

# A Critique of Gender Identity Disorder and its Application

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## Résumé : (traduction)

Pour certains, avoir un trouble de l'identité sexuelle (TIS) devient la seule manière d'obtenir une inversion sexuelle chirurgicale (ISC). L'auteur va démontrer que, en fonction de son application, le TIS agit comme un mécanisme de régulation problématique.

L'auteur expliquera que les TIS normalisent une vision dichotomique de la notion de genre. C'est ainsi que les applications implicites du TIS permettent aux professionnels de la santé de consolider leur opinion relative à ce qu'est un comportement approprié en fonction du genre, ce qui normalise encore davantage la vision binaire de la notion de genre.

Les compagnies d'assurance exigent un diagnostic de TIS pour fournir une aide économique à ceux qui souhaitent obtenir une inversion sexuelle chirurgicale (ISC). Ceux qui n'ont pas les moyens de s'offrir une inversion doivent correspondre à un profil de TIS pour pouvoir obtenir une ISC. L'auteur va démontrer que c'est inacceptable, et que cela fait fonctionner le TIS comme un mécanisme de régulation.

Faire appel à un diagnostic de TIS risque de stigmatiser encore davantage le sujet qui souhaite avoir une inversion, car il doit avoir recours à la détresse comme mécanisme explicite de diagnostic. Le fait de devoir obtenir un diagnostic de TIS peut mener à l'intériorisation des côtés négatifs du diagnostic.

L'auteur fera une critique du TIS comme forme de psychopathologie, et le reliera à l'idée de TIS à titre d'appareil de régulation. L'auteur démontrera qu'il ne devrait pas y avoir de lien entre l'inconfort éthique et une inversion sexuelle chirurgicale exempte de tout TIS. Il montrera aussi que cette psychopathologie a des capacités normalisatrices qui enracinent encore davantage la dichotomie entre les genres.

Il est important d'envisager de supprimer la TIS du DSM, à condition toutefois de toujours offrir au sujet un soutien financier pour son inversion sexuelle chirurgicale sans qu'il ait besoin d'avoir recours à l'évaluation d'un professionnel de la santé mentale.

## Mots-clés :

Trouble de l'identité Sexuelle, éthique, psychiatre, psychopathologie

**Abstract:**

For some, Gender Identity Disorder (GID) becomes the only way to achieve sex reassignment surgery (SRS). It will be shown that GID acts as a problematic regulatory mechanism based on its application.

It will be argued that GID normalizes a dichotomous view of gender. In this way, GID's implicit applications allow the mental health professional to assert their views of what proper gendered behavior is, further normalizing a binary view of gender.

Insurance companies require a GID diagnosis in order to provide economic assistance to those wishing to undergo sex reassignment surgery. Those who cannot afford to transition must fall under GID's gaze in order to achieve SRS. This will be shown to be unacceptable and a way in which GID operates as a regulatory mechanism.

Appealing to a GID diagnosis can further stigmatize the individual who wishes to transition due to the necessitation of distress as an explicit mechanism of diagnosis. Having to fall under GID may internalize the negative aspects of the diagnosis.

A criticism of GID as a form of psychopathology will be given and also be linked to the idea of GID as a regulatory apparatus. It will be shown that there should be no link between ethical discomfort and GID-free sex reassignment surgery. Also, it will be shown that psychopathology has normalizing capabilities that further entrench gender binaries.

It is important to consider the removal of GID from the DSM, but, as a condition, still offer funding for sex reassignment surgery without having to appeal to a mental health professional's assessment.

**Keywords:**

Gender Identity Disorder, ethics, psychiatrist, psychopathology

## Introduction

The Diagnostic and Statistical Manual of Mental Disorders (DSM), which has gone through several revisions and editions, has become the holy grail of psychiatric nosology. With the DSM-V set to be released in 2013 (American Psychiatric Association, 2000), it becomes important to critique contentious “conditions” contained in the previous edition, allowing them to become skeletons in the closet instead of relevant points of staunch criticism. In the past, homosexuality was included in the DSM. Today there is Gender Identity Disorder (GID), or gender dysphoria. GID is identified in the DSM-IV as consisting of four mechanisms of diagnosis:

A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

The disturbance is not concurrent with a physical intersex condition.

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2000).

GID first made its appearance in the DSM-III, shortly after the establishment of the Harry Benjamin Gender Dysphoria clinic, and has made its way into the DSM-IV and the DSM IV-TR (American Psychiatric Association, 1980; Lev, 2006; Meyer-Bahlburg, 2009). The founding of the Harry Benjamin Gender Dysphoria clinic created a centralized force from which to offer standards of care and research in regards to Sex Reassignment Surgery (SRS; also called transitioning) and provide this information publicly (Meyer-Bahlburg, 2009). In the US, a GID diagnosis is needed before insurance coverage for SRS can be given/performed (Butler, 2004; Lev, 2006; Levine & Solomon, 2009). As Lev (2006) explains, “[i]n Western cultures...sexed bodies and gender expressions are severely proscribed, assigned, and delineated and deviations from these norms are classified within the sphere of the medical and psychiatric establishments” (p. 42).

The purpose of this paper is to critique the use of GID as a “regulatory apparatus”, as Butler (2004) has referred to it, in achieving hormone prescriptions and SRS. A GID diag-

nosis also acts as a regulatory apparatus by having the authority to approve economic assistance for those who could not otherwise afford SRS. The process of SRS will also be referred to as transitioning throughout this paper. The mental health professional’s role in regulating the implicit aspects of a GID diagnosis will be critiqued. Also, the explicit need for “significant distress or impairment” to satisfy the fourth mechanism will be considered as a limitation of the individual’s narrative (American Psychiatric Association, 2000).

It will be argued that GID allows further stigmatization of the individual by the continued application of this diagnosis. Many authors believe GID is psychopathologic and should remain in the DSM because of this (ex. Levine & Solomon, 2009; Zucker, 2009). Psychopathology is defined as the extreme end on a continuum of behavior (in this case gendered behavior), or any condition that requires one to be seen by a mental health professional (Levine, 2009). When looked at through a psychopathologic lens, GID becomes transphobic as it assumes normal gendered behavior in relation to disordered behavior (Lev, 2006).

This critique is by no means an attempt to invalidate the benefits that have been obtained by those who have been able to transition because of GID’s inclusion in the DSM. Instead it is an attempt to argue for the same benefits of coverage (and more) free of psychopathology. It is an argument for freedom in transitioning without the use of a regulatory apparatus that serves to further marginalize the individual.

## GID as a regulatory apparatus

It seems important to submit a brief explanation of the Foucauldian regulatory apparatus in order to proceed. For this, we will be examining Butler’s interpretation of GID as a regulatory apparatus. An individual precedes regulation, but one is only realized as a subject through regulation (Butler, 2004). To explain further, GID represents a regulatory force that lays the framework for comprehension of the subject within a system that maintains a binary view of gender (Butler, 2004). GID as a regulatory apparatus serves to pathologize “abnormal” gender behavior in individuals as a means of social control. In this way, when an individual submits to GID, they must be weighed against what is deemed to be “normal” gendered behavior in order to fall under this diagnosis (Butler, 2004).

## **GID: Promoting a Problematic Binary View of Gender**

In 1980 the DSM-III provided the first incarnation of GID (contained under Psychosexual Disorders) under which fell the subcategories of Transsexualism, Atypical GID, and GID of Childhood (American Psychiatric Association, 1980; Meyer-Bahlburg, 2009). It was not until 1994 that the DSM-IV (American Psychiatric Association) saw GID under its current position within the realm of “Sexual and Gender Identity Disorders” (Meyer-Bahlburg, 2009).

Prior to the inclusion of GID in the DSM-III, researchers maintained vitriolic views towards persons who are transsexual. For instance, Simolopoulos (1974) viewed gender identity within the transsexual community to be entrenched in psychosis. It seems that GID was created in a time when the social climate was much harsher towards individuals transitioning (not to say it is far better today), but it still persists as a diagnosis.

GID rests deeply ingrained in the current binary norms of gender (i.e., masculine/feminine), pathologizing attempts at creating a gender identity that strays from the norm (Butler, 2004). GID requires that a correction be made due to discomfort in one’s current gender role (Butler, 2004). To echo a popular Foucauldian analysis, the existence of GID reveals an inherent medical prejudice due to its ability to institutionally seek out “deviant” behavior in an attempt to maintain social control (Lev, 2006).

Instead of a binary view of gendered behavior it seems reasonable to assume the gendered behavior occurs along a spectrum, but never reaches the point of abnormality simply because it does not reflect the physical representation of one’s sex. The desire to transition should not necessitate conforming to the gendered behavior of one’s desired post op sex to satisfy a binary view that is upheld by the mental health professional. Viewing gendered behavior free from abnormality in this way ensures that the more dominant modes of gender behavior are not viewed as the only legitimate forms of behavior.

### **GID as a Gateway for funding**

Under our current system, medical/mental health professionals are the gatekeepers for SRS for people wishing to transition. Insurance providers within the US require a GID diagnosis to offer financial compensation for expen-

sive procedures and to be prescribed hormones by a physician, which are given prior to SRS (Lev, 2009; Levine & Solomon, 2009; Murphy, 2010). Thus, one would have to appeal to all four mechanisms of a GID diagnosis for economic assistance.

Financial support is crucial for those who wish to transition. The various procedures and hormones that are needed by transitioning individuals are extremely expensive (Butler, 2004; Lev, 2006). For those who are not independently wealthy, being diagnosed with GID becomes the only way to receive aid from insurance companies who offer economic assistance. Currently we hold people hostage to diagnostic nosology for insurance coverage (Butler, 2004; Lev, 2006).

Many view transitioning to be an essential step in their life, one that can make life livable (Butler, 2004; Giordano, 2010). GID acts as a regulatory apparatus by serving to dismiss the complexities of the individual in favor of deciding who can fit within transsexualism and who deserves insurance coverage (Lev, 2006). An attempt to display behavior that is abnormal by GID’s standards is to be forced to proceed without the economic assistance that it is currently used for. Providing insurance coverage for SRS free from GID should be acknowledged as a proper move towards curbing this problem.

There are more implicit uses of GID by the mental health professional. Before economic aid in transitioning can be given, one has to “prove” to the mental health professional that they can live within the desired gender role (Butler, 2004; Lev, 2006). In fact, the diagnosis is not complete until written proof from the “treating” psychiatrist states the individual transitioning will be able to “live and thrive” in their new gender (Butler, 2004, p. 78). This can mean having to cross-dress for certain periods of time and then, once “approved”, hormones are prescribed for a certain period of time pre-SRS (Butler, 2004). Thus, a complete diagnosis of GID requires the mental health professional to assert their own view of the “normal” through absolute definitions of proper gendered behavior in order to legitimize an individual’s desire to transition.

### **An Argument Against the Use of GID as a Form of Psychopathology**

If psychopathology does in fact draw the line between the “adaptive and the maladaptive” behavioral spectrum, ne-

cessitating the mental health professional, it follows that we should examine how such a spectrum works for GID (Levine, 2009, p. 46). As previously explained, those who have to appeal to the four mechanisms of diagnosis in order to get SRS and economic assistance for SRS are automatically funneled into the maladaptive section of this spectrum.

GID's implicit nature of allowing the mental health professional to define proper gendered behavior only allows individuals to display behavior and narratives that coincide with norms enforced by the mental health professional. Regulation acts in this way by defining what will be considered permissible within the interaction between the individual and the mental health professional. What of the individual who sees no impairment (social, occupational, etc.), but wishes to transition?

GID serves as a regulatory apparatus by labeling those who do not identify within the gender binaries as suffering from psychiatric illness in an attempt to control "atypical behavior". Labeling individuals as "deviants" who exist outside of the gender/sex binary normalizes a dichotomous view of gender (i.e., male and female). Appealing to GID is to disregard the lived experiences of individuals who do not fit within the medical model (Lev, 2006).

Levine and Solomon (2009) believe that if we were to discard GID physicians may experience something he calls "ethical discomfort." Levine and Solomon (2009) believe that ethical validation for physicians in aiding people will only be achieved by "compassionate treatment of an illness" (p. 46). Apparently, if GID slips away from medical discourse, physicians will become incapable of ethically validating the use of readily available procedures in aiding individuals in their transition. However, physicians readily dispense treatment outside of illness nosology and the maladaptive. Employing a similar argument to Hale (as cited in Butler, 2004): surgeons readily dispense breast reductions, penile enlargements, and various offshoots of the aforementioned procedures while paying little lip service to ethical validation through diagnosis.

Many authors cite post op regret as a reason for mental assessment prior to SRS (ex. Levine & Solomon, 2009). It is true, regret may occur following any type of transformative plastic surgery, but it does not follow that rigorous assessments and a diagnosis be required as a regulation. Breast augmentation and penile enlargement do not necessitate psychopathology's grip in being achieved. Yet, regret

may be exhibited after each operation.

The argument from ethical discomfort opts for a more paternalistic relationship between the physician and the patient by simply addressing the doctor's autonomy and brushing off the patient's knowledge of their body and the freedom to alter it accordingly. Using this train of thought, it becomes increasingly important to address why procedures for the "gender atypical" presenting person deserves the stigmatizing diagnosis of GID in order to be realized. As Butler (2004) puts it, "most medical, insurance, and legal practitioners are only committed to supporting access to sex change technologies if we are talking about a disorder" (p. 92).

It seems necessary to consider why we readily draw a moral line down the acceptability in altering one's body through surgical procedures. The aforementioned procedures that exist without regulation all support a dichotomous normalization of gender. Only procedures that seem to reaffirm or rest within the "normal" are allowed to exist without psychopathology (Butler, 2004). In this way, GID acts as a regulatory apparatus by existing as a means to label certain gendered behavior as abnormal and psychopathologic, necessitating the mental health professional.

### **GID: Marginalizing the Individual**

We should consider the ramifications of having to appeal to GID as a gateway for transitioning. Acting in a way to achieve a diagnosis can further marginalize the individual, as one has to appeal to a narrow classification in order to fulfill a requirement. The fourth mechanism of diagnosis in GID requires distress and impairment in individuals who are transsexual. Because insurance coverage requires a GID diagnosis, one has to be distressed and impaired in order to transition with financial aid.

Transitioning through the aid of insurance coverage presupposes disorder in the individual, presenting a problematic link between "disorder" and those wishing to transition (Lev, 2006). Should not coverage be granted to people who courageously decide to transition regardless of whether or not a distressed narrative may be present? As such, GID acts in a way that is restrictive of the individual (Butler, 2004).

Having to appeal to the fourth mechanism of diagnosis may internalize various pitfalls of the diagnosis, negatively

impacting the person in question. With a GID diagnosis one has been found “sick, wrong, out of order, abnormal, and to suffer a certain stigmatization as a consequence of the diagnosis” (Butler, 2004, p. 76).

Butler (2004) goes on to explain that GID only perpetuates the pathologization of individuals who are transsexual, instead of acknowledging an individual’s ability to freely decide their gender. Despite supporting a certain form of GID psychopathological classification, Meyer-Bahlburg (2009) acknowledges that it will only perpetuate discrimination within the population. One would hope a diagnosis characterized by discomfort would not result in any more discomfort, but that is what GID may serve to do.

### Psychopathology’s Normalizing Capabilities

GID’s normalizing capabilities are shown effectively through its labeling of “disorder” in children. Several authors assert that we should consider how such a diagnosis affects the self-esteem of the child who otherwise suffers no mental “disorder” (Isay, 1997; Lev, 2006). GID, as a label for children, fosters condemning regulation of gendered behavior that is problematically labeled “abnormal” behavior. A child may have yet to develop the ability to withstand the stigma of being labeled abnormal in some way. A child may be greatly impacted by the view that they are somehow wrong in the way they behave (Butler, 2006).

The problem is also in how GID leaves the psychiatrist more concerned with the fulfillment of gender norms opposed to asking whether or not one has the support network to contend with a harsh social climate (Butler, 2004; Lev, 2006). With GID the focal point becomes the “condition” and the “curing” of the dysphoria. In this way GID only seeks to further a discourse concerned with re-establishing “typical” gender norms.

GID requires a persistent desire to fulfill one of the dominant binary gender roles in order to appear as a successful candidate of SRS (Butler, 2004). Any definition of normal gendered behavior is well beyond problematic and nebulous. Still, the mental health professional is allowed to perform a regulatory function by deciding who deserves insurance coverage for SRS based around certain notions of problematic gendered behavior.

GID enforces a form of regulation due to its normalization of a masculine/feminine view that is instituted by the men-

tal health professional (Butler, 2004). Considering this, GID no longer represents the individual properly, but instead removes the freedom from the individual to display a full spectrum of behavior (Butler, 2004). Appealing to GID turns individuals into a series of transposable cogs that, when operating in unison, create the process of normalization (Butler, 2004).

### In Closing

This is not an attempt to dissuade people from seeking aid from a mental health professional, but an argument against forcing those who are economically disadvantaged to see a mental health professional and submitting to a diagnosis that normalizes a dichotomous view of gender. A GID diagnosis provides individuals who are transsexual the channel to receive economic assistance in transitioning, which may not have occurred otherwise. In fact, it is necessary to stress how important it is that funding has been provided through this diagnosis.

Still, can financial assistance be given without its existence? One should be even more critical of a diagnosis that holds the less financially well-off individuals under its gaze (Butler, 2004). Should not regulatory pathways that further marginalize those who cannot afford treatment be viewed with harsh criticism? GID disregards the complexities of the individual and applies a widely stigmatized label to the individual.

Many researchers believe that the removal of GID from medical discourse would cause insurance coverage for those transitioning to dry up (Levine & Solomon, 2009; Meyer-Bahlburg, 2009). The argument that has been made throughout this paper hinges on continued coverage free of GID. Prior to GID’s elimination, a policy should be in place to ensure continued coverage for those transitioning. Some believe Civil Rights and anti-discrimination movements will be hindered once GID ceases to exist within the DSM (Meyer-Bahlburg, 2010). However, there were marked political improvements in these areas once homosexuality was removed from the DSM, which would have been near impossible to realize for a population deemed “mentally ill” by the DSM (Lev, 2004).

GID should be acknowledged as a regulatory apparatus that enforces problematic notions of “proper gender behavior” that serves to limit the expression of the individual. The removal of GID will provide an adequate step towards

acknowledging that “gender typical behavior” is not the standard, nor the only legitimate form of behavior. Homosexuality’s removal from the DSM provides an adequate example of how removing GID can work to further acknowledge the individual without the use of pathologizing language. It is clear that continued coverage should be viewed as a necessity for those who wish to transition without the use of GID as a form of regulation.

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