriately diagnosed. (p. 17.9)

Removing references to gender role nonconformity and "typical feelings and reactions of the other sex," and clarifying "the other sex" to describe present rather than natal sex characteristics, would hold similar promise for Criterion A for adults.

It is recommended that Criterion B be limited to actual gender dysphoria, defined here as chronic distress with one's present physical sex characteristics or their associated social roles. Ambiguities that implicate non-gender dysphoric individuals or those successfully treated in the past should be clarified. For example, the phrase "belief that he or she was born the wrong sex" should be removed along with the characterization of seeking treatment for gender dysphoria as "preoccupation."

It is suggested that Criterion D, the clinical significance criterion, be limited to the context of gender dysphoria and clearly exclude sequelae of social prejudice and discrimination.

Regarding the title, Gender Identity Disorder, Reid Vanderburgh (2001) has suggested the term *gender dissonance* as an alternative to *gender dysphoria* or *disorder* in describing the distress of incongruence between one's experience gender identity and natal sex. *Gender Dissonance* seems a fitting title for a reformed diagnostic category to replace GID. *Dissonance* lacks the social controversy of the former terms and seems to have a more cogent shade of meaning. It implies the incongruence or disconnection of experienced gender and physical sex as the focus of clinical interest rather than gender identity itself as pathological or disordered.

Just as DSM reform reduced stigma and fear surrounding same sex orientation over thirty years ago (Bayer 1981), reform of the Gender Identity Disorder diagnosis holds similar promise today. It is possible to define a diagnosis that both reduces the stigma of gender difference while legitimizing the medical necessity of sex reassignment treatment for gender dissonance with criteria that are clearly and appropriately inclusive (Wilson 1998).

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