

The (Dis) Order of Transgender Identities: How the Requirement for a Mental Health Diagnosis

Inhibits Transgender Autonomy

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## Introduction

In recent years, the debate surrounding the access that transgender individuals have to gender-affirming medical treatment has grown substantially to reflect the increase in transgender visibility. The insistence upon medical review of transgender individuals in order to assess their mental wellbeing has been formally in place since the 1960s, and only within the twenty-first century has limited medical intervention on behalf of transgender affirmation—such as hormone replacement therapy or gender reassignment surgeries—become marginally accepted within the United States, shown by the larger accessibility of medical care. As such, it is necessary to analyze the history regarding the pathology of transgender individuals—the treatment of the transgender identity as a mental disorder—in America in order to look at how the past has influenced present medical/social opinion on transgenderism.

Behind this debate is a complex history of informally categorizing transgenderism as a disorder, whether it be a social, physical, or mental one, to a strict set of guidelines that denote a mental illness. Currently, transgenderism is defined as the incongruence between one's biological sex and gender identity (Stryker 2017). The history of transgenderism that this research focuses on will trace the medicalization of transgender individuals, in order to demonstrate how such perceptions of transgender individuals have become embedded in American society, and affect how transgender individuals are viewed and treated—both medically and socially. The effects of the medicalization of transgender individuals are demonstrated in a short period of time, from the initial theorizations of gender disorders, in the late-nineteenth century, to the mid-twentieth century research of the distress caused by existing in the 'wrong' body, to today's battle with

insurance companies in recognizing transgenderism as a legitimate reason for medical intervention.

A second area of focus will look at the changing diagnoses of transgenderism within the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the leading tool for assessing mental disorders. Within the *DSM*, I will note how the differences in diagnoses has affected medical treatment, and the level of difficulty transgender individuals have had in obtaining a mental health diagnosis. I seek to assess how de-medicalizing identities can both help and hurt a movement for greater rights. The issues with de-medicalizing an identity extends to the accessibility of care, the stigma attached to a diagnosis, the legitimate recognition of a disorder, treatment by medical professionals, and the overarching themes present in the history of transgender medical care. The issues that many transgender Americans face are fundamentally caused by the requirement for a mental health diagnosis before one can receive transgender-related medical care

From building a solid foundation depicting the medicalization of transgender identities, I will move to critique the current systems in place. The necessitation of a mental health diagnosis limits the freedom transgender individuals can have over their bodies, and such diagnoses are counterproductive to the affirmation of one's gender identity. The question that guides my research is as follows: Is the diagnosis of a mental health disorder still necessary in legitimizing transgenderism? This question encompasses research on the applicability of mental health diagnoses to transgender identities, the availability of alternatives to a mental health diagnosis, and how the American medical community could move forward in its overall regard for transgender individuals.

To present a rounded argument, current theorizations of gender in conjunction with the current medical research on the congruency of one's sex with one's gender identity will be evaluated as well. There is a larger discussion to be had surrounding how mental health diagnoses such as Gender Identity Disorder and Gender Dysphoria Disorder limit the expression, mobility, and autonomy of transgender individuals. In addition, this limitation is fostered by private insurance agencies and the American government that seek to de-legitimize the transgender identity. This area of research will look at arguments for and against transgender pathology. Diagnosing transgender individuals with mental illnesses is extremely controversial across American society, and my research seeks to evaluate both sides of the argument to present a clear picture of the effects of a mental health diagnosis for transgender individuals. The research here will culminate in an argument for a greater understanding of the social construction of bodies and how American society can progress, new conceptualizations for gender and sex outside of a binary or spectrum structure, and solutions that work toward creating a society that allows for the existence of an autonomous transgender body.

## **The History of Transgender Medicalization**

It is undisputed that, throughout history, individuals have existed that were dissatisfied living as their born sex and as such have chosen to identify or live as the opposite. However, these instances were not noted as a medical oddity until the late nineteenth century (Stryker 2017). This section delineates the history of transgenderism becoming, what psychiatrists and medical doctors deemed, a mental disorder of the most extreme kind.

## Pre-Nazi Europe

In 1877, Austrian psychiatrist Richard von Krafft-Ebing published a landmark study: *Psychopathia Sexualis* in which he describes case studies of a myriad of psychiatric anomalies—including what he termed to be “metamorphosis sexualis paranoica,” characterized by psychotic delusions of becoming the opposite sex (Stryker 2017:54). One case in particular, Case 131, depicts what he called “gynandry,” which would today be known as female-to male transgenderism (Stryker and Whittle 2006:21). He details the life of a woman who, as he saw it, desired women so much that her only choice was to portray herself as a man (Krafft-Ebing 1877). Krafft-Ebing (1877) ties this gender variance to homosexuality, seeing it as an extension of homosexuality—which he viewed as a psychiatric disorder—rather than as a disorder existing separate from sexual desire. He is considered to be one of the first medical doctors to write about what is now considered to be transgenderism, and while his writings were not popular or significant at the time, they are important in establishing a historical context in which transgenderism can be seen. It is also worth noting that he most likely viewed transgenderism as a form of homosexuality due to the illegality of cross-dressing present in many Western countries at the time which was frequently attributed as homosexual behavior (Stryker 2017). While his work is foundational to studies of transgender individuals, at the time it was nothing more than a loose classification of transgender people, and held no formal implications for their status as sexual deviants.

In comparison to Krafft-Ebing, who likened transgenderism to a mental disorder, Magnus Hirschfield viewed transgenderism as a part of normal biology. Hirschfield, a pioneering

sexologist in the early 1900s, was the founder of the first gay rights organization, and also one of the world's first physician to support transgender people's desire to be viewed as the opposite sex (Stryker 2017). He wrote the "first book-length treatment of transgender phenomena" (Stryker 2017:55). In his book, he openly disagreed with Krafft-Ebing's assertion that transvestism<sup>1</sup> was a symptom of homosexuality, and states that it is his assessment that gender diversity was a part of the natural order, and that "society and laws should reflect this biological reality" (Stryker and Whittle 2006:28). His position was that the transgender phenomenon was one of a complex nature, but ultimately he concluded that,

the number of actual and imaginable sexual varieties is almost unending; in each person there is a different mixture of manly and womanly substances, and as we cannot find two leaves alike on a tree, then it is highly unlikely that we will find two humans whose manly and womanly characteristics exactly match in kind or number (Hirschfield 1910:37).

He goes on to say that "transvestite" is not an accurate term to represent the group of people who identify as the opposite sex because it only applies to the exterior presentation of an individual, "while the internal is limitless" (Hirschfield 1910:38). Hirschfield's challenge of Krafft-Ebing's position on transgenderism marked a shift from advocating for the treatment of an individual to rectify their psychosis to treating the condition as a way of allowing transgender individuals to function in normative society.

Hirschfield's role in transgender medical history is significant, not only for his support of transgender individuals, but also for his very active role in the first sex-reassignment surgeries.

He is known for overseeing Lili Elbe's first genital surgery (known in popular culture as "The Danish Woman"), as well as the first documented sex-reassignment surgery, performed on Dorchen

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<sup>1</sup> At that time, while transvestism (cross-dressing) was often conflated with homosexuality, it was also used to by Hirschfield to denote sexual disorders that is now called transgenderism.

Richter (Stryker 2017). These two cases demonstrate his active role in the advocacy for sex-reassignment surgery. Hirschfield's research and participation in formative sex-reassignment surgeries paved the way for the mid-twentieth century scientific work done regarding the treatment transgender individuals, and while his views on transgenderism fell out of favor in lieu of formal psychiatric diagnoses, his work with transgender people have had a lasting impact.

## **Post-World War II: The Shift to America**

It wasn't until the late 1940's that the transgender phenomenon really began to be studied in America. It was actually American sexologist, David O. Cauldwell (1949), that coined the term "transsexual" to refer to those that are now called transgender (Stryker and Whittle 2006:40). At the time, the term transsexual referred to individuals who expressed a wish to change their biological sex (Cauldwell 1949). Today, the term transsexual is sometimes used to denote individuals that have had some sort of medical intervention, and has since fallen out of favor with current theorists and medical practitioners (Stryker 2017). Cauldwell (1949:41) theorized that the psychopathy of transsexual individuals was a combination genetics and a dysfunctional childhood that then lead to a "mentally unhealthy" adult. Cauldwell's position marks one of the first extremely pathologizing view of transgenderism. He advocated for rehabilitation of these individuals that he found to be diseased in the mind, and did not see surgery as a solution, but rather an indulgence of their psychopathy (Cauldwell 1949).

The beginning studies of transgender individuals in America are largely attributed to the Langley Porter Psychiatric Clinic at the University of California, San Francisco, an institution that began researching sexual deviances in the 1940s (Stryker 2017). It is through the former

president of the American Psychiatric Association<sup>2</sup>, Karl Bowman, that the research on sexual deviances began at the Langley Porter Psychiatric Clinic, as he spearheaded research on homosexuality and transsexualism (Stryker 2017). His research later informed his work in the legal sphere on the subject of transsexuality. In 1949, Karl Bowman advised the California's attorney, Edmund P. Brown, general in a court case regarding sex-reassignment surgery (Stryker 2017). From Bowman's advice, Brown argued that, "transsexual genital modification would constitute 'mayhem' (the willful destruction of healthy tissue) and would expose any surgeon who performed such an operation to possible criminal prosecution" (Stryker 2017:62). As a result, few surgeries were performed in the 1950s, and medical opinion on transsexual individuals stayed firmly rooted in the belief of psychopathy that could only be cured through intense psychotherapy.

However, in opposition to Brown and Bowman, physician Harry Benjamin of Germany sympathized with the transsexual individual in question of the legal proceedings. He had been working in America as an endocrinologist, and began his work in transsexual medicine as a result of the court case (Stryker 2017). Benjamin is perhaps the most prominent figure in the history of what is now considered to be transgender medicine, and is often thought to be the father of modern transgender medicine. His work has had the most significant lasting impact on the treatment of transgender individuals by physicians, surgeons, and mental health professionals. His work focused solely on male-to-female transsexuals, and he did little research on female-to-male transsexuals. Benjamin is known for the popularization of the term "transsexual," as well as his dedication to what he called "the transsexual phenomenon"—a phrase that he aptly applied as

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<sup>2</sup> The American Psychiatric Association is responsible for the publication of the *Diagnostic and Statistical Manual of Mental Disorders*.

the title of his prominent work on transgenderism (Stryker and Whittle 2006). His use of “transsexual” combined with other efforts to redefine transvestism as the cross-dressing of heterosexual males led to the shift in terminology that brought us close to the terms of today (Stryker 2017).

It is said that Benjamin’s work with transsexual individuals “determined much of the modern medical approach to the transgender phenomena” (Stryker and Whittle 2006:45). The key emphasis of his views was that psychotherapy on its own was unproductive to the ailing of truly transsexual individuals. Previously, psychotherapy was considered the sole treatment of transgender individuals, aiming to fix their mentality to conform to normative standards (Krafft-Ebing 1877). Benjamin (1954) felt that psychotherapy was necessary, but also should be combined with some form of medical intervention such as hormone replacement therapy or surgery. He viewed therapy as a helpful tool in managing the symptoms of transsexuality, but ultimately ineffective if not combined with surgical measures—which truly allowed the transsexual individual to function as part of normative society (Benjamin 1966). Differentiating himself from his predecessors, Benjamin deemed the psychopathy of transsexual individuals to be in relation to their disgust with their genitals, a disgust that separated transvestites and ‘true’ transsexuals (Benjamin 1954). In describing this separation he says that,

while the male transvestite, *enacts* the role of a woman, the transsexualist wants to *be* one and *function* as one, wishing to assume as many of her characteristics as possible, physical, mental and sexual (Benjamin 1954:46).

This separation is seen today when transgender individuals who do not desire surgery or hormones, or do not experience dysphoria—the antipathy towards one’s body as it is not congruent with the normative body of one’s gender identity—are rejected as being truly

transgender. Similar to Alfred Kinsey's scale of heterosexuality to homosexuality, Benjamin created a scale to reflect his experiences of the levels of transsexuality (see, Appendix A, Table 1). His number one criterion for determining the eligibility of identifying as transsexual and therefore being allowed medical care was the experience of disgust toward one's body, and the resulting overwhelming desire to change it (Benjamin 1966). Another criterion for determining if someone was 'truly' transsexual was if their sexual desire reflected heterosexual normals. Benjamin believed that transsexual individuals held the disgust for their bodies and the desire to live as the opposite sex because subconsciously they wanted to be normative, heterosexual members of society, and thusly identified as homosexuals prior to a change in sex (Benjamin 1966).

It is notable to say, that in his essay entitled "Should Surgery Be Performed on Transsexuals?" he makes a decided effort to be blunt in his support of transsexual individuals. He goes against his previous work and says that while "transsexualism can be a part of psychosis... as a rule, transsexuals are non psychotic individuals" (Benjamin 1971:75). He believed that psychotherapy can help manage the dysphoria they feel, but ultimately surgery is the only cure of, what he considered to be, a solely medical disorder. Central to his idea of surgical treatment of transgender individuals is that surgery was not intended to act as a cure to eliminate transgenderism, but rather a procedure used to make transsexuals into functional, normative members of society.

It is his essay that truly sets the tone for the decades that follow. Benjamin's (1971) medical opinion is that if left untreated, as with many diseases, the symptoms of the disease become worse and more debilitating. He asserts that denying transsexuals surgery (unless there is

sufficient reason to do so) is “positively wrong, cruel, unrealistic, and unscientific” (Benjamin 1971:78). He follows this statement with how medical doctors can properly determine who is eligible for surgery. His recommendations are as follows: (1) There should be a wait time between psychiatric treatment, hormone therapy, and surgery (2) Transsexual patients should live and work as their desired gender for a substantial period of time before surgery. (3) Patients should express an unwavering desire to become the opposite sex. (4) Patients whose physical build lends itself to appearing as the opposite gender (feminine, petite boys) are preferred for younger patients, otherwise the older patients are preferred for surgical intervention (Benjamin 1971). While these standards have varied based on insurance requirement and wording, they largely remain the same even today. Benjamin’s standards for transsexual care, while informally addressed in *The Transsexual Phenomenon*, became formalized in his foundation of the Harry Benjamin International Gender Dysphoria Association (HBIGDA), in 1979, that sought to legitimize transgenderism within the medical community (Stryker 2017).

### **The 1970s to 2000s: The End of a Century, The Beginning of a New Era**

The formation of the Harry Benjamin International Gender Dysphoria Association (HBIGDA) that brought together specialists from a variety of fields to research the best methods of care for transgender individuals is considered one of Harry Benjamin’s biggest contributions to the field of transgender medicine (Stryker 2017). In addition to research HBIGDA—now known as the World Professional Association for Transgender Health (WPATH)—created “diagnostic criteria” that solidified transgenderism as a disorder formally in American medicine (Stryker 2017:139). The transgender *Standards of Care (SOC)*, first published in 1979, were

intended to “set minimal standards for assessment and determination of eligibility for hormonal and surgical reassignment, and to provide guidelines for optimal care for patients” (Coleman 2016:36). While, at first, these standards of care adhered to Benjamin’s initial recommendations, as more research regarding transgender people became available, the standards shifted to reflect the social reality of transgender individuals (Coleman 2016).

The work of WPATH has been a huge contributor to the formal diagnoses of transgender individuals found in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. This disorder was formally known as Gender Identity Disorder (GID). GID was the diagnosis of transgender individuals based on Benjamin’s own work and required them to follow his eligibility criteria to gain transgender-related medical care. Gender Identity Disorder first appeared in the third edition of the *DSM* in 1980, and was marginally revised in 1994, in the fourth edition, to be more specific in the symptoms of Gender Identity Disorder (see. Appendix B, *DSM-III* and *DSM-IV*). The criteria for diagnosis were similar to Harry Benjamin’s requirements for surgery.

The formal diagnoses found in the *DSM* moved away from Benjamin’s philosophy of helping ease the transsexual’s suffering toward pathologizing transsexuals as mentally disordered. Gender Identity Disorder as a diagnosis in the *DSM-III* was negatively received within parts of the transgender community. These negative feelings included the following,

most people with transgender feelings resented having their sense of gender labeled as a sickness and their identities classified as disordered... Some transgender people have questioned why gender change needed to be medicalized in the first place, while others argued that they should have access to health care services without having their need to do so be considered pathological (Stryker 2017:139).

However, in other parts of the transgender community, supporters of the diagnosis felt that their needs were finally being recognized because there was a medical path to the ‘cure’ (Stryker 2017). Regardless of these feelings, it wasn’t until the 1990s that the formal diagnosis had any effect and transgender people were able to access healthcare for the disorder (Stryker 2017). Many doctors did not treat transgender patients until the *DSM-IV* was published, at which point doctors who claimed to specialize in transgender care began to appear and take advantage of a limited market (Meyerowitz 2009).

The 1990s and early 2000s moved to advance transgender rights, medically and legally, and saw the growing acceptance of Gender Identity Disorder by insurance companies, doctors, and surgeons alike. After 2006, private insurance companies began to offer limited coverage of transgender-related services, such as hormones and surgery so long as the guidelines set forth were followed (Stroumsa 2008).

### **The Twenty-First Century: Claims of Depathologization**

In the 2009 version of WPATH’s *Standards of Care*, gender variance is not considered to be a disorder, psychological help is not considered necessary, and addresses the variety of transgender people that exist (Coleman 2016). In 2013, the American Psychiatric Association released the fifth version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)*, which removed Gender Identity Disorder and replaced it with Gender Dysphoria Disorder (see, Appendix B, *DSM-V*), a move that was commended by WPATH and transgender activists. This change, which Susan Stryker calls the “formal depathologization of transgender identity,” represented an almost mainstream attention of transgender issues (Stryker 2017:195). Now,

almost every insurance company has some sort of guidelines on transgender care, and in most states there are providers that actively specialize in transgender care.

However, nearly all of the requirements for being diagnosed with Gender Dysphoria Disorder (see, Appendix B) are the same as Gender Identity Disorder, and as such nearly all the requirements for medical care remain the same with doctors, surgeons, and insurance companies. While WPATH has encouraged the depathologization of transgenderism, and the identity itself has been, the symptoms and larger concerns of the identity are still pathologized under Gender Dysphoria. There is more variety of care, more overall acceptance of the transgender identity, but a lot of work still needs to be done regarding perception of the transgender identity and how it is treated medically.

## ***DSM Diagnoses: Necessity or Nonsense?***

### **The History of Transgenderism in the *DSM***

The *DSM* has been a tool used by psychiatrists to determine whether or not someone is to be considered transgender following the appearance of Gender Identity Disorder in the third edition. Nearly all surgeons and medical practitioners require a psychiatric diagnosis before even considering treatment for transgender individuals (de Vries and Cohen-Kettenis 2016). While Stryker calls the change found in *DSM-V* to be the “formal depathologization of transgender identity” (Stryker 2017:195), Daphna Stroumsa, M.D., (2014) considers the change to just be a step toward depathologization rather than an end of the discussion. She argues that the change in terminology does not depathologize the transgender identity as it is still considered a mental

disorder (Stroumsa 2014). This section looks at how the diagnoses present in the *DSM* limit and expand avenues of care for transgender individuals, and seeks to evaluate the necessity of mental health diagnoses for medical care.

Central to the diagnoses in the *DSM* is that the identity or symptoms of transgenderism are indicators of a mental health disorder. However, the attitudes of psychologists and psychiatrists toward transgenderism as a mental illness are closely linked to the prevailing attitudes of society at any given time. As early as the 1960s, a movement for the separation of sex and gender was already occurring. Dr. Robert Stoller (1968:55-56) believed that one's gender could be separated into three parts: (1) biological sex (2) social gender role (3) psychological gender identity (Stoller 1968). His work popularized the psychological sex/gender distinction that consumes transgender politics today, and the term "gender identity" went on to become a dominating force within the medical community (Meyerowitz 2009). Unfortunately, his work was not taken into consideration by the time the third edition of the *DSM* was released, which featured the first iteration of Gender Identity Disorder (see, Appendix B, *DSM-III*).

The years following the official diagnosis of transgenderism could not be characterized as seeing much forward momentum. Many doctors still refused to take on transgender patients or to authorize surgery or hormone treatment (Meyerowitz 2009). While the number of surgeries increased due to medical recognition of transgenderism, the formal diagnosis shut out many individuals who did not fit in the appropriate box (Meyerowitz 2009). Previously, if one had the money and a sympathetic doctor, there was a much simpler path to surgery or hormones due to the exploratory nature of the procedures. Starting in the 1980s, private doctors began taking the cases of transgender individuals, moving the medical care of transgender patients from the public

sphere to a more privatized, and thus a more regulated sphere (Meyerowitz 2009). The 1980 version of Gender Identity Disorder was lacking in specificity, and often allowed doctors to define it through their own perceptions of the diagnosis.

Through the work of HBGDA, Gender Identity Disorder was expanded upon in the fourth edition of the *DSM*, published in 1994 (see, Appendix B, *DSM-IV*). As a whole, the 1990s saw the emergence of united transgender activism, with WPATH especially working to destigmatize transgenderism and widen the accessibility of transgender-related care (Meyerowitz 2009). The more specific diagnosis, along with the rising number of doctors that specialized in transgender care, had both positive and negative affects on the transgender community. The medical diagnosis of transgenderism had gained legitimacy in the medical community, which had a two-fold effect. The legitimacy allowed doctors to more openly cater to the needs of transgender individuals, which meant there was larger access to medical care for transgender individuals (Vitale 2010). However, this legitimacy meant that there were more stringent rules in place for identifying as transgender, and a number of formal steps one had to take to be considered a ‘true’ transgender individual in the eyes of the medical community (Vitale 2010). These steps included intensive psychotherapy, which often was considered to be more necessary than surgery or hormones (Vitale 2010). Through a medical diagnosis, transgender individuals were being shut out of the medical treatments they desired.

From 1994 to the publication of the fifth edition of the *DSM* in 2013, transgender activists fought the diagnosis of Gender Identity Disorder. The wording in the *DSM* considered the mental capacity of transgender individuals to be “disordered” and created stigmatization of the identity itself (Vitale 2010:49). Transgender activist Dean Spade (2000:321) criticized the

diagnosis of Gender Identity Disorder because it “produces a fiction of natural gender,” that promotes the idea that only transgender individuals have trouble with gender identity and expression, and this trouble only exists in a binary manner of being either a man or a woman. Spade points out that the rigid gender binary creates a lack of bodily autonomy for transgender individuals within the medical industry. One has to be clinically diagnosed as non-normative to exert control over their body, and to enact any change that they desire.

The notion that one has to be identified as transgender to want hormones or surgery is problematic. There are plenty of individuals that do not identify as such who desire bodily changes, and there are individuals who do identify as transgender that do not want medical treatment at all. The inclusion of GID in the *DSM* forced the transgender identity to become a medical identity rather than a social one. Once transgenderism was seen as a disease, there was no stopping the treatment that followed. In other words, transgender as it exists now, exists because the medical community worked to legitimize it as a disease (Billings and Urban 1982). As a pathological problem, transgenderism requires treatment, requires a cure. As such, the ability to explore the greater implications of gender non-normativity have been stifled in an attempt to ‘fix’ the body of the transgender individual to align it with normative societal expectations of the body and gender expression.

The question then remains, should transgenderism be considered a mental illness? Both society and the medical community remain divided on this issue. Many within the transgender community feel that gender variance is completely normal, as is any variance of the human condition (Gorton 2013). Unsurprisingly, this group of people do not agree that GID is the best way to describe transgenderism, nor that transgenderism in any form should be considered a

disease. However, some do see transgenderism as a disease, but not necessarily one of a psychiatric nature, and prefer the recent change in the *DSM-V* from GID to Gender Dysphoria Disorder (Gorton 2007). These views represent the different ends of the spectrum of thinking regarding transgender pathology. While many consider the identity itself to no longer be pathologized, the existence of a *DSM* diagnosis remains clouded in debate.

The change from Gender Identity Disorder to Gender Dysphoria Disorder was intended to create a more accurate portrayal of transgender individuals who desire medical treatment, as well as an effort to lessen the stigma surrounding the transgender identity. The innovation that came along with the term is the specificity of transgender individuals who had such a discomfort with their anatomy that they desired to change their body to match the opposite sex (Hausman 1995). What was once just a symptom of Gender Identity Disorder now constitutes a disorder in itself.

Despite the supposed openness of Gender Dysphoria Disorder, one now must actively desire surgery or hormones to be considered transgender. There is a direct link in the eyes of the medical community between who is transgender based on the desire for medical services. It can be argued then that transgender has been constructed through its medical identity, something Billings and Urban would readily agree with. With regards to the new diagnosis, Stroumsa (2014:36) writes that,

despite the APA's stated intention, the new criteria seem to retain diagnosis based on gender nonconformity and fail to differentiate between distress caused by social prejudice and that caused by a mental disorder...The inclusion of gender identity and transgender-related matters in the *DSM* reflects an inherent problem.

The problem is that transgenderism is treated medically more so than psychiatrically. It is nearly universal among healthcare professionals that therapeutic treatment is not necessary, and yet transgenderism is still considered to be a mental health issue.

Spade (2000) argues that it is the way that transgender bodies are viewed socially that cause dysphoria, not an innate mental disorder. Transgender bodies are categorized based on rigid binary gender rules that leave little room for variation: one must be a man or a woman, there is no in between. This is why treatments for transgenderism work toward ‘fixing’ a physical problem, and do little to rehabilitate a person’s mental state (Stroumsa 2014).

### **The *DSM* Diagnosis is a Necessary Evil**

Transgender theorist, A. Finn Enke (2012:236), states that “the distinction between living a life in congruence with static medico-juridical determinations of one’s sex/gender and living a life in defiance of that congruence is a highly consequential one, because our social institutions are structured to uphold and privilege the former.” Perhaps the biggest reason that transgenderism needs to be classified as a mental disorder is due to insurance restrictions. In America, one must pay out-of-pocket for transgender-related medical care unless their insurance will cover it. However a 2016 survey found that 25% of transgender individuals were denied coverage of hormones, and over 50% were denied coverage of transgender-related surgeries (Learmonth et al. 2018). With the high rates of poverty present within the transgender population, especially among transgender people of color, insurances coverage is often the only way to receive the care they require. Before the 2014 iteration of the Affordable Care Act, transgenderism was considered to be a pre-existing condition, and therefore many individuals

would be denied insurance or have to pay higher premiums for basic coverage that rarely even included transgender care (Learmonth et al. 2018). The Affordable Care Act marked a turning point for many, and opened the doors for private insurance companies to follow suit and make transgender healthcare more accessible. Many employers, such as Bank of America, fast food chains including Burger King and Wendy's, and Verizon now offer transgender coverage in their company-wide health insurance plans (Human Rights Campaign).

It is in the insurance guidelines that the most substantial evidence for transgender individuals needing a mental health diagnosis is found. Looking at three of the top private health insurance companies in America—Aetna, Cigna, and United Healthcare—all have guidelines for transgender healthcare and coverage. All three of these insurance carriers have nearly identical requirements for coverage. One would need to have letters from a mental health professional, documented gender dysphoria in accordance with the *DSM-V*, no medical or mental health issues that could hinder informed consent, and must be at least 18 years old unless their circumstance is covered by way of WPATH regulations (see, Appendix C). Furthermore one must also live in the opposite gender for a twelve month period of time, and potentially take hormones for a twelve month period of time. The entire basis for coverage of transgender-related care is predicated upon the diagnosis of a mental disorder. Without such diagnosis, transgender individuals are routinely denied coverage. Furthermore, even when providers do not accept insurance for necessary procedures, they still require a letter from a mental health professional that confirms a diagnosis (Stroumsa 2014).

The larger issue outside of the availability of transgender health care is the legal hindrance that not having a medical diagnosis can cause. Griet De Cuyper (2016) states that “in

medicine the general rule is that diagnosis should precede treatment.” As it stands in American society today, without a diagnosis, most transgender individuals would not have access to hormones or surgery. Without access to hormones or surgery, in a majority of American states, transgender individuals are not allowed to legally change their documentation to reflect their identity. While the absolute insistence of a medical diagnosis has been instrumental in obtaining a higher availability of services for the transgender population, and legitimizing the severe need that some members of the transgender population have for treatment, its necessitation upon a mental health diagnosis has been the first step in the denial of rights and agency for transgender people (Vitale 2010).

### **The *DSM* Diagnosis Adds Insult to Injury**

While some believe that a mental health diagnosis is necessary when it comes to the accessibility of care for transgender people, others believe that it is completely unnecessary (Vitale 2010). The implementation of a mental health diagnosis is often used as a tool for gate-keeping the ‘fake’ transgender individuals, even though many medical institutions now recognize that the transgender identity takes a variety of forms (Vitale 2010). Despite the acknowledgement of diversity within the transgender identity, the medical industry only recognizes transgender individuals diagnosed along the guidelines present in the *DSM*, and as such, only considers transgender individuals with symptoms of gender dysphoria as valid (Stroumsa 2014). Furthermore, most transgender individuals do not have any hormone treatment or surgery to treat their supposed condition, and yet the two are defining factors in assessing if one is truly transgender (Enke 2012).

While many transgender individuals do experience gender dysphoria, not all do. Gender dysphoria as a primary symptom of the transgender existence can be directly traced to Harry Benjamin's strict rules for determining eligibility for transgender-related care. Furthermore, the demand for a mental health diagnosis lends itself to the opinion that therapy and psychiatric care is the best option for treatment (Vitale 2010). The strong insistence upon 'true' transgender people having a legitimate mental health issue to explain their non-normative behavior has in turn caused young people who are exploring their gender to be socialized to associate gender dysphoria with being transgender. Gender dysphoria is a learned behavior that is constantly reinforced by the 'normative' cisgender medical community. From a young age children are indoctrinated with ideas of normative gender and the subsequent idea that one should feel wrong if they do not align with normativity. Gender dysphoria, then, isn't as much of a mental disorder so much as a response to societal pressure.

Categorizing gender dysphoria as a mental health disorder leads to the insistence upon psychotherapy for treatment. In their analysis of psychotherapy for transgender individuals, Lin Frasier and Griet De Cuypere (2016:120) note that there are two types of transgender individuals:

People with transgender issues seeking transgender health care can be subdivided more or less into two categories: those who have made their self-diagnosis of being "gender-dysphoric" and wanting a medical treatment to alleviate the gender dysphoria without specific psychological needs, and those who come to the mental health provider/psychotherapist with questions such as: "Who am I? And where do I fit in this world?" People in this group typically want to explore questions having to do with who they are as a gendered person and how they can relate to others as their authentic gendered self, whether those others be partners, family members, their work environment, communities, or in their spiritual life. For the latter group, psychotherapy can be useful.

While psychotherapy can be helpful for transgender individuals looking to make sense of what they already know about themselves, it is by no means necessary. A mental illness, inherently, demands some sort of psychological treatment. However, as demonstrated by the former assertions of WPATH and others, psychological treatment of transgender individuals can be helpful, but ultimately are unnecessary as a standard and do not solve the primary issues that transgender individuals face in relation to their bodies; rather, psychotherapy can act as a support for the mental health issues that can arise as a result of one's identification as transgender, such as anxiety or depression (De Cuypere 2016).

Transgenderism—or the symptoms it is supposedly made up of—when diagnosed as a mental illness create a far-reaching stigma. The diagnosis of Gender Dysphoria Disorder maintains that transgender individuals have some form of a psychological problem that must be treated. In opposition, WPATH has found that such a wide reach of gender variance exists that, while there are general standards of medical treatment such as hormones or surgery, not one path of treatment can be prescribed for all transgender individuals (De Cuypere 2016). By homogenizing the transgender population under a mental illness, a stigma of inherent mental imbalance is created. Historically, the psycho-pathologization of the transgender identity has been a result of hetero-normatization and general antipathy toward non-normative sexual and gender identities—in other words, therapy has often been used as a tool of ‘fixing’ transgender people to reflect normative behavior rather than normalizing gender diversity (Gherovici 2011). It is antithetical that Benjamin advocated strongly against psychotherapy for these reasons, and yet the protocol built out of his work is fundamentally tied to the use of psychotherapy as a treatment of transgenderism as a mental disorder (Gherovici 2011).

A prominent issue with classifying transgenderism as a mental disorder is the removal of autonomy that transgender individuals have over their identities. While a person might identify as transgender, they are not seen as legitimate until they are assessed by a mental health professional (Vitale 2010). The requirement of one's identity having to be legitimized by an outside 'authority' is not only dehumanizing, it limits the autonomy that they have over their identity. The transgender identity has been co-opted and further maintained by the medical community, to the point where medical practitioners are telling transgender people what makes them disordered, promoting their own prevailing attitudes regarding transgenderism rather than looking for other explanations. While many theorists and transgender advocates, such as WPATH, have offered explanations for the existence of transgender individuals as part of normal gender variation, the medical community, psychiatry and psychology in particular, continues to view transgenderism outside of normative behavior and seeks to correct, rather than affirm, the identity.

Furthermore, the insistence upon a diagnosis of a mental health disorder creates the stigma that transgender individuals do not have the ability to make decisions regarding health care themselves. Dr. Sarah Schulz (2018) states that requiring a diagnosis for treatment causes transgender individuals to become passive recipients of care that is up to the discretion of their medical doctor or mental health provider rather than allowing them to take an active role in deciding their care. The passivity with which a transgender person is expected to handle their healthcare is absurd when most transgender individuals are functioning, contributing members of society. There is no legitimate reason for the transgender population to be treated as if they

cannot make an informed decision about their own healthcare, especially now that the symptoms are considered to be disordered and not the identity itself.

Establishing transgenderism as a normal part of gender variance is key to the progression of transgender rights within the medical field. Much of the transgender-related medical treatment sought is done by a regular physician, not a mental health professional. Despite having a *DSM* diagnosis, it is still up to the discretion of a medical practitioner whether or not they prescribe hormone therapy (Gooren 2016). Furthermore, a diagnosis does not guarantee coverage by insurance, and there are often strict limitations on what will be covered, as some insurance companies have specific guidelines for mental health coverage. While it is unclear how exactly the problem of categorizing transgenderism within the medical field will be solved, it is clear that a mental health diagnosis is outdated, insufficient, and simply unnecessary.

## **Moving Forward: Alternatives for Transgender Care**

Establishing that categorizing transgenderism, or its symptoms, as a mental health disorder is an incorrect solution to a complex problem is an important step that the medical community must take. The question that remains is then, how do we categorize transgenderism in the medical community? As shifts have occurred over the past decade to foster transgender autonomy in the medical field, this question becomes critical to moving forward. This section aims to explore the options that are available, and the possibilities of implementation.

## The Trans-Health Model

One alternative to the current system in place, which T. Benjamin Singer (2006: 615) calls the “pathology model,” is a paradigm shift within healthcare to a model that emphasizes transgender subjectivity. In such a model (see, Appendix D, Table 1), Singer (2006) notes that gender is re-evaluated to include non-normativity, in order to include a range of differing body types and genders. Most importantly, this model of healthcare operates on informed consent, a non-disordered view of gender variety, and focuses on advocacy rather than gate-keeping (Singer 2006:615). Singer’s “trans-health model” allows for transgenderism to be removed from the *DSM*, yet stay in the lexicon of medical professionals so it remains under insurance coverage. In the trans-health model, rather than stigmatizing the transgender population with a mental disorder, transgenderism would be categorized as a part of larger gender complexity (Singer 2006:615). Providers would learn about gender variety not in the binary male versus female sense, but rather in a way that emphasizes gender as a spectrum with more than two options. Central to this model of healthcare is the education of healthcare professionals in a way that enhances their competency and allows for easier access to treatment by transgender individuals (Singer 2006).

Biologically, a model founded upon gender diversity has merit. Evolutionary biologist Joan Roughgarden (2004) notes that to most in the field, definitionally, male and female refer to the size of the gametes an organism makes. She goes on to point out that gender in all species is incredibly diverse—with some changing genders during its lifetime, a variety of chromosomal makeups found in both males and females, differences in appearances, size, physiology, and

behavior—that contradict the medical community’s insistence upon a two sex/two gender system (Roughgarden 2004). She says that,

up to now, we’ve come up with two generalizations: (1) Most species reproduce sexually. (2) Among the species that do reproduce sexually, gamete size obeys a near-universal binary between very small (sperm) and large (egg), so that male and female can be defined biologically as the production of small and large gametes, respectively. Beyond these two generalizations, the generalizing stops and diversity begins (Roughgarden 2004:150).

The biological existence of gender variety, in humans and other species alike, should be more readily considered by the medical field when looking at transgenderism. Perhaps, gender diversity is not as abnormal as research once suggested, but rather is indicative of larger biological forces at play that we do not yet fully understand yet.

The dichotomy of male versus female is an ideal that the medical community clings to, with almost no substantial basis anymore. Kessler and McKenna (1985) further this idea, by asserting that the biological possession of certain genitalia is no more than a cultural event in which gender is attributed to members of society. They argue that “attributed genitals are constructed out of our ways of envisioning gender and *always* exist in everyday interactions. Males have cultural penises and females have no cultural penises” (Kessler and McKenna 1985:173). Gender attribution affects everything an individual does, and most usually comes from cues that others see, or think they see, rather than a concrete biological definition of gender (Kessler and McKenna 1985). Destabilizing such notions of gender are crucial to the progression of transgender care within the medical field. A shift from the pathology model to the trans-health model is contingent upon expanding the education of medical professionals about current gender theory and how such theory can be put into practice in everyday medical interactions.

## The Informed Consent Model

A first step in changing the health care system to reflect the needs to transgender individuals, that doesn't challenge larger societal notions of gender, is moving away from a diagnostic model to an informed consent model. Informed consent in its own right is an extremely important system of operating different from the current one in place. In practice, informed consent

(a) promotes a departure from the use of the diagnosis of gender dysphoria as a prerequisite for accessing transition services and (b) attempts to impact the way that transgender individuals experience and access health care by removing the psychotherapy/gatekeeping requirement (Shulz 2018:83).

As previously stated, in order to obtain medical treatment, a transgender individual is usually required to see some sort of psychologist in order to obtain a diagnosis of Gender Dysphoria Disorder, and then a medical doctor will choose whether or not to provide treatment. Under the model of informed consent, rather than requiring a diagnosis of Gender Dysphoria Disorder, medical doctors review the benefits and costs of obtaining specific medical treatments, and then the transgender individual consents to being treated knowing of the risks that such treatments pose (Shulz 2018). The use of the informed consent model allows transgender individuals greater autonomy in choosing the path that is right for them when it comes to transition-related care, emphasizing that they have the ability to understand the risks, benefits, and consequences of the treatment and can make an informed decision about health care (Shulz 2018).

The issues that arise when moving away from a diagnostic model of care are minor. For example, Schulz (2018) notes that many medical practitioners have expressed concern over how to code transgenderism and subsequent treatments if it is not classified as a disorder. In response,

she demonstrates that there are a variety of “unspecified” labels for treatments that do not disorder a patient, but mark the treatment as necessary—such as “unspecified endocrine disorder” for hormone replacement therapy (Schulz 2018:87). Such non-disordered codes exist and cover a wide variety of medical treatments.

A model of healthcare that reflects the individual nature of the transgender identity, the variety that can be found within it, and the ability of transgender people to make decisions regarding their own healthcare is incredibly important and necessary to improve the care of transgender individuals within the medical field. The aforementioned alternatives that center subjective transgender experiences could revolutionize the way transgender people access healthcare. Changing the current operating system of health care is key to the affirmation of the transgender identity within the medical community. Transgenderism is not a disorder, it is not a detriment to a person’s mental state, but rather it is a part of the biological diversity of the human species. The medical field needs to reflect the reality of gender diverse individuals and evolve into a more accepting, affirming practice that recognizes the rights of transgender individuals in psychology, medicine, and health care in general.

## **Conclusion**

Instead of classifying transgenderism as a mental disorder, the medical field—practitioners, mental health professionals, and insurance providers alike—should be moving toward a mindset that reflects the reality of gender diversity seen today. Historically, transgenderism has been pathologized as a severe psychopathic disorder, one that needed intense

counseling to combat. What began being seen as purely a psycho-sexual disorder became legitimized through the work of sexologists, activists, and medical doctors such as Magnus Hirschfield, Harry Benjamin, and WPATH. Their work has allowed for treatment for transgender individuals to enter into the medical sphere and has caused the evolution of transgender-related care from a nonexistent practice into a monumental industry. However, the deep-rooted ideas of transgenderism as a mental disorder still remain.

The changing diagnosis of Gender Identity Disorder to Gender Dysphoria Disorder in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* has reflected shifts in the attitudes of the medical field regarding the psychopathology of transgender individuals; however, it has had a microscopic effect on the medical and psychological treatment of transgenderism. Over 50 years from when Harry Benjamin argued that psychological treatment was not a sufficient treatment for the distress faced by a transgender individual, psychotherapy remains as the primary practice that rules on the eligibility of transgender individuals for transition-related treatment. Against the recommendations of WPATH, psychologists are still the first line of defense in treating transgenderism, and are the gatekeepers of transgender healthcare.

A more accessible model of healthcare is one that reflects the gender diversity found in humans, that extends beyond the binary notions of male and female to the multitude of genders that can and do exist. Biology has found that not only do more than two genders exist, but the forms that they take are not mutually exclusive. There is variety in gender found all across the spectrum of life, and humans are not unique in this. Destabilizing binary notions of gender and educating medical professionals on the far-reaching existence of non-normative genders is critical to the furthering of transgender affirmation in health care. The practices of the medical

community need to reflect the biological diversity that is present in all life, including humans, in order to provide the best care possible for all individuals, especially ones who identify as transgender.

Furthermore, a healthcare system that truly prioritizes transgender autonomy is one that utilizes the informed consent model. Informed consent is critical to allowing transgender individuals to access health care as an active participant rather than as a passive recipient (Schulz 2018). The current system that emphasizes diagnoses as the center of medical treatments exists to limit the accessibility of care by transgender individuals, both medically and financially. Transgender individuals deserve the right to make informed decisions about their health care, and should not be limited by the outdated views of psychologists regarding their supposed mental incapacity.

Shifts have already occurred in the way the medical community treats transgender patients, with regard to the improved accessibility of care, larger research on treatment, and a wider variety of options for transgender individuals seeking transition-related services. However, despite all of the advancements that have been made, there is more to be done. Transgenderism, and its symptoms, should be formally declassified in the *DSM*—meaning it should no longer be categorized as a mental health disorder by medical professionals. It is unacceptable to continue to limit the transgender population's accessibility to health care with outdated notions of gender, psychopathy, and ability to make informed decisions about personal care. Transgenderism is first and foremost an identity, individual to a person's subjective experience and expression of gender, and is most decidedly not a disorder as it has long been categorized by psychologists and medical practitioners.

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## Appendices

### Appendix A

Table 1: Sex Orientation Scale (S.O.S.): Sex and Gender Role Disorientation and Indecision (Males)

Profile	Type I Transvestite (TV) <i>Pseudo</i>	Type II Transvestite <i>Fetishistic</i>	Type III Transvestite <i>True</i>	Type IV Transsexual (TS) <i>Nonsurgical</i>	Type V True Transsexual <i>Moderate Intensity</i>	Type VI True Transsexual <i>High Intensity</i>
Gender "Feeling"	Masculine	Masculine	Masculine (but with less conviction)	Undecided, Wavering between TV and TS.	Feminine. ("Trapped in the male body").	Feminine. Total "psycho-sexual" inversion.
Dressing Habits and Social Life	Lives as a man. Could get occasional "kick" out of "dressing." Not truly TV. Normal male life	Lives as a man. "Dresses" periodically or part of the time. "Dresses" underneath male clothes.	"Dresses" constantly or as often as possible. May live and be accepted as woman. May "dress" underneath male clothes, if no other chance.	"Dresses" as often as possible with insufficient relief of his gender discomfort. May live as man or woman; sometimes alternating.	Lives and works as woman if possible. Insufficient relief from "crossdressing."	May live and work as woman. "Dressing" gives insufficient relief. Gender discomfort intense.
Sex Object Choice and Sex Life	Hetero-, bi-, or homosexual. "Dressing" and "sexchange" may occur in masturbation fantasies mainly. May enjoy transvestite literature only.	Heterosexual. Rarely bisexual. Masturbation with fetish. Guilt feelings. "Purges" and relapses.	Heterosexual, except when "dressed." "Dressing" gives sexual satisfaction with relief of gender discomfort. May "purge" and relapse.	Libido often low. Asexual or auto- erotic. Could be bisexual. Could also be married and have children.	Libido low. Asexual, auto- erotic, or passive homosexual activity. May have been married and have children.	Intensely desires relations with normal male as "female," if young. Later, libido low. May have been married and have children, by using fantasies in intercourse.
Kinsey Scale	0-6	0-2	0-2	1-4	4-6	6
Conversion Operation?	Not considered in reality.	Rejected.	Actually rejected, but idea can be attractive.	Attractive but not requested or attraction not admitted.	Requested. Usually indicated.	Urgently requested and usually attained. Indicated.
Estrogen Medication?	Not interested. Not indicated.	Rarely interested. Occasionally useful to reduce libido.	Attractive as an experiment. Can be helpful emotionally.	Needed for comfort and emotional balance.	Needed as substitute for or preliminary to operation.	Required for partial relief.
Psychotherapy?	Not wanted. Unnecessary.	May be successful. (In a favorable environment.)	If attempted is usually not successful as to cure.	Only as guidance; otherwise refused or unsuccessful.	Rejected. Useless as to cure. Permissive psychological guidance.	Psychological guidance or psychotherapy for symptomatic relief.
Remarks	Interest in "dressing" only sporadic.	May imitate double (masculine and feminine) personality with male and female names.	May assume double personality. Trend toward transsexualism.	Social life dependent upon circumstances.	Operation hoped for and worked for. Often attained.	Despises his male sex organs. Danger of suicide or self- mutilation, if too long frustrated.

\*Type 0: Normal sex orientation and identification, heterosexual or homosexual. The ideas of "dressing" or "sex change" foreign and unpleasant. Vast majority of people (Benjamin 1966: )

## Appendix B

### DSM Diagnoses of Gender Identity Disorder

Table 1: *DSM-III* (1980)

Requirements
<p>A. Sense of discomfort and inappropriateness about one's anatomic sex.</p> <p>B. Wish to be rid of one's own genitals and live as a member of the other sex.</p> <p>C. The disturbance has been continuous (not limited to periods of stress) for at least two years.</p> <p>D. Absence of physical intersex or genetic abnormality.</p> <p>E. Not due to another mental disorder, such as Schizophrenia</p> <p>(<i>DSM-III</i> 1980:263-264)</p>

Table 2: *DSM-IV* (1994)

Requirements
<p>A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).</p> <p>In children, the disturbance is manifested by four (or more) of the following:</p> <ol style="list-style-type: none"> <li>(1) Repeatedly stated desire to be, or insistence that he or she is, the other sex.</li> <li>(2) In boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing.</li> <li>(3) Strong and persistent preferences for cross-sex roles in make believe play or persistent fantasies of being the other sex.</li> <li>(4) Intense desire to participate in the stereotypical games and pastimes of the other sex.</li> <li>(5) Strong preference for playmates of the other sex.</li> </ol> <p>In adolescents and adults, the disturbance is manifested by symptoms such as 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.</p>
<p>B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.</p> <p>In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.</p>

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.

(*DSM-IV* 1994:537-538)

*Table 3: DSM-V (2013)*

Requirements
<p>Gender Dysphoria in Children</p> <ul style="list-style-type: none"> <li>A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1): A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).               <ol style="list-style-type: none"> <li>1. In boys (assigned gender), a strong preference for crossdressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.</li> <li>2. A strong preference for cross-gender roles in make-believe play or fantasy play.</li> <li>3. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.</li> <li>4. A strong preference for playmates of the other gender.</li> <li>5. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.</li> <li>6. A strong dislike of one's sexual anatomy.</li> <li>7. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.</li> </ol> </li> <li>B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.</li> </ul> <p>Gender Dysphoria in Adolescents and Adults</p> <ul style="list-style-type: none"> <li>A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:               <ol style="list-style-type: none"> <li>1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).</li> </ol> </li> </ul>

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

A. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

(*DSM-V* 2013:452-453).

## Appendix C

### Insurance Guidelines on Transgender Coverage

Table 1: Aetna (2018)

Requirements
<ol style="list-style-type: none"> <li>1. Requirements for mastectomy for female-to-male patients: Single letter of referral from a qualified mental health professional (see Appendix); and               <ol style="list-style-type: none"> <li>1. Persistent, well-documented gender dysphoria (see Appendix); and</li> <li>2. Capacity to make a fully informed decision and to consent for treatment; and</li> <li>3. Age of majority (18 years of age or older); and</li> <li>4. If significant medical or mental health concerns are present, they must be reasonably well controlled.</li> </ol> </li> <li>2. Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female):               <ol style="list-style-type: none"> <li>1. Two referral letters from qualified mental health professionals, one in a purely evaluative role (see appendix); and</li> <li>2. Persistent, well-documented gender dysphoria (see Appendix); and</li> <li>3. Capacity to make a fully informed decision and to consent for treatment; and</li> <li>4. Age of majority (18 years or older); and</li> <li>5. If significant medical or mental health concerns are present, they must be reasonably well controlled; and</li> <li>6. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones)</li> </ol> </li> <li>3. Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male to female)               <ol style="list-style-type: none"> <li>1. Two referral letters from qualified mental health professionals, one in a purely evaluative role (see appendix); and</li> <li>2. Persistent, well-documented gender dysphoria (see Appendix); and</li> <li>3. Capacity to make a fully informed decision and to consent for treatment; and</li> <li>4. Age of majority (age 18 years and older); and</li> <li>5. If significant medical or mental health concerns are present, they must be reasonably well controlled; and</li> <li>6. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones); and</li> <li>7. Twelve months of living in a gender role that is congruent with their gender identity (real life experience).</li> </ol> </li> </ol>
<p>Aetna considers gonadotropin-releasing hormone medically necessary to suppress puberty in trans identified adolescents if they meet World Professional Association for Transgender Health (WPATH) criteria.  <a href="http://www.aetna.com/cpb/medical/data/600_699/0615.html">http://www.aetna.com/cpb/medical/data/600_699/0615.html</a></p>

Table 2: Cigna (2018)

Requirements
<p>Medically necessary treatment for an individual with gender dysphoria may include ANY of the following services, when services are available in the benefit plan:</p> <ul style="list-style-type: none"> <li>• Behavioral health services, including but not limited to, counseling for gender dysphoria and related psychiatric conditions (e.g., anxiety, depression)</li> <li>• Hormonal therapy, including but not limited to androgens, anti-androgens, GnRH analogues, estrogens, and progestins.</li> <li>• Laboratory testing to monitor prescribed hormonal therapy</li> <li>• Age-related, gender-specific services, including but not limited to preventive health, as appropriate to the individuals biological anatomy (e.g., cancer screening [e.g., cervical, breast, prostate]; treatment of a prostate medical condition)</li> <li>• Gender reassignment and related surgery (see below).</li> </ul> <p>Gender reassignment surgery is considered medically necessary treatment of gender dysphoria when the individual is age 18 years or older and when the following criteria are met:</p> <ul style="list-style-type: none"> <li>• For initial mastectomy: one letter of support from a qualified mental health professional.</li> <li>• For hysterectomy, salpingo-oophorectomy, orchiectomy: <ul style="list-style-type: none"> <li>• documentation of at least 12 months of continuous hormonal sex reassignment therapy AND</li> <li>• recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery. (If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both [for example, if practicing within the same clinic] are required.</li> </ul> </li> <li>• For reconstructive genital surgery: <ul style="list-style-type: none"> <li>• documentation of at least 12 months of continuous hormonal sex reassignment therapy AND</li> <li>• recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery. (If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both [for example, if practicing within the same clinic] are required AND</li> <li>• documentation the individual has lived for at least 12 continuous months in a gender role that is congruent with their gender identity.</li> </ul> </li> </ul> <p>(<a href="https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0266_coveragepositioncriteria_gender_reassignment_surgery.pdf">https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0266_coveragepositioncriteria_gender_reassignment_surgery.pdf</a>)</p>

Table 3: UnitedHealthcare (2018)

Requirements
<p>Gender reassignment surgery may be indicated for individuals who provide the following documentation:</p> <ul style="list-style-type: none"> <li>• A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria is needed for breast surgery. The assessment must document that an individual meets all of the following criteria: <ul style="list-style-type: none"> <li>• Persistent, well-documented Gender Dysphoria</li> <li>• Capacity to make a fully informed decision and to consent for treatment</li> <li>• Must be at least 18 years of age (age of majority)</li> <li>• If significant medical or mental health concerns are present, they must be reasonably well controlled</li> </ul> </li> <li>• A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the individual, are required for genital surgery. The assessment must document that an individual meets all of the following criteria: <ul style="list-style-type: none"> <li>• Persistent, well-documented Gender Dysphoria</li> <li>• Capacity to make a fully informed decision and to consent for treatment</li> <li>• Must be at least 18 years of age (age of majority)</li> <li>• If significant medical or mental health concerns are present, they must be reasonably well controlled</li> <li>• Complete at least 12 months of successful continuous full-time real-life experience in the desired gender</li> <li>• Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated)</li> </ul> </li> <li>• Treatment plan that includes ongoing follow-up and care by a qualified behavioral health provider experienced in treating Gender Dysphoria.</li> </ul> <p>(<a href="https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan/gender-dysphoria-treatment-cs.pdf">https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan/gender-dysphoria-treatment-cs.pdf</a>)</p>

## Appendix D

### T. Benjamin Singer's Healthcare Proposal

Table 1: Healthcare Paradigm Shift

Pathology Model	Trans-health Model
<ul style="list-style-type: none"> <li>• Normative bodies and Genders               <ul style="list-style-type: none"> <li>- M/F—only two types</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Nonstandard Bodies and Genders               <ul style="list-style-type: none"> <li>- Spectrum of body types and genders</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Institutional Regulation               <ul style="list-style-type: none"> <li>- Gate-keeping (meeting standard criteria)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Harm Reduction and Advocacy               <ul style="list-style-type: none"> <li>- Informed Consent</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Experts and Providers in Control</li> </ul>	<ul style="list-style-type: none"> <li>• Peer Expertise and Community Partnering</li> </ul>
<ul style="list-style-type: none"> <li>• Pathologization               <ul style="list-style-type: none"> <li>- Gender Identity Disorder</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Self-determination               <ul style="list-style-type: none"> <li>- Non-disordered Gender Complexity</li> </ul> </li> </ul>

(Singer 2006:615)