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DSM Discrimination and the LGBT Community: Using the History of Diagnostic Discrimination Against Sexual Minorities to Contextualize Current Issues in Transgender and Gender Diverse Mental Healthcare

Ginelle Wolfe
The University of Akron

Nicole Fogwell

The field of psychology has a long history of discrimination against lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons that continues to impact the queer community's ability to access competent psychological care (Moleiro & Pinto, 2015; Richmond et al., 2012; Schulz, 2018). The field has moved away from explicit pathologizing of sexual minority identity, although discrimination and lack of competent services still impact sexual minorities. However, transgender and gender diverse (TGGD) individuals continue to be formally pathologized and face, in some cases, more extreme barriers to accessing non-discriminatory, culturally competent care, with significantly fewer psychologists reporting any training for clinical practice with TGGD persons relative to training related to lesbian, gay, and bisexual (LGB) identities (Schulz, 2018; American Psychological Association [APA] 2015). Recommendations for working with TGGD populations remain disorganized, conflictual, and in flux (Richmond et al., 2010). We seek to explore the history of psychology's approach toward queerness to contextualize current issues and provide recommendations for practice. That is, we explore the history of discrimination and cis-heteronormative belief systems in the fields of psychology and psychiatry by examining first the ways that sexual minority individuals have been historically pathologized for their gender deviance and using this as a framework to explore current discrimination against transgender and gender diverse persons.

It is important to note that sexual orientation and gender identity are distinct and separate constructs and that we do not intend to collapse the two into one, as has often been done by scholars who give but a perfunctory nod to transgender individuals when studying the LGBTQ community (Moradi et al., 2016). Rather, we aim to use the overlap in the type of oppression that these groups face (i.e., oppression based on cisheteronormative beliefs about gender and sex) to understand how psychology has shifted from pathologizing sexual minority identity to pathologizing gender identity. We also discuss the progression of various gender and sexual identity-related disorders in the DSM that pathologize LGBTQ+ identities. This historical approach is used to contextualize the DSM-V-TR diagnosis of Gender Dysphoria and provide related recommendations for psychological practice with TGGD populations.

Author Positionality

It is considered best practice in queer research to disclose and explore how one's positionality may impact the content and process of research (Tebbe & Budge, 2016). The first author is a cisgender heterosexual white woman. My research interests include gender ideology and feminist research broadly. I recognize that as a cisgender, heterosexual woman, I will not have the lived experiences and, therefore, not fully understand the experiences of the populations discussed in this

paper. I use intersectional theories, particularly queer theory, to guide my work of questioning systems that pressure people to conform to gender expectations.

The second author is a queer, white, cisgender, middle-class woman. As cisgender researchers, our experiences as cis people shape the research process- including but not limited to the way that we formulate research questions and hypotheses, how we interpret and frame results, and the way our work is regarded by others in the field (Galupo, 2017). My lived experiences in community with other queer people, societal and interpersonal oppression, and experiences in long-term same-gender relationships also inform the way that my research is formulated and perceived. As a queer person, I consider gender-diverse persons members of my community. However, there is a significant history of cisgender queer women, particularly white cis women, centering their own voices and perspectives at the expense of transgender women, nonbinary people, and people of color (Galupo, 2017). I hope that by intentionally grounding myself in the suggestions made by trans researchers for research on trans persons (i.e., Tebbe & Budge, 2016) and grounding my work in feminist principles, I will minimize the impact of biases and blind spots. This involves engaging in vigilance around the assumptions underlying my goals related to conducting this research, as well as making certain this work is used to advance the treatment of gender-diverse people in society (Fisher & DeBoard, 2012).

Use of Language

The language used around sexual orientation and gender identity rapidly evolves and changes, and the use and meaning of a particular term may vary according to context and speaker (Tebbe & Budge, 2016). To orient the reader, we provide a brief description of the different terms used throughout:

- Cisgender: Individuals who identify with the gender they were assigned at birth.
- Cis-heteronormativity: A pervasive societal belief system that privileges and centers heterosexuality and binary gender, assuming that there are only two ways of being- men who were assigned male at birth and women who were assigned female at birth.
- Homosexual/homosexuality: These terms are used frequently throughout the text due to their historical significance in referring to individuals who are attracted to the same gender. While the term homosexual is no longer popular and may be considered by some to be offensive, it is used in this text in keeping with historical context. Note that this term is not used exclusively. That is, it also includes individuals who are attracted to both the same gender and other genders. Multisexual: Being attracted to more than one gender. Includes the identities of bisexuality, pansexuality, etc.

- Queer: Queer is used as an umbrella term to describe all individuals who identify with a marginalized gender identity or sexual orientation. Reclaimed by queer activists beginning in the 1960s, queer was previously used as a derogatory term for anyone who did not subscribe to cisheteronormative standards of gendered behavior (Halperin, 2003).
- Sexual Minority: This term is used to refer to all individuals who are not heterosexual.
- Transgender and Gender Diverse (TGGD): These terms are used interchangeably to refer to individuals who do not identify with the gender they were assigned at birth. The term transgender is used due to its historical and cultural importance. However, since not all individuals who do not identify with the gender they were assigned at birth identify with the label transgender, we also include the more expansive term gender diverse, consistent with current research (Rider et al., 2019). Given that gender is a fluid concept that has various cultural influences, there are many terms that folks often use to describe their identities. These can include but are not limited to: TNB, trans and nonbinary, trans people, two-spirit, and genderfluid. However, for clarity and consistency, we use the acronym "TGGD."

Binary Beliefs

It is worth noting that almost all theories of sexual orientation variance draw upon gender beliefs that contain implicit ideas about the "essential" qualities of men and women (De Block & Adriaens, 2013). Binary gender beliefs and their associated moral underpinning frequently play a role in theories about the causes and/or meaning of homosexuality (Drescher, 2015). These gender beliefs are based on gender binaries, the most ancient of which is the male vs. female binary. The 20th century saw the invention of a binary of straight vs. gay, discounting and ignoring all multisexual individuals and downplaying the rich complexity of human sexuality (Drescher, 2015). In the 21st century, the binary of cisgender vs. transgender has gone unquestioned by many, and public discourse around non-binary identity and fluidity and space between the labels of cis and trans is in its infancy (Moradi et al., 2016). These binaries, formed by and central to a Western colonialist perspective, have been globally exported and are now present in almost all cultures, including many with traditionally expansive views of gender and sexuality (De Block & Adriaens, 2013). Research on gender and sexuality often reinforces these beliefs. For example, the intersex hypothesis of homosexuality maintains that the brains of homosexual individuals exhibit characteristics that would be more typical of the "opposite" sex (Drescher, 2015), reinforcing essentialist beliefs (e.g., the idea that attraction to women is a masculine trait). Such

binary beliefs around gender only allow for the recognition of the existence of two sexes and treat the categories of "man" and "women" as if they are mutually exclusive. This leads to a torrent of deleterious consequences, from homophobia to unnecessary surgeries on intersex children to the murder of TGGD people.

Theories of Homosexuality

The ways that theories of same-sex sexual behavior have developed and progressed provide us with a framework with which to analyze theories of gender variance. Three theories regarding the nature of homosexuality dominated late 19th and early 20th-century psychological discourse on the topic. The most popular perspective of the era was that of homosexuality as a type of pathology (Feray et al., 1990). Richard Von Krafft-Ebing, a turn-of-the-century German psychiatrist, developed one of the first theories of pathology in 1886 (Kennedy, 2002). He described this theory in his seminal work, *Psychopathia Sexualis* (1998 [1886]), one of the first books about sexual practices in the western world to investigate homosexuality and bisexuality (Kennedy, 2002). In it, he wrote:

> Homosexuals are essentially disagreeable people, regardless of their pleasant or unpleasant outward manner... [their] shell is a mixture of superciliousness, fake aggression, and whimpering. Like all psychic masochists, they are subservient when confronted with a stronger person, merciless when in power, unscrupulous about trampling on a weaker person (Von Krafft-Ebing, 1886, p. 155)

Von Krafft-Ebing's work set the stage for pathologizing assumptions in psychiatric diagnostic manuals. However, his conclusions fell out of fashion relatively quickly, partly due to physicians' preference for psychoanalytic theories of homosexuality that presented same-sex attraction as a psychological problem (Drescher, 2015). Freud's theory of homosexuality considered same-sex attractions to be a sign of immaturity, as he viewed the expressions of homosexual feelings or behavior at a young age as a normal step toward the development of adult heterosexuality (Goldberg, 2001). Freud theorized that all humans were innately bisexual and that individuals become heterosexual through a psycho-sexual developmental process. Homosexuality was thus considered by Freud's devotees as a passing phase that should be outgrown before adulthood (Goldberg, 2001). These theorists viewed the immaturity of homosexuality in adults as more benign than theorists who considered it a disease. Freud wrote in 1935 to the mother of a homosexual, published in the American Journal of Psychiatry nearly two decades later:

> Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness; we consider it to be a variation of the sexual function produced by certain arrest of sexual

> development. Many highly respectable individuals of ancient and modern times have been homosexuals, several of the greatest among them (Plato, Michelangelo, Leonardo da Vinci, etc.). It is a great injustice to persecute homosexuality as a crime, and cruelty too (Freud, 1951, p. 787).

Freud's understanding of homosexuality, while not consistent with current perspectives that affirm and celebrate sexual minority identity, was relatively progressive for that of his era. Freud was against trying to "convert" homosexuals into heterosexuality and viewed this as a futile endeavor.

The next generation of psychoanalysts disagreed with Freud on this count. Led by Sandor Rado, these analysts viewed heterosexuality as the only biological norm, while homosexuality was seen as a phobic avoidance of the other sex caused by inadequate parenting (Tontonoz, 2017). Rado, a Hungarian psychologist who spent most of his career practicing in the United States, is credited with playing a central role in shaping American psychoanalytic attitudes towards homosexuality. He rejected Freud's notion of initial bisexuality and viewed homosexuality as pathological, albeit "curable" (Tontonoz, 2017). Rado considered homosexuality to be a sociopathic personality disturbance, and his influence and legacy played a large role in the inclusion of homosexuality in the first edition of the DSM.

Theories of normal variation that describe homosexuality as a phenomenon that occurs naturally were not entirely missing from the turn-of-the-century discourse. Hungarian journalist Karoli Maria Kertbeny was one of the first to put forth this perspective. Kertbeny fought against Germany and Prussia's laws that criminalized gay male sexual behavior (Feray et al., 1990). Kertbeny is credited with coining the term "homosexual" in two anonymous pamphlets published in Leipzig in 1869, wherein he criticized laws that criminalized same-sex sexual activity. Kertbeny argued that homosexuality was inborn and unchangeable, and considered attraction to the same sex to be a normal and natural variation in the population (Feray et al.,1990). Many hypothesized that Kertbeny himself was gay, as he detailed his affinity for male beauty in diaries discovered after his death, and his relationships with women were somewhat ambiguous (Herzer, 1986). If so, Kertbeny may be considered one of the earliest gay activists in the modern era of Western Europe and the U.S. (Herzer, 1986).

Theories of Gender Variance

Gender identity and sexual orientation have been historically confused and conflated both broadly in popular culture and in the field of psychology (Drescher, 2015). Theories of traditional masculinity ideology have described belief in a strictly adhered-to gender binary as part of traditional masculinity ideology, with negative attitudes towards sexual minorities stemming from these beliefs (Levant et al., 2013). Research shows that according to this theory, men who were attracted

to men are seen as "less of a man" or more feminine (David & Brannon, 1976), with similar logic applied to queer women, blending the concepts of sexual orientation and gender.

While the history of sexual orientation beliefs has considerable overlap with the history of gender beliefs, the history of gender variance in psychology is distinct. However, because history and theory have so often tied and conflated the two and because of the similarity of their roots in gender beliefs and gender roles, the history of diagnoses related to homosexuality in the DSM may be considered part of the history of the pathology of gender variance.

In his book, *Psychopathia sexualis*, Von Krafft-Ebing (1998[1886]) also asserted that gender variance was pathological, and he extended this argument to TGGD folks when he discussed individuals living as a gender that was different from their sex assigned at birth. Hirschfield (1923; as cited in Drescher, 2010) was the first person documented in history as distinguishing between wanting to have partners of the same gender and wanting to live as a gender not assigned at birth. John Money (1955, 1957; as cited in Drescher, 2010) was the first person to coin the term "gender identity" (p.437). He was a psychologist and sexologist who coined the term to separate gender identity from sexual orientation. Money went on to open the first sex reassignment surgery clinic and founded the Scientific Humanitarian Committee.

Harry Benjamin (1967) was a German American physician who worked to spread awareness about gender identity and coined the term "transsexual" (p. 428) in ADD. Throughout his work, he provided biological explanations for gender variance and "believed that the transsexual suffers from a biological disorder, that his brain was probably 'feminized' in utero. He eschews any psychological explanation'' (Person, 2008, p. 272). Rather than viewing feelings of incongruency as pathological, as most medical and psychiatric practitioners at the time did (Socarides, 1969), Benjamin affirmed the legitimacy of gender variance and began providing hormonal treatments to gender variant individuals.

Robert Stoller (1964) introduced a psychological component to gender identity, asserting that childhood family dynamics played a role in gender identity. He postulated that an absent father coupled with too much mother involvement could impact gender identity. A student of John Money, Stoller studied children who displayed gender variance. Although much of Stoller's theories have been discredited, Stoller was one of the main psychiatrists who advocated for the removal of homosexuality from the DSM- and then recommended the inclusion of transsexualism as a diagnosis.

The DSM and DSM-II

The Diagnostic and Statistical Manual for Mental Disorders (DSM; APA, 2013), in its various editions, has served as the gold standard for psychological and psychiatric diagnoses in the United States since the mid-20th century. The DSM-V's purpose is to be used by health care professionals as a common language "to provide clear descriptions of diagnostic categories to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders" (APA, 2013, p. 1). In the first edition of the DSM (APA, 1952), homosexuality was in the *Sexual Deviations* section of the manual, along with transvestism, pedophilia, fetishism, and sexual sadism (APA, 1952). The section on sexual deviations was included within the *Sociopathic Personality Disturbance* category of the personality disorders section (APA, 1952). The DSM-II (APA, 1968) retained the homosexuality diagnosis. Many who recognized the problematic nature of the diagnosis advocated for the removal of the diagnosis from the DSM since its inception in hopes of depathologizing sexual orientation both in psychological and psychiatric discourse and in United States culture (Drescher, 2015; Greenberg, 1997).

Path to Depathologizing Homosexuality

Mid-Century Influences

Many of the prevalent myths surrounding homosexuality in academic discourse were shattered by The Kinsey Reports in the 1940s (Drescher, 2015; Geddes & Curie, 1948; Kinsey et al., 1948). Alfred Kinsey, a biologist, was interested in bringing a taxonomical approach to the study of sexual expression by classifying and describing sexual behavior in a large sample under conditions of anonymity-an endeavor that had not yet been undertaken in Western science (Bullough, 1998). In his landmark report, Kinsey demonstrated that homosexuality was much more common than anyone had previously imagined. He found that 4% of white males were exclusively homosexual throughout their lives, with 10% of males exclusively homosexual for at least three years between adolescence and old age. Perhaps most surprising to people at the time was Kinsey's finding that 37% of the total male population reported at least one overt homosexual experience to the point of orgasm between adolescence and old age (Drescher, 2015). Kinsey's work is credited with challenging many of the widely held sexist and homophobic beliefs of the time and contributing to both feminist and gay liberation movements; such large numbers of men reporting some level of homosexual behavior called into question the logic of homosexuality as a personality disorder diagnosis (Bullough, 1998; Drescher, 2015).

Soon after the Kinsey Report, anthropologist Clellan Ford and ethologist Frank Beach explored both biological and social influences on sex in their classic text "Patterns of Sexual Behavior" (Lyons & Lyons, 2004). In this 1951 book, Ford and Beach explored same-sex behavior across 76 different cultures and in a variety of animal species. Out of the 76 societies studied, 49 societies approved of male same-sex behavior, with significantly fewer cultures condoning sexual relationships between females (Ford & Beach, 1951). The authors noted that homosexual behavior was particularly accepted in many Indigenous American societies and concluded that there is a "basic mammalian capacity" for same-sex behavior (Ford & Beach, 1951, p. 156). Overall, the text is credited with making homosexuality more acceptable and visible in the culture of the time (Minton, 2002).

Hooker and the Fairy Project

Evelyn Hooker, an American psychologist, made significant contributions to the movement to depathologize homosexuality in the field of psychology (Shneidman, 1998). Hooker's close gay male friend, a former student named Sam From, told her that, because he and his friends had welcomed her into queer subculture despite the risks to themselves, it was her duty to make a study of homosexuals to show that there was nothing "wrong" with gay people (Drescher, 2015). Hooker was hesitant and concerned that her objectivity on the subject was compromised by these friendships, but From insisted and promised that he and his friends would supply any number of gay participants for her study (Hooker, 1993).

Hooker began her research with simple interviews of the gay men that she had social connections with but soon turned to more rigorous inquiry (Kimmel & Garnets, 2003). She applied for a six-month grant from NIMH and, to her surprise, was awarded the money for her work that quickly became known as the "fairy project" (Minton, 2002). Hooker recruited 30 exclusively homosexual men for this project with relative ease thanks to her connections to the community but encountered much more difficulty recruiting heterosexual men (Hooker, 1957).

Each participant in Hooker's study took three projective assessment measures. After scoring the tests, she gave the de-identified testing protocols to three judges who were test experts. She asked the judges to rate the men's adjustment, from superior to pathological, based on their performance on the psychological measures (Hooker, 1957). Judges were then given pairs, one homosexual man and one heterosexual, and asked to determine which protocol belonged to the homosexual and which to the heterosexual. The judges were not able to distinguish between the protocols at levels above chance, and no significant differences were found in the percentages of men in each of those categories of adjustment for any of the three judges (Hooker, 1957). Hooker's results have been

repeated with different methodologies in hundreds of different research studies, but her work was the first in American psychology to show that homosexual people are not less well-adjusted than heterosexuals (Shneidman, 1998). Hooker went on to present the results of her groundbreaking research at the 1956 Chicago American Psychological Association convention, sparking a massive amount of discussion on LGB issues at an APA convention for the first time (Hooker, 1993).

Activism and Removal

Psychiatry's reaction to the growing body of evidence demonstrating that homosexuality was a natural aspect of human diversity rather than a sign of a disordered personality or mental illness varied from neglect to outright hostility (De Block & Adriaens, 2013). In response, a growing anti-psychiatry movement ridiculed medicine's history of diagnostic access, often citing the historical "diagnosis" of drapetomania, a so-called mental illness that affected enslaved Africans fleeing their captors (Drescher, 2015). In the wake of the 1969 Stonewall riots, queer activists disrupted the 1970 and 1971 APA conventions as they saw psychiatric theories as a major contributor to the stigma surrounding homosexuality (Minton, 2002). At the Gay is Good 1971 APA educational panel, gay activists Frank Kameny and Barbra Gittings explained to psychiatrists the stigma caused by the "homosexuality" diagnosis. They returned for the 1972 convention with John Freyer, a gay psychiatrist who disguised his identity and spoke of the discrimination that gay psychiatrists faced from within their own profession (Drescher, 2015). The advocacy and activism of the gay community are considered by many scholars to have been the biggest catalyst for diagnostic change (Minton, 2002).

The APA engaged in internal deliberative processes during this time to determine whether homosexuality should remain a diagnosis. Robert Spitzer, chair of a subcommittee tasked with looking into the issue, concluded that all disorders other than homosexuality regularly caused subjective distress or were associated with generalized impairment in social functioning (Minton, 2002). This need for subjective distress was a new definition of mental disorder at the time, and Spitzer's work led to the nomenclature committee's decision that homosexuality was not, in fact, a mental disorder (Minton, 2002). In December 1973, the APA board of trustees, at last, voted to remove homosexuality from the DSM. For their part, the psychoanalytic community was enraged and petitioned APA to hold a referendum vote on the decision. The decision to remove homosexuality as a diagnosis was upheld by 58% majority of 10,000 voting members (Drescher, 2015).

DSM-II-TR

The American Psychiatric Association removed the homosexuality diagnosis in their 1973 release of the DSM-II-TR and replaced it with the diagnosis of Sexual Orientation Disturbance (SOD), with the stated goal of focusing more on distress related to the identity rather than the identity itself (APA, 1973; Drescher, 2010). The underlying message was that homosexuality was an illness only if one with same-sex attractions found them distressful and wanted to change. Although this change was touted as a significant step towards depathologizing, it legitimized the practice of conversion therapies. Conversion therapy is defined as "any attempt to change a person's sexual orientation, gender identity, or gender expression" (GLAAD, n.d.). The SOD diagnosis was still rooted in the belief that same-sex attraction was an abnormality and something that needed to, or could, be changed. Rather than focusing on or addressing the societal reasons for identity-related distress such as homophobia and systemic discrimination, the treatment considerations for SOD placed blame on the individual by encouraging people who felt distressed to change their attraction (Drescher, 2010; Drescher, 2015). The language of the SOD diagnosis as "distress associated with one's sexual orientation" (p. 390; APA, 1980) located the problem within the individual rather than questioning the systems of oppression leading to distress. This pattern of moving from explicit pathologizing of identity towards diagnoses that reflect identity- and discrimination-related distress continues today in gender-variance-related diagnostic categories.

DSM-III

In the DSM-III, Ego Dystonic Homosexuality replaced SOD. Ego-dystonic homosexuality (EDH) was used as a diagnosis to describe distress associated with the inability to become attracted to the opposite sex (APA, 1980). Proponents of the EDH diagnosis argued that this diagnosis was more focused on the desire to be heterosexual than the distress associated with homosexuality (Spitzer, 1981). Despite the change in verbiage, both SOD and EDH operated on the premise that people with same-sex attractions who were distressed by it could receive treatment to become heterosexual, legitimizing conversion therapies. Both diagnoses continued to pathologize internalized homophobic oppression and, rather than seeking to liberate queer people from an oppressive social order, made distress related to living with a minoritized identity a mental illness (Bayer, 1987; Wilson et al., 2002). Burgeoning research on internalized homophobia strengthened the argument to consider distress related to sexual orientation as reflective of a toxic social environment rather than an issue of the individual (Meyer, 2003). This mirrored the work of scholars of color who framed internalized racism, then known

as psychological oppression, as an unavoidable consequence of living in a systemically and politically oppressive environment (Prilleltensky & Gonick, 1996). Proponents of change came to realize that this diagnosis resulted from prior political settlements and did not meet the current criteria for a disorder (Mass, 1990). The DSM-III also included the diagnosis of Transsexualism, which replaced the previous diagnosis of "Transvestism", which constituted sexual arousal from "cross-dressing" (APA, 1980). This edition also saw the introduction of "gender identity disorder (GID) in Childhood." In the revision of the DSM-III, "GID of adolescence and adulthood, non-transsexual type" was added. This was also the introduction of "sexual disorder not otherwise specified" (SDNOS), often used as a way to continue to diagnose distress about sexual orientation.

DSM- IV and DSM-IV-TR

In the DSM-IV, the APA (1994) removed transsexualism and kept GID, adding separate GID diagnoses for children and adolescents/adults. The SDNOS diagnosis also remained. These diagnoses were moved into a new category titled "Sexual and Gender Identity Disorders." The same diagnoses and category reappeared in the DSM-IV-TR. The introduction of GID in the version of the DSM directly following the removal of homosexuality led to speculation that the GID diagnosis was serving as a "backdoor diagnosis" (p.31) to the homosexuality diagnosis as a new way of pathologizing queerness (Zucker & Spitzer, 2005). The main GID criterion included: (Criterion A) There must be evidence of strong and persistent cross-gender identification, which is the desire to be or the insistence that one is of the other sex, and (Criterion B) There is evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex. Additionally, a person must not be physically intersex and there must be a significant decline in social and occupational functioning (APA, 1994; APA, 2000). The DSM-IV also included sub-classifiers for GID that specified sexual orientation.

GID continued to pathologize gender variant behavior. In fact, treatment recommendations of GID had many similarities to sexual orientation conversion therapy, particularly as they pertained to children (Menvielle, 1998). For example, if a child were diagnosed with GID, parents would be encouraged to ignore behavior or play that resembled a different gender and to reward behaviors that were consistent with the stereotypical gender behaviors associated with the child's sex assigned at birth (Zucker, 2003; Zucker, 2006). Parents were also encouraged to model behavior of the "appropriate" gender and set up playdates for the child with members of the same gender (Bradley & Zucker, 1997). Another approach that is still currently used is to "affirm" the child's gender assigned at birth, stating that they are a valued boy or valued girl (Zucker, 1999). Successful treatment is then marked by the child conforming to the cis-heteronormative ideals for their sex

assigned at birth (Richmond et al., 2010). Research does not support these interventions, and they are often described as a type of conversion therapy with roots in psychoanalysis and religious beliefs (Drescher, 2009).

GID was the beginning of a psychological diagnosis being linked to the ability to receive medication or surgery to transition genders. Proponents of the GID diagnosis saw this as creating a pathway for transgender individuals to get treatment (Minter, 1999). However, many queer persons and their allies expressed concerns that this so-called pathway leads to gatekeeping and ignores sociopolitical factors (Schulz, 2018), creating barriers to transition for all gender diverse people and particularly those who are multiply marginalized. Further, the language of GID continued to reinforce the gender binary by constantly using terms such as "the other gender" or "the opposite sex," which further invalidates and renders invisible nonbinary experiences.

Once again, researchers, clinicians, and activists advocated for the removal of a disorder that pathologized a person's identity (Richmond et al., 2010). The American Psychiatric Association's reaction was like their reaction to protests related to the homosexuality diagnosis- by replacing GID with a diagnosis that sought to capture distress related to the identity rather than the identity itself (APA, 2013; Lev, 2013; Schulz, 2018).

DSM-V and DSM-V-TR: Gender Dysphoria

The fifth edition of the DSM was released in 2013. In the DSM-V, the APA removed GID and replaced the diagnosis with Gender Dysphoria (G.D.; APA, 2013). Like the GID diagnosis, gender dysphoria had two associated diagnoses: gender dysphoria in adolescents or adults and gender dysphoria in children. The diagnosis was moved out of the sexual disorders category into a separate category, and the sexual orientation specifier was removed. In March of 2022, the DSM-V-TR (APA, 2022) was revised. The APA released a document summarizing the changes in the gender dysphoria diagnosis. Terminology changes included replacing "desired gender" with "experienced gender," "cross-sex medical procedure" with "gender-affirming medical procedure," "cross-sex hormone treatment with "gender-affirming hormone treatment," "natal male" with "individual assigned male at birth" and "natal female" with "individual assigned female at birth" (APA, 2022, p. 1). This edition also includes "differences in sex development" as another term for "disorders of sex development." A post-transition specifier was also added.

Evaluating Benefits and Challenges

Implications of the G.D. diagnoses are complex and nuanced. For some individuals who feel discomfort around their gender, the diagnosis can be validating. In the case of gender dysphoria, the discomfort one feels with their physical body and appearance may be due to feelings of incongruence, not only internalized oppression (Schulz, 2018). The diagnosis continues to be the only way that people can qualify for gender affirmation surgery (Moleiro & Pinto, 2015). However, like the homosexuality diagnosis, the gender dysphoria diagnosis can be pathologizing and justify harmful treatments that further marginalize TGGD individuals. Drescher (2009) states,

> Activists argued, as in the case of homosexuality in the 1970s, that it is wrong to label expressions of gender variance as symptoms of a mental disorder and that perpetuating DSM-IV's GID diagnoses in the DSM-V would further stigmatize and cause harm to transgender individuals. Other advocates in the trans community expressed concern that deleting GID would lead to denying medical and surgical care for transgender adults. (p. 340)

In sum, there is a fear that the removal of the diagnosis would cause problems with accessing medical transition, but also great concern around pathologizing trans identity. It should be noted that if the diagnosis were to be removed, gender-affirming medical care providers might introduce another structured process for treatment access.

Benefits

The current diagnostic system concerns distress associated with an identity or experiences rather than pathologizing the identity itself. Rather than listing the actual behaviors or gender expression as the disorder, gender dysphoria is diagnosed by having marked distress due to incongruence between one's sex assigned at birth and gender identity (APA, 2013). As mentioned, this mirrors the diagnostic transition from homosexuality to ego-dystonic homosexuality, a diagnosis that was associated with numerous challenges and eventually removed. In the current system, a diagnosis of gender dysphoria is considered a stamp of approval for those seeking gender-affirming medication, surgery, or legal processes (Schulz, 2018). Thus, in some ways, the diagnosis does systematically preserve access to this care by implementing a structured process. In the current socio-political context, the diagnosis can also sometimes allow for reimbursement from insurance companies by providing documented justification for gender-affirming care (Schulz, 2018).

Challenges

Advocates against the diagnosis of gender dysphoria assert that it is short-sighted and harmful. One uniformity we see in the psychiatric pathologizing of queerness from the homosexuality diagnosis to gender dysphoria is the enforcement of conformity to gender expectations in treatment and stigmatization of behaviors that do not align with stereotypical gendered behavior. This includes but is not limited to sexual behavior, gender expression, attraction, and gender expressions. The potential for negative impacts on children continues. Past research indicated that conversion therapy is especially harmful to children as children are not required to give consent for their treatment (Zucker & Spitzer, 2005). The diagnosis legitimized the enforcement of gender conformity and resulted in children being forced to endure harmful conversion therapy (Higbee et al., 2020).

The G.D. diagnosis still gatekeeps access to certain types of gender-affirming care. To complete a medical procedure, an ICD medical diagnostic code is needed (U.W. Health, 2022). Requiring a DSM diagnosis adds an extra step and further medicalizes psychology (Schulz, 2018). This is especially important because many insurance companies still view gender affirmation surgery as a cosmetic or experimental procedure, leading to a lack of coverage (Schulz, 2018). Given that LGBT studies are not a focal point of most graduate training programs in psychology (Richmond et al., 2012; Schulz, 2018), there is a lack of practitioners who can provide gender-affirming and empowering care to TGGD individuals (Hong, 2002; Lind, 2004). In the current system, an individual who wants to undergo surgical treatment must obtain a letter from a mental health practitioner at the master's level or above (Schulz, 2018). By mandating this letter and therefore therapy and a G.D. diagnosis, there is a high likelihood that trans individuals will work with a mental health provider that lacks cultural competency. Similarly, TGGD individuals face an overall lack of cultural competence at best and intense discrimination at worst in the medical field (Drescher, 2010; Richmond et al., 2012; Schulz, 2018). The use of the medical model in the treatment of trans persons leads to an over-medicalized and medical transition-focused view of the trans community (Bryant, 2006). This particularly serves to marginalize individuals who do not identify within the gender binary.

Additionally, insurance does not always cover therapy as it relates to gender-affirming care. Even for the practitioners and agencies who accept a variety of insurances, many of the most vulnerable queer community members do not have access to insurance altogether (Harawa & Bingham, 2009; Xavier et al., 2005). The process of working with a practitioner to get this diagnosis and "the letter" from a psychologist is extensive and may take anywhere from several months to years (Schulz, 2018). Many insurance companies require twelve or more months of psychotherapy before offering reimbursement for gender-affirming surgical

interventions. Treatment that requires such financial means or insurance will disproportionately affect the most marginalized communities (Potter et al., 2019). TGGD individuals already face financial oppression due lack of access to educational and occupational opportunities and ongoing discrimination in these spheres (Grant et al., 2011; Sausa, 2003). This entire process serves to increase the financial burden on an already under-resourced group (Schulz, 2018).

The current diagnostic system continues to promote binary views of gender and pathologize TGGD individuals (Bolin, 1994). Although the language of the Gender Dysphoria diagnosis expands definitions of gender, the unstated goal is still for patients to either conform to the gender they were socialized in or to pass as the "opposite gender"- enforcing the idea of the gender binary and further marginalizing people who do not identify as strictly men or women. This diagnostic system also ignores societies that include more than two gender identities in their culture's conceptualizations of gender. Many such cultures (e.g., Indigenous Americans) have been pushed by Western colonizers to abandon their diverse ancestral understandings of gender and sexuality in favor of white Puritanical notions of biological essentialism and cis-hetero dominance (De Block & Adriaens, 2013). It is worth considering how continuing to push a binary within the medicalized system may affect queer individuals in these communities. The current diagnostic system also includes a post-transition signifier, which is used in a similar way to an "in remission" specifier for other diagnoses. Transition is different for each person, and whether medical and/or social transition is a goal differs widely across individuals. This emphasis on transition creates pressure for people to feel that they need to choose a binary identity and take prescribed steps that may or may not fit for them, with those who do not wish to medically transition often encouraged to keep their gender identity private (Green, 2004; Schulz, 2018).

Summary and Recommendations

To provide recommendations and suggestions for working with TGGD populations, it is imperative to understand the APA's history of enforcing cisheteronormativity and gender conformity while punishing and pathologizing queerness and gender variant behavior throughout the DSM's history. Much of what we see in the current psychological discourse around transness mirrors the trajectory of the discourse around LGB identities, particularly the reasons for and the pathways of changing diagnoses. Psychology will continue to face the consequences of pathologizing and/or trying to remediate the symptoms of living in an oppressive system rather than seeking to dismantle the system. If gender dysphoria is taken out of the DSM, we must be aware of a new diagnosis that may take its place and act in a preventative rather than remedial manner. The DSM will continue to reflect gender policing and enforcement of the gender binary if the

underlying issues are not resolved. Nonbinary individuals will most likely continue to be pathologized, even after gains have been made for binary transgender communities (Singh, 2016), and trans people of color will remain at the highest risk of discrimination and violence. Based on current best practices and informed by historical context, we present our recommendations for clinicians working with TGGD populations.

Gender Affirming Care: "The Letter"

"The letter" refers to a requirement needed to qualify for gender affirmation surgeries. Depending on the type of surgery, a person may need one to two letters from a mental health professional with a minimum of a master's degree. The letter also needs to be dated within 12 months of the initial consultation. One letter is needed to qualify for chest surgery or facial surgery, and two letters of readiness from two different practitioners are needed for genital surgery (U.W. Health, 2022). The letter is not currently needed to begin hormone therapy, but a referral from a mental health practitioner often is. To qualify for any of these treatments, a person must be 18 or over or have parental consent if they are 16-17. However, some bills are seeking to ban the provision of these services, labeling them as "child abuse." Although these are the current procedures, it is important to check the requirements in each state to better understand the specific requirements and eligibility.

The Informed Consent Model

The Informed Consent Model was put forth to allow for access to gender-affirming medical interventions without the need for a pathologizing G.D. diagnosis. The model describes a process where a patient has a session with their general practitioner and gets to decide if and when they are ready for treatment. In this process, "the practitioner is viewed as having unique skills and clinical knowledge, while the patient is viewed as having knowledge of their own beliefs, personal value systems, and individual conception of self with regard to transgender identity" (Schulz, 2018, p. 85). The practitioner shares with the patient comprehensive information about risks, side effects, benefits, and potential consequences (Schulz, 2018). Then, the patient can make the informed decision to consent to the gender-affirming medical interventions that are right for them.

In some cases, assessment or therapy may still be sought out by the patient or recommended by the practitioner. In the Informed Consent model, however, therapy is an option rather than the standard, and the focus of therapy would not be fully based on treating a disorder (Schulz, 2018). The Informed Consent model emphasizes a collaborative decision-making process with a focus on the practitioner-patient relationship. Whether one meets eligibility criteria is de-

emphasized, as well as the reliance on the disease/medical model to "treat" a disorder. Importantly, the patient does not have to prove that they experience distress in their current body to be able to access medical transition (Schulz, 2018). The Informed Consent model shows that it is possible to create and implement new systems for accessing gender-affirming care outside of the psychiatric process.

Fenway Health in Boston, Massachusetts, has already implemented this process as a standard of care (Reisner, 2015). One study of multiple institutions using this model showed that out of 1944 individuals who sought gender-affirming care through this model, only 17 reported some type of feelings of regret, and there were no related malpractice charges (Deutsch, 2011). It is important to note that the 17 individuals in the study do not necessarily all regret their decision to access the gender-affirming medical intervention that they chose, as the term was broadly defined. Overall, this model may serve to provide care to TGGD individuals from a more holistic lens in a way that depathologizes gender variance.

Gender Affirming Clinical Care

Gender affirmation is an interpersonal, interactive process whereby a person receives social recognition and support for their gender identity and expression (Bockting et al., 2006). Research demonstrates that access to gender affirmation is vital to an array of positive outcomes for TGGD persons (Sevelius et al., 2021). Providing gender-affirming care (GAC) is key to ethical psychological practice with TGGD persons (Morris et al., 2020). Research on GAC is still in its early stages, and there is not yet one comprehensive and prescriptive set of guidelines for the practice of GAC. Qualitative literature around GAC describes the importance of establishing safety and belonging using inclusive language, demographic forms, and physical environment considerations, providing effective referrals for gender affirming healthcare as necessary, balancing clinical attention on gender, and utilizing trans-affirmative interventions (Budge et al., 2020; Matsuno, 2019; Morris et al., 2020). Finally, GAC involves intentionally learning about the TGGD community writ large outside of session (Mizock & Lundquist, 2016).

To establish safety and belonging, one must avoid microaggressions and communicate respect for the client's gender identity and knowledge about/acceptance of the TGGD community (Mizock & Lundquist, 2016). Establishing safety/belonging involves asking the client for their pronouns, sharing your pronouns, ensuring the clients are always gendered correctly by all staff members (Kattari et al., 2020), mirroring client language around gender, and using gender-inclusive language (such as person instead of man/woman, sibling instead of brother/sister), among other behaviors (Matsuno, 2019). Considerations related to the physical environment include the use of inclusive demographic forms that ask for both name and legal name and have an open response for gender (Anzani et

al., 2019), posting trans-affirmative signage around the office and on printed materials and webpages, providing access to all-gender restrooms (Kattari et al., 2020), and possibly providing telehealth options for individuals who do not feel safe accessing services in person. It is critical to consider the intersections of clients' identities and ensure that all TGGD persons feel safe and welcome. Thought should be given to those with marginalized racial/ethnic identities- the environment, therapeutic services, and all resources must be safe and affirming for TGGD People of Color (Singh, 2016).

When providing gender-affirming psychotherapy, providers must give gender concerns balanced attention- neither presenting as ignorant or avoidant regarding transness nor overly focused on gender (Mizock & Lundquist, 2016). GAC involves being open and attending to the impacts of gender and transphobia while refraining from assuming that all distress results from gender-related concerns (Morris et al., 2020). Clinicians should develop true comfort with gender diversity and an attitude of cultural humility, regularly evaluating their biases and taking cues from the client (Anzani et al., 2019). Relatedly, GAC involves avoiding gatekeeping or focusing the counselor's role on controlling access to critical hormonal or surgical gender-affirming interventions (Mizock & Lundquist, 2016).

Higher-level GAC skills involve the utilization of trans-affirmative intervention strategies (Budge et al., 2020). Conceptualizing clients within minority stress and resilience models can help clinicians to look for and target internalized stigma. Clinicians may facilitate discussions around societal messages regarding transness and reinforce the client's ability to reject negative messages (Matsuno & Israel, 2018). Consciousness-raising related to the effects of oppression and minority stress theory combined with validation of experiences of minority stress and oppression can also be powerful tools (Budge et al., 2020). Additionally, therapists can facilitate gender exploration and help clients navigate the intrapersonal, social, and medical transition processes they wish to pursue (Budge et al., 2020). Therapists and clients can also collaborate to build strategies for managing gender dysphoria (APA, 2015), including increasing gender euphoric experiences through self- and social-care plans, distress tolerance skill-building, and promoting resilience and pride (Matsuno & Israel, 2018).

We also recommend that clinicians make efforts to connect clients to resources and support groups. This can include starting a support group in a practice to facilitate a space for consciousness-raising and establishing community and peer connections. Additionally, it is important to obtain resources for gender-affirming care and support in the area in which the practitioner works. Given the current nature of changing laws, we recommend that clinicians stay up to date on resources, including support groups, PRIDE clinics, and gender-affirming practitioners. This will allow clinicians to provide referrals that may be beneficial for clients. Clinicians can also attend webinars and training on LGBTQ+ affirmative care.

These often offer CEU credits and are therefore beneficial in helping clinicians meet their requirements for continued licensure. One example may include the Division 17 webinar (Div17CounselingPsych, 2021) on gender-affirming care.

Advocacy

Richmond et al. (2010) affirm that it is important to advocate for clients at the systemic and policy levels, integrate competent care into training, and conduct research that highlights strengths rather than using the deficit model. Culturally competent work with TGGD populations necessarily involves engaging in advocacy (Richmond et al., 2012). The bidirectional relationship between the sociopolitical context and the psychology and psychiatry positions on queerness is obvious when we consider historical patterns. In particular, the removal of diagnoses has led to the reversal of some forms of legal discrimination and changes in societal attitudes, and vice versa. Thus, to promote the well-being of TGGD populations, it is imperative to continue critically examining the effects of the existing diagnostic system and advocating for changes at legal and systemic levels. As discussed, advocacy around bills and laws was imperative to remove antidiscrimination laws for sexual minorities and promote the removal of the homosexuality diagnosis.

Currently, there are many laws and bills in different stages of the legislative process that aim to increase legal TGGD discrimination. In 2021, 22 states introduced legislation that would prevent gender-affirming care, and in the first two months of 2022, 29 new bills and laws were introduced in the United States. Further, in 2022, more than 225 anti-LGBTQ+ bills were introduced (ACLU, 2022). This legislation includes banning gender affirmation surgery and hormones, labeling them as "child abuse," as well as discrimination in athletics, the military, bathrooms, and several settings. In August 2022, Florida banned Medicaid coverage for gender-affirming care (ACLU, 2022). Additionally, the "Don't Say Gay" bill in Florida seeks to ban discussions of gender identity and sexual orientation in the classroom. Other states have adopted similar laws, including Georgia, effective July 1, 2022. This bill has been combined with bills that seek to ban critical race theory discussions and any discussion of "divisive topics" into HB616 in Ohio.

Similarly, the governor of Tennessee signed a bill that requires athletes to compete in school sports according to their sex at birth. Governors of Arkansas, Louisiana, and Mississippi also signed bills to ban transgender girls and women from participating in school sports, set to go into effect July 1, 2022. These arguments are often rooted in rhetoric that circles "protecting women" and "fairness." Advocacy against these bills can include writing letters, making phone calls to officials, or donating to organizations that are already working on these

causes. It is recommended that practitioners utilize legislation trackers to keep track of laws and bills in the states where they practice. Practitioner training programs provide another opportunity for advocacy. To ensure that gender-diverse individuals receive and can access competent psychological care, it is important for the individual practitioner to gain competence but also to advocate for comprehensive training in graduate school curriculums. For faculty, this may include adapting syllabi to make sure that LGBTQ+ topics are being covered throughout the coursework. For students, this may include advocating for syllabi changes, specific training, and opportunities for the program.

Conclusion

This paper highlights the connections between DSM discrimination of gender and sexual minorities. By understanding the discrimination rooted in attempting to control gender variance in relation to the homosexuality diagnosis, we can better understand the current challenges of the gender dysphoria diagnosis and provide informed recommendations for working with TGGD populations. This includes understanding the history of pathologizing gender variance in the field of psychology and its impact on treatment goals and intervention recommendations. Specifically, we presented guidelines on clinical practice and advocacy with TGGD clients to best support and affirm members of this community.

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