Western Undergraduate Psychology Journal

Volume 1 | Issue 1 Article 1

1-3-2014

Deconstructing a DSM Diagnosis: Gender Identity Disorder (GID) in Adolescents and Adults

Saralyn Russell
UWO

Deconstructing a DSM Diagnosis: Gender Identity Disorder (GID) in Adolescents and Adults

Saralyn Russell*

The present article discusses the DSM-IV-TR diagnosis of gender identity disorder (GID) in adolescent and adults. A brief summary of GID's historical evolution is provided, followed by an extensive literature review. Peer reviewed articles were selected for relevance and rates of citation. It is acknowledged that high citation rates do not directly translate into article quality, and therefore some references may not meet the highest research standards. In an effort to acknowledge other relevant perspectives, additional sources included writing by individuals with GID and reports released by invested organizations. Ten topics were identified: gatekeeping, post-operative patient satisfaction and regret, theoretical criticisms, reliability and validity, criterion C (absence of an intersex condition), criterion D (presence of distress or impairment), prevalence, comorbidity, homosexuality, and specifiers. Conflicting findings were acknowledged and implications were discussed when appropriate. Although the GID diagnosis underwent several changes with the release of the DSM-V in May 2013, this article only briefly touches upon that process. Ultimately, the present article focuses on the literature's state immediately before the DSM-V release in May 2013.

Gender identity, or one's internal sense of gender, is a complex and multi-faceted construct. Most people's gender identity aligns with their external anatomy; however, in some cases it does not. Many psychologists and sexologists have historically studied this issue, such as Hirshfeld (1923) and Cauldwell (1949). Perhaps one of the most influential contributions to this topic was offered by Dr. Harry Benjamin, who published The Transsexual Phenomenon in 1966. Rejecting psychotherapy as a valid form of treatment, Benjamin helped to pioneer hormonal and surgical methods that are still used today (Person, 2008).

Fourteen years after The Transsexual Phenomenon, gender identity disorder of childhood (GIDC) and transsexualism appeared in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980). Seven years after that, gender identity disorder of adolescence and adulthood (nontranssexual type) was introduced, but transsexualism was retained (DSM-III-R; APA, 1987). Next, GID for adolescents/adults replaced transsexualism (DSM-IV; APA, 1994). Six years later, the DSM was revised to include only GID for children, GID for adolescents/adults, and GID Not Otherwise Specified (GIDNOS) (DSM-IV-TR; APA, 2000a). Despite these distinctions, the present article will employ the term "GID" in reference to the lengthier "gender identity disorder in adolescents and adults". This is not meant to diminish the significance of others GID types. Rather, it reflects the article's limited scope and a goal of maintaining clear terminology. Interested readers may refer to Zucker (2010) for a discussion of GID in children, or else Rachlin, Dhejne, & Brown (2010) for more information about GIDNOS.

GID currently has four diagnostic criteria. As would be expected, Criterion A requires a cross-gender identification. Criterion B requires that the individual is also uncomfortable with their current assigned sex. Criterion C states that the diagnosis cannot be made with a concurrent physical intersex condition. Lastly, as with most diagnoses in the DSM-IV-TR, the individual must experience distress or impaired functioning.

The topic of GID is controversial and may elicit extreme opinions. The present article aims to maintain balance by situating the diagnosis in a critical framework that acknowledges the

*Initially submitted for Psychology 4791G at the University of Western Ontario. For inquiries regarding the article, please email the author at *srusse44@uwo.ca*.

perspectives of several interested parties. This will be achieved with a thorough literature review that addresses conflicting findings. Ten subtopics will be discussed: gatekeeping, post-operative patient satisfaction and regret, theoretical criticisms, reliability and validity, criterion C, criterion D, prevalence, comorbidity, homosexuality, and specifiers. These topics represent the crux of most controversies and will allow for a deconstruction of the diagnosis' underlying assumptions. As a result, questions may be raised concerning its social, cultural, biological and psychological implications. Although focus will be placed on widely cited articles in peer reviewed psychology journals, some references to other sources will also be used. This is meant to provide a voice to gender variant individuals and other interested parties who may not be able to publish in peer reviewed journals.

Literature Review

Gatekeeping

Not all individuals who are diagnosed with GID wish to alter their body through hormone therapy or surgery. However, there are guidelines in place for those who do. The World Professional Association for Transgender Health (WPATH) recently released the seventh edition of its Standards of Care (SOC) (2012). Although some trans-activists have criticized the SOC (e.g. STP, 2012), it is widely referred to by psychologists and other health care providers. The SOC provides different criteria to be met for hormone therapy, breast/chest surgery, and genital surgery (sex reassignment surgery (SRS)). For example, criteria for metoidioplasty or phalloplasty (in Female to Male, or FtM, candidates) and vaginoplasty (in Male to Female, or MtF, candidates) include: two referrals by medical professionals, well-documented gender dysphoria, informed consent and age of majority, one year of hormones, and one year of living in the gender role that matches internal gender identity. The last criterion is sometimes referred to as real-life experience (RLE). The SOC also recommend that these patients have regular sessions with a mental health professional, and psychotherapy is indeed often an integral part of treatment. WPATH justifies their strict criteria by stating: "changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be" (p. 61).

However, as with most systems, glitches may arise. Stone (1991) asserted that some candidates are familiar with the criteria, and purposely display behavior that will result in a diagnosis and subsequent treatment. Another problem, which is arguably more serious, is the route taken by individuals who are unable to navigate the system. They may resort to unsafe methods of self-treatment such as illegal or non-prescribed hormones (Ray, 2006). In addition to dangers stemming from improper doses, such hormones may be injected with shared needles and thus increase the risk of HIV infection (Nemoto, Luke, Mamo, Ching & Patria, 1999). Such individuals may also inject silicone in an effort to achieve a more feminine or masculine appearance (Ray, 2006). Sadly, one study found that 2.4% of male identifying participants and 9.4% of female identifying participants had performed self-mutilation of the genitals or the chest (Dixen, Maddever, Van Maasdam, Edwards, 1984). However, it should be noted that this study was published before the present editions of the SOC and DSM.

Post-Operative Satisfaction and Regret

The definition of "success" in the context of post-operative transsexuals is difficult to establish, although there has been a recent shift to measure it in terms of patient satisfaction. Caroll (1999) found that several of the WPATH criteria did indeed predict patient satisfaction. These included one year of RLE, use of hormones, and psychological treatment. Other predictors were social support and good surgical outcomes. Interestingly, Lawrence (2003) surveyed 232 transsexuals and found that good surgical outcome was the most important predictor of post-operative satisfaction. She reported that adherence to the WPATH (at that time, the Harry Benjamin International Gender Dysphoria Association) criteria were not associated with more positive

outcomes. However, it should be noted that the WPATH criteria have changed since the Lawrence study. Currently, it is still widely assumed that the WPATH should be adhered to.

In any case, there is a general consensus that SRS has a beneficial effect on patients (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010). It has consistently been found to be followed by low rates of regret (Rehman, Lazer, Benet, Schaefer, & Melman, 1999; Krege, Bex, Lümmen, & Rübben, 2001). One study extended this retrospective evidence by assessing 325 adult and adolescent participants before and after SRS (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). The researchers reported several positive outcomes and a regret rate lower than 2%. Thus, although some health care professionals disagree on the actual criteria that should be met, SRS itself is accepted as a useful treatment option for patients with GID who wish to pursue that route.

Theoretical Criticisms

Several authors have critiques the GID diagnosis on a theoretical basis. For example, Lev (2005) argues that the issue must be approached by acknowledging the historical, social and political implications of diagnostic classification systems. More specifically, she draws upon Foucault (1978) to argue that the GID diagnosis serves as a tool of social control. Lev points out that cross-gender identity have existed in other cultures and times without being pathologized (i.e., specifically defined), and that the present diagnostic criteria support sexist ideologies.

Dr. Kelley Winters is a passionate and vocal advocate for GID reform. She published an article in 2005, arguing that the current diagnostic criteria emphasize differences from cultural norms instead of distress and impairment. Winters wrote that the diagnosis is stigmatizing, and that this results in distress. She also pointed out that the words "identity disorder" imply that an individual's identity is itself defective; a line between symptoms and the actual individual is blurred in the case of GID. Indeed, some individuals deem the word "disorder" stigmatizing and insulting, and also urge for the de-psychopathologisation of gender variance (e.g. WPATH, 2010). For these reasons, some have called for a complete removal of the diagnosis (e.g. Isay, 1997).

In addition to the word "disorder", some people have considered implications of terminology used in the actual APA text. Cohen-Ketennis and Pfafflin (2010) argue that phrases such as "the other sex" and "cross-gender identification" assume the existence of two opposite and complimentary sexes. Some gender variant individuals endorse a perspective that moves beyond binaries to conceptualize gender as multi-dimensional and ultimately indefinable (e.g. Butler, 1990; Bornstein, 1994). Indeed, some individuals describe their identity as "3rd gender", "gender fluid", "bigender/two-spirit", "genderless" or "pan-/poly-/omnigendered" (Bockting, 2008, p. 214). Individuals who understand their own gender through this lens may reject a diagnosis of GID but still desire some combination of hormones or surgery.

Reliability and Validity

Considering the permanence and magnitude of some treatments for GID, validity and reliability of the diagnostic criteria are important. Unfortunately, formal assessments of these constructs have not been completed. As of 2006, "no one ha[d] ever conducted a formal reliability study for the GID diagnosis as it pertains to adolescents (or adults for that matter)" (Zucker, 2006, p. 541). Four years later, Cohen-Kettenis and Pfafflin (2010) noted that this had not changed. According to these authors, no inter-rater reliability studies or structured interviews assessing DSM-IV-TR GID had been conducted. The same article also acknowledged that there is a lack of studies examining the validity of the measures in the area. GID's controversial nature does not lend itself to validity studies; it is difficult to determine the validity of shifting criteria that are widely contested for multiple reasons. The authors suggested using the success of SRS as an indirect test of the diagnosis' validity. This success has indeed been demonstrated, as already discussed in the present article.

Criterion C: Absence of a Concurrent Physical Intersex Condition

As noted earlier, criterion C requires that the person does not have a concurrent physical intersex condition (or disorder of sex development or DSD; Hughes, I. A., Houk, C., Ahmed, S. F., Lee, P. A., & LWPES/ESPE, 2006). An individual with DSD who satisfies all other criteria would be diagnosed with GIDNOS. This was added as a criterion because people with DSD differ in some relevant ways from those without DSD. For example, Meyer-Bahlburg (1994) reported differences in age of onset, sex ratio, prevalence and predictive factors between groups of transsexuals with and without DSD. Cohen-Kettenis and Pfafflin (2010) acknowledged that some people believe this leads to the performance of unnecessary physically invasive exams in an effort to ensure that DSD is not present. The authors promptly dismissed this concern by stating that this rarely occurs, since a brief non-invasive examination usually confirms the absence of indications of DSD. Richter-Appelt and Sandberg (2010) also defended the criterion, concluding that the distinction should be maintained in the fifth edition of the DSM. The authors argued that this would allow more individualized and beneficial care. The general consensus seems to be that criterion C is justified.

Criterion D: Distress and/or Impairment

In order for a condition to qualify as a mental disorder in the DSM-IV-TR, there must be evidence of impairment and/or distress. This criterion was originally added to the DSM III to avoid labeling individuals with mental disorders when unnecessary. However, in the case of GID, this criterion can take on a new meaning. It implies that individuals must be distressed or experiencing impaired functioning in order to qualify for SRS. This is usually not a barrier in clinical settings, as most clinicians assume distress is inherent in the “dysphoria” aspect of the diagnosis (Cohen-Kettenis & Pfafflin, 2010). However, Meyer-Bahlburg (2010) reviewed this issue and ultimately disagreed with this assumption. He stated that patients in clinical settings vary in their stress levels and coping strategies, just as non-gender variant individuals. Furthermore, he noted that distress varied across time, and it is therefore inappropriate to assume all individuals who wish to change gender are distressed.

Slippery Statistics: Prevalence and Epidemiology

Unfortunately, it has proven difficult to accurately determine the prevalence of GID. The DSM-IV (APA, 1994) states that the prevalence is 1:30,000 adult males and 1:100,000 adult females. However, these numbers are likely based on outdated European data collected by Hoenig and Kenna (1974). When work began on the seventh edition of the SOC, WPATH commissioned an article on the epidemiology of GID. The result was an up-to-date summary submitted by Zucker and Lawrence (2009). Notably, the authors reported that there have been absolutely no formal studies that accurately determine the prevalence of GID in adults and adolescents. They explained that researchers have mainly attempted to determine prevalence by assessing the amount of patients who visit clinics with the goal of receiving hormones or SRS. The authors clearly stated that this method of sampling likely underestimates GID prevalence. Nevertheless, they attempted to draw tentative conclusions using data from 25 clinics. Several overarching trends were identified, including: more MtF transsexuals than FtM transsexuals, a lower age of presentation for FtM transsexuals than MtF transsexuals, and a significant increase in number of patients in recent years. They concluded by accepting that GID is rare, while acknowledging that their data are informed estimates at best.

Comorbidity

Comorbid disorders in GID seem to be common. Although causation is difficult to determine, it is likely that these figures are partially attributable to societal stigma experienced by individuals with GID. One study assessed a sample of 31 patients treated for GID, reporting that 71% of the participants also met the criteria for a current or lifetime Axis I diagnosis (Hepp, Kraemer, Schnyder, Miller, & Delsignore,

2005). Axis I diagnoses can be quite serious, as they include clinical disorders and developmental and learning disorders. Another study examined psychological functioning in 13 FtM and 22 MtF transsexuals in Belgium after their transitions. Although high rates of comorbid mental disorders were found in both groups, higher rates emerged in the MtF group (De Cuypere, Jannes, & Rubens, 1995).

Of particular importance are comorbid psychotic disorders such as schizophrenia. In the current practice, an individual can be diagnosed with both GID and schizophrenia (APA, 2000a, p. 537). The relationship between the two disorders is complicated. Some individuals with schizophrenia have delusions involving gender change (Borras, Huguenet, & Eytan, 2007). Maderson and Kumar (2001) described a case in which GID manifested along with schizophrenia. This is not to say that all individuals with GID are psychotic; rather, it is presented as information to consider when making diagnoses and treatment recommendations. It is unwise for a diagnosis to be made during an acute psychotic episode, and care should also be taken in the case of more chronic presentation.

GID and Homosexuality: Parallel Diagnoses?

Homosexuality was replaced in the DSM by ego-dystonic homosexuality in 1973, with the latter subsequently being removed in 1986. Recall that gender identity disorder of children (GIDC) and transsexualism were introduced in 1980, which laid the groundwork for the present diagnosis of GID. This timing led some critics to make an intriguing argument that GID and its related diagnoses were a covert way of "catching" individuals who would have been diagnosed with homosexuality before 1973. A summary of this criticism in the literature, as well as a rebuttal, was provided by Zucker and Spitzer (2005).

Some people draw parallels between homosexuality and GID, arguing that GID should be removed from the DSM because it pathologizes natural variance just as the homosexuality diagnosis did (e.g. Ault & Brzuzy, 2009). This is a view that is particularly endorsed by many activists. While this argument does have some merits, it draws an oversimplified parallel between the two diagnoses. Homosexuality cannot be treated (APA, 2000b), but some individuals with GID seek out and benefit from treatment. Thus, "while removal from the DSM led to a liberating and immediate 'cure' for members of the gay community, a similar approach with GID could have adverse treatment consequences, particularly for the anatomically dysphoric transgender individuals seeking or in need of medical transition" (Drescher, 2010, p. 446). In other words, if hormones or surgery were no longer medically necessary to treat a disorder, insurance coverage in some areas could cease. Although this may appear to be a mere practical snag, it would potentially have far-reaching and serious consequences. This is a concern that has been echoed by non-psychologists invested in the issue. For example, Vance et al. (2010) surveyed 43 organizations concerned with the welfare of gender variant people. While 55.8% agreed that GID should be excluded from the DSM V, those who thought it should be maintained cited health care reimbursement as the most common reason. In addition, Green et al. (2011) noted that the diagnosis can help establish legal identity rights for individuals with GID. Thus, removing the diagnosis would not be the simple cure that some activists advocate for. Forty years after the removal of homosexuality from the DSM, the issue of GID removal is still muddled and capable of eliciting passionate opinions among invested parties.

Specifiers

As seen in the previous section, sexuality and gender identity often cross paths in the DSM. Interestingly, sexuality is implicated in GID in a direct way through four specifiers: sexually attracted to males, females, both, or neither. The specifiers originally emerged in the DSM-IV (APA, 1994) and are based on work published by Ray Blanchard (e.g., Blanchard, 1989; Blanchard, Clemmensen, & Steiner, 1987).

Cohen-Kettenis and Pfafflin (2010) noted that although no clinical decisions are based on the subtypes, distinguishing between them may be useful for research purposes. However, they also

noted that applicants may not be truthful when reporting their sexual orientation clinically. Lawrence (2010) strongly supported retention of the sexual orientation subtypes in the upcoming version of the DSM. She argued that the subtypes are useful for several reasons: they "can be easily ascertained", they "facilitate concise, comprehensive clinical description", they "offer prognostic value for treatment-related outcomes", they "offer predictive value for comorbid psychopathology", they "facilitate research and offer heuristic value", and they are "unambiguous" (p. 530). Despite these interesting points, the sexual orientation specifier was deleted in the DSM V because it was "not considered clinically useful" (APA, 2013b, p.15).

Brief Commentary on DSM V

The present article offers a review of the literature concerning GID up to 2012. However, significant new developments have occurred with the publication of the DSM V in May 2013. In preparation for the new DSM, the APA created a Work Group for Sexual and Gender Identity Disorders. The group was chaired by Dr. Kenneth Zucker. The Gender Identity Disorders sub-work group consisted of Dr. Peggy Cohen-Kettenis, Dr. Jack Drescher, Dr. Heino Meyer-Bahlburg, and Dr. Friedemann Pfafflin. These individuals, all of whom were cited in the present literature review, were charged with the task of reviewing literature and making recommendations. They wisely sought out opinions from activists by surveying invested organizations that are active with transgendered individuals (Zucker, 2009). After working for several years on the issue, decisions were finalized and the process came to a close. Gender identity disorder has been replaced by the arguably more respectful diagnosis of Gender Dysphoria, defined as "a marked incongruence between one's experienced/expressed gender and assigned gender" (DSM V; APA, 2013a). A full discussion of the issues surrounding this new diagnosis is beyond the scope of this article. Interested readers can refer to an article written by the APA which summarizes the DSM V changes (APA, 2013b, p. 14-15).

Conclusion

The present article has reviewed several topics that are relevant to GID. These include psychologists' role as gatekeepers, post-operative patient satisfaction and regret, theoretical criticisms, reliability and validity, criterion C, criterion D, prevalence, comorbidity, homosexuality, and specifiers. As this review has perhaps demonstrated, GID is one of the most controversial disorders in modern day psychology. Its diagnostic criteria have evolved with each new edition of the DSM and will continue to do so in the future.

History suggests that our understanding of gender shifts based on social factors, such as political and cultural influences. It is therefore understandable that critics both within and outside the field of psychology have questioned the diagnosis of GID, which has now been replaced with gender dysphoria. It is important to acknowledge the views of all stakeholders, although this author believes that the most important stakeholders are the clients themselves. Despite the passionate disagreements which arise at times, all parties share the same goal of improving patients' quality of life. Dialogue and future research will facilitate the achievement of that goal.

First Received: 1/23/2013
Final Revision Received: 4/7/2013
ISBN: 978-0-7714-3034-3

References

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000a). Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2000b). Commission on Psychotherapy by Psychiatrists (COPP), Position statement on therapies focused on attempts to change sexual orientation (Reparative or conversion therapies*). American Journal of Psychiatry, 157*, 1719-1721.

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

American Psychiatric Association. (2013b). Highlights of Changes from DSM-TR-IV to DSM-5. Washington, DC.

Ault, A., & Brzuzy, S. (2009). Removing gender identity disorder from the diagnostic and statistical manual of mental disorders: A call for action. *Social Work, 54*(2), 187-189. doi: 10.1093/sw/54.2.187

Benjamin, H. (1966). The Transsexual Phenomenon. New York: The Julian Press, Inc.

Blanchard, R. (1989). The classification and labeling of nonhomosexual gender dysphorias. *Archives of Sexual Behavior*, 18(4): 315-334. doi:10.1007/BF01541951

Blanchard, R.; Clemmensen, L. J.; Steiner, B. W. (1987). Heterosexual and homosexual gender dysphoria. *Archives of Sexual Behavior*, *16*(2): 139-152. doi:10.1007/BF01542067

Bockting, W. O. (2008). Psychotherapy and the real-life experience: From gender dichotomy to gender diversity. *Sexologies*, *17*(4), 211–224. doi: 10.1016/j.sexol.2008.08.001

Bornstein, K. (1994). Gender outlaw: On men, women and the rest of us. London: Routledge.

Borras, L., Huguenet, P., & Eytan, A. (2007). Delusional ‘‘pseudotranssexualism’’ in schizophrenia. *Psychiatry, 70*(2), 175–179. doi: 10.1521/psyc.2007.70.2.175

Butler, Judith (1990). Gender Trouble: Feminism and the Subversion of Identity. London: Routledge Classic.

Carroll, R. A. (1999). Outcomes of treatment for gender dysphoria. *Journal of Sex Education & Therapy*, *24*(3), 128-136. Retrieved from https://www.lib.uwo.ca/cgi-bin/ezpauthn.cgi/docview/619540008?accountid=15115

Cauldwell, D. A. (1949). Psychopathia Transexualis. *Sexology*, *16*: 274-280.

Cohen-Kettenis, P., & Pfäfflin, F. (2010). The DSM diagnostic criteria for gender identity disorder in adolescents and adults. *Archives of Sexual Behavior, 39*(2), 499-513. doi: 10.1007/s10508-009-9562-y

De Cuypere, G., Jannes, C., & Rubens, R. (1995). Psychosocial functioning of transsexuals in Belgium. *Acta Psychiatrica Scandinavica*, *91*(3), 180-184. doi: 10.1111/j.1600-0447.1995.tb09763.x

De Cuypere, G., T’Sjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebeke, P., Rubens, R. (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior, 34*(6), 679-690. doi:10.1007/s10508-005-7926-5

Dixen, J. M., Maddever, H., Van Maasdam, J., & Edwards, P. W. (1984). Psychosocial characteristics of applicants evaluated for surgical gender reassignment. *Archives of Sexual Behavior*, *13*(3), 269-276. doi: 10.1007/BF01541653

Drescher, J. (2010). Queer diagnoses: Parallels and contrasts in the history of homosexuality, gender variance, and the diagnostic and statistical manual. *Archives of Sexual Behavior, 39*(2), 427-460. doi: 10.1007/s10508-009-9531-5

Foucault, M. (1978). The history of sexuality: An introduction (Vol. 1). NY: Pantheon Books.

Garaffa, G., Christopher, N. A., & Ralph, D. J. (2010). Total phallic reconstruction in female-to- male transsexuals. *European Urology*, *57*(4), 715-722. doi:10.1016/j.eururo.2009.05.018

Green, J., McGowan, S., Levi, J., Wallbank, R., & Whittle, S. (2011). Recommendations from the WPATH consensus process for revision of the DSM diagnosis of gender identity disorders: Implications for human rights. *International Journal of Transgenderism*, *13*(1), 1-4. doi: 10.1080/15532739.2011.606193

Hepp, U., Kraemer, B., Schnyder, U., Miller, N., & Delsignore, A. (2005). Psychiatric comorbidity in gender identity disorder. *Journal of Psychosomatic Research*, *58*(3), 259-261.doi: 10.1016/j.jpsychores.2004.08.010

Hirschfeld, M. (1923). Die intersexuelle Konstitution. *Jarhbuch fuer sexuelle Zwischenstufen 23*: 3-27.

Hoenig, J., & Kenna, J. C. (1974). The prevalence of transsexualism in england and wales. *The British Journal of Psychiatry*, *124*, 181-190. doi: 10.1192/bjp.124.2.181

Hughes, I. A., Houk, C., Ahmed, S. F., Lee, P. A., & LWPES/ESPE Consensus Group. (2006). Consensus statement on management of intersex disorders. *Archives of Disease in Childhood*, *91*(7), 554–563. doi: 10.1136/adc.2006.098319

Isay, R. A. (1997). Remove gender identity disorder from DSM. *Psychiatric News*, *32*(1), 13.

Krege, S., Bex, A., Lümmen, G., & Rübben, H. (2011). Male-to-female transsexualism: a technique, results and long-term follow-up in 66 patients. *BJU International*, *88*(4), 396-402. doi: 10.1046/j.1464-410X.2001.02323.x

Lawrence, A. A. (2003). Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Archives of Sexual Behavior*, *32*(4), 299-315. doi: 10.1023/A:1024086814364

Lawrence, A. A. (2010). Sexual orientation versus age of onset as bases for typologies (subtypes) for gender identity disorder in adolescents and adults. *Archives of Sexual Behavior*, *39*(2), 514-545. doi: 10.1007/s10508-009-9594-3

Lev, A. (2005). Disordering gender identity disorder in the DSM-IV-TR. *Journal of Psychology and Human Sexuality*, *17*(3/4), 35-69. doi: 10.1300/J056v17n03_03

Manderson, L., & Kumar, S. (2001). Gender identity disorder as a rare manifestation of schizophrenia. *Australian and New Zealand Journal of Psychiatry*, *35*(4), 546-547. doi: 10.1046/j.1440-1614.2001.0911h.x

Meyer-Bahlburg, H. (1994). Intersexuality and the diagnosis of gender identity disorder. *Archives of Sexual Behavior*, *23*(1), 21-40. doi: 10.1007/BF01541616

Meyer-Bahlburg, H. (2010). From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Archives of Sexual Behavior*, *39*(2), 461-476. doi: 10.1007/s10508-009-9532-4

Nemoto, T., Luke, D., Mamo, L., Ching, A., & Patria, J. (1999). HIV risk behaviours among male-to-female transgenders in comparison with homosexual or bisexual males and heterosexual females. *AIDS Care*, *11*(3), 297-312. doi: 10.1080/09540129947938

Rachlin, K., Dhejne, C., & Brown, G. R. (2010). The future of GID NOS in the DSM 5: Report of the GID NOS working group of a consensus process conducted by the world professional association for transgender health. *International Journal of Transgenderism*, *12*(2), 86-93. doi: 10.1080/15532739.2010.509209

Ray, N. (2006). Lesbian, gay, bisexual and transgender youth: An epidemic of homelessness. New York: National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless. Retrieved from http://www.thetaskforce.org/downloads/HomelessYouth.pdf

Rehman, J., Lazer, S., Benet, A. E., Schaefer, L. C., & Melman, A. (1999). The reported sex and surgery satisfactions of 28 postoperative male-to-female transsexual patients. *Archives of Sexual Behavior*, *28*(1), 71-89. doi: 10.1023/A:1018745706354

Richter-Appelt, H., & Sandberg, D. E. (2010). Should disorders of sex development be an exclusion criterion for gender identity disorder in DSM 5? *International Journal of Transgenderism*, *12*(2), 94-99. doi: 10.1080/15532739.2010.515181

Smith, Y. L. S., Van Goozen, Stephanie H. M., Kuiper, A. J., & Cohen-Kettenis, P. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine, 35*(1), 89-99. doi: 10.1017/S0033291704002776

Stone, A. R. (as Sandy Stone) (1991). The empire strikes back: A posttranssexual manifesto. In: Body Guards: The Cultural Politics of Gender Ambiguity, eds. J. Epstein & K. Straub. New York: Routeledge, p. 280-304.

STP (Stop Trans Pathologisation). (2012). Reflections on the SOC-7. Retrieved from http://www.stp2012.info/STP2012_Reflections_SOC7.pdf

Vance, S. R., Cohen-Kettenis, P., Drescher, J., Meyer-Bahlburg, H., 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), 1-14. doi:10.1080/15532731003749087

Winters, K. (2005). Gender dissonance: Diagnostic reform of gender identity disorder for adults. *Journal of Psychology & Human Sexuality*, *17*(3-4), 71-89. doi: 10.1300/J056v17n03_04

WPATH Board of Directors. (2010). De-psychopathologisation statement released May 26, 2010. Retrieved from http://www.wpath.org/announcements_detail.cfm?pk_announcement=17

WPATH. (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. (7th ed.). Retrieved from http://www.wpath.org/documents/SOC%20V7%2003-17-12.pdf

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 & Marital Therapy, 31*(1), 31-42. doi: 10.1080/00926230590475251

Zucker, K. J. (2006). Commentary on Langer and Martin's (2004) "how dresses can make you mentally ill: Examining gender identity disorder in children". *Child & Adolescent Social Work Journal*, *23*(5-6), 533-555. doi: 10.1007/s10560-006-0074-5

Zucker, K. J. (2009). Report of the DSM-5 Sexual and Gender Identity Disorders Work Group. Retrieved from http://www.dsm5.org/progressreports/pages/0904reportofthedsm-vsexualandgenderidentitydisordersworkgroup.aspx

Zucker, K. J. (2010). The DSM diagnostic criteria for gender identity disorder in children. *Archives of Sexual Behavior*, *39*(2), 477-498. doi: 10.1007/s10508-009-9540-4

Zucker, K. J., & Lawrence, A. A. (2009). Epidemiology of gender identity disorder: Recommendations for the standards of care of the world professional association for transgender health. *International Journal of Transgenderism*, *11*(1), 8-18. doi: 10.1080/15532730902799946