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COMMENTARY ON DSM-5

Gender Assignment Dysphoria in the DSM-5

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The new diagnosis of Gender Dysphoria (GD) in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association [APA], 2013) is a major disappointment. In many respects, it is a significant step backwards from the diagnosis of Gender Identity Disorder (GID) in the DSM-IV-TR (APA, 2000), and the members of the GID Subworkgroup (Zucker et al., 2013) have done a disservice to both patients with GD and the clinicians who treat them. Several specific problematic features of the new GD diagnosis—including elimination of subtypes based on sexual orientation and extension of the diagnosis of GD proper to persons who identify as "some alternative gender" that is neither male nor female—were among the Subworkgroup's original proposals. I criticized these features in an earlier commentary (Lawrence, 2010) and will not repeat my criticisms here. In this commentary, I will instead focus on two broader problems of the new GD diagnosis: (1) the conceptualization of GD as distress about "assigned gender" rather than about biologic sex and (2) the implication that gender transition automatically results in loss of the GD diagnosis.

Trapped in the Wrong Gender Assignment

Although male-to-female (MtF) transsexuals and males with GD cannot accurately be described as "women trapped in men's bodies," nor can female-to-male (FtM) transsexuals and females with GD accurately be described as "men trapped in women's bodies," both MtF and FtM transsexuals and the clinicians who treat them have traditionally recognized that a profound sense of "wrong embodiment"—distress related to biologic sex and sexed body characteristics—is almost always a prominent feature of transsexualism and GD, in part because such wrong embodiment usually makes it difficult or impossible to "live and be accepted as a member of the opposite sex" (World Health Organization, 1992, p. 365). This "trapped in the wrong body" metaphor is not mere poetic rhetoric but offers an authentic description of transsexuals' subjective experience. Based on his analysis of dozens of transsexual autobiographies, Prosser (1998) observed that:

> The figure of being trapped in a wrong body, of being wrongly encased, continues to be evoked in transsexual accounts. A transsexual leitmotif appearing across transsexual narratives, the proliferation of the wrong-body figure is not solely attributable to its discursive power. My contention is that transsexuals continue to employ the image of wrong embodiment because being trapped in the wrong body is simply what transsexuality feels like…. The image of wrong embodiment describes most effectively the experience of pre-transition (dis)embodiment: the feeling of a sexed body dysphoria profoundly and subjectively experienced. (p. 69)

This understanding has been largely, if not quite completely, abandoned in the DSM-5. It has been replaced by an emphasis on "assigned gender," a change that seems to have occurred entirely for political and social reasons, not for scientific or clinical ones.

In the DSM-5, all the clinical indicators of GD—even those that refer to biologic sex characteristics—are now conceptualized as being clinically relevant only by virtue of their evincing an "incongruence between one's experienced/expressed gender

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and assigned gender" (APA, 2013, p. 452; the neologism "experienced/expressed gender" is essentially synonymous with "gender identity"). In this formulation, the principal thing that feels wrong in transsexualism and GD is not one's biologic sex but one's assigned gender. This same perspective is, as we shall see, also reflected in the Subworkgroup members' implicit position that effective treatment of transsexualism and GD does not require changing sexed body characteristics but only changing nominal gender assignment, as evidenced by their contention that undergoing gender transition—the only absolute criterion for which is "full-time living in the desired gender" (APA, 2013, p. 453)—automatically results in loss of the GD diagnosis.

The DSM-5 conceptualization of GD as reflecting an incongruence between gender identity and "assigned gender" necessarily renders the new diagnostic criteria semantically incorrect as written, because it is biologic sex, not gender, that is recognized—and is "assigned" only in accordance with that recognition—at birth. Birth certificates list sex, not gender. Even the Subworkgroup members seemingly understood that what they mislabeled *gender* actually involved biologic sex: Their chapter states that "*gender assignment* refers to the initial assignment as male or female" (APA, 2013, p. 451)—and *male* and *female* are categories of biologic sex, not categories of gender. Moreover, the Subworkgroup members apparently felt compelled to include, among the six diagnostic criteria for GD in Adolescents and Adults, three criteria describing dysphoria related to biologic sex characteristics ("primary and/or secondary sex characteristics"; APA, 2013, p. 452), albeit accompanied by the dubious assertion that these were somehow symptomatic of dysphoria concerning "assigned gender." Given the unavoidable relevance of biologic sex characteristics for understanding the phenomenon of GD—something that was apparently beyond the ability of the Subworkgroup members to ignore completely—one must wonder what the Subworkgroup's obsessive emphasis on assigned gender and its awkward de-emphasis of biologic sex were intended to accomplish.

The ostensible rationale for emphasizing assigned gender—making the same diagnosis applicable to persons with and without a disorder of sex development (DSD; see Zucker et al., 2013, p. 903)—was clearly a smokescreen, because such an outcome was actually undesirable, as several international experts (Mazur, Colsman, & Sandberg, 2007; Meyer-Bahlburg, 1994, 2009; Richter-Appelt & Sandberg, 2010; Zucker, 2010)—including two Subworkgroup members themselves—have repeatedly and persuasively argued. The reason for not assigning the same diagnosis to persons with and without a DSD was explained by Meyer-Bahlburg (1994), who used the then-current terms *intersex* and *GID*:

> Intersex patients with significant gender identity problems or gender change do differ from nonintersex patients with GID in prevalence, in age at onset and presentation, and in the sex ratio, and the evidence available—in spite of its methodological shortcomings—makes it very likely that the development of gender problems in intersex patients is in most cases not directly comparable to GID as it develops in nonintersex patients. The two forms of gender identity problems are unlikely to be the same disorder. (p. 33)

Given these facts, it is impossible to believe that the Subworkgroup's real intention was to facilitate the assignment of identical diagnoses to persons with and without DSDs. Presumably, this merely provided a convenient rationalization for the Subworkgroup's actual intention: decoupling, insofar as possible, the diagnosis of GD from its traditional definition in relation to biologic sex and reframing its definition in relation to "assigned gender." Why would the Subworkgroup members want to achieve this dubious end?

Here is what I hypothesize: Some persons with GD—especially a vocal group of late-transitioning MtF transsexual activists—do not like being reminded that they have chosen to live in a gender role that is inconsistent with their biologic sex. They appear to experience such reminders as inflicting narcissistic injury (Kohut, 1972; see also Lawrence, 2008). They seemingly would prefer to believe that their biologic sex is indeterminate, arbitrary, or unimportant, that they suffer from some subtle, undiagnosed neurologic intersex condition, or both. These activists would predictably applaud the implication—inherent in the wording of the new diagnostic criteria for GD—that by undergoing sex reassignment, they have merely cast off their original inappropriately assigned gender and taken on a new appropriately assigned gender that is congruent with their gender identity. This gender-focused reframing of their condition facilitates their denial of the unpleasant reality of their biologic sex.

Thus, while conceptualizing GD as an incongruence between gender identity and assigned gender is clinically and scientifically dubious, it constitutes a clever public relations ploy on the part of the Subworkgroup members. Because this paradigm privileges socially constructed gender over the unfashionable essentialism of biologic sex, many persons with GD, along with their clinical and academic allies, will predictably applaud it as liberal and progressive. It is likely to be comforting, for example, to MtF transsexuals who adhere to the fantasy that their cross-gender identification makes them just as much "real women" as natal females are. This paradigm simultaneously lends credence to the notion that GD involving DSDs is a prevalent phenomenon of significant clinical importance, which it actually is not. Therefore, it is also likely to be comforting to those transsexuals who believe that they suffer from an undiagnosed neurologic intersex condition and that their GD reflects an incongruence between their "real" (neurologic) sex and their assigned gender.

Automatic Loss of the Gender Dysphoria Diagnosis with Gender Transition

The Subworkgroup members argued that one additional advantage of conceptualizing GD as an incongruence between gender identity ("experienced/expressed gender") and assigned gender is that "the change also makes it possible for individuals who have successfully transitioned to the preferred gender to 'lose' the diagnosis" (Zucker et al., 2013, p. 903)—supposedly because their new assigned gender would no longer be incongruent with their gender identity.[1] This explanation—in which loss of the GD diagnosis is accomplished simply by redefining a term in the diagnostic criteria—makes sense only if the Subworkgroup members are correct in assuming that the term "assigned gender" undergoes an automatic redefinition following transition. This assumption, however, is directly contradicted by the text of the DSM-5, in which *gender assignment* is formally defined as "the *initial* [italics added] assignment as male or female"[2] (APA, 2013, p. 451). Perhaps for this reason, the Subworkgroup's contrived explanation never actually appears in the DSM-5. But it does appear in the Subworkgroup's official explanatory document (Zucker et al., 2013), and therefore it is unfortunately likely to be regarded as authoritative.

The Subworkgroup's argument—that gender transition results in automatic loss of the GD diagnosis through a redefinition of "assigned gender"—is completely unconvincing. This is not only because such a redefinition is contradicted by the text of the DSM-5, but also because the outcome the Subworkgroup is attempting to achieve—automatic loss of the GD diagnosis after transition—is so inconsistent with clinical reality. Anyone who has had much experience providing care to transsexuals and persons with GD will be aware that the mere fact of gender transition (i.e., living full-time in the desired gender role) does not necessarily "cure" GD or make the diagnosis inapplicable. This is because the profound sense of wrong embodiment that transsexuals and persons with GD typically experience is not relieved simply by transition to living in the desired gender role, but only by the effective realignment of the individual's sexed body characteristics with his or her gender identity—something that is usually very difficult, if not impossible, to satisfactorily achieve. Based on the dozens of transsexual autobiographies he analyzed, Prosser (1998) pointedly observed that sex reassignment per se does not automatically relieve the sense of wrong embodiment that is central to transsexualism and GD: "Even once the transsexual has achieved sex reassignment, the figure of being trapped in the wrong body, of being wrongly encased, continues to be evoked in transsexual accounts" (p. 69).

Moreover, the Subworkgroup's proposal that gender transition results in automatic loss of the GD diagnosis through a redefinition "assigned gender" is not only unconvincing: It is also unnecessary, because patients who have been diagnosed with GD can, in principle, "lose" the diagnosis simply by no longer satisfying the "B" criterion of "clinically significant distress or impairment" (APA, 2013, p. 453). This is precisely the way in which *all* the elements of sex reassignment—including changes in sexed body characteristics (and perhaps in gender-typical behaviors) as well as transition to living in the desired gender role—were traditionally intended to work together in the treatment of GD, leading in favorable circumstances to loss of the diagnosis through alleviation of symptoms, rather than through redefinition of a term in the diagnostic criteria. The problem with this traditional method of losing the diagnosis, however, is that success is not guaranteed—and is, moreover, subject to the clinician's judgment. Accordingly, some persons with GD—especially a vocal group of late-transitioning MtF transsexual activists who appear to experience the diagnosis of GD as a source of narcissistic injury—have demanded some mechanism for guaranteeing that the GD diagnosis can be made inapplicable to themselves (see Zucker et al., 2013, p. 903). Unable to convince the Subworkgroup members to "depathologize" GD completely, they were nevertheless able to obtain a compromise allowing themselves to "lose" the diagnosis—and perhaps the feeling of narcissistic injury accompanying it—simply by undergoing transition to the desired gender, irrespective of whether any meaningful alleviation of distress or impairment had occurred.

Anyone who doubts that the Subworkgroup's position on this matter was ill-advised should examine a recent article by Dhejne et al. (2011), which reported the results of a long-term follow-up study of 324 Swedish transsexual patients who underwent legal, hormonal, and surgical sex reassignment between 1973 and 2003. Despite their "successful" reassignment, these transsexual persons displayed strikingly higher mortality rates than non-transsexual controls; in particular, they were over 19 times more likely to die from suicide. They were also hospitalized for psychiatric disorders nearly 3 times more often than controls and they attempted suicide about 5 times more often. Dhejne et al. concluded that:

> Even though surgery and hormonal therapy alleviates gender dysphoria, it is apparently not sufficient to remedy the high rates of morbidity and mortality found among transsexual persons. Improved care for the transsexual group after the sex reassignment should therefore be considered. (p. 7)

[1] Note that the Subworkgroup's proposed attribution of a new assigned gender to individuals who had "successfully transitioned" does not depend on such a transition being successful in the usual sense, given that such a new assigned gender would also be attributed to persons who had transitioned and regretted having done so (see Zucker et al., 2013, p. 903).

[2] Note that *gender assignment* could have been defined as "the initial assignment as male or female, or any subsequent reassignment as male, female, or some alternative gender," but it was not.

The implications of these findings are evident: Although sex reassignment usually alleviates the symptoms of GD, it is not always curative. Sometimes it is merely palliative.

My clinical experience with transsexual patients has made it clear to me that some persons who have undergone "successful" sex reassignment continue to fulfill two or more of the A1–A6 criteria for GD in Adolescents and Adults and continue to experience associated clinically significant distress or impairment. By any meaningful standard, these persons continue to suffer from GD. Accordingly, I believe it is appropriate that the diagnosis of GD continue to apply to them—especially because their unresolved GD is probably at least partly responsible for the increased risks of psychiatric comorbidity and excess mortality, especially death by suicide, that they experience. To regard these persons as having automatically lost the GD diagnosis simply by virtue of having undergone gender transition is the height of irresponsibility: It is an attitude the GID Subworkgroup members should have had the good sense not to encourage.

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