
Giving Voice to the Trans Community on GID Reform in the *DSM-5*: A Saskatchewan Perspective

Donner la parole à la communauté trans au sujet de la réforme du trouble d'identité sexuelle dans le *DSM-5* : un point de vue de la Saskatchewan

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ABSTRACT

The inclusion of the diagnosis of gender identity disorder (GID) within the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is a contentious issue. A summary of the arguments for retention, removal, or reform of the diagnosis in the *DSM-5* is presented. A qualitative study with 7 individuals from Saskatchewan, Canada, was conducted. They discussed being diagnosed with a “disorder,” their experience of being transgender in Saskatchewan, and their opinions about the current debate. There is a discussion of the themes from the interviews. The implications for counsellors and other health providers and recommendations for further inquiry are also presented.

RÉSUMÉ

Le fait d'inclure le diagnostic de trouble d'identité sexuelle dans le *Diagnostic and Statistical Manual of Mental Disorders (DSM)* est une question litigieuse. L'article présente un résumé des arguments visant à conserver, à retirer, ou à réformer le diagnostic dans le *DSM-5*. On a mené une étude qualitative auprès de 7 personnes de la Saskatchewan, au Canada. Elles ont discuté du fait d'être l'objet d'un diagnostic de « trouble », de leur expérience en tant que transgenres en Saskatchewan, et de leurs opinions au sujet du débat actuel. L'article présente aussi une discussion des thèmes qui se dégagent des entrevues. On y expose également les implications pour les conseillers et autres fournisseurs de soins de santé, ainsi que des recommandations pour de futures enquêtes.

Is it a boy or a girl? This is one of the first questions posed to parents of a newborn child. For most parents, the simple answer to this question is based on the information provided by the obstetrician and the outward appearance of the infant's genitalia. Imagine the resulting confusion when that child ages and begins to feel at odds with their biologically prescribed gender identity, or during key moments when an adult realizes that their biological gender and psychological gender are not in sync. Individuals that step outside of society's prescribed gender norms or roles have led to confusion for centuries, although it is a phenomenon that has been documented throughout history. There is a debate underway with regard to the inclusion of gender identity disorder (GID) in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, which is currently undergoing

revision (Melby, 2009). This has provided the opportunity to gather information regarding the diagnosis and how it should be presented, if at all, within the nomenclature. There is little research on how those most affected by the decision (i.e., transgender-identified people) feel about the situation. The trans-identified population is already marginalized and their opinions should be considered in the process of making this decision. To be involved in the decisions that affect one's life gives an individual a sense of empowerment and control instead of alienation and suppression.

There are a number of positions on the issue of GID in the upcoming *DSM-5*. Lev (2006) questions whether GID is truly a mental disorder and thus believes it should be removed. There are also those who believe it should be retained (Fink, 2006; Spitzer, 2006). Most proponents for keeping GID in the *DSM* express concern that its removal would also remove access to treatment through insurance coverage. There are also those who believe the diagnosis should remain, but be reformed (Bockting & Ehrbar, 2006; Winters, 2006).

This study adds the voice of the affected population to the existent data. There is also little research conducted specifically within Canada. The purpose of this study is to provide useful information and potential strategies for those who are working with trans-identified clients. It also provides an opportunity for transgender people to voice their opinion regarding the diagnosis of GID and the current debate regarding its removal, retention, or reform in the *DSM-5*. The questions to be answered by this research are:

- What is it like to live as a trans-identified person in Saskatchewan?
- What effects does being diagnosed with a “disorder” have on you?
- How does the debate regarding GID inclusion in the *DSM-5* affect you?
- What differences do you believe you would experience if GID were removed from the *DSM-5*?

The diagnosis of GID as it currently stands in *DSM-IV-TR* (4th ed., text rev.; American Psychiatric Association, 2000) draws both criticism and support regarding the diagnostic criteria and, in fact, its inclusion in the nomenclature. Following is a discussion of the evolution of the *DSM* diagnosis and a brief review of the current literature regarding the debate.

GENDER IDENTITY DISORDER

GID first appeared in *DSM-III* (APA, 1980) as a subclass of psychosexual disorders with two diagnostic categories: transsexualism and gender identity disorder of childhood (Winters, 2006). In the *DSM-III-R* (APA, 1987), GID was moved to “disorders usually first evident in infancy, childhood, or adolescence,” which recognized that symptoms generally appear in childhood (Winters, 2006). The diagnostic criteria were expanded to include gender role nonconformity in girls, which indicated an increased emphasis on social nonconformity. The diagnostic criteria were also expanded to include a wider range of gender variant individuals,

with gender identity disorder of adolescence or adulthood, nontranssexual type (GIDAANT) in section 302.85 (Winters, 2006). In *DSM-IV*, gender identity disorders returned to the class of sexual disorders, which was renamed sexual and gender identity disorders (Winters, 2006). Section 302.85 is used for diagnosing adults and adolescents, and section 302.6 for children. A text revision occurred, with no change in the criteria, resulting in the current version: *DSM-IV-TR* (APA, 2000).

GID is characterized in adults by “the persistent idea that one is, or should have been, a member of the opposite sex and, in children, by pervasive patterns of behavior consistent with such a belief” (Cantor, Blanchard, & Barbaree, 2009, p. 540). In the *DSM-IV-TR*, there are two components that must be present to make the diagnosis in adults: “evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex (Criterion A)” (APA, 2000, p. 576) and “evidence of persistent discomfort about one’s assigned sex or a sense of inappropriateness in the gender role of that sex (Criterion B)” (APA, 2000, p. 576). The diagnosis is only given when there is “evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion D)” (APA, 2000, p. 576). In children, GID typically involves preference for opposite-sex clothing, playmates, and urinary position, along with an insistence that they will grow up to be the opposite sex. In adults, they are usually preoccupied with the wish to live as the other sex, dressing and “passing” (living) as the other sex, and are uncomfortable with others regarding them as members of their designated sex (Gosselin, 2006).

As a result of its medicalization, the standard treatment consists of hormone therapy, sex reassignment surgery (SRS), other surgical procedures, and potentially therapy/counseling. There are strict treatment criteria laid out in the *Standards of Care* (Version 7) guidelines developed by the World Professional Association for Transgender Health (WPATH, 2011). Harry Benjamin, an endocrinologist who was a pioneer in the treatment of gender-variant people, encouraged the development of a treatment system that would support transsexuals in gender transitioning (Lev, 2004, 2007).

DEBATE

The debate regarding the inclusion of GID in the new *DSM-5*, which is scheduled to be released in May 2013, has strong arguments from three broad categories: retain the diagnosis as is, remove it completely, or reform some aspects of the diagnosis. Currently, the proposed changes to *DSM-5* are no longer open to public scrutiny (APA, 2012). When they were, it was proposed that the name of the condition be re-named to “gender dysphoria,” reflecting a less pathological view than has previously been the case (APA, 2010a).

The focus of this study is on adolescent/adult individuals with GID (Section 302.85 of *DSM-IV-TR*; APA, 2000), and thus the positions discussed will focus on these groups. This does not mean that the same arguments are not applicable

to the diagnosis for children (Section 302.6 of *DSM-IV-TR*; APA, 2000). The major arguments from all three viewpoints are reviewed below.

It should be mentioned that the sub-workgroup for the *DSM-5* recognized the importance of considering the perceived impact of the diagnosis on the lives of the individuals upon which the diagnosis has a direct impact. Vance et al. (2010) completed an international survey of organizations that work with and/or on behalf of the transgender community. Although the participation rate was not as high as they had hoped (only 25 out of 201, or 12.4%), there were respondents from across the globe. They also included responses from organizations that had the survey forwarded to them by one of the solicited organizations, as well as a few mental health and educational professionals, for a total of 43 survey respondents.

Retain

There are those who believe *GID* should remain a diagnosable disorder in the *DSM-5*. Fink (2006) argues that the stigma of being diagnosed with a disorder is no worse than the everyday stigma experienced by those who step outside of gender norms. The difficulty with this is that it implies that stigma is acceptable, when actually efforts should be made to reduce, and ultimately discard, stigmas. According to Spitzer (2006), we are all born biologically male or female with very few exceptions. He does not believe there are more than two genders and that most children know they are male or female. According to this perspective, if a child fails to develop a gender identity congruent with their biological sex, the child in question is experiencing a recognizable and treatable disorder, which should remain in the *DSM*. An exception to this assertion is non-Western cultures—for example, the Hijra of India—that recognize more than two genders and, perhaps, accept the concept of gender variation better than does North American culture.

Most proponents for keeping *GID* in the *DSM* express concern that its removal would also remove access to treatment through insurance coverage. If it were removed, then treatment would only be available to those who have the financial means to cover the costs themselves. Treatment should be available and accessible to anyone requiring it; however, that does not imply it is necessary to retain the current diagnostic criteria. If *GID* were treated as a medical condition rather than a psychological disorder, the treatment protocols could remain the same and be accessible through standardized health care or insurance plans.

In the Vance et al. survey, 20.9% of respondents felt that *GID* should remain in the *DSM* (APA, 2010b). The main reasons cited for retaining the diagnosis included “preventing misdiagnosis of transgender individuals with other mental illness, facilitating acceptance of the person’s gender identity by family and employers, legitimatizing the condition, guiding research, and furthering the development of transgender services” (Vance et al., 2010, p. 10). There are also those who argue that the diagnosis should remain because there are an increasing number of individuals using the diagnosis in disability discrimination claims and other antidiscrimination laws (Drescher, 2009; Meyer-Bahlburg, 2009; Romeo, as cited in Vance et al., 2010).

There are some who argue that experiencing an identity different from one's biological sex is, by nature, a mental disorder and thus should be a diagnosis in the *DSM-5* (Spitzer, 2006). However, most of the support for retaining the diagnosis in the *DSM-5* is not theoretical or philosophical in nature, but is due to the need for access to services, compensation, and financial support that the diagnosis has provided in recent history.

Removal

There are also arguments in favour of removing the diagnosis of GID from the *DSM* altogether. Lev (2006) questions whether GID is truly a mental disorder and thus believes it should be removed. The *DSM* definition of a mental disorder specifies that the dysfunction cannot be a result of conflict experienced between an individual and society (APA, 2000). The question is whether the dysfunction associated with GID is a result of something within the individual or whether it is a reaction to living in a society that has an intolerance, hatred, and fear of anyone who steps outside of recognized gender norms. There is a history of pathologizing human diversity; we have only to look at the removal of homosexuality from the *DSM-III* in 1973 as an example. The diagnosis of being psychologically "deviant" has numerous consequences on the civil rights and social status of minority people (Lev, 2006). Civil rights opponents use the *DSM* diagnosis as evidence that transgender people are mentally ill (Melby, 2009).

Ross (2009) posits that the treatment for GID "is designed to reinforce and agree with the so-called disturbance that is the basis of the disorder" (p. 166). The treatment goal for other disorders is the removal of the symptoms. The patient diagnosed with GID is not delusional about their biological gender, as they know what biological sex they are, but has a variant perception of their psychological gender. They are not offered antipsychotic medication or behaviour therapy, but are instead referred for gender reassignment, thus making GID the only disorder for which the treatment is to agree with the "delusion" and change the physical body (Ross, 2009).

In their international survey, Vance et al. (2010) found that 55.8% of organizations were in favour of removing GID from the *DSM*. Although some feel that the diagnosis assists in acquiring the necessary treatment, others claim that a diagnosis with a "mental disorder" is used to deny treatment, as it is seen as psychopathology and not a medical condition (Winters, as cited in Vance et al., 2010). As the diagnosis now stands, it is a person's nonconformity that is labelled as disordered instead of the chronic distress that someone experiences. "[I]t inappropriately pathologizes an aspect of one's core identity, thereby facilitating societal discrimination" (Vance et al., 2010, p. 7). There is no "exit clause" from the diagnosis. Once someone has received the diagnosis, they can continue to be labelled with it, even if they have undergone SRS or other treatments and are adjusted to their new gender (Cohen-Kettenis & Pfafflin, 2010; Winters, as cited in Vance et al., 2010).

Reform

Some individuals believe the diagnosis should remain, but be reformed. Winters (2006) suggests that the prescribed treatment for GID (hormones and surgery) actually worsens the condition as it is presently defined. While Winters argues that the administration of hormones and surgery to emulate the other sex creates more incongruence with their biological sex, thereby worsening their gender dysphoria, a recent meta-analysis based on 28 studies found that SRS with hormonal interventions generally improves gender dysphoria and psychological functioning (Murad et al., 2010). Regardless of whether hormones and SRS worsens or improves gender dysphoria, Winters posits that a new diagnosis needs to be created: one that is defined by chronic distress rather than social nonconformity. This would reduce the harm of unnecessary stigma and help to support the medical necessity of sex reassignment procedures for those who require them.

The distress experienced as a result of gender dysphoria is real, and not just a manifestation of societal pressures. This distress justifies a diagnosis (Bockting & Ehrbar, 2006). The reform of the diagnosis would allow those who need access to treatment to obtain it. However, it is unclear whether it would actually alter the stigma that individuals face when diagnosed with the condition. Winters and Ehrbar (2010) suggest a “harm reductionist” approach to reforming the diagnosis. They recommend that gender dysphoria be emphasized in the diagnostic criteria rather than behavioural differences and gender nonconformity. They also suggest limiting the diagnosis to the chronic distress with physical sex characteristics (and those anticipated in adolescents) that individuals experience. In their survey, Vance et al. (2010) found that 58.8% of organizations reported that the name, criteria, and language of the diagnosis should change if it is decided to keep the diagnosis in the *DSM*.

PROPOSED CHANGES

The proposed changes to the diagnosis include a change in name as well as the criteria. The proposed new name is *gender dysphoria* (GD). The change in name is felt to better reflect the core issue: the incongruence between one’s experienced/expressed identity and that expected based on assigned gender (Meyer-Bahlburg, 2009; Winters, as cited in APA, 2010b). There is a change in the characteristics of the criteria. The focus has been placed on the discrepancy (the gender dysphoria) between an individual’s experienced/expressed and expected gender rather than cross-gender identification and same-gender aversion (APA, 2010b). Finally, the sub-workgroup has proposed eliminating the sexual orientation subtype and adding a subtype that delineates the presence or absence of a disorder of sex development (DSD; i.e., an intersex condition). The presence of an intersex condition was an exclusion criterion in the *DSM-IV-TR*, although someone could still be diagnosed with GID NOS (Not Otherwise Specified) (APA, 2000). Lastly, there is an additional argument that the diagnosis should not be included with the “sexual disorders,” but a consensus has not yet been reached.

SASKATCHEWAN PROCESS

Saskatchewan is an anomaly among the Canadian provinces and territories regarding treatment for GID. A number of provinces (Ontario, British Columbia, Alberta, and Quebec, as well as the Canadian military) will pay the costs associated with the treatment of GID (SRS and hormone therapy). The remaining provinces and territories will cover none of the costs unless an individual is diagnosed with a different condition that results in similar treatment. In comparison, Saskatchewan will cover approximately 30% of the costs. However, a Saskatchewan resident must travel to Toronto to the Centre for Addiction and Mental Health (CAMH), meet their criteria, and receive a letter of support in order to receive surgery. The surgeries are performed outside of Saskatchewan. SaskHealth will cover only the cost of the surgeon and anesthesiologist's time (Dr. D. Hendrickson, personal communication, April 13, 2010). This means the individual has to pay all of the associated travel expenses, both to Toronto and Montreal, and the pre- and post-operative treatment costs. These expenses can be used as a tax credit on their annual income taxes, but puts the cost of treatment out of the realm of possibility for many individuals living in Saskatchewan. Living as a trans-identified person in Saskatchewan poses significant challenges. This study conveys these experiences as well as their feelings regarding the inclusion of GID in the *DSM-5*.

METHOD

Participants

The participants in this research are trans-identified/gender-variant individuals living in Saskatchewan. The researcher conducted individual interviews with 7 participants. Four are female to male (FTM) transsexuals (biologically female with a male gender identity) and 3 are male to female (MTF) transsexuals (biologically male with a female gender identity). They were recruited through advertisements in the newsletter of the Avenue Community Centre for Gender and Sexual Diversity (ACC; the local queer organization), their e-mail distribution list, a local queer newsmagazine (*Perceptions*), the local psychiatrist that sees most of the transgender clients in Saskatoon, the University of Saskatchewan Pride Centre, and by word of mouth. All of the participants self-identified as gender-variant/transgender. The researcher attempted to be as inclusive of gender, biological sex, and sexual orientation as possible. The participants ranged in age from 19 to 62 ($M = 38.6$ years). Those who have had SRS and/or hormone therapy, those who wish to, as well as those who do not wish to or are undecided were eligible to participate.

Procedure

The data were collected using face-to-face interviews (3 participants), e-mail conversations (3 participants, along with a follow-up phone call when necessary), and a telephone interview (1 participant) in May and June of 2010. The questions (see Appendix) were unstructured and open-ended to allow the participants the

most freedom with their answers. Interviews were conducted in three locations: the separate “Lounge” space of ACC, the Pride Centre, and the interviewer’s home. All of these locations ensured the anonymity, comfort, and safety of the participants. The interviews were conducted at the convenience of the participants (predominantly in the evening) to increase anonymity.

Each face-to-face interview was approximately one hour in length. The data were collected using a digital recorder. The audio was transcribed either by the primary researcher or a university researcher. The primary researcher also took handwritten notes during the course of the interviews. The notes of those who responded through e-mail constituted their transcript. The audio recording of the interview via telephone was not audible, and thus the handwritten notes of the interview constituted the transcript for that 1 participant. Due to the nature of qualitative research, reliability can be difficult. The transcripts were rechecked and then given to the participants to review for accuracy. To maintain validity, once the themes of the data were developed, they were given to the participants to check for accuracy and agreement.

This study was approved by the Internal Review Board (IRB) of Goddard College. The participants of this study (trans-identified individuals) are a marginalized population about which little has been written, most without their active participation. As a member of this marginalized community, I am aware of many of these issues and used my experience and training to ensure the safety of the participants. I was available for follow-up during the course of the study if any of the participants wanted support. In keeping with the ethics required of sound qualitative research, it was necessary for this researcher to identify any biases, values, and/or personal background that may shape or influence interpretations of the data. This researcher self-identifies as a gender-variant individual, has been diagnosed with GID, has considered the possibility of SRS (at the time of this writing is now undergoing hormone therapy), and is the Executive Director of the Avenue Community Centre where one of the interviews took place.

Each participant was required to sign an informed consent document prior to their participation in the study and received a copy of their transcribed interview for their approval prior to the writing of the final report. Each participant was given the option to use their real name or a pseudonym, and they all chose to use pseudonyms.

RESULTS

A number of common themes emerged from the interviews. The first commonality is that all of the participants felt they were “different” before puberty. In fact, 6 of 7 (86%) felt by age 5 that they were not their assigned gender. As young children, they thought that everyone felt the way they did. They quickly realized this was not the case. Four of the 7 participants discussed experiencing difficulty with puberty and feelings of being “betrayed” by their bodies. Refuge was sought through information on the Internet and connecting with other like-minded

people. The sense of belonging to a community helps to deflate the feelings of self-hatred and shame internalized from the messages received from society regarding individuals who are “different” (Alderson, 2013).

In response to the research question “What is it like to live as a trans-identified person in Saskatchewan?” most participants have had “good” experiences on a personal level. Ernie (note that all names are pseudonyms), age 21, mentioned that before he started taking testosterone, people would stare at him. He would have to “flex [his] gender muscle,” so that people would read him as male. However, after he started testosterone, he found that he had more energy because he did not have to attempt to get people to read him as male. Both Michelle, age 25, and Angela, age 50, used drugs and alcohol as a means of coping with their internal struggle regarding their identity. These feelings arose from an internalized sense of shame and self-hatred brought on by society’s messaging that to be different is to be “bad” or “wrong.” But they have both moved forward in their lives by accepting who they are and achieving sobriety as a result. Stan, age 19, has had a few issues with co-workers regarding pronoun usage as most of them refer to him by name, but still refer to him as “she.” Angela moved to a new city where she was known as Angela from the very beginning. She had no need to “teach” people about her “change” as they have only known her as female. It should not be necessary to move away from one’s home community in order to find acceptance for oneself. It raises the question as to why we use pronouns such as s/he or her/him. These words are yet another way of labelling the participants and fitting them into prescribed boxes as to how to behave, dress, and so on. However, the overwhelming majority of participants have had positive responses from friends and family. Many difficulties stem from “strangers” not being able to read the participants’ preferred gender. The inability to “pass” before the use of hormones and pre-surgery seems to have an impact on the personal interactions that one has.

With regards to treatment access, all of the participants are in agreement that accessing treatment in Saskatchewan is a “painful experience.” There is a distinct lack of professionals with knowledge of trans issues. Three participants saw three different psychiatrists who were described as “horrible”; one participant was even asked “inappropriate sexual questions” and was expected to answer or be denied service. They all felt judged by the professionals they have seen. Jamie, age 40, saw a psychiatrist who was so confused that he reversed the direction of Jamie’s transition (the psychiatrist thought Jamie was male and wanted to transition to female).

All of the participants agree that the current treatment system has failed them and they feel underserved. One participant went as far as to move to Alberta where she underwent her transition, and all of the associated surgical costs were covered through that province’s health care system. Since that time, Alberta removed coverage for SRS and then reinstated it. Two of the four transmen (i.e., FTM) paid for their chest surgery privately, rather than “jump through the hoops” that would have been expected of them and would still have only partially covered the costs.

The other two men are trying to fundraise and save money in order to afford chest surgery on their own. It seems as though the low reimbursement rate is designed specifically to discourage people from transitioning.

All of the participants agree that the inconsistency of treatment coverage across Canada is “unfair,” “stupid,” and “ridiculous.” Access to treatment is determined by where you live. As Canadian citizens, we are all eligible for health care, but each province is given the power to determine what that entails. Becky, age 55, has enough money in her retirement savings plan to cover her vaginoplasty (“bottom surgery”), but is afraid this would leave her with no money if she ever had an emergency and needed to access her savings. She has considered having an orchiectomy (removal of the testicles), as this procedure can be done in Saskatchewan “under the guise of something else.” However, Becky is worried about the procedure; she has heard that it is not recommended for those wanting to have a vaginoplasty at a later time as there is “the possibility of maybe too much skin being removed or scar tissue in the wrong place ... [it] can cause problems ... to actually make the proper, complete vagina.” If she lived in Ontario instead of Saskatchewan, she would have been eligible and received her surgery many years ago. Her hormones are covered through a health plan because her annual income is low enough that she is eligible for extended health benefits through the province. However, unless an individual has an extended health care plan through their place of employment or a private plan, these hormones are not covered by SaskHealth. In fact, one of Becky’s prescriptions (an androgen blocker) was originally covered but no longer is, as the cost of the prescription has become prohibitive. This opens the door to the possibility that other prescriptions or services may also be lost if their costs increase too sharply. The present charge for chest surgery (by a surgeon in Ontario) for FTMs rose from \$6,780 to \$7,660 in one month. For both Ernie and Stan, that increase has delayed surgery for both of them because they now have to raise even more money to be able to pay for it.

If there were 25 people a year in Saskatchewan that wanted SRS, the financial costs associated with those transitions would be far less than the costs associated with the possible repercussions (e.g., addictions, mental health issues, physical health issues, suicide) of not providing the necessary treatment and services. A person should be able to choose where they live based on their desire to be there, not because one province/territory pays for something that another will not cover.

All but one of the participants has received a GID diagnosis. Becky first received a diagnosis of “transvestite” at the age of 15 (in 1963). She was told that it was “deviant behaviour” but could be “cured.” In the early 1990s, she attended the Clarke Institute (the former name of CAMH) in Toronto, but they would not give her a GID diagnosis as she “was not prepared to leave her marriage.” In order to receive the diagnosis, she was expected to live as a woman full-time and, therefore, would not have been able to remain married to her wife. Stan, the youngest participant, is the only one not to have received a diagnosis, which is attributable to his inability to find a psychiatrist able to make that assessment. Stan obtained a referral to the psychiatrist that most trans-identified people in Saskatchewan see,

but received news that she was no longer accepting new patients (at the time this manuscript was written, she has begun seeing new clients).

The majority of the participants did not feel they experienced any negative effects from being diagnosed with a “disorder.” The overwhelming response was that it was a step in the process of getting what they wanted. “I knew I’d get T [testosterone],” “[I got] hooked into the system and would get hormones,” and “it was a confirmation, not a revelation” were some of the responses received. A few of the participants replied, “Call it what you want; just give me what I want” and “[I was just] happy I could be a man.”

As for the debate regarding GID’s inclusion in the *DSM-5*, the majority of participants did not know about it and do not feel it has a direct impact on their lives. As the vocal opponent of the diagnosis, Michelle was very clear that she would like the diagnosis removed from the *DSM*. She feels that it “pathologizes an otherwise legitimate aspect to one’s identity. This will continue to be the case as long as our culture adheres to a dichotomous system of gender classification.” However, her greatest concern is access to treatment “coverage [which] is already too minimalistic.” She currently agrees with the proposed changes to the diagnosis as it affords access to treatment that full removal will not.

In response to the question, “What differences would you experience if GID were removed from the *DSM-5*?” the overwhelming response to this question was “None.” Most of the participants were too far along in their process for its removal to have any effect; for those who have not completed their transition, they do not feel that removal at this time is warranted. None of the participants want access to treatment to be lost, which is their greatest fear. Angela mentioned that she would like the diagnosis to be a medical one, believing that the change would help to “improve public perception” of transsexual people. The removal could have an impact on Ernie, who is pre-surgical, as he is not yet sure whether he will access the partial coverage available through provincial healthcare. The overwhelming response by those who have completed transitioning is that they no longer are really interested in trans issues as it applies to the mental health field. They do not want those transitioning from one gender to another to lose access to treatment, but they no longer need affirmation from anyone other than themselves, and they have moved on to live as their true selves.

DISCUSSION

A distinct question arises repeatedly in any discussion about the GID diagnosis: Is variant gender expression a “dysfunction?” According to Lev (2006),

the diagnosis invokes challenging questions about the use of psychiatric diagnoses to label as mentally ill those with sexual behaviors and gender expressions that differ from the norm, and on the other hand, raises equally compelling questions about the ethics of using a psychiatric diagnosis within a manual of mental illness to provide legitimacy for transsexuals’ right to attain necessary medical treatments. (p. 37)

The labels “normal” and “abnormal” are determined arbitrarily and are tied to the social norms of a particular time and place (Marecek, Crawford, & Popp, as cited in Gosselin, 2006). “[B]eing labeled psychologically deviant has inevitable consequences for the civil rights and social status of minority peoples” (Lev, 2006, p. 38). Is the distress that some, but certainly not all, trans-identified people experience a result of their “wrong body” experience, or is it a result of society telling them that they have to be one or the other? The societal expectation is to fall within incredibly strict guidelines as to what is considered appropriate gender identification.

Gender is a socially constructed concept. Society has not always operated under the assumption that there are only two genders (Feinberg, 1996; Lev, 2004). This binary concept of gender is a relatively recent phenomenon. “Gender is critically important as an overarching organizer of social and interpersonal experience” (Bieschke, Perez, & DeBord, 2007, p. 7). People categorize one another by gender before any other demographic distinction. This researcher and most of the FTM participants have had numerous occasions in public restrooms where they were accused of being in the wrong one. It is obvious we were perceived as male in the female restroom based solely on physical appearance, because we did not fit the norm of what one should look like if they are in fact biologically female. Hines (2007) posits, “The demand for surgery may be seen to be an outcome of the social and cultural investment in a gender binary system” (p. 65).

If societal beliefs held gender variation as normal, perhaps there would be less need for surgery. There would most likely always be individuals who need SRS in order to feel complete and whole as their desired gender, but if people were not only allowed to express themselves as the gender they *are*, but also able to match their personal identification with their expressed gender, possibly fewer individuals would require surgical and/or hormonal treatment. At this point in time, “Bodily modifications may also bring increased levels of safety and emotional ease as bodily appearance and gender identity meet to confer with normative assumptions” (Hines, 2007, p. 69). The participants of this study all found societal acceptance increased with the administration of hormones and surgery.

How effective is a system when the individuals accessing that system know exactly what they need to say in order to get what they want (Hines, 2007)? The participants in this study knew that once they received their diagnosis, the path to their desired gender had begun. How effective is a system when those with the power to make profound decisions about another individual have little or no training in formulating that decision?

None of the participants have accessed SaskHealth for the partial coverage that is available for their SRS surgeries. They all spoke of the “fear” and “intimidation” they felt at the thought of trying to work their way through the system. Instead of negotiating a system perceived to be laden with “bureaucratic red tape” that won’t “end up amounting to much” coverage, they opted to pay for the procedures on their own or move to a province where coverage was available. There is something intrinsically wrong with a system when individuals find it easier to raise thousands

of dollars on their own than to participate in what is the official process for SRS in this province.

Implications for Counsellors

There is a profound dearth of professionals with knowledge of trans issues in both the mental health and medical fields in Saskatchewan. There is one psychiatrist in the province knowledgeable about trans issues, who, at the time of this study, had one year of not accepting any new clients. The transition process—if one wants to access what little coverage is available—requires an individual to see a psychiatrist and be diagnosed with GID. Where does one turn when no such professional is available (i.e., across the rest of the province)? Ernie mentioned in his interview that people might choose to take an “alternative route” (i.e., illegal hormones, surgeries outside of the “prescribed” realm), which can result in putting themselves at risk. If there is a requirement to see a professional, then there needs to be a knowledgeable professional available.

As it stands now, therapists with little or no training in trans issues are in a position of power regarding the diagnosis of GID. Current training programs for mental health and medical professionals do not address concerns specific to the trans community (Korell & Lorah, 2007). In Saskatchewan, ACC is invited to provide educational training to nursing, social work, psychology, and sociology classes across the province; however, this is not required education and is only provided at the inclination of an astute professor. There is no national standard with regards to the education of medical and mental health professionals about trans people and their needs.

In a utopian world, the binary system of gender identification would no longer exist. Individuals would be allowed to define themselves in whatever way they like, and if they needed treatment in order to match their body to that vision, it would be available. Until Canadian society operates under more inclusive norms, there is a need for access to treatment for anyone who wants it; at this point, that access requires the diagnosis in the *DSM*.

Another possibility is that the diagnosis could be changed to a medical condition instead of a mental disorder. The medical condition could be recognized, with the standard treatment of hormones and/or surgery remaining the same. However, this would likely be a long and arduous process, and, until such time, access to treatment should still be available to those who need it.

Limitations of the Study

The limitations of this study include the small sample size. It should be noted that while attention was paid to the recruitment of participants, with a number of avenues being used, only those who are active in the community would have received the request. Thus, people who are isolated may not have received the invitation to participate; their responses may have been quite different.

Saskatchewan is an anomaly in its coverage of SRS; thus, it may not be possible to generalize the results to those living in other Canadian provinces and territo-

ries, where SRS expenses are covered completely or where there is no coverage available. It is possible that individuals living in different situations would have very different experiences than those living here. Saskatchewan is a relatively small province (population just under 1.1 million) and contains two larger cities (Saskatoon and Regina), each with a population of about 200,000. The rest of the province is made up of smaller centres and rural communities. Those living in more populated provinces, particularly with larger cities (Ontario, Quebec, British Columbia, and Alberta, which also happen to be the provinces that cover SRS), would potentially have access to greater support services, and thus would have different experiences as well.

A number of the participants have already transitioned and are living their lives as their true selves. The impact of the proposed changes to the *DSM* will have little, if any, effect on them. However, receiving the *DSM* diagnosis was a required step in their transition. It appears that the diagnosis is more important to those making the diagnosis and those paying for SRS (i.e., the government) than it is for those who receive the diagnosis. It also appears to have an impact on those outside of the trans world, as they may hold negative views regarding gender variant individuals, seeing them as having a disorder. The medical and mental health establishment should listen to the opinions of those who are just beginning their journey and consider the impact that changing or eliminating *GID* may have on them.

Recommendations for Future Research

It would be prudent to determine, both nationally and internationally, the potential impact of removing the *GID* diagnosis from the *DSM*. Debate regarding this has now occurred in preparation for *DSM-5*, and what is clear is that the diagnosis, under a new name, will remain. There are also unanswered questions regarding a binary concept of gender. Historically, we have seen that gender was not always viewed as an either/or choice. A distinct possibility remains that over time societal views of gender norms and roles will change. When this happens, there would no longer be a need for a mental diagnosis of *GID*. Because the binary concept of gender is socially constructed, who is to say that gender is dichotomous? Perhaps gender exists on a continuum of sexual orientation with male at one end, female at the other, and plenty of degrees of variation between the two. If *GID* were not labelled as a psychological diagnosis, then perhaps gender variant individuals would experience less emotional, legal, and social distress (Lev, 2006). Many individuals do not feel they are suffering from a disorder. Even within the group of those who do identify as gender dysphoric, individuals can come to terms with who they are and choose not to undergo hormone therapy or surgery to alter their physical bodies.

CONCLUSION

The intent of this research was to give voice to the trans community of Saskatchewan regarding the debate over the inclusion of *GID* in the *DSM*.

They are the people most affected by the decision, and thus have the right to be heard. They are the ones who know what it is like to live outside of societal norms and the impact that has on their daily lives. Canada is built on a foundation of acceptance of diversity and the valuing of individuality. This ethos should be reflected in equal access to treatment regardless of one's diagnosis. Canada needs a national standard for access to SRS treatment. Education must be provided to those entering the mental health and medical fields as well as continuing education for those already established in their profession. A trans person should not have to educate the professional from whom they are seeking help. It is the responsibility of the professional to obtain information from other sources. The mental health and medical fields need to remain open to the future removal of GID from the *DSM*.

It is imperative that we ask those most affected by decisions for their input into those decisions. From this study, I have learned that, for these participants, the *DSM* and the diagnosis do not appear to play a major role in their lives other than as a step to getting what they want. It is the professional communities that have a need for a system with which to diagnose individuals as it then outlines treatment protocol. As the researcher, I was surprised by the lack of knowledge the participants had about the debate, but realize this is something they live with, in a meaningful way, every day of their lives. We are not talking about a diagnosis; we are talking about people—individuals who experience repercussions from the decisions that others make. We need to remember that when considering making changes that will impact directly on people's lives.

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Appendix

Interview Questions

1. Name
2. Age
3. Born as which sex?
4. Please describe your gender identity.
5. How would you describe your sexual orientation? Has this changed since transitioning? How?
6. When did you first realize that you were _____?
7. What was that discovery like for you?
8. Describe your experience of living in Saskatchewan as a _____ (insert their wording here) person?
 - A) Personally
 - B) Access to treatment
9. How familiar are you with the diagnosis currently used with regards to Gender Identity?
10. Have you been officially diagnosed? If yes, from whom did you receive the diagnosis? What was that like?
11. Are you aware of the proposed changes to the *DSM* that will impact GID? (If not, researcher will briefly outline the debate and proposed changes.)
12. What reaction do you have towards the proposed changes?
13. How do you think the proposed changes will change/alter your experience as a trans individual?
14. How have these policies already affected your experience and/or transition?
15. Have you made any physical changes to your body?
16. Have you made changes to your personal identification (i.e., birth certificate, driver's license)? How was that experience?
17. If yes [to Question 15], did you access SaskHealth coverage for them? Explain. If no, are you planning on any surgeries/hormone therapy? Are you planning on accessing SaskHealth coverage?
18. Is there anything else you would like to add that has not already been discussed?

About the Author

Jai Richards is the executive director of the Avenue Community Centre for Gender & Sexual Diversity in Saskatoon. He also operates a private counselling practice, JTR Counselling & Consulting, and works for Mental Health & Addiction Services with the Saskatoon Health Region. Jai is interested in queer health issues, particularly trans health. This research was completed as a thesis requirement for a M.A. in counselling psychology at Goddard College, Plainfield, Vermont, USA.

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