

The Misuse of Gender Dysphoria: Toward Greater Conceptual Clarity in Transgender Health

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Abstract

The notion of gender dysphoria is central to transgender health care but is inconsistently used in the clinical literature. Clinicians who work in transgender health must understand the difference between the diagnosis of Gender Dysphoria as defined and described in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* and the notion of this term as used to assess eligibility for transition-related interventions such as hormone-replacement therapy and surgery. Unnecessary diagnoses due to the belief that a diagnosis is clinically required to access transition-related care can contribute to stigma and discrimination toward trans individuals.

Keywords

transgender, access to health care, diagnosis, pathologization, gender dysphoria

Gender dysphoria, which refers to the distress and discomfort some trans people experience because of the discrepancy between their gender assigned at birth and gendered self-image, has been a centerpiece concept of trans health care in recent years. Yet wielding the unwieldy notion of gender dysphoria is an arduous task for even the most hardened of clinicians. Unlike wielding Mjölnir, however, this may have less to do with the worth of the wielder than the misshapeness of the instrument.

In this article, I argue that the notions of gender dysphoria as outlined in the seventh version of the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (Coleman et al., 2012) and in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*; American Psychiatric Association, 2013) are different and that clinicians should not routinely diagnose patients who wish to access transition-related interventions with Gender Dysphoria.¹ A diagnosis of Gender Dysphoria should be limited to situations in which it is genuinely necessary (such as for insurance coverage) or is done at the express request of the patient.

The Depathologization of Transgender People

Noncorrespondence of gender identity and gender assigned at birth is increasingly understood as a matter

of human diversity rather than as pathology (Coleman et al., 2012, p. 168; Suess, Espineira, & Walters, 2014). People naturally develop gender identities, and some people turn out to be trans as a result. The growing understanding of transgender identities as nonpathological builds on trans communities' self-conception as normal people and is foundational in trans advocacy and scholarship. Many trans people are healthy and well-adjusted people. Applying the label of mental illness seems ill-suited. And although many trans people do suffer from mental-health issues, these tend to occur as a by-product of stigma and minority stress rather than because of transness (Askevis-Leherpeux et al., 2019; Herman, 2013; McLemore, 2018; Rood et al., 2016).

This reconceptualization of trans people as normal has been operating in trans communities, scientific and clinical communities, and broader society alike. A crucial moment in depathologization was the 2010 statement by the WPATH Board of Directors to the effect that gender variance is not inherently pathological or negative and that depicting trans people as inherently disordered can reinforce and encourage stigma (Bockting et al., 2010).

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From a depathologizing perspective, the distress in gender dysphoria is not indicative of mental illness but is a normal psychological response to having a body that does not correspond to one's gendered self-image. Trans people's gender identities are part of normal human diversity and, for some people, those gender identities involve gendered self-images that differ from their bodies. Because being trans is normal, resulting distress is understood as relating to the body rather than to the mind. Most cisgender (i.e., nontransgender) people would also be distressed if they woke up one day in the body of someone of a different gender, but we would be hard-pressed to label them mentally ill—it is merely a normal psychological reaction to an atypical situation. It makes more sense to locate the problem of gender dysphoria in the body rather than in the mind, especially given that the indicated treatment for gender dysphoria involves changing the body through hormones and surgeries. Medical transition lessens or extinguishes gender dysphoria. To be sure, the body is not cast as a problem because it is inherently gendered but rather because it clashes with the person's gendered self-image (Ashley, 2019; Ashley & Ells, 2018; Ramachandran & McGeoch, 2007, 2008).

Removing gender dysphoria from the category of mental illnesses is also defended on the basis of the relationship between psychiatric diagnoses and stigma. Stigma toward trans communities is frequently predicated on the belief that being trans is a mental illness and, more specifically, a delusion (Serano, 2009; Suess et al., 2014). However, the stigma-based argument for depathologization must be contextualized alongside the belief that nonpathological understandings of gender dysphoria and of transgender existence are theoretically viable and that pathologization serves no other legitimate clinical purpose. Contribution to stigma is not sufficient on its own to justify declassifying a psychiatric diagnosis.

Debates are ongoing regarding how depathologization should be put into practice given the role of the *DSM* in ensuring access to insurance coverage (Ehrbar, 2010; Inch, 2016). However, the question we are concerned with now is not whether trans-related diagnoses should exist and how but rather how clinicians should approach the diagnosis of Gender Dysphoria in their practices. Diagnostic practices should be informed by the view that being transgender or having gender dysphoria is not inherently disordered despite the existence of a Gender Dysphoria diagnosis in the *DSM-5*.

Gender Dysphoria in the *DSM-5*

A year after the publication of Version 7 of the WPATH Standards of Care, the *DSM-5* replaced Gender Identity

Disorder with Gender Dysphoria (American Psychiatric Association, 2013). As I explain in this section, this relabeling muddied the waters by reusing the term gender dysphoria but attributing to it a different meaning. As Davy and Toze (2018) point out, using “existing and familiar terminology with a goal to reduce pathologization is potentially counter-productive if the result is lack of clarity over how terminology is being used” (p. 159).

Although the *DSM-5* defines gender dysphoria as “the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender” (p. 451), which is somewhat similar to the definition I provided earlier, its operationalization of the term retains many elements of the previous diagnosis of Gender Identity Disorder that was criticized for pathologizing the gender identities of trans people. Despite the definition, distress is not required to satisfy the diagnostic criteria because functional impairment is enough.

In adolescents and adults, the diagnosis of Gender Dysphoria focuses on the presence of an incongruence between “experienced/expressed gender and assigned gender” (p. 452). Individuals must meet two of the following six criteria:

1. Marked incongruence between gender identity and primary or secondary sex characteristics;
2. Strong desire to be rid of primary or secondary sex characteristics for gender-related reasons;
3. Strong desire for the primary or secondary sex characteristics of “the other gender”;
4. Strong desire to be of a gender other than the one assigned at birth;
5. Strong desire to be treated as a gender other than the one assigned at birth; and
6. Strong conviction that one has the emotions and attitudes of a gender other than the one assigned at birth. Sufficient distress or impaired functioning is also required.

Some of the criteria fall under the notion of gender dysphoria, but others generally relate to the fact of being trans, such as criteria 4 to 6. This could be criticized as a surreptitious way of pathologizing trans people's gender identities despite the shift in nomenclature. The distress requirement also distinguishes the *DSM-5*'s and WPATH Standards of Care's understandings of gender dysphoria. Impaired functioning without distress suffices to meet the diagnostic criteria, and distress due to the denial of transition-related interventions fulfills the requirement, even though such distress is not traditionally included in gender dysphoria. With the “posttransition” specifier, the *DSM-5* diagnosis also applies to individuals who have medically transitioned

and do not currently experience gender dysphoria. The specifier notably serves to ensure the availability of health-insurance coverage to people who have already transitioned (Zucker et al., 2013).

A Short Genealogy of Gender Dysphoria in the Standards of Care

Gender dysphoria in the latest Standards of Care does not refer to the *DSM-5* diagnostic category. In this section, I provide a short genealogy of gender dysphoria in the Standards of Care to highlight the Standards' evolving relationship to diagnosis.

The term *gender dysphoria* is commonly attributed to Norman Fisk, who wrote an editorial in *The Western Journal of Medicine* in 1974 on what he called the "gender dysphoria syndrome" (Fisk, 1974). In the editorial, Fisk proposes this term as a more progressive and flexible alternative to the diagnosis of transsexualism.

Whether Fisk coined the term is unclear. Before his 1974 editorial, Fisk coauthored an article with Donald Laub that also refers to gender dysphoria (Laub & Fisk, 1974). They refer to their clinic as the Stanford University Gender Dysphoria Program, suggesting that the term may date back to the clinic's creation in 1968. By 1973, the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome was held, suggesting that the term may have already been well established by the time of Fisk and Laub's publications (Fisk, 1974; Laub & Fisk, 1974).

In 1979, the WPATH was formed under the name of Harry Benjamin International Gender Dysphoria Association and published its first Standards of Care, in which gender dysphoria was defined as a "primary working diagnosis applied to any and all persons requesting surgical and hormonal sex-reassignment" (Berger et al., 1979, para. 3.4). However, this first version also established that recommendations for transition-related care should be made on the basis of the criteria for transsexualism from the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychological Association, 1980). The second to fourth versions of the Standards of Care substantially reproduced the content of the first version in that regard.

The Harry Benjamin International Gender Dysphoria Association overhauled its Standards of Care for a fifth time in 1998. In Version 5, gender dysphoria was listed as one of many informal terms for persistent struggles related to gender identity (Levine et al., 1998). In contrast to the previous Standards of Care, which retained both gender dysphoria and transsexualism as central notions to trans health, Version 5 clearly positioned gender identity disorder as the term of choice in trans

health. The role of assessing mental-health professionals was to "accurately diagnose the individual's gender disorder according to either the *DSM-IV* or ICD-10 [International Classification of Diseases, 10th revision] nomenclature," a role that is retained in Version 6 (Levine et al., 1998). The decision to replace gender dysphoria and transsexualism with gender identity disorder in the Standards of Care paralleled the shift from transsexualism (for adults and adolescents) to gender identity disorder in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

The seventh version of the Standards of Care returned to gender dysphoria as its term of choice in establishing access to transition-related medical interventions. In this version, hormone-replacement therapy and transition-related surgeries require an assessment of "persistent, well-documented gender dysphoria" (Coleman et al., 2012, pp. 227–228). For the purposes of the Standards of Care, gender dysphoria is defined as "distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)" (p. 221).

The WPATH supported its definition of gender dysphoria with references to the Fisk (1974) editorial as well as its own recommendations for revising the *DSM-5*, which found that no consensus could be reached as to whether a diagnosis should remain in the manual. The WPATH consensus statement to the *DSM-5* Work Group on Sexual and Gender Identity Disorders proposed relabeling gender identity disorder to either gender dysphoria or gender dysphoric disorder to shift the focus from gender identity to the subjective experience of distress. However, they were unable to reach a consensus over whether a diagnosis should remain in the manual. Some members believed that having "a diagnostic category related to gender dysphoria pathologizes one's identity, perpetuates stigma and discrimination, medicalizes the 'condition' and drives people into treatment, diminishing autonomy in making personal decisions about their body and gender expression" (Knudson, De Cuypere, & Bockting, 2010, p. 58; see also Ehrbar, 2010).

This absence of consensus explains the ambivalence of Standards of Care Version 7 toward diagnosis. Although Standards of Care Version 7 sometimes refers to gender dysphoria as a diagnosis (e.g., Coleman et al., 2012, pp. 170, 172), the primary stated role of mental-health professionals in relation to medical transition is to assess, not diagnose. Standards of Care Version 7 distinguishes assessment and diagnosis throughout (e.g., Coleman et al., 2012, p. 179), suggesting that the WPATH does not view the two terms as synonymous but rather as having distinct meanings.

Standards of Care Version 7 does not appear to require a diagnosis related to gender dysphoria as a requirement for transition-related medical interventions. The WPATH instead opted to require an assessment of “persistent, well-documented gender dysphoria,” as defined by Fisk (Coleman et al., 2012, pp. 221, 227–228). Although the Standards of Care acknowledges the possibility of formal diagnoses relating to gender dysphoria (Coleman et al., 2012, p. 180), hormone therapy and surgery do not require one. The choice not to require diagnosis plausibly stems from the absence of consensus in the WPATH membership surrounding the continued need for a mental-health diagnosis specific to trans people, departing from WPATH’s approach in Versions 1 through 6 that required a diagnosis as a condition of access to medical transition.

The Confusion of Assessment

The understandings of the term gender dysphoria as used in the *DSM-5* and in the Standards of Care are often merged or conflated in the academic literature (Davy & Toze, 2018). Although scholars commonly refer to the *DSM-5* when mentioning gender dysphoria, the term is used in different and inconsistent manners: as a descriptor for people who experience gender dysphoria, for people who are undergoing a medical transition, or for people who have been referred to a gender clinic, independently of whether a diagnosis was made (Davy & Toze, 2018, p. 166). This muddled conceptual landscape leads many clinicians to believe and/or claim that a diagnosis of gender dysphoria is required to meet the WPATH requirements for hormone-replacement therapy and surgery (e.g., Hyderi, Angel, Madison, Perry, & Hagshenas, 2016; Schulz, 2018).

Applying a mental-health diagnosis to all people who wish to undergo a medical transition is unnecessarily pathologizing and ethically and medically questionable (Ashley, 2019; Campbell, Artz, & Stein, 2015; Davy, Sørli, & Schwend, 2018; Davy & Toze, 2018; Drescher, Cohen-Kettenis, & Winter, 2012; Gherovici, 2017; Gӱldenring, 2015; Inch, 2016; Suess et al., 2014). For patients who can obtain hormones or surgeries without one, such a diagnosis does not foster access to care. There are also multiple reasons why trans people may wish to access transition-related interventions, and not all of them display the degree of distress or impairment required for a diagnosis despite medical transition being justified (Ashley, 2019; Ashley & Ells, 2018; Askevis-Leherpeux et al., 2019). Not all patients are comfortable with having a diagnosis related to being trans because they understand it as a nonpathological, normal human variation.

A few reasons may be given in support of giving a mental-health diagnosis. First, it may be argued that a

diagnosis of gender dysphoria is helpful in guiding treatment. However, the *DSM-5* is a diagnostic manual, not a treatment manual. Though it may be helpful in guiding treatment recommendations, treatment indication is only one of the criteria used by the *DSM-5* to validate diagnostic categories. Unlike the *DSM-5*, the WPATH Standards of Care requirements for hormones and surgeries are crafted with treatment indication in mind. The Standards of Care, which does not require a diagnosis of gender dysphoria, is a more useful tool in guiding treatment than the *DSM-5*. In terms of guiding treatment, a mental-health diagnosis seems ill-suited to a condition that is primarily treated by altering the body using hormones and surgeries rather than psychotherapy or drugs that do not alter the body. If a diagnosis is desired, a non-mental-health label such as gender incongruence as defined in the *International Classification of Disease, Eleventh Revision* (ICD-11; World Health Organization, 2018) seems better suited.

Second, it may be argued that the diagnosis is helpful in shielding surgeons from liability. However, legal liability is based on respect for standards of care, not the presence of diagnosis (*ter Neuzen v. Korn*, 1995). An assessment of gender dysphoria pursuant to the WPATH Standards of Care requirements should suffice to preclude liability. Referring professionals may, however, be justified in diagnosing patients with gender dysphoria if the chosen surgeon requires it. Likewise, it is legitimate to diagnose patients with gender dysphoria if it is required for insurance purposes.

Third, it may be argued that a diagnosis of gender dysphoria helps to identify trans patients in medical charts in hospital settings. However, trans patients have diverse medical needs, and not all trans patients are diagnosed or diagnosable with gender dysphoria. It would be preferable to instead include the patient’s gender identity and gender assigned at birth, hormonal regiment, and organ inventory in the medical chart (Deutsch & Buchholz, 2015; Deutsch et al., 2013; Deutsch, Keatley, Sevelius, & Shade, 2014; Freeman & L3pez, 2018). This multifactorial approach better communicates the patient’s individual needs.

Whether a diagnosis is offered should be determined on a case-by-case basis and should not automatically proceed from the patient being trans or seeking transition-related care. In many jurisdictions, a diagnosis may be required or may otherwise facilitate access to care (Budge & Dickey, 2017). Clinicians should discuss with their patients the potential impact of diagnoses on well-being, self-concept, stigma, and access to health coverage before initiating the diagnostic process. In some cases, a mental-health diagnosis will serve no useful purpose, especially if ICD-11 codes can be used for insurance.

Conclusion

A diagnosis of gender dysphoria is not required to access transition-related interventions in the WPATH Standards of Care. Unnecessary diagnoses of gender dysphoria are incompatible with the depathologizing animus of contemporary trans health. Clinicians should be aware of the different uses of the term gender dysphoria in the literature and clearly distinguish between the notions of gender dysphoria in the Standards of Care and *DSM-5*. In their revisions for Version 8 of the Standards of Care, the WPATH should consider adding language that unambiguously states that no diagnosis is clinically required to access transition-related interventions.

Transparency

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Note

1. The capitalized form "Gender Dysphoria" refers to the *DSM-5* diagnostic category, whereas the lowercase form refers to the non-diagnostic sense of the term defined in the first paragraph and in the WPATH Standards of Care.

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