Chapter 7
Gender Identity Diagnoses: History and Controversies

Jack Drescher

Abstract This chapter begins with a review of psychiatric and medical theorizing about transsexualism and transgender presentations since the nineteenth century. Until the middle of the twentieth century, with rare exceptions, transgender presentations were usually classified as "psychopathological." By the middle of the twentieth century, transsexualism and sex reassignment surgery became more common and more available, leading to greater popular, medical, and psychiatric awareness of the concepts of *gender identity* and recognition of an increasing number of people wishing to "cross over" from their birth-assigned sex to another. In the twenty-first century, international expert guidelines support transition in carefully evaluated individuals, although the healthcare systems in only a minority of countries now cover needed medical services for sex reassignment.

This chapter then goes on to review the shifting placement of gender identity and gender role diagnoses over time within both the World Health Organisation's (WHO) *International Statistical Classification of Diseases* (ICD) and the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual* (DSM). In recent years, gender identity diagnoses of both the ICD and DSM have generated several controversies, reflecting not only differing perspectives of mental health professions from those of transgender advocacy groups but also differences of opinion within the lesbian, gay, bisexual, and transgender community (LGBT) itself. These controversies are briefly reviewed. The professionals charged with ICD-11 and DSM-5 revisions have attempted to balance both concerns about retaining access to care and perpetuating the stigma associated with a mental disorder diagnosis. This chapter reviews how the diagnostic classification of disorders related to transgender identity has been an area long characterized by constant shifts in placement and renaming of these diagnoses in various editions of the ICD

J. Drescher, M.D. (✉)
Department of Psychiatry, New York Medical College, William A. White Institute,
440 West 24 Street, #1A, New York, NY 10011, USA
e-mail: jackdreschermd@gmail.com

B.P.C. Kreukels et al. (eds.), *Gender Dysphoria and Disorders of Sex Development: Progress in Care and Knowledge*, Focus on Sexuality Research,
DOI 10.1007/978-1-4614-7441-8_7,

and DSM. Therefore, another name change and another category move would be more reflective of current thinking in this area of clinical work.

7.1 Introduction

Psychiatric and medical theorizing about transsexualism and transgender presentations began in the nineteenth century. Until the middle of the twentieth century, with rare exceptions, transgender presentations were usually classified as "psychopathological." Krafft-Ebing (1886) took this view and his *Psychopathia Sexualis* might be thought of as an early psychiatric diagnostic manual that documented cases of individuals who desired to live as members of the other sex and those who had been born to one sex and were living as members of the other. In the chapter entitled "General Pathology" he presented, in Latin, an autobiographical case (#129) of what he called *Metamorphosis Sexualis Paranoia*:

> … at the age of twelve or thirteen, I had a definite feeling of preferring to be a young lady… But I was careful not to allow this to be noticed; and yet I am sure that I should not have shrunk from the castration-knife, could I have thus attained my desire … Girls liked my society; and though I should have preferred to have been with them constantly, I avoided them when I could, for I had to exaggerate in order not to spear feminine. In my heart I always envied them … I remember, when fifteen, to have first expressed to a friend the wish to be a girl. In answer to his question, I could not give the reason why … At the high school I finally once had coitus; I felt that I would rather have lain under the prostitute and would have preferred to exchange my member for her genitals … Thus I went through life, such as it was, never satisfied with myself, full of dissatisfaction with the world … (pp. 263–266).

Krafft-Ebing then goes on to describe another case (#130) of *Metamorphosis Sexualis Paranoia*, this time in a natal woman:

> As a girl Mrs. X had decided inclinations for boys' sports. So long as she wore short dresses she used to rove about the fields and woods in the freest manner, and limbed the most dangerous rocks and cliffs. She had no taste for dresses and finery … Otherwise nothing betrayed her homosexual inclinations. Up to her marriage (at the age of twenty one) she could not recall to mind a single instance in which she felt herself drawn to persons of her own sex … At the age of thirty-six she had an apoplectic stroke which confined her to bed for two years … She refused to wear anymore a lady's nightdress or a lady's cap, and put away her bracelets, earrings and fans. Her maid and her dressmaker noticed a different odor coming from her person; her voice also grew deeper, rougher and quite masculine. When the patient was finally able to leave her bed, the female gait had altered, feminine gestures and movements in her female attire were forced, and she could no longer bear to wear a veil over her face. Her former period of life spent as a woman seemed strange to her, as if it did not belong to her existence at all; she could play no longer the role of woman (pp. 276–278).

It was typical of these early theories to conflate transgender presentations with homosexuality. For example, Ulrichs' (1864) *third sex theory* of men's spirits in women's bodies (*urningen*) and women's spirits in female bodies (*urnings*) was his explanation of the "cause" of homosexuality (several years before the latter term was actually coined). Yet a female spirit in a male body bears narrative kinship with

twentieth-century theories of transsexualism. So does Freud's (1910) attribution of Leonardo da Vinci's homosexuality to his being "a man who loved like a woman," that is, someone who identified with his mother. From a narrative perspective, a man's identification with his mother is not altogether unlike a woman's spirit trapped in a man's body. Both theories explain homosexuality based on the binary belief that there are only two genders and that some quality of one gender has found its way into the other.

It is Magnus Hirschfeld (1923) who is credited with being first to distinguish the desires of homosexuality (to have partners of the same sex) from those of transsexualism (to live as the other sex). However, those distinctions were not broadly accepted until decades later. Further, although physicians in Europe had begun performing sex reassignment surgery (SRS) in the 1920s, transsexualism and SRS sensationally really entered the popular imagination when the US media reported on the case of George Jorgensen. Jorgensen went to Denmark as a natal man and returned to the USA in 1952 as a trans woman with a new body and a new name: Christine (Jorgensen, 1967). Shortly thereafter, the Danish physicians who participated in Jorgensen's SRS published a report of her medical and surgical treatment in the *Journal of the American Medical Association* (Hamburger, Stürup, & Dahl-Iversen, 1953).

The publicity surrounding Jorgensen's transition would eventually lead to greater popular, medical, and psychiatric awareness of the concepts of *gender identity*, and later terms like *expressed gender* and *experienced gender*, as well as recognition of an increasing number of people wishing to "cross over" from their birth-assigned sex to another. Within professional circles, changes in attitude toward transition were spearheaded by the pioneering work of Harry Benjamin (1966), John Money (1994), Robert Stoller (1964), and Richard Green (1974). Increased public discussions of sex reassignment and gender identity would provide those who would eventually come to identify as *transsexual* or transgender with a category and a name for their feelings and desires (Denny, 2002). In time, what was once considered an exceedingly rare condition gradually became more publicly visible, and in recent years, an increasing number of nations, provinces, and municipalities have enacted laws establishing "gender identity" as a protected group along the line of categories like race, ethnicity, age, sex, and sexual orientation.

However, these changes did not take place overnight. At the time of Jorgensen's 1950s SRS and for several decades afterward, many mental health practitioners were critical of sex reassignment as a treatment for gender dysphoric individuals (e.g., Hertoft & Sørensen, 1978; McHugh, 1992; Socarides, 1969). As much psychiatric theorizing of that time continued to conflate sexual orientation and gender identity, many physicians and psychiatrists criticized using surgery and hormones to irreversibly—and in their view incorrectly—treat people suffering from what they perceived to be either a severe neurotic or psychotic, delusional condition in need of psychotherapy and "reality testing." This was the mainstream view of the time and it was captured in a 1960s survey of 400 physicians that included psychiatrists, urologists, gynecologists, and general medical practitioners asked to give their professional opinions about what to do in the case of an individual seeking SRS. The case was as follows:

> Since early childhood, this 30-year-old biological male has been very effeminate in his mannerisms, interests, and daydreams. His sexual desires have always been directed toward other males. He would like to be able to dress exclusively in woman's clothes. This person feels inwardly and insists to the world that he is a female trapped in a male body. He is convinced that he can only be happy if he is operated on to make his body look like that of a woman. Specifically, he requests the removal of both testes, his penis, and the creation of an artificial vagina (all of which can, in fact, be done surgically). He also requests that his breasts be made to appear like a woman's, either surgically or by the use of hormones (this, too, is medically possible) (Green, 1969, p. 236).

Green summarized the survey's findings as follows:

> Eight percent [8%] of the respondents considered the transsexual "severely neurotic" and fifteen percent [15%] considered the person "psychotic." The majority of the responding physicians were opposed to the transsexual's request for sex reassignment even when the patient was judged nonpsychotic by a psychiatrist, had undergone two years of psychotherapy, had convinced the treating psychiatrist of the indications for surgery, and would probably commit suicide if denied sex reassignment. Physicians were opposed to the procedure because of legal, professional, and moral and/or religious reasons. In contrast to the conservatism with which granting of sex-reassignment procedures was viewed, there was a paradoxical liberalism in the approach to these patients should they already have been successful in obtaining their surgery elsewhere. Among the respondents, three quarters [75%] were willing to allow the postoperative patient to change legal papers such as a birth certificate and to marry in the new gender, and one-half [50%] would allow the person to adopt a child as a parent in the new gender (pp. 241–242).

Although these were once the prevailing views, they are no longer part of the mainstream of psychiatric or general medical thought and practice. In the twenty-first century, international expert guidelines support transition in carefully evaluated individuals (WPATH, 2011), although the healthcare systems in an only minority of countries around the world now cover needed medical services for sex reassignment (Kreukels et al., 2012; Yogyakarta Principles, 2007).

7.2 History of Diagnostic Placement: ICD and DSM

The placement of gender identity and gender role diagnoses has shifted over time within both the World Health Organisation's (WHO) *International Statistical Classification of Diseases* (ICD) and the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

Table 7.1 summarizes the placements of gender diagnoses in the ICD and in the DSM.

7.2.1 ICD

ICD-6, approved in 1948, was the first version of the ICD published by WHO, the first version of ICD to include a classification of morbidity, and the first version that included a classification of mental disorders. Prior to ICD-6 and the founding of

Table 7.1 Gender diagnoses in the ICD and DSM

Year	ICD	DSM	Parent category	Diagnosis name
1948	ICD-6	–	N/A	N/A
1952	–	DSM-I	N/A	N/A
1955	ICD-7	–	N/A	N/A
1965	ICD-8	–	Sexual deviations	Transvestitism
1968	–	DSM-II	Sexual deviations	Transsexualism
1975	ICD-9	–	Sexual deviations	Transvestism
				Trans-sexualism (sic)
1980	–	DSM-III	Psychosexual disorders	Transsexualism
				Gender identity disorder of childhood
1987	–	DSM-III-R	Disorders usually first evident in infancy, childhood, or adolescence	Transsexualism
				Gender identity disorder of childhood
				Gender identity disorder of adolescence and adulthood, nontranssexual type
1990	ICD-10	–	Gender identity disorders	Transsexualism
				Dual-role transvestism
				Gender identity disorder of childhood
				Other gender identity disorders
				Gender identity disorder, unspecified
1994	–	DSM-IV	Sexual and gender identity disorders	Gender identity disorder in adolescents or adults
				Gender identity disorder in children
2000	–	DSM-IV-TR	Sexual and gender identity disorders	Gender identity disorder in adolescents or adults
				Gender identity disorder in children
2013	–	DSM-5	Gender dysphoria	Gender dysphoria in adolescents or adults
				Gender dysphoria in children
2015	ICD-11	–	?	Gender incongruence of adolescents and adults
				Gender incongruence of children (proposed)

WHO, ICD was exclusively a mortality classification. Mental disorders in general and sexual disorders in particular were not considered to be causes of mortality, so they were not included in these classifications.

In ICD-6 (1948), there is no reference to the diagnosis of transsexualism; nor does it appear in ICD-7 (1955).[1] The ICD-8 (1965), reflecting changing clinical and theoretical views, separated out *sexual deviations* from *personality disorders*. The sexual deviations included the new diagnosis of *transvestitism* for the first time (Table 7.1). Definitions of diagnostic categories were not provided in ICD-8, so the intended meaning of *transvestitism* is not entirely clear. Historically, however, an alternative spelling of *transvestism* was used as an early synonym for what later came to be known as transsexualism (i.e., Hamburger et al. (1953) use the term transvestism in their description of Jorgensen's surgery) and that may have been part of the reason for placing it in ICD-8.

Further change occurred in the ICD-9 (1975), in which transvestitism was replaced by *transvestism*. It was defined as a "Sexual deviation in which sexual pleasure is derived from dressing in clothes of the opposite sex. There is no consistent attempt to take on the identity or behaviour of the opposite sex." While still in the sexual deviation category, it was now a separate and exclusionary diagnosis for a newly added diagnosis of *trans-sexualism* (sic) (Table 7.1). Again, it is reasonable to assume that this new separation was made to accommodate a growing body of research about clinical presentations and treatment of transsexualism in the previous two decades.

The ICD-10 (1990) saw a significant reorganization of the classification system and some new gender diagnoses that reflected a growing body of clinical experience and research. Under *disorders of adult behaviour and personality* appears a new category of *gender identity disorders* (F64) which includes five diagnoses: *transsexualism*, *dual-role transvestism*, *gender identity disorder of childhood*, *other gender identity disorders*, and *gender identity disorder*, *unspecified* (see Table 7.1).

At the time of this writing, there have been preliminary proposals made for the ICD-11 revision currently underway, and the ICD revision is scheduled to be published in 2015. WHO's Working Group on the Classification of Sexual Disorders and Sexual Health (WGSDSH) has been charged with evaluating clinical and research data to inform revision of diagnostic categories related to sexuality and gender identity currently in the Mental and Behavioural Disorders chapter of ICD-10, and with making recommendations regarding whether and how these categories should be represented in ICD-11. At present, the preliminary proposals include a name change of the diagnosis to *gender incongruence* and a recommendation that the entire diagnostic category be moved outside the mental disorders section of the ICD. Whether that would be in a new section of its own or elsewhere in the ICD remains to be determined (Drescher, Cohen-Kettenis, & Winter, 2012).

[1]By way of contrast, and as previously noted, sexual orientation and gender identity were often conflated at that time; a diagnosis called *homosexuality* does appear in both ICD-6 and ICD-7. Homosexuality is listed as an example of the diagnostic category *sexual deviation*, which is further classified as a *pathologic personality* under the supra category of *disorders of character, behaviour, and intelligence*. The diagnosis of homosexuality persisted into ICD-8 and ICD-9 but was removed from ICD-10 and replaced by *egodystonic sexual orientation* (Drescher, 2010).

7.2.2 DSM

In a similar if not entirely parallel manner, gender identity diagnoses underwent category migration and renaming in the APA's Diagnostic and Statistical Manual (DSM). It is also a history that illustrates the shifting views about what to call the diagnosis, what it means, and where to place it over time. As in the ICDs 6–8, no mention of the diagnosis exists in either the DSM-I or DSM-II (1952, 1968). In 1980, however, a revamped DSM-III abandoned the psychodynamic theorizing of the first two manuals and adopted a neo-Kraepelian, descriptive, symptom-based framework drawing upon contemporary research findings. Zucker and Spitzer (2005) describe the environment leading to gender diagnoses being included in the DSM:

> During the 1960s, North American psychiatry had begun to take a look at the phenomenon of transsexualism in adults [see, for example, Green and Money (1969) and Stoller (1968)]. It became apparent that psychiatrists and other mental-health professionals had become increasingly aware of the phenomenon, that is, of adult patients reporting substantial distress about their gender identity and seeking treatment for it, typically hormonal and surgical sex-reassignment. Indeed, there were enough observed cases that it was possible in the 1960s to establish the first university- and hospital-based gender identity clinics for adults. Many clinicians and researchers were writing about transsexualism, and by 1980, there was a large enough database to support its uniqueness as a clinical entity and a great deal of empirical research that examined its phenomenology, natural history, psychologic and biologic correlates, and so forth. Thus, by the time DSM-III was in its planning phase in the mid-1970s, there were sufficient clinical data available to describe the phenomenon, to propose diagnostic criteria, and so on (p. 37).

Zucker and Spitzer (2005) also summarize the vicissitudes of the current gender diagnoses from DSM-III through DSM-IV-TR:

> In the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) [1980], there appeared for the first time two psychiatric diagnoses pertaining to gender dysphoria in children, adolescents, and adults: gender identity disorder of childhood (GIDC) and transsexualism (the latter was to be used for adolescents and adults). In the DSM-III-R [1987], a third diagnosis was added: gender identity disorder of adolescence and adulthood, nontranssexual type. In DSM-IV [1994, and DSM-IV-TR (2000)], this last diagnosis was eliminated ("sunsetted"), and the diagnoses of GIDC and transsexualism were collapsed into one overarching diagnosis, gender identity disorder (GID), with different criteria sets for children versus adolescents and adults (p. 32).

It should be further added that in addition to name changes, the diagnostic category migrated within DSM chapters. In DSM-III (1980), both GIDC and transsexualism are listed among the *psychosexual disorders*. In DSM-III-R (1987), both are moved to a category of *disorders usually first evident in infancy*, *childhood, or adolescence.* In DSM-IV (1994) and DSM-IV-TR (2000), they are moved again to a new parent category, *sexual and gender identity disorders*, and transsexualism is renamed *gender identity disorder in adolescents or adults*. It is then clustered with the paraphilias and sexual dysfunctions (Table 7.1).

At the time of this writing, the DSM-5 is in the closing stages of preparation for 2013 publication. The accepted proposals of the DSM-5 Workgroup on Sexual and

Gender Identity Disorders for the DSM-5 (APA, 2013) are (1) to have one overarching diagnosis, *gender dysphoria* (*GD*); (2) to have GD include separate, developmentally appropriate criteria sets for children (*gender dysphoria in children*) and another for adolescents and adults (*gender dysphoria in adolescents and adults*); and (3) to move GD into a separate category separated from sexual dysfunctions and paraphilias.[2]

7.3 Controversies

In recent years, gender identity diagnoses of both the ICD and DSM have generated several controversies. These controversies reflect not only the differing perspectives of mental health professions from those of transgender advocacy groups but also differences of opinion within the lesbian, gay, bisexual, and transgender community (LGBT) itself.

For example, some LGBT advocacy groups have argued that it is wrong for psychiatrists and other mental health professionals to label variations of gender expression as symptoms of a mental disorder. These advocates have argued for removal of the diagnoses from the diagnostic manuals.

Others decry as unscientific, unethical, and misguided the use of the childhood gender identity diagnoses to justify clinical efforts aimed at getting them to reject their expressed gender identity and to accept the sex (and gender) they were assigned at birth. In doing so, they have compared clinical efforts to treat gender-variant children with clinical efforts to change homosexuality [Pickstone-Taylor, 2003; see Drescher (2010) for discussion of this issue]. The controversies surrounding the treatment of children and young adolescents, however, raise many complex issues which are not entirely the same as those involving the treatment of older adolescents and adults, and consequently, a detailed discussion of those issues is beyond the scope of this chapter [see Drescher and Byne (2013) for an interdisciplinary discussion of clinical ethical issues in the treatment of children and adolescents].

Alternatively, other advocacy groups have raised concerns that removing the adolescent and adult gender identity diagnoses would lead to loss of private and public insurance coverage for necessary medical and surgical treatment, since all medical treatments require some form of diagnostic coding. In addition, at least in the United States, removing the gender identity diagnoses entirely from the diagnostic manual would lead to the loss of a potent and increasingly successful argument of medical necessity in legal cases challenging denial of medical treatment to transgender individuals. Consequently, in both the DSM-5 and ICD-11 revision processes, the professionals involved have tried to find a balance between the competing issues of stigma versus access to care (Drescher, 2010).

[2]The proposed DSM-5 revisions of this category are available on line at http://www.dsm5.org/ProposedRevision/Pages/GenderDysphoria.aspx. Also see Cohen-Kettenis and Pfäfflin (2010), Drescher (2010), Meyer-Bahlburg (2010), and Zucker (2010).

7.4 Stigma

The relationship between psychiatric diagnosis and stigma is documented lucidly by the history of the removal of homosexuality from the DSM-II in 1973 (Bayer, 1987). In the aftermath of the APA decision, psychiatry abandoned its historical participation in stigmatizing homosexuality. Those who accepted scientific authority on such matters gradually came to accept the APA's position, and a new cultural perspective emerged: (1) if homosexuality is not an illness, and (2) if one does not literally accept biblical prohibitions against homosexuality, and (3) if contemporary, secular democracy separates church and state, and (4) if openly gay people are able and prepared to function as productive citizens, then what is wrong with being gay? And if there is nothing wrong with being gay, then what moral and legal principles should the larger society endorse in helping gay people openly live their lives? This led to a historically unprecedented social acceptance of gay men and women across much of the world which, in many countries and cultures, has culminated in the contemporary social and policy debates about gay civil rights and marriage equality (Drescher, 2012).

The movement for transgender civil rights began more slowly but followed, nevertheless, in the wake of the larger gay rights movement (Drescher, 2010). By the late 1990s, trans-inclusion had increasingly become a focus of LGBT rights groups, and support by these groups for transgender rights continues to this day. Given that the removal of homosexuality from the DSM was a watershed in the gay civil rights movement, a similar goal is being sought for transgender people as well. For example, as the ICD revision process has unfolded, many advocates, several countries, the Council of Europe Commissioner for Human Rights (2009), and the European Parliament (2011) have taken strong positions that issues related to transgender identity should not be classified as mental disorders in the ICD-11. The European Parliament resolution *"roundly condemns the fact that homosexuality, bisexuality and transsexuality are still regarded as mental illnesses by some countries, including within the EU, and calls on states to combat this; calls in particular for the depsychiatrisation of the transsexual, transgender, journey, for free choice of care providers, for changing identity to be simplified, and for costs to be met by social security schemes."* The document goes on and *"calls on the Commission and the World Health Organisation to withdraw gender identity disorders from the list of mental and behavioural disorders, and to ensure a non-pathologising reclassification in the negotiations on the 11th version of the International Classification of Diseases* (*ICD-11*)*."*

Similar concerns about diagnostic retention were raised in the DSM revision process. For example, the World Professional Association for Transgender Health (WPATH) called for depathologization and removal of transgender diagnoses from the DSM-5 (Knudson, DeCuypere, & Bockting, 2010). In a survey by the DSM-5 GID subworkgroup of 201 organizations concerned with the welfare of transgender people from North America, Europe, Africa, Asia, Oceania, and Latin America, a majority (55.8 %) believed the diagnosis should be removed from the DSM (which is,

of course, a classification consisting exclusively of mental disorders). The major reason for wanting to keep the diagnosis in the DSM was healthcare reimbursement. Regardless of whether groups were for or against the removal of the diagnosis from the mental disorders classification, the survey revealed a broad consensus that if the diagnosis remains in the DSM, there needs to be an overhaul of the name, criteria, and language to minimize stigmatization of transgender individuals (Vance et al., 2010).

While reducing the stigmatization of mental disorders is important, arguing to remove a diagnostic category from the DSM or the mental disorders section of the ICD simply because mental disorders are stigmatized is neither compelling nor persuasive. Stigmatization of individuals with psychiatric disorders is a social problem across cultures. Organized psychiatry and other mental health professionals have spent decades trying to reduce the stigma of psychiatric illness in order to increase access to care and to encourage people to avail themselves of mental health services. Mental health professions are themselves stigmatized because of their association with the conditions affecting the populations they treat. Further, there is a general consensus that mental disorders are health conditions; otherwise, why would they be in the ICD? One unintended consequence of belaboring distinctions between medicine and psychiatry, and this is a wider problem also beyond the scope of this chapter, is the perpetuation of existing stigma and prejudices against the mentally ill (Drescher, 2010).

However, the combined stigmatization of being transgender and of having a mental disorder diagnosis creates a doubly burdensome situation for this population, and it would be fair to say that this situation supports arguments for moving the category out of the mental disorders section.

7.5 Issues of Placement

From a historical perspective, the classification of gender diagnoses as mental disorders was serendipitous. If, in the mid-twentieth century, the narrative had been that transsexualism was related to a "hormone imbalance" rather than being a "sexual deviation," the category could very well have been placed in the ICD-10 chapter on "Endocrine, nutritional, and metabolic diseases." In fact, the etiology of the condition was unknown when placement decisions were made in the past and remains unknown now. Further, there are no scientifically based criteria to differentiate normal and pathological gender identity, and the manner in which *any* gender identity develops remains unknown and a matter of theoretical speculation. The extant scientific database cannot empirically answer the question of whether this diagnosis is purely a "mental disorder" or a disorder with another physical cause. There are a growing number of studies that posit physical rather than mental causes of transgender presentations (Berglund, Lindström, Dhejne-Helmy, & Savic, 2008; Garcia-Falgueras & Swaab, 2008; Herbert, 2008; Kruijver et al., 2000; Rametti et al., 2011; Schöning et al., 2010; Zhou, Hofman, Gooren, & Swaab, 1995).

7.5.1 Medical Diagnosis

It is possible to classify gender identity diagnoses as purely medical conditions. In 2010, for example, France removed transsexualism from its mental disorders section and placed it in a category known as *maladie rare* (Brunet, 2010). Another alternative would be placing these diagnoses in either the endocrinological or genitourinary sections. The latter approach solves the problem of the diagnoses being stigmatized as a mental disorder while still allowing access to care. On the other hand, much of the healthcare accessed by this patient population is not directly related to endocrinology, although the case could be made that other health and mental health services required are indirectly related in many cases. A genitourinary placement is also problematic since many people who might be diagnosed do not seek or require such surgery.

7.5.2 V- and Z-Codes

DSM's V-codes and ICD's Z-codes are used to indicate conditions or clinical situations that might come to the attention of a mental health professional but are not in and of themselves considered to be mental disorders. Such a change in the diagnostic systems would serve the purpose of depathologizing and destigmatizing the category; it would be neither a mental disorder nor a physical one (physical disorders are also stigmatized, although not typically as much as mental ones). While this would reduce stigma, such a move is likely to interfere with access to care as third-party payers rarely reimburse V- and Z-codes.

7.6 Conclusion

Since 2008, this author has been a member of the DSM-5 Workgroup on Sexual and Gender Identity Disorders and, since 2011, a member of the ICD-11 Working Group on the Classification of Sexual Disorders and Sexual Health. In the midst of the DSM-5 deliberations, this author made the argument for retention of the mental disorder diagnosis:

> How should APA proceed? Physicians need to take to heart the dictum "first do no harm." This guides many clinical encounters in which physicians and patients must make treatment choices, all of which are potentially fraught with harm. In those cases, the best approach is to make choices that maximize benefits and minimize harm (or side effects). At this moment in time, I believe the less harmful choice would be retaining and modifying the adolescent and adult GID diagnostic criteria to make them more narrowly inclusive of individuals who are distressed about the dissonance between their anatomical and psychological gender (Drescher, 2010, p. 454).

The principles of reducing stigma and reducing false-positive diagnoses, such as labeling non-distressed expressions of gender variance as mental disorders, did in fact guide the workgroup in its deliberations. However, as a member of the ICD Working Group on Sexual Disorders and Sexual Health, the opportunity arose to further reduce stigma by moving the gender identity diagnoses out of the mental disorders section entirely (Drescher et al., 2012). Such a move would not be entirely unprecedented. As this chapter has shown, the diagnostic classification of disorders related to transgender identity has been an area long characterized by constant shifts in placement and renaming of these diagnoses in various editions of the ICD and DSM. Another name change and another category move would simply be more reflective of current thinking in this area. There is also a strong possibility that such a change would lead to the removal of the gender dysphoria diagnoses from the DSM, reflecting the changing values in many cultures where gender variance is increasingly accepted as a normal part of life.

Acknowledgement This chapter is a revised version of an article, Minding the Body: Situating Gender Identity Diagnoses in the ICD 11, published in the International Review of Psychiatry, 2012.

References

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Press.

Bayer, R. (1987). *Homosexuality and American psychiatry: The politics of diagnosis*. Princeton, NJ: Princeton University Press.

Benjamin, H. (1966). *The transsexual phenomenon: A scientific report on transsexualism and sex conversion in the human male and female*. New York: Julian Press.

Berglund, H., Lindström, P., Dhejne-Helmy, C., & Savic, I. (2008). Male-to-female transsexuals show sex-atypical hypothalamus activation when smelling odorous steroids. *Cerebral Cortex, 18*(8), 1900–1908.

Brunet, M. (2010). Le transsexualisme n'est plus une maladie mentale. *Le Figaro*. Accessed November 22, 2012, from http://www.lefigaro.fr/actualite-france/2010/02/12/01016-20100212ARTFIG00756-le-transsexualisme-n-est-plus-une-maladie-mentale-.php.

Cohen-Kettenis, P. T., & Pfäfflin, F. (2010). The DSM diagnostic criteria for gender identity disorder in adolescents and adults. *Archives of Sexual Behavior, 39*(2), 499–513.

Council of Europe. Commissioner for Human Rights. (2009). *Issue Paper: Human rights and gender identity*. Accessed August 1, 2012, from https://wcd.coe.int/ViewDoc.jsp?id=1476365.

Denny, D. (2002). A selective bibliography of transsexualism. *Journal of Gay and Lesbian Psychotherapy, 6*(2), 35–66.

Drescher, J. (2010). Queer diagnoses: Parallels and contrasts in the history of homosexuality, gender variance, and the Diagnostic and Statistical Manual (DSM). *Archives of Sexual Behavior, 39*, 427–460.

Drescher, J. (2012). The removal of homosexuality from the DSM: Its impact on today's marriage equality debate. *Journal of Gay and Lesbian Mental Health, 16*(2), 124–135.

Drescher, J., & Byne, W. (2013). *Treating transgender children and adolescents: An interdisciplinary discussion*. New York, NY: Routledge.

Drescher, J., Cohen-Kettenis, P., & Winter, S. (2012). Minding the body: Situating gender diagnoses in the ICD-11. *International Review of Psychiatry, 24*(6), 568–577.

European Parliament (2011). *28 September 2011 on human rights, sexual orientation and gender identity at the United Nations*. Accessed August 1, 2012, from http://www.europarl.europa.eu/sides/getDoc.do?type=TA&language=EN&reference=P7-TA-2011-0427.

Freud, S. (1910). Leonardo da Vinci and a memory of his childhood. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 11, pp. 59–138). London: Hogarth Press, 1957.

Garcia-Falgueras, A., & Swaab, D. F. (2008). A sex difference in the hypothalamic uncinate nucleus: Relationship to gender identity. *Brain, 131*, 3132–3146.

Green, R. (1969). Attitudes toward transsexualism and sex-reassignment procedures. In R. Green & J. Money (Eds.), *Transsexualism and sex reassignment* (pp. 235–251). Baltimore: The Johns Hopkins University Press.

Green, R. (1974). *Sexual identity conflict in children and adults*. New York, NY: Basic Books.

Green, R., & Money, J. (Eds.). (1969). *Transsexualism and sex reassignment*. Baltimore: The Johns Hopkins University Press.

Hamburger, C., Stürup, G. K., & Dahl-Iversen, E. (1953). Transvestism: Hormonal, psychiatric, and surgical treatment. *Journal of the American Medical Association, 12*(6), 391–396.

Herbert, J. (2008). Who do we think we are? The brain and gender identity. *Brain, 131*, 3115–3117.

Hertoft, P., & Sørensen, T. (1978). Transsexuality: some remarks based on clinical experience. *Ciba Foundation Symposium, 62*, 165–181.

Hirschfeld, M. (1923). Die intersexuelle konstitution. *Jahrbuch fur Sexuelle Zwischenstufen, 23*, 3–27.

Jorgensen, C. (1967). *Christine Jorgensen: A personal autobiography*. New York: Paul S. Ericksson, Inc.

Knudson, G. A., DeCuypere, G., & Bockting, W. (2010). Recommendations for revision of the DSM diagnoses of gender identity disorders: Consensus statement of the World Professional Association for Transgender Health. *International Journal of Transgenderism, 12*(2), 115–118.

Krafft-Ebing, R. (1886). *Psychopathia sexualis*, trans. H. Wedeck. New York: Putnam, 1965.

Kreukels, B. P., Haraldsen, I. R., De Cuypere, G., Richter-Appelt, H., Gijs, L., & Cohen-Kettenis, P. T. (2012). A European network for the investigation of gender incongruence: The ENIGI initiative. *European Psychiatry, 27*(6), 445–450.

Kruijver, F. P. M., Zhou, J.-N., Pool, C. W., Hofman, M. A., Gooren, L. J. G., & Swaab, D. F. (2000). Male-to-female transsexuals have female neuron numbers in a limbic nucleus. *Journal of Clinical Endocrinology and Metabolism, 85*(5), 2034–2041.

McHugh, P. R. (1992). Psychiatric misadventures. *American Scholar, 61*(4), 497–510.

Meyer-Bahlburg, H. F. (2010). From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Archives of Sexual Behavior, 39*, 461–476.

Money, J. (1994). The concept of gender identity disorder in childhood and adolescence after 39 years. *Journal of Sex and Marital Therapy, 20*, 163–177.

Pickstone-Taylor, S. D. (2003). Children with gender nonconformity [Letter to the editor]. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*, 266.

Rametti, G., Carrillo, B., Gómez-Gil, E., Junque, C., Zubiarre-Elorza, L., Segovia, S., et al. (2011). The microstructure of white matter in male to female transsexuals before cross-sex hormonal treatment: A DTI study. *Journal of Psychiatric Research, 45*(7), 949–954.

Schöning, S., Engelien, A., Bauer, C., Kugel, H., Kersting, A., Roestel, C., et al. (2010). Male-to-female transsexuals before and during hormone therapy. *Journal of Sexual Medicine, 7*(5), 1858–1867.

Socarides, C. W. (1969). The desire for sexual transformation: a psychiatric evaluation of transsexualism. *American Journal of Psychiatry, 125*(10), 1419–1425.

Stoller, R. J. (1964). A contribution to the study of gender identity. *International Journal of Psycho-analysis, 45*, 220–226.

Stoller, R. J. (1968). *Sex and gender*. New York: Science House.

Ulrichs, K. (1864). *The riddle of "man-manly" love* (Trans., M. Lombardi-Nash). Buffalo, NY: Prometheus Books, 1994.

Vance, S. R., Cohen-Kettenis, P. T., Drescher, J., Meyer-Bahlburg, H. F. L., Pfäfflin, F., & Zucker, K. J. (2010). Opinions about the *DSM* Gender Identity Disorder diagnosis: Results from an international survey administered to organizations concerned with the welfare of transgender people. *International Journal of Transgenderism, 12*(1), 1–24.

World Professional Association for Transgender Health (WPATH). (2011). *Standards of care for the health of transsexual, transgender and gender non-conforming people, 7th Version.* Accessed August 1, 2012, from http://www.wpath.org/.

Yogyakarta Principles. (2007). *Principles on the application of international human rights law in relation to sexual orientation and gender identity.* Accessed July 7, 2009, from http://www.yogyakartaprinciples.org/principles_en.htm.

Zhou, J.-N., Hofman, M. A., Gooren, L. J. G., & Swaab, D. F. (1995). A sex difference in the human brain and its relation to transsexuality. *Nature, 378*, 68–70.

Zucker, K. J. (2010). The DSM diagnostic criteria for gender identity disorder in children. *Archives of Sexual Behavior, 39*(2), 477–498.

Zucker, K. J., & Spitzer, R. L. (2005). Was the Gender Identity Disorder of Childhood diagnosis introduced into DSM-III as a backdoor maneuver to replace homosexuality? A historical note. *Journal of Sex and Marital Therapy, 31*, 31–42.