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Gender Identity Disorder (GID) is very unique among the other disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) because the treatment is used to confirm the alleged disordered belief (Ross 2009). All other disorders in the *DSM-IV-TR* are defined as the treatment altering the disordered belief and removing the symptoms, not reinforcing them as GID does (Ross 2009). This contradictory nature of the diagnosis has received lots of criticism from professionals over the years and many have offered alternatives. Gender variant individuals have also criticized the diagnosis due their lived experiences and different ideas about gender that are incongruent with the criteria. Some professionals find the diagnosis problematic due to concerns about the criteria being inaccurate and not illustrating the range of gender variance (Cohen-Kettenis & Pfafflin 2009). Other critics have disputed the diagnosis because gender and gender variance is understood differently over time and across cultures (Langer & Martin 2004; Newman 2002; Lev 2005).

In the *DSM-III,* transsexualism was the first gender identity diagnosis to appear in the *DSM*. Originally, this former diagnosis stated that mainly discomfort with one's anatomic sex and desire to be the other sex was required to be diagnosed (APA 1980). Today, in the *DSM-IV-TR*, the disorder includes much broader criteria for a diagnosis (APA 2000). For instance, discomfort in the gender role associated with one's sex is now part of the criteria necessary for a diagnosis. It has been suggested this change to include gender roles is due to more rigid attitudes toward gender non-conformity by American psychiatrists currently, which is descried as inherently a political issue (Langer & Martin 2004). Many others also find this change problematic due to gender roles not being static across cultures or over time (Newman 2002).

The amount of controversy over GID has sparked much debate and research to discover how to approach gender-variance. Some have suggested removal of the diagnosis from the *DSM*

completely, and others have urged that the criteria just need to be revised (Cohen-Kettenis & Pfafflin 2009; Lev 2005; Ross 2009). In order to understand these differing proposals, one must consider the different models that are used to understand gender and gender variance. As Newman (2002) explains, GID is currently based on a biological understanding of gender that claims gender variance is caused by brain sex abnormalities resulting in conflicts in development and gender role. Gender can also be understood from a sociocultural viewpoint that defines gender as a social construct that varies across cultures and over time, suggesting gender variance does not need to be pathologized (Newman 2002). In order to conclude the appropriate diagnosis and criteria or if there needs to be a diagnosis at all for atypical gender behavior and cognition, it first must be determined on how to understand gender itself.

Advocates to keep the diagnosis of GID in the *DSM* suggest examining the current criteria to ensure it is accurate and reflective of scope of gender variance. Some critical issues with the current diagnosis are that it has little reliability and validity, it does not examine the severity of the condition and the actual spectrum of gender variance is inaccurately defined (Cohen-Kettenis & Pfafflin 2009; Langer & Martin 2004). The change in the diagnosis from transsexualism to GID was to differentiate between those who wanted sex reassignment surgery and those who did not (Cohen-Kettenis & Pfafflin 2009; Lev 2005). Despite the GID diagnosis now being broader in the current *DSM*, it is still treated by professionals as severely as transsexualism (Cohen-Kettenis & Pfafflin 2009). The problem with this is that individuals who have an intense discomfort with their sex are very different from individuals who just feel uncomfortable in the gender role associated with their sex (Cohen-Kettenis & Pfafflin 2009; Lev 2005) However, these two criteria are now necessary for a diagnosis (APA 2000). In addition, some people who are gender variant and desire treatment are typically rejected because they do

not completely fulfill the GID diagnosis, which is required for hormonal treatment and sex reassignment surgery (Cohen-Kettenis & Pfafflin 2009). Advocates for criteria reform state that the diagnosis must reflect the dimensionality and level of severity of gender variance that individuals experience in order for them to receive their desired treatment (Cohen-Kettenis & Pfafflin 2009; Lev 2005).

Many critics have issues with pathologizing gender variance because it is suggested to be a normal variance in the human condition (Langer & Martin 2004; Lev 2005). Critics explain that because a diagnosis is necessary for gender variant people to continue receiving treatment, many support the continued inclusion of the diagnosis whether or not they agree it is a disorder. The requirement of a diagnosis for gender nonconformists to acquire treatment and surgery is considered problematic by some because there are similar surgeries that do not need a diagnosis for approval, such as cosmetic surgeries (Ross 2009). Ross (2009) suggests that this is illogical because both surgeries are altering individuals' bodies because they feel uncomfortable in their natal characteristics and want to align their physicality to be congruent with their inner desires.

Lev (2005), who disagrees with pathologizing gender variance, argues that GID is simply used as a tool for social control and by managed care and insurance companies. The *DSM* is notorious for pathologizing normal human diversity in the past regarding race, sex and sexual orientation in an attempt to institutionalize the social control of minorities, justify prejudice and maintain the status quo (Lev 2005). An example of this is the previous inclusion of homosexuality in the *DSM*. It was removed after concluding that the distress homosexuals experienced is due to social prejudice (Lev 2005; Ross 2009). As previously with homosexuality, the diagnosis of GID assumes that the emotional pain transgender people experience is because of their gender nonconformity rather than a consequence of being stigmatized. Instead of

addressing the distress as within the individual, it has been suggested to understand the distress as a result of one's social environment (Cohen-Kettenis & Pfafflin 2009; Langer & Martin 2004; Lev 2005; Newman 2002). If the distress is due to the environment, this approach supports the theory that GID should be understood from a sociocultural viewpoint.

Due to the structure and policies of American psychiatry, managed care and insurance companies, it is required to have a diagnosis in order to receive treatment (Cohen-Kettenis & Pfafflin 2009). This becomes very problematic for many gender variant individuals because either they do not feel they are suffering from a pathological disorder or they do not qualify for a diagnosis, but they still want treatment because they experience distress due to social biases. To support this, Newman (2002) explains how many gender variant individuals do not experience profound distress due to their gender nonconformity when they are accepted within a society. This variance in experience depending on culture illustrates that there is a flaw in how gender non-conformity is viewed within American social policies and the psychiatric field. Instead, gender variance must be understood as normal human diversity because many are able to live free of distress, impairment or dysfunction (Cohen-Kettenis & Pfafflin 2009; Langer & Martin 2004; Lev 2005). As Ross (2009) explains, sex reassignment surgery can only be an ethical procedure if gender variance is not a mental disorder. Because people are allowed to get cosmetic surgery and alter their bodies for non-medical reasons, it is completely unethical to not allow transgender people do the same. If it is a right for all people to practice the civil liberty of complete physical autonomy, then GID must be an unethical diagnosis (Lev 2005; Ross 2009).

In order for all individuals to have the right to physical autonomy, transgender people must be allowed to receive treatment and necessary surgeries without a false and unethical diagnosis. Instead of keeping the invalid GID diagnosis in the *DSM* to ensure transgender

individuals can receive treatment, a complete reform of the psychiatry and medical field needs to be done. Hormonal treatment and sex reassignment surgery is simply medical treatment that some people seek due to a variance in the human condition, not a mental health problem (Lev 2005).

It is a social injustice that transgender people are pathologized for a normal variance within the human condition. Gender atypicality is a social construction that changes over time and varies across cultures. Since conceptualizations of gender appropriateness is a social construction, is cannot be pathologized (Langer & Matin 2004). Social and institutionalized biases and policies of gender need to be addressed in order to free gender variant people from being ostracized and controlled. To ensure gender variant individuals will receive necessary therapy for their distress due to the environment, it is imperative that their suffering will be pathologized appropriately (Newman 2002). Gender variant individuals are not disordered and deserve the right to live functional and autonomous lives. In order for these individuals to have the civil liberty of physical autonomy and the right to desired therapy and treatment, Gender Identity Disorder must be removed from the *DSM*.

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