The (Slow) Depathologizing of Gender Incongruence

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Abstract: Psychiatric nosology has at times mirrored cultural mores and societal values, pathologizing behaviors seen at the time to be either immoral or outside the norm. This has been particularly true when it comes to issues related to sexuality and gender. Such pathologizing has resulted in further stigmatization and discrimination in society. Gender incongruence, the experience of an individual whose internal sense of gender is at odds with the sex they were assigned at birth, has long been pathologized. This article will compare the history of the psychiatric depathologizing of homosexuality to the current process of depathologizing gender incongruence.

Key Words: Gender incongruence, transgender, psychiatry

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Gender incongruence is a general term denoting the experience of an individual whose psychic sense of their gender does not correlate with the sex they were assigned at birth. This term encompasses both individuals who identify as the "opposite gender" and those who do not identify on the societal binary construct of gender (that there is only male or female). This latter group includes individuals who identify as nonbinary, gender queer, transmasculine, transfeminine, and other gender variant identities. It is synonymous with the term "transgender," although avoids the latter's historical connection to the gender binary.

The creation of some psychiatric diagnoses has mirrored cultural mores and societal values. Nowhere is this more evident than in issues related to gender and sexuality. Such pathologizing often results in stigmatizing certain groups and increasing societal discrimination against them. With an expanding understanding of the constructs of sex and gender in both social and scientific realms, as well as gradual changes in social views, the concept of gender incongruence has slowing started to be depathologized.

The current process and debate regarding psychiatric depathologizing of gender incongruence mirrors the historical depathologizing of homosexuality and offers lessons regarding the cultural and psychiatric ambivalence toward sexual and gender minorities. Homosexuality was included in the American Psychiatric Association's (APA's) first *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), published in 1952 (American Psychiatric Association, 1952). In this first attempt to standardize psychiatric nomenclature, homosexuality was included as an example, along with pedophilia, fetishism, and transvestitism, of sexual deviation as a type of sociopathic personality disturbance. In the second edition of the *DSM*, published in 1968 (American Psychiatric Association, 1968), homosexuality was listed as a sexual deviation, following under the category of personality disorders and other nonpsychotic mental disorders (Krajeski, 1996).

Evolving social attitudes about homosexuality and protests from activists and members of the APA compelled the Board of Trustees to reconsider their previous classification and put the matter of declassifying homosexuality as a mental disorder to a vote in 1973. This vote was instrumental in bringing broader awareness to psychiatric diagnoses being value laden (Sadler, 2005).

When "homosexuality" was removed from *DSM-2*, it was replaced by the separate category of sexual orientation disturbance (SOD), which continued to define homosexuality as an illness if an individual with same-sex attractions found them distressing and wanted to change (Spitzer, 1981). SOD was renamed ego-dystonic homosexuality (EDH) when *DSM-3* (American Psychiatric Association, 1980) was published in 1980. The diagnoses of SOD and EDH perhaps represented the APA's attempt to satisfy the internal schism created by the 1973 decision to declassify homosexuality (Drescher, 2015). In 1987, EDH was later expanded in the *DSM-3-R* (American Psychiatric Association, 1987), now called sexual disorder not otherwise specified (SDNOS), and went on to include any individual with a "persistent and marked distress about one's sexual preferences" (American Psychiatric Association, 1987). This classification survived until the publication of *DSM-5* (American Psychiatric Association, 2013) when all references within diagnostic categories finally removed sexual orientation—40 years after "homosexuality" was supposedly first declassified as a psychiatric disorder.

While the declassification of homosexuality in the *DSM* has been considered a significant factor in shifting medical and social attitudes, as well as being a catalyst for societal changes in the decades that followed (Drescher, 2015), the resulting diagnoses of SOD, EDH, and SDNOS had unforeseen negative consequences. These diagnoses pathologized an individual's psychological reaction to the society in which they existed, not taking into account the societal pressures that might result in someone being distressed by their sexual identity and desires, a normal part of the "coming out" process. In addition, these diagnoses existed during the height of the HIV/AIDS epidemic, a time when there was a social backlash against homosexuals and the very real threat of death from disease within the gay community. As described by Meyer's Minority Stress Model, external, or "distal," stressors, including stigmatization, discrimination, harassment, and victimization, lead to more internalized, or "proximal," stressors such as negative expectations of the future, internalized homophobia, and avoidance of disclosure (Meyer, 2003). Recent research has demonstrated that the internalization of these stressors leads to psychiatric pathology, including anxiety, depression, and suicidality (Testa et al., 2017). The continued categorization of disorders relating to an individual's sexuality maintained stigmatization of the gay community, which, in an absurd feed-back loop, was likely to result in more individuals meeting criteria for those disorders.

The diagnoses of SOD, EDH, and SDNOS also had the unfortunate consequence of justifying the practice of conversion therapy that continues to this day (Drescher, 2015). Logically, if not wanting to be homosexual were considered a disorder, then it follows that the likely treatment would include changing one's sexual orientation. Recent research has confirmed the assumed dangers of this practice, demonstrating that, when compared with LGBT youth with no history of conversion attempts, those who have undergone conversion therapy have increased rates of depression, suicidal thoughts, suicidal attempts, less educational attainment, and less weekly income in (Ryan et al., 2018). In 1998, the APA issued a position paper against conversion therapy and warned of the negative impact such therapy could likely have on the individual (American Psychiatric Association, 2000).

The condemnation of this practice has been echoed by almost every national medical and mental health organization, although to date, this form of therapy is only banned in 18 states and the District of Columbia.

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The history of classification of gender incongruence in the *DSM* closely mirrors that of homosexuality. Like homosexuality, the pathologizing of gender incongruence has been a direct reflection of popular attitudes regarding how sex and gender function in human beings. Gender as a social and ideological construct is a relatively new phenomenon, one gaining attention in medical, social, and political spheres. Up until the last several decades, psychological research and practice has been entrenched in the gender binary—the belief that there are only two types of people: male and female (Hyde et al., 2019). Individuals born male were meant to be "masculine" and those born female "feminine." Presentations outside of this norm were typically seen as psychopathological. This classification was a direct reflection of sex and gender being perceived as rigid and essential characteristics of one's being. As a result of this view, much of the psychological analysis in the late 19th and early 20th centuries conflated gender incongruence with homosexuality (particularly male homosexuality).

One of the first academic studies to do so was Richard von Krafft-Ebing's *Psychopathia Sexualis* (originally published in 1886). Krafft-Ebing classified four fundamental types of sexual "perversions," the first of which was contrary sexual feelings or (gender) inversion, which included various physical and psychological fusions of masculinity and femininity (Kennedy, 1997). Later in the 20th century, these "fusions" would gradually be differentiated into homosexuality, bisexuality, androgyny, transvestitism, and transsexuality (Oosterhuis, 2012).

Karl Heinrich Ulrichs, in his attempt to first explain homosexuality, argued that homosexuality arose in a man whose mind was overtaken by a female psyche. In his opinion, there were actually three sexes, the third of which explained a "disharmony" between sexual drive and an individual's sexual organs. Ulrichs went on to state that these individuals were "neither fully men nor fully women" (Kennedy, 1997).

The German physician and sexologist Magnus Hirschfeld is considered one of the pioneers in developing the beginnings of a modern taxonomy of sexual and gender identities. In his 1910 treatise *Die Transvestiten*, Hirschfeld focused on creating a distinction between homosexuals and individuals who preferred to dress as the opposite sex, coining the term "transvestite" (Hill, 2005). Havelock Ellis, a contemporary of Hirschfeld's, agreed with this distinction, but renamed this "condition" sexo-aesthetic inversion, and then eventually eonism—two terms that did not survive (Ekins and King, 2006). Hirschfeld eventually went on to further distinguish transvestites from what he called "transsexuals," individuals who were unhappy with their sexual organs. This early distinction between homosexuality, transvestitism, and transsexualism lead to the beginnings of a more focused examination and understanding of gender incongruent states.

Having spent time with Hirschfeld and his patients, endocrinologist and sexologist Harry Benjamin wrote a comprehensive study of transsexuals entitled *The Transsexual Phenomenon* (Benjamin, 1966). Benjamin made a clear distinction between those labeled as transvestite, transsexual, and homosexual, and differentiated between issues of sexuality and issues of gender identity. Benjamin clearly defined what was meant by transsexual as an individual who was extremely unhappy as a member of the gender to which he or she was assigned at birth because of the anatomical structure of the body, particularly the genitals (Benjamin, 1966). Although his understanding of the homosexual and transgender experience was rudimentary, his work laid the groundwork for how the professional community understands gender incongruence today.

Based in part on Benjamin's work, transsexualism first appeared in the *DSM-3* (American Psychiatric Association, 1980). It was the first time that there were clearly defined criteria for diagnoses related to gender identity (Beek et al., 2016). Under the section "psychosexual disorders," the *DSM-3* included three gender identity–related disorders: transsexualism, gender identity disorder of childhood (GIDC), and atypical gender identity disorder. The two main criteria for the diagnosis of transsexualism were "a persistent sense of discomfort and inappropriateness about one's anatomic sex" and "a persistent wish to be rid of one's genitals and to live as a member of the opposite sex" (American Psychiatric Association, 1980, pp 261–262). The first criterion, requiring the desire to be rid of one's genitals, demonstrated a lack of understanding of the full range of gender incongruence recognized today, while the term "opposite" in the latter criterion exemplified the reliance in social and scientific realms on the gender binary. The main criteria for GIDC was the persistent and strong desire to be the opposite gender or insistence that the child was the opposite gender. Secondary criteria were different for natal males and females. Natal males either had to have a strong rejection of their male genitals or a preoccupation with stereotypically female activities. Criteria for natal females, on the other hand, focused solely on the denial of having a female body or that they will develop female secondary sex characteristics (American Psychiatric Association, 1980). This difference in criteria for GIDC between natal males and females reflects the social intolerance of gender nontypical behavior in boys—underscoring a continued societal influence on psychiatric diagnosis.

DSM-3-R moved the gender identity diagnoses to a new subclass "disorders usually first evident in infancy, childhood, or adolescence" (American Psychiatric Association, 1987). The gender identity diagnoses now included specifiers for the individual being homosexual, heterosexual, or asexual, based on the person's natal sex (*e.g.*, a natal male identifying as female who was attracted to men was classified as a "homosexual" transsexual—further emphasizing the natal sex as being paramount). This confusing distinction furthered the conflation of sexual orientation and gender identity, and was eventually experienced as invalidating of an individual's gender identity (Bradley et al., 1991). In addition, a new diagnosis was added, "gender identity disorder of adolescence and adulthood, nontranssexual type" (GIDAANT) (American Psychiatric Association, 1987). This diagnosis described individuals who did not desire medical intervention to aid with their gender identity, as opposed to those who did (transsexuals). This addition possibly demonstrated a growing understanding of the variance of experience for gender incongruent individuals. A further change was made to the diagnosis of GIDC, requiring natal females to actually verbalize their desire to the opposite gender. A similar requirement for natal males was not included (American Psychiatric Association, 1987). No clear justification for inclusion of this disparity was evident.

Many of the changes seen in *DSM-4* reflected a growing understanding and experience with gender incongruent individuals. The various gender identity diagnoses were moved from the "disorders usually first evident in infancy, childhood, or adolescence" category to a new "sexual and identity disorders" category as it became more apparent that many gender incongruent adults did not verbalize or demonstrate their internal experience until adulthood. Unfortunately, this new category also included paraphilias and sexual dysfunctions, which made for a confusing, and potentially stigmatizing, connection. The diagnoses of GIDC and transsexualism were combined to be classified under gender identity disorder (GID) with criteria for adolescents and adults differing from those for children (American Psychiatric Association, 1994). The diagnosis of GIDAANTS was removed while the criteria for GID no longer required a desire for medical intervention. The sexual attraction identifiers were changed to specify which gender, if any, the individual was attracted to without labeling a sexual identity. For GIDC, the criteria for natal males and natal females were made more comparable with the criterion for verbalizing the desire to be the opposite gender now applying to either natal gender.

In addition, this criterion was no longer required (American Psychiatric Association, 1994). The changes to GIDC worked to shift the main focus away from gender identity and toward cross-gendered behavior (Beek et al., 2016). The influence of social values and the adherence to the gender binary, however, were still apparent in the diagnosis of GIDC, with examples for natal males being "aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities" and for natal females including "marked aversion toward

normative feminine clothing" (American Psychiatric Association, 1994, p 537). While the changes made in *DSM-4* were significant and for the most part reflected growing understanding of gender incongruence, the mere name, gender identity disorder, was experienced as further stigmatizing this population and fueling societal discrimination (Byne et al., 2018).

The first step toward psychiatric depathologizing of gender incongruence did not occur until the publication in 2013 of the *DSM-5*. GID was removed altogether. A new diagnosis, gender dysphoria (GD), was included that shifted focus toward the distress caused by gender incongruence as the target of treatment, rather than gender identity itself or an individual's distress from having gender incongruence. There are also references to hormonal treatment and surgery improving the primary symptom of dysphoria (American Psychiatric Association, 2013). The diagnosis also for the first time allowed for a broader gender spectrum, including the option of gender identity to be "some alternative gender different from one's assigned gender" rather than only the "opposite" or "other" gender (American Psychiatric Association, 2013, pp 452–453), although the discussion in the diagnostic features section for children still relied heavily on the gender binary (American Psychiatric Association, 2013). Sexual orientation specifiers were removed altogether, signally a clear differentiation between gender identity and sexual identity or preference. Overall, the dramatic change in perspective laid out in *DSM-5* demonstrated a significant attempt to decrease stigmatization of gender incongruent individuals and reflected a growing societal and medical understanding of gender fluidity. The careful wording used throughout the text was an attempt to avoid the pitfalls seen when SOD, EDH, and SDNOS replaced homosexuality 40 years earlier.

Unfortunately, as the *DSM* is a manual on mental disorders, GD retains its classification as such, despite the changes in criteria and name (Byne et al., 2018). Given the history of psychiatric stigmatization and pathologizing of gender incongruence, it is understandable that many gender incongruent continue to be wary of seeking mental health care.

The upcoming World Health Organization's *International Classification of Diseases, Revision 11* (*ICD-11*) has taken the final step in the psychiatric depathologizing of gender incongruence by removing GD from the section on mental disorders and replacing it with gender incongruence in the section on conditions related to sexual health (Reed et al., 2016). This significance of this change cannot be overstated. It reinforces gender incongruence as not being a psychiatric disorder, thereby decreasing the stigmatization of gender incongruent individuals, while maintaining it as a condition that may require medical intervention and care (Moser, 2017). Some in the transgender/gender incongruent community may be concerned that the elimination of the diagnosis "gender dysphoria" may limit access to physical and mental health care (Elder, 2016), a concern echoed by some in the psychiatric field. This situation, however, should be no different than how we address issues related to sexual orientation and code visits for sexual minorities in the time since all forms of "homosexuality" has been removed from the *DSM*. Mental health professionals routinely identify anxiety, depression, substance use disorders, relationship problems, and so on as the focus of treatment and billing—it will be no different for individuals with gender incongruence. It remains to be seen if the APA will adopt a similar approach and eliminate gender incongruence–related diagnoses altogether, finally completing the full psychiatric depathologizing of gender incongruence.

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