

Hierarchies of ‘Treatment’: The Influences of Comorbid Psychiatric Diagnoses on Individuals with Gender Dysphoria

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Abstract

Since the introduction of the gender dysphoria (GD) diagnosis, previously marginalized trans individuals, such as emancipated minors, incarcerated individuals, and individuals with cognitive disabilities that are deemed able to participate in their various medical treatments, have been invited to have an autonomous role in their decisions to access medical methods of gender affirmation. It is important to note that trans individuals with psychiatric diagnosis/es in addition to GD are prohibited to this sense of autonomy since they are deemed to be incompetent due to these comorbid ‘psychiatric’ diagnoses. I investigate the creation and consequences of a hierarchy of treatment that is created by conceiving of the trans phenomenon as a psychiatric disorder which prioritizes effective management of the non-GD diagnosis/es before validating the gender identity through both social and medical methods. This hierarchical creation invariably leads to a pathologization of the trans phenomenon as medical professionals attempt to prove through causation the actual ‘true’ diagnosis embedded within the comorbidity. The consequences of this hierarchy of treatment denies a trans person with a multiplicity of psychiatric diagnoses access to gender affirming medical methods in favor of uncovering the truth of their pathology, which can exacerbate emotional distress, distress that can potentially have lethal physical manifestations, that an individual is already experiencing. The medical institution needs to reevaluate the principle “first, do no harm,” to understand how their resistance to grant autonomy to trans individuals with comorbid diagnoses can, in actuality, create the most harm. In order avoid further marginalization of this sub-population within the trans community, I propose an eradication of any diagnosis that attempts to depict the trans phenomenon in favor of a new reimagining of reimbursable medical methods of gender affirmation that privileges the autonomy of trans individuals.

Introduction

1 The medical community has historically misunderstood trans identity. Since the late 19th century, this identity has been conflated with intersexuality and homosexuality through the medical community’s invention of the term “sexual invert” (Dreger, 2003). Conflations with intersexuality, homosexuality, and “transvestitism” in addition to stigmatizing misconceptions about the trans population as a whole have created historically inaccurate diagnoses for “transsexualism” as well as subjective and ineffective standards of care for trans individuals seeking medical methods of gender affirmation¹ (American Psychological Association). While

¹ The term medical methods of gender affirmation is used here to describe the medical technologies, interventions, and procedures used for gender affirmation such as hormone replacement therapy and a variety of gender affirming surgeries.

the diagnosis and the criteria to characterize the trans population have changed over time in the American Psychiatric Association Diagnostic and Statistical Manual (DSM), a hierarchy of treatment has been embedded into the medical community's standards of care since the initial publication of the DSM, where it states

The condition which most urgently requires treatment should be listed first. For example, if a patient with simple schizophrenia was presented to the diagnostician because of pathological alcohol intoxication, then the order of diagnoses would be first, Pathological intoxication, and second, Schizophrenia, simple type. (American Psychological Association, 4)

While these hierarchical standards of care affect all individuals with comorbid psychiatric diagnoses, for trans individuals this presents a unique conundrum when individuals have a psychiatric diagnosis for a mental phenomenon in addition to the current diagnosis characterizing trans identity, gender dysphoria (GD). Additionally, the World Professional Association for Transgender Health's (WPATH) seventh edition to Standards of Care (SOC) insists that individuals' mental illnesses be "well controlled" before proceeding with medical methods of gender affirmation, which enacts barriers, potentially life-long barriers, for trans individuals with a comorbid psychiatric diagnosis. This historical influence of medicalization of trans people has led to the current construction of the mandatory GD diagnosis that trans individuals are required to be diagnosed with before being granted access to medical methods of gender affirmation. Access, though, is contingent upon meeting additional, and often subjective, medical criteria which includes marginalizing parameters that most individuals with a psychiatric diagnosis cannot meet.

The History of the Medicalization of Trans Identity

2 Before an official diagnosis that characterized trans identity emerged in the third edition of the DSM in 1980, a diagnosis which was distinctly different than the "transvestitism" diagnosis within the two prior DSM editions, trans bodies were already being medicalized in the United States. In the mid-twentieth century, numerous academic gender clinics were established across the country and effectively replaced "on-demand" surgeries that some financially established trans people had utilized in the past (Stryker & Sullivan). The Stanford Gender Dysphoria Program was established in 1968 to collect historical information about "transsexualism", provide diagnostic criteria for medical professionals to reference, and to

determine the appropriate methods of care for trans individuals (Stone). The research conducted by medical professionals consistently had skewed population samples of trans individuals since they had a convenience sample from nearby psychiatric clinics instead of utilizing a simple random sample across a broader population. Despite this methodological anomaly, which was even addressed within disclaimers by the researchers themselves, the consequent data was used to describe the entire trans population;

[Leslie Lothstein] concluded that [transsexuals as a class] were depressed, isolated, withdrawn, schizoid individuals with profound dependency conflicts. Furthermore, they were immature, narcissistic egocentric and potentially explosive, while their attempts to obtain [medical professional assistance] were demanding, manipulative, controlling, coercive, and paranoid. (Stone, 282)

While these results were concluded from questionable methodology or exceptionally marginal data, ultimately “they came to represent transsexuals in medicolegal/psychological literature, disclaimers and all, almost to the present day,” (Stone, 283). This problematic research led to the characterization of all trans individuals as being “sick”, which has initiated incredible barriers to accessing desired medical methods of gender affirmation. Before academic gender dysphoria clinics, such as Stanford’s Gender Dysphoria Program, began to monopolize on trans bodies, there were some earlier clinics which were not academically affiliated that would perform surgeries on demand (Stone; Stryker & Sullivan). The change from non-academic to academic gender clinics came when American medical professionals began to demand that there be an objective test to ‘verify’ the trans person’s subjective understanding of themselves since performing surgeries on demand was believed to involve too many professional risks for the medical staff who were providing “experimental surger[ies] on ‘sociopaths’,” (Stone, 290; Stryker & Sullivan).

From Transsexualism to Gender Dysphoria: The Construction of Diagnoses in the DSM

3 Over the past six decades, the DSM has added, eliminated, and changed, both subtly and dramatically, a variety of diagnoses. The original DSM included the sexual deviance diagnosis as a new classification than what was formerly categorized, prior to the first publication of the DSM, as “psychopathic personality with pathologic sexuality,” (American Psychological Association, 1952). As stated in the diagnostic criteria, “the diagnosis will specific the type of

the pathologic behavior, such as homosexuality, transvestitism, pedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation),” (American Psychological Association, 1952). In both the first and second versions of the DSM, there were limited diagnostic criteria of sexual deviation beyond what was previously stated, which made understanding trans identity all the more challenging for medical professionals since transvestitism did not accurately describe what their trans patients, who were overwhelmingly trans women, were reporting as their experience. As academic gender clinics continued to treat the trans population, they struggled to find an objective method to measure the presence and validity of that experience so they dedicated significant research to create a differential diagnosis or objective test (Stone). Even though, “after considerable research, no simple unambiguous test for gender dysphoria syndrome could be developed,” by medical professionals, they were successful in creating the official “transsexualism” diagnosis, which was introduced into the third edition of the DSM (Stone, 290). The diagnostic criteria for transsexualism in the DSM III-R was described as,

... a persistent sense of discomfort and inappropriateness about one’s anatomic sex and a persistent wish to be rid of one’s genitals and to live as a member of the other sex. The diagnosis is made only if the disturbance has been continuous (not limited to periods of stress) for at least two years, *is not due to another mental disorder, such as Schizophrenia*, and is not associated with physical intersex or genetic abnormality. (emphasis added; American Psychological Association, 261)

As evidenced by the diagnostic criteria, medical professionals were already concerned that trans people, usually already regarded as being mentally ill for being trans, could also be suffering from delusions about their gender identity due to underlying mental illness. This fear of causation, where trans identity is ‘truly’ caused by mental illness as articulated in the DSM III-R, continues to permeate in subsequent editions of DSM diagnoses that attempt to characterize trans identity.

4 Within the DSM IV, the revision changed both the name of the diagnosis from transsexualism to gender identity dysphoria (GID) as well as the diagnostic criteria. The revision seemed to recognize the fact that trans people are at a higher risk for some other psychiatric diagnoses such as anxiety, depression, and suicidal ideation, but mentioned how some psychiatric diagnoses, like schizophrenia, could be a comorbid factor. The criteria states that “there may rarely be delusions of belonging to the other sex” due to schizophrenia and insistence of ‘other sex’ identification should not be considered to be a delusion, “because what is

invariably meant is that the person feels like a member of the other sex rather than truly believes that he or she is a member of the other sex. In very rare cases, however, Schizophrenia and severe Gender Identity Disorder may coexist,” (American Psychological Association, 537). This diagnostic criterion recognizes that comorbid mental illness in addition to the GID diagnosis can exist in some cases, but does not automatically exclude an individual from being ‘authentically’ trans. The recognition of comorbid potentiality, though, seems limited to mental illnesses that are not considered, by medical professionals, to be “severe” as it is stated that in “rare” cases that schizophrenia can cause delusions about gender as well as the “very rare” instances of diagnosable comorbidity of GID and schizophrenia.

5 In the DSM V, published in 2013, the diagnosis changed from GID to GD. During the revision process, medical professionals, trans advocates, and members of the trans community came together to constructively critique how the transsexualism and GID diagnoses have functioned. Since both of these diagnoses have historically pathologized trans identity, the creation of the GD diagnosis was meant to address the “real problem” that trans individuals face, which is dysphoria caused by gender incongruence. Similar to the DSM IV, the fifth edition emphasizes that there may be rare instances where schizophrenia or other psychotic disorders cause delusional desires to be “the other gender,” but there are instances where those two diagnoses can co-occur (American Psychological Association). Additionally, it is clearly stated that “in an absence of psychotic symptoms, insistence by an individual with gender dysphoria that he or she is of some other gender is not considered a delusion,” (American Psychological Association). Within the section about comorbidity possibilities, the DSM-V recognizes that comorbid diagnoses can exist while citing anxiety and depressive disorders as being the most common type.

6 The DSM is typically only referenced in order to make a psychiatric diagnosis for transsexualism, GID, and now, GD, but WPATH’s SOC are guidelines that professionals refer to when trans individuals are seeking medical methods of gender affirmation. The SOC was first created in 1979 and have had frequent revisions between the first and the seventh edition, which is the latest version that was published in 2011, only two years before the publication of the DSM V. A section in the SOC, titled “Mental Health”, provides guidelines for any professionals who may have concerns about working with trans people with mental illness. Within this section it is stated that,

Addressing these [mental health] concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life... The presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria. (WPATH SOC, 25)

The above passage initially reinforces a fear about causation, where it is believed that the mental illness causes GD, as it implies that treating the mental illness first might help a trans person to revert back to a cisgender identity. Shortly after mentioning the fear mongering possibility of causation, it is stated that the comorbid psychiatric diagnoses with GD and another mental illness does not necessarily have to result in denial of access to medical methods of gender affirmation, but instead that a hierarchy of care needs to be implemented where the mental illness is ‘optimally managed’ before the person’s gender identity is validated.

7 Within the seventh edition of the SOC there are explicit criteria that need to be met before beginning various medical methods of gender affirmation. For hormone replacement therapy and chest surgery there is four criteria that needs to be met, but two are of particular interest. These two criteria are listed as “capacity to make a fully informed decision and to consent for treatment” and four being listed as “if significant medical or mental health concerns are present, they must be reasonably well-controlled,” (WPATH SOC). What is implied with these two statements is that trans individuals have the ability to consent unless they have ‘significant’ mental health concerns, which then strips them of their own bodily autonomy and requires for them to address the mental phenomenon before being given access to medical methods of gender affirmation. Additionally, these standards are left inherently vague with terms and phrases such as “significant” and “reasonably well controlled,” which allow for professionals to have subjective interpretation of the meaning of these vague terms (WPATH SOC).

8 For the past 40 years, trans identity has been medically categorized as a psychiatric disorder as evidence by its diagnostic presence since the third edition of the DSM. While this was initially intended by medical professionals as being beneficial to the trans community in order to finally recognize and safely treat trans people suffering from gender dysphoria and desiring medical methods of gender affirmation, the classification of trans identity as a psychiatric diagnosis continues to marginalize trans people who have a comorbid psychiatric

diagnosis in addition to their GD diagnosis. This marginalization occurs since a hierarchy of care is implemented by medical professionals that privileges treatment of the other psychiatric diagnosis before validating the individual's gender identity both socially and medically. The two case studies presented by Mizock and Fleming and Donnelly-Boylen reveal how the hierarchy of care endorsed by WPATH can actually be detrimental to trans people with a comorbid psychiatric diagnosis.

Case Studies Analysis

9 The four case studies presented in the article *Transgender and Gender Variant Populations with Mental Illness: Implications for Clinical Care* are used to argue for gender validation amongst trans and gender variant individuals presenting with mental illness while being with psychiatric inpatient units. The fourth case presented by Mizock and Fleming examines how the hierarchy of treatment, where mental illness is addressed before validation of gender variant identity, can be detrimental to an individual. A person identifying himself to be a man named George Johnson III, which Mizock and Fleming rename to the initials E.C., was admitted to the emergency room after he disclosed his suicide plan to the staff at his homeless shelter (Mizock & Fleming, 211). To the inpatient staff, "E.C. appeared identifiably female-bodied, and the majority of the inpatient staff referred to him by a female alias that was given to him by the shelter," (Mizock & Fleming, 211). Even though E.C. expressed continuous "humiliation he [that] suffered in responding to this female name," he also feared that he would appear to be noncompliant with his treatment plan and subsequently extend his hospitalization if he did not allow the inpatient staff to call him by this 'female alias', (Mizock & Fleming, 211). It appeared to inpatient staff that E.C. was experiencing delusions, as evidenced by his beliefs that there was an ongoing governmental conspiracy, one where the government had not only successfully "butchered" his male genitalia but, that they were also attempting to poison him through his blood tests. In addition to these aforementioned statements, he also claimed that he was a retired biochemist with two doctoral degrees. These claims led inpatient staff to believe that E.C. was experiencing delusions and the staff expressed concern that validating his gender identity would 'reinforce' these delusions (Mizock & Fleming, 211). The clinical team maintained this theory despite the fact that, "he sustained his gender identity presentation over the course of his hospitalization," which also manifested in discomfort and agitation as he was

repeatedly misgendered by the inpatient staff and was given numerous referrals to gender segregated women's homeless shelters. Mizock and Fleming conclude that while it is standard practice when working with individuals with serious mental illness to avoid struggling with or validating delusions, they posit that validating the gender identity of people with serious mental illness should take precedence in order to show respect for that person, which helps to foster a treatment alliance and reduce potential barriers and stress that often result from chronic and purposeful misgendering.

10 Gender validation of trans and gender non-conforming individuals with mental illness is an imperative part of inpatient treatment because “supporting the individual in the gender identity that is currently presented or being explored is essential to avoid contributing to stress and stigma that interfere with recovery from acute symptoms of mental illness,” (Mizock & Fleming, 212). These case studies, though, only pertain to incidents where trans people are hospitalized due to acute symptoms of mental illness where gender validation simply includes using the individuals correct name, pronouns, and gendered nouns. For the trans and gender non-conforming people with mental illness who are seeking medical methods of gender affirmation, only gender validation is not sustainable. Additionally, I argue that, for some, mental illness cannot simply be ‘overcome’ or even consistently ‘well-managed’, notions which are popularized in mainstream American culture. This coupled with the fact that medical histories, including psychiatric, have the potential to be authenticated by various medical care providers continues to deny trans people with mental illness access to medical methods of gender affirmation since their mental illness have historically been poorly managed and/or will never be ‘well-managed’.

11 In *Gender Dysphoria, Serious Mental Illness, and Genital Self-Mutilation: A Case Report*, the attending psychiatrist and author, Donnelly-Boylen, reconsiders the hierarchy of care that had been continuously imposed on a trans woman presenting with a multifaceted psychiatric medical history. The forty-three-year-old woman was admitted to the emergency room after having self-inflicted several severe lacerations to her penis and scrotum (Donnelly-Boylen, 376). Once the woman's condition had been stabilized, she was asked by her attending medical professionals to explain why she had self-injured and she lucidly rationalized her actions by stating, “that she wished to be rid of her genitals and to possess female secondary sex characteristics. She stated that she had been repeatedly denied any form of sex-reassignment

treatment, including both hormonal and surgical interventions” (Donnelly-Boylen, 377). After a comprehensive medical history had been gathered during her time in the hospital’s inpatient unit it was realized that this was not her first incident of self-injury to her genitals. At the age of fourteen she had used a nail gun to drive several nails through her scrotum (Donnelly-Boylen, 377). With this additional patient history, it comes as no surprise that she listed this constant denial of access to desired medical methods of gender affirmation, a denial that as lasted for nearly thirty years, as a chronic stressor that triggered her most recent incident of genital self-injury.

12 The medical community’s justification to deny this trans woman any gender affirmation, despite obvious symptoms of dire gender dysphoria, is a result of her various psychiatric diagnoses of severe mental illnesses. Her extensive psychiatric history dated back to her early twenties when she was hospitalized after an unsuccessful suicide attempt by overdose with illicit drugs (Donnelly-Boylen, 377). The multiple proposed diagnoses included, “bipolar disorder with psychotic features, schizoaffective disorder, bipolar type, in addition to PTSD and cognitive impairments following a traumatic brain injury 15 years prior,” (Donnelly-Boylen, 377). The symptoms of these illnesses resulted in multiple hospitalizations as well as numerous incarcerations. Donnelly-Boylen takes note that her most recent incarceration was a result of her committing arson while “reportedly manic and paranoid”, (Donnelly-Boylen, 377). There were substantiated reports that, “she responded well to antipsychotics while incarcerated, but had a consistent history of disconnection from psychiatric care when living in the community,” (Donnelly-Boylen, 377). The limited access to mental health care was suspected to have contributed significantly to her psychiatric and legal recidivism. Within his discussion, Donnelly-Boylen reveals problematic treatment requirements within both the DSM’s GD diagnosis as well as WPATH’s Standards of Care. With this particular case study in mind, he concludes that,

experts in care of transgender patients [WPATH] emphasize providing medical treatment for gender dysphoria when underlying psychiatric disorders are well controlled... However, limitations in access to treatments for transgender patients may ultimately serve to worsen outcomes in transgender patients suffering from SMI (severe mental illness). (Donnelly-Boylen, 380).

13 I use the aforementioned case not to say that all trans people engage in genital mutilation when being barred from medical methods of gender affirmation, since this is actually very rare

(Donnelly-Boylen, 380), but instead it should be used as an example of medical abuse against trans people where, in this particular instance, a trans woman experienced blatantly consistent and severe gender dysphoria for over thirty years without being given the opportunity to begin her desired medical methods of gender affirmation whereas E.C.'s case might have been considered by medical professionals as example of a more subtle form of gender dysphoria.

14 Within these two case studies, there is clear evidence of a hierarchy of treatment where mental illness is addressed before validating gender identity since there is perceived, but unsubstantiated, causation due to comorbid psychiatric diagnosis/es with GD. Both of these individuals were admitted into emergency care due to intended or successful self-harm and given psychiatric diagnoses from those observable symptoms. Despite their clear identification as being trans, their medical professionals did not even think it would be beneficial to socially validate their gender identity by using their correct name, pronouns, or gendered nouns nor were either of them given the opportunity to undergo any desired medical methods of gender affirmation since these two particular trans individuals had comorbid psychiatric diagnosis/es in addition to GD.

Conclusion

15 While the psychiatric classification of trans identity was intended by the medical community to be beneficial for trans people, it has inevitably led to the marginalization of trans people who have another diagnosed mental illness in addition to a diagnosis characterizing trans identity. Within WPATH's SOC they reinforce a hierarchy of treatment that strongly suggests through a fear of causation and emphasizes the need to 'reasonably well control' a trans person's mental illness before validating their gender identity, both socially and medically. As Donnelly-Boylen argues, though, this hierarchal standard of care can exasperate symptoms of both gender dysphoria and symptoms of mental illness. For this reason, the WPATH's SOC in particular needs to be amended so that trans and gender non-conforming people with mental illness(es) can regain their autonomy for both social and medical gender affirmation.

16 A serious inquiry into the purpose of a psychiatric diagnosis that characterizes trans identity needs to be had. As stated before, many medical professionals, advocates, and trans people worked to maintain a psychiatric diagnosis in the DSM-V instead of proposing an eradication of the diagnosis. A popular argument for maintaining a psychiatric diagnosis in the

DSM is that being diagnosed with a psychiatric diagnosis, which is currently GD, makes it possible for medical methods of gender affirmation to be covered, usually through reimbursement, by insurance. While a different paper should be dedicated to the validity of this claim as well as interrogating the inherent classism imbedded within a reimbursement model, the question still needs to be asked; is it still reasonable that some trans and gender non-conforming people are facing challenges and, in some instances, outright denial to desired medical methods of gender affirmation due to psychiatric comorbidity with GD?

17 It is imperative that this current model of medical gender affirmation be entirely reimaged. Currently, there are trans and gender non-conforming people with comorbid psychiatric diagnoses facing challenges or barriers to accessing their desired medical methods of gender affirmation as well as many trans and gender non-conforming people facing financial difficulty funding these desired medical methods. Stated simply, the current system in place is insufficient since it marginalizes many and may even be chronically detrimental to those trans and gender non-conforming people.

18 Since an entire repurposing of this current system of medical gender affirmation is not currently feasible, I propose two revisions to WPATH's SOC, the 'gold standard' in trans health care. First and foremost, immediate social validation of a trans and/or gender non-conforming person's gender identity regardless of their mental ability status needs to happen consistently. Secondly, the informed consent model, a model that reinstates trans and gender non-conforming people's autonomy, needs to expand its implementation to all states in the country and beyond go just hormone replacement therapy (HRT). The aim of these revisions is to first alleviate any distress that occurs from misgendering and then address the challenges to accessing medical methods of gender affirmation, which can be some of the repercussions of this hierarchy of treatment. Since trans and gender non-conforming people with mental illness experience medicalization that enforces cisgender, patriarchal control of their bodies, it is crucial that these doubly marginalized individuals have autonomy to their bodies and identities that is independent of this problematic hierarchy of treatment.

Acknowledgements

First and foremost, I would like to thank Dawna Thomas for her guidance and encouragement throughout my research into this piece. I would also like to thank both Olga Tarapata and Sarah Youssef for their insightful comments. And finally, Emiliano Portillo, you have my endless gratitude.

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