The Proposed Revision of the D.S.M. V

A Critique of Proposed Changes to the Way that Transsexualism is Classified

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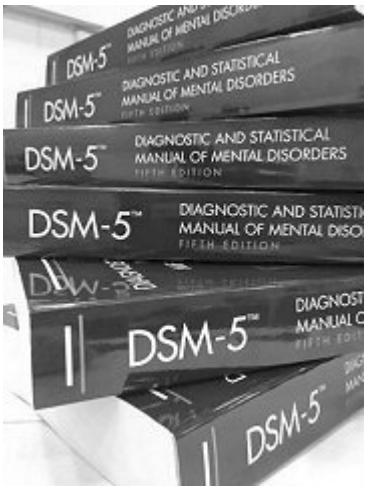

The W.P.A.T.H. does have criticisms which focus on several issues: Continued inclusion of the diagnosis or its removal; the very broad reach of the diagnostic criteria; the desirability of separate or combined diagnoses for adolescents and adults; the name of the diagnosis; and the location of the diagnoses within the *D.S.M.*.

I hope this will be the first of a short series of articles that will explore certain inter-related themes of contemporary interest for transsexuals and for transgendered people generally. It begins with an outline of the changes proposed by the American Psychiatric Association (A.P.A.), a leading professional association of psychiatrists in the U.S., to its diagnostic manual. Some of these changes are relevant for transsexuals. They include changes to the language used to refer to gender variance, the concepts which professionals use when referring to gender variant clients, or clients experiencing "gender incongruence", and the diagnostic criteria themselves. There appears to be a quiet revolution underway in professional circles, by which they refer to us, which is important, for example, if you flinch when being referred to as a person suffering from a mental disorder or possessing a disordered identity (Gender Identity Disorder), simply because you may be gender variant.

At irregular intervals, the A.P.A. reviews its *Diagnostic and Statistical Manual of Mental Disorders*, which is usually abbreviated simply as *D.S.M.*. It is a significant document and represents an attempt by the A.P.A. to provide a common language and standard criteria for the classification of mental disorders. It is used in the United States and to varying degrees around the world by psychiatrists, psychologists, insurance companies, drug regulation agencies and pharmaceutical companies. The current version *D.S.M. IV-T.R.*, which was published in 2000 is being revised and the revision is referred to as *D.S.M. V* and is the fifth since the first edition in 1952.

I suppose that at first glance, if you are not a professional working in the area of mental health this news is hardly breathtaking. After all, the *D.S.M.* is not binding on Australian psychiatrists or psychologists. For transsexuals and certain transgendered people however, the *D.S.M.* is an important document indeed. Ever since the second version in 1968, the *D.S.M.* has been the only manual produced by a professional body anywhere which recognised "Gender Identity Disorders" (G.I.D.) and provided criteria by which clinicians could diagnose patients who may be suffering distress as a result of being "gender-variant". I am putting these phrases in quote marks because for many people who regard themselves variously as being in some way gender-variant or transgendered, the labels themselves can be contentious terms. Nevertheless, because the *D.S.M.* reflected the *Standards of Care (S.O.C.)* first developed by Harry Benjamin in 1966 in his book *The Transsexual Phenomenon*, it developed considerable status among mental health professionals working with transgendered clients. The *Standards of Care* subsequently became the ongoing focus of the work of the former Harry Benjamin International Gender Dysphoria Association, now known as the World Professional Association for Transgender Health (W.P.A.T.H.).

Before getting into the proposed changes themselves, it should be recognised that there is a lively debate in the various gender communities about the very role and necessity for medical gatekeepers. Beyond that, there is also a questioning of the much wider issue of the necessity for legal regulation of any person's gender. Indeed, the very medicalisation of gender-variance has been vigorously contested in some circles. Leaving Harry Benjamin's contribution to one side for a moment, these ideas often surface in debates within the communities regarding, for example, the necessity to sacrifice one's fertility in order to achieve internal and external gender congruence. More and more transgendered people are questioning the necessity for married couples to divorce, where one spouse is undertaking medically assisted gender reassignment and seeking to obtain legal recognition of their preferred gender status. These debates often stray into politically contentious areas within contemporary Australia, such as the current movement in support for same-sex marriage.

At this point I believe some personal disclosure is appropriate. I am a woman who has managed to achieve that status after a long and, at times, painful struggle. I am by no means alone in this. I am a woman who comes from a transsexual background, viz., my birth-assigned gender was male, and that was changed in 2008. I am a woman who has fathered two children and who has four grandchildren. I am fortunate in that I enjoy good relations with my children and grandchildren. Most of my family and siblings and most of my friends accept me as a woman called Jessica. Outside of my family, I find my acceptance by many old friends who knew me before I transitioned, and new friends who have only known me as Jessica, to be wonderfully affirming. Despite this, I am also aware that I am visibly transgendered. I see no point in deluding myself about this. Even if I could afford additional surgical procedures (apart

from my G.R.S.), my skeletal frame still transmits its own gender signals. Not for nothing did I enjoy the physicality of country living! I mention this not to complain about my "lot in life", rather to introduce the concept of a specifically transgender identity to which I will return later in this paper.

Harry Benjamin's great contribution in 1966 was to develop the original standards of care which could be used by medical professionals in caring for clients seeking relief from an inability to live successfully in their birth-assigned gender and to deal with the high levels of stress generated by conflict between their innate and assigned genders. Indeed it can be argued that the only framework in which transsexual clients could seek relief in the second half of the twentieth century, was the medical model. Further, this model provided the framework through which sympathetic governments around the world eventually introduced procedures by which transsexuals could obtain legal recognition of their innate gender.

From a clinical perspective, the medical and surgical treatment parameters and standards of care have improved significantly over the years and a high degree of functional and cosmetic success is often now achieved. However, this earlier, medically pathologising model from 1968 reflected in earlier versions of the *D.S.M.* has outlived its "use-by date" and this is now reflected in the changes that the American Psychiatric Association is proposing to introduce in the *D.S.M. V*.

This is not to deny that there remain many other issues to be addressed, even from a clinical perspective. For example, transsexualism is conceived by many in the medical profession as a self-diagnosed condition and viewed with scepticism: there is as yet no medical test which can definitively provide an objective clinical identifier for the way we feel. As a result, governments in Australia regard gender-affirming surgical interventions as elective, and place the procedures in a group that includes cosmetic procedures, ineligible for government financial support through Medibank. So what exactly is proposed by the A.P.A.? The new diagnostic criteria are shown below:

D.S.M. IV 302.85

GENDER IDENTITY DISORDER IN ADOLESCENTS OR ADULTS

PROPOSED REVISION (*D.S.M. V*)

Gender Incongruence (in Adolescents or Adults)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months duration, as manifested by two or more of the following criteria [2,3,4]:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated sex characteristics)

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, the 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 treated as the other gender (or some alternative gender different from one's assigned gender)

5. 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)

Subtypes

With a disorder of sex development (i.e. intersex)

Without a disorder of sex development (i.e. intersex)

(Source: American Psychiatric Association *D.S.M. V* Development Website)

What are the significant differences between this and the earlier version (*D.S.M. IV-T.R.)* which at first glance looks very bland?

First, there is now a separate set of criteria for children (302.6) where previously the criteria were included with those of adults. These will be discussed below.

There is now provision for a diagnosis to be made in a client who also presents with a Disorder of Sex Development. This is often referred to as "intersex" and previously there was no such provision. In fact in *D.S.M. IV-T.R.*, individuals with intersex conditions were specifically excluded. See the heading "Subtypes" in the box above for the proposed version, and below diagnostic criterion C in *D.S.M. IV*.

D.S.M. IV-TR.

302.85 GENDER IDENTITY DISORDER IN ADOLESCENTS OR ADULTS

Gender Identity Disorder

A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by four (or more) of the following:

1. Repeatedly stated desire to be, or insistence that he or she is, the other sex

2. In boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing

3. Strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex

4. Intense desire to participate in the stereotypical games and pastimes of the other sex

5. Strong preference for playmates of 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 to 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 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 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 to normative feminine clothing.

In adolescents or adults, the disturbance is manifested by symptoms such as pre-occupation 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

Sexually attracted to Females

Two other important changes are: First *D.S.M. V* replaces the word "sex" (e.g., "insistence that he or she is of the other sex") found frequently in *D.S.M. IV* with the word "gender" (e.g., "marked gender incongruence"). The exception is where references are made in *D.S.M. V* to "primary or secondary sex characteristics". This has been done to make the criteria applicable to individuals with a Developmental Sex Disorder (D.S.D.-i.e..., Intersex).

D.S.M. V removes the requirement to specify the sexual orientation of clients seeking a diagnosis. (See the specifier at the foot of the table above setting out the *D.S.M. IV* criteria.) This appears to be consistent with the general thrust of the proposals which have emerged from the A.P.A. Working Group, to move awareness from diagnostic criteria which require the clinician to identify the existence of a gender-identity disorder, and the client to demonstrate ability to conform to a gender binary model (e.g. female versus male). Although not explicitly stated, heteronormative gender conformity in sex roles is implied by the earlier criteria: viz., M.T.F. would be expected to be sexually attracted to men, and F.T.M. to be sexually attracted to women. None of this applies with the proposals for *D.S.M. V*.

Transgendered Children

Since the publication of *D.S.M. IV* the clinical management of very young transgendered clients has become a professionally and politically contentious issue. In North America, clinicians were reporting increasing numbers of very young children, typically from age three to five, presented by distraught parents because of their child's adamant refusal to accept their birth-assigned gender role. Clinicians increasingly found that the diagnostic criteria (*D.S.M. IV*) were of little use in dealing with these clients. Over time, longitudinal data emerged from these clinics indicating that many of these children did not go on to present in adolescence with symptoms of gender incongruence but typically began to indicate same-sex sexual preferences and in other cases heterosexual social and sexual development.

Clinicians began to have concerns that a premature diagnosis of gender incongruence could well have a "lock-in" effect, when in fact

the behaviour patterns exhibited by these children which may have been distressing to parents, formed a part of normal psychological growth and development.

In response to professional concerns and to meet the needs of transgendered children a separate set of diagnostic criteria has been developed. In contrast to the criteria for adolescents and adults where the number of diagnostic indicators has been reduced typically to three, there are six criteria proposed for children. The language has been strengthened typically with phrases such as "a strong desire to be of the other gender" or "a strong dislike of one's sexual anatomy".

Critique of the Proposed Revision

The responses from professionals have been positive. The W.P.A.T.H., in its response applauds many of the diagnostic changes put forward by the working group, adding that "it is clear that the work group has made a serious effort to respond to the criticisms over the years by both consumers and professionals in the area of transgender care". - (W.P.A.T.H.: Response of the World Professional Association for Transgender Health to Proposed *D.S.M. V* Criteria for Gender Incongruence. 25th May 2010).

Thus the changes are reflected in both the language and the criteria used. The proposed change in name from Gender Identity Disorder to Gender Incongruence is less pathologising and no longer suggests that one's identity is disordered. This is not a trivial matter. This pathologising is regarded by many in transgender communities as one major cause for the very high levels of stigma associated with being transgendered. Further, the very high levels of social stigma are the major cause of the high levels of psychological distress and morbidity experienced within transgendered communities.

The changes with regard to Intersex clients, the new separate criteria for transgendered children and the removal of the requirement to specify sexual orientation have all been well received by professionals.

The W.P.A.T.H. does have criticisms which focus on several issues: Continued inclusion of the diagnosis or its removal; the very broad reach of the diagnostic criteria; the desirability of separate or combined diagnoses for adolescents and adults; the name of the diagnosis; and the location of the diagnoses within the *D.S.M.*. Two of these are interesting.

The very broad reach of the diagnostic criteria indicates a marked divergence of views within the W.P.A.T.H. focus group. W.P.A.T.H. prefers the term "gender dysphoria" rather than "gender incongruence", because they argue that this better reflects that a diagnosis is only necessary (W.P.A.T.H.s view) when clinically significant levels of distress are associated with gender-variance in a client.

They argue, moreover, that the term "gender incongruence" implies that congruence is the norm and that incongruence is by definition problematic, which is not necessarily the case. W.P.A.T.H. believes that in removing "distress" and "impairment" from the diagnostic criteria undercuts the necessity for having a diagnosis. It is distress and impairment which lead transgendered clients to seek treatment.

"If there is no distress or suffering and no treatment is desired, why is a diagnosis needed? - (W.P.A.T.H.: Response of the World Professional Association for Transgender Health to the Proposed *D.S.M. V* Criteria for Gender Incongruence. 25th May 2010)

The answer appears to be found in the debate about where to place the diagnoses in the new *D.S.M.*. This has not yet been decided by the A.P.A., but W.P.A.T.H. responded that any location which de-pathologises gender variance is seen as acceptable, as long as it does not endanger health insurance coverage for transgender specific health care.

Towards a Transgender Identity – Dichotomy or Diversity

From a historical perspective, there has been a marked evolution during the twentieth century in the diagnostic concepts and possible treatments available to people who sought help for feelings of distress experienced because of a conflict between their perceived and birth-assigned genders.

Although transgendered people have existed throughout recorded time and across many cultures, the development of medical technology, especially since 1945, has steadily transformed the options available to gender-variant people. This is no accident. Although surgical procedures existed before then, it was only in 1931 that the male sex-hormone testosterone was first synthesised, it was 1934 when progesterone was first isolated and 1938 when the British chemist Charles Dodd synthesised the first synthetic oestrogen which later gave rise to the first contraceptive pill.

In 1966, the work of Harry Benjamin enabled sex-reassignment to become the treatment of choice, replacing earlier attempts at behaviour modification through psychotherapy.

The task of the medical professionals was to determine whether the client was a "true transsexual", that is a woman trapped in a man's body or a man trapped in a women's body, or a transvestite whose primary motivation for cross-dressing and spending time in the cross-gender role was regarded as sexual and/or compulsive.

Before the 1990s, the treatment for both transsexualism and cross-dressing followed a binary conceptualisation of gender. Transsexuals were candidates for a change of sex. Cross-sexed hormone therapy and sex-reassignment surgeries were recommended. The emphasis in the "real life test" was on "passing" in the "opposite" gender role.

Increasingly, however, transgender people describe their gender identities in ways that transcend a dichotomous view of gender. The following tables list responses received when transgender individuals were asked to respond to the following query: "Please describe how you identify in terms of your transgender-identity". Responses were categorised as reflecting dichotomy or diversity (Bockting 2008). The conclusion is that there is no one way of being transgender.

Dichotomy

From Bockting W. 2008, Self-identification of gender-identity among national sample of the U.S. n=1,229

- Female M.T.F. / Male F.T.M.
- Female with the genitalia of a male - M.T.F.
- Woman with a correctable birth defect
- Woman with a transsexual history
- Displaced Male - F.T.M.
- Boy who's syringe gives him the testosterone his balls cannot
- Man to male - F.T.M.
- Formerly transsexual
- Survivor of transsexuality
- Closet transsexual
- God just made a slight error

Diversity

From Bockting W. 2008, Self-identification of gender-identity among national sample of the U.S. n=1,229

- Transgender
- post-op. man of transsexual experience
- 75 percent Female, no plans on surgery or hormones
- Shemale
- Bi-Gender / Two Spirit
- Gender neutral / Genderless / neither male nor female
- Androgyne
- Third Gender
- Pan / Poly / Omni / Gendered
- M.T.F. Dyke, Tomboy, Butch Queen, F.T.M. Fag
- (non-biological Intersexed female to none of the above
- Gender Queer: Female bodies but neither female nor male in gender

Given this diversity, treatment protocols are changing. Clinical management now focuses on a more individualised approach rather than following a standardised protocol of sex-reassignment. H.R.T. and genital reconstruction surgery (G.R.S.) are no longer part of linear progress to "sex-reassignment", but are treatment options which may be used in conjunction or standing alone. "The motivation for G.R.S. today is not so much to "change sex" or confirm gender-identity, but more to improve body image and improve sexual functioning". (Bockting 2008)

Given this increasing flexibility in treatment parameters however, the "gender diverse" universe still needs to intersect with a largely gender-binary world of the wider community in which we live. A binary world in which our non-transgendered fellow-citizens often cannot make the distinction between gender-identity and sexual orientation and do not understand that "who we are" is separate from "whom we prefer to relate to".

Even within the "gender-dichotomous" world, however, there exists a debate in the wider community about what it means to be a "woman" or a "man". There are plenty of examples of families where the husband is a "stay-at-home" husband and carer of the children and the wife is the bread-winner. Later the roles within the family may revert to a more "traditional" pattern. There are women who play rugby and cricket and men who are ballet dancers as well as husbands and fathers (in either hetero or same-sex families).

There are examples of same-sex couples who are parents and decide how the child-rearing burden will be shared and who will be the primary bread winner. Women increasingly comprise more than 50 percent of the graduation lists in professions such as law, and engineering as well as dominating the lists in traditionally feminised occupations such as nursing and teaching.

All these decisions of daily life are also made within families in which one parent may be transgendered. The only distinction between "women" and "men" in these two circumstances is that transgendered men and women usually reach that status some time after receiving a birth-assigned gender. That means that the experiences of transgendered men and women will inevitably be different from those of their natal brothers and sisters. That difference has positive as well as negative dimensions: If we only focus on the negative aspects of this exclusionary process, we will neglect the positive contribution that transgendered men and women can make to debates about gender relations and the unique perspectives we can offer.

Select References

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American Psychiatric Association Proposed Revisions to *D.S.M. V* 302.6 Gender Identity Disorder in Children

American Psychiatric Association Proposed Revisions to *D.S.M. V* 302.85 Gender Identity Disorder in Adolescents or Adults

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