Gender Identity Disorder: Diagnosis, Treatment and Counselling Issues

Contemporary Debates and Dilemmas

Arlene Istar Lev (2005), in her article, "Disordering gender identity: gender identity disorder in the DSM-IV-TR" argues that the diagnostic category and labeling of gender-variant individuals in the current **Diagnostic and Statistical Manual of Mental Disorders**, **4th edition, Text Revision** (DSM-IV-TR) continues to pose "potential damage" to sexual behaviors and gender expressions that differ from the norm and is used as a "tool of social control". She claims that such labeling causes emotional pain due to social pressure which stigmatizes one's gender identity but also that people who persistently identify themselves as being the opposite gender despite their biologically assigned gender characteristics would be deprived of the hormonal treatment and **sex reassignment surgery** (SRS) desired should **Gender Identity Disorder** (GID) as a diagnostic tool and category be removed from the DSM in a pending revision due in May 2013. Lev proposes that GID as a diagnostic category should remain in the DSM not for the purpose of "treatment based in "curing" the dsyphoria, but rather in helping young children (including adolescents and adults) cope with actualizing their gender within an often hostile social environment" (p. 50).

While Lev has raised ethical dilemmas of clinical approaches for assessment, diagnosis and treatment under the DSM IV-TR GID category, she fails to see the dilemmas are not so much due to poor clinical judgments alongside a perceived hostile social environment but rather due to the anomaly whereby GID and its related manifestations such as **transvestic fetishism** (TF), **skoptic syndrome** (SS) and **paraphillias** (fetish) are deemed to be medically treatable, (i.e. normalizing the mental distress and physical condition) but <u>not</u> psychiatric treatment, (i.e. adjustment and sufficient enablement in social, occupational or other important areas of functioning) which is the intention of the DSM protocol in the first place.

It was this sort of anomaly that plague the previous DSM III whereby homosexuality as a category itself was removed and now the team of revisionists for DSM IV faces the same dilemma as their predecessors. Lev and others are reluctant to remove GID for fear that access to medical treatment would become limited should the condition be deemed to conform to social norms and cultural practices resulting in it being regarded as a medical problem no more. Consequently, insurance payout for medical treatment and surgery is no longer tenable. In effect then, it would consign people with such gender dsyphoria and those who ultimately desire SRS to seek cosmetic and plastic surgery instead, which can become highly unaffordable except to the rich. Yet, those who support the retention of GID in order to access treatment and make insurance claims continues to perpetrate the "myths" and stigmatization they wish to avoid, whereas supporting its removal would bring immediate relief if it no longer remain a DSM category.

These contemporary issues are ethical, professional and counseling concerns and dilemmas in an increasingly globalised and post-modern world that places each of us in specific geo-political and unique cultural as well as other contexts which we will consider in detail later within the framework of GID as part of the DSM IV-TR category. In considering which treatment and counseling therapy to promote, we will weigh its effectiveness within a multi-cultural and pluralistic Asian society which is not necessarily dissimilar to Western European physiological categories and psychological norms but certainly more nuanced because of the different societal contracts, government policies and legal statutes which exist uniquely in each country.

Summary of Diagnostic Criteria for GID: Causes, Diagnosis and Etiology

There are criteria which must be met in order for a diagnosis to confirm if a patient or client is suffering from gender identity disorder (DSM IV-TR, 2000) for children and adolescents/adults respectively. The **American Psychological Association** (APA) states that "gender identity refers to an individual's self-perception as male or female" (p. 535) which is not the same or to be confused with one's physical or genetic sex (male or female) at the time of birth. Furthermore, APA provides an operational definition of "sexual orientation" as "the erotic attraction to males, females, or both."

The four diagnostic categories are as follow:

A. Strong and persistent cross-sex identification (not merely a desire for any perceived cultural advantages of being the other sex).
    a. Children (at least four criteria must be met)
        i. Repeatedly stated desire/insistence to be a member of the opposite sex
        ii. Boys: prefer cross-dressing/female attire;
        iii. Girls: wearing only stereo-typically masculine clothing
        iv. Strong persistent preferences/fantasies for cross-sex roles or being a member of the other sex
        v. Intense desire to participate in stereotypical games/pastimes of the other sex
        vi. Strong preference for playmates of the other sex
    b. Adolescents and adults (at least one criterion must be met)
        i. Stated desire to be of the other sex
        ii. Frequent attempts to pass as the other sex
        iii. Desire to be treated or live or is treated as the other sex
        iv. Conviction of having the typical feelings and reactions of the other sex
B. Discomfort with original sex or sense of inappropriateness in the role of that sex
    a. Children (at least one criterion must be met)
        i. Boys: assert that penis or testes are disgusting or will disappear;
        ii. Girls: assert she wants to have penis or does not want breasts/menstruations
    b. Adolescents and adults (at least one criterion must be met)
        i. Preoccupation with getting rid of primary and secondary sex characteristics (e.g. request for hormones, surgery to alter original for other sex) or
        ii. belief in having been born with the wrong sex
C. No concurrent physical intersex condition
D. Clinically significant distress or impairment in social, occupational, or other important areas of functioning

According to Kirk & Belovics (2008), "APA (2000) has held that individuals experiencing schizophrenia or obsessive-compulsive disorder (e.g. skoptic syndrome), in which these conditions mimic symptoms of gender identity disorder or gender dsyphoria (e.g. being uncomfortable with their gender identity), should not be diagnosed with gender identity disorder" but that GID "can be a comorbid condition that exists with a diagnosis of an inherited chromosomal or developmental intersex condition" (p. 30). Kirk & Belovics remarked that the causes of gender dysphoria and GID remain a mystery although a widely held causal theory has to do with exposure to unnatural levels of male or female hormones but insist that despite the APA having included it as part of the diagnostic criteria, one's sexual orientation is not a contributing factor to the overall diagnosis (p. 32).

Sims (2004), in his article, quoted one report alluding to "claims that variants in pre-natal exposure to hormones or pesticides like DDT can influence a person's sexual orientation and may play a role in establishing transsexuality" and other reports where researchers measuring the volume of an area in the red nucleus (a region in a part of the brainstem essential for sexual behavior) in different people found that "while this region was larger in men than in women, male-to-female transsexuals had female-sized regions" which "raises the question of whether the brain areas develop and then dictate behavior, or whether their size changes in response to altered behavior?" Sims point is that "psychiatric diagnostic classifications say nothing about underlying causes" and "the terms are intended purely to describe symptoms" and he rightly caution that there is really no conclusive findings to its causes even as the DSM-IV emphasizes that its inclusion in the manual "does not imply that the condition meets legal or other non-medical criteria for what constitutes mental disease, mental disorder, mental disability."

Elsewhere in etiology literature, Drescher (2010) traces the decision to place transsexualism in the DSM to the research and clinical contributions of John Money, Harry Benjamin, Robert Stoller, and Richard Green. Money theorized that one's gender identity was acquired by external, psychological environmental factors largely determined by parental attitude having a strong effect on whether a child accepts the gender category which he believes is fixed by three years of age. Benjamin had an essentialist view that transsexual suffers from a biological disorder whose brain was probably "feminized" in utero and also pioneered the treatment of gender dysphoric individuals using sex hormones. In contrast to Benjamin, Stoller believed that in some cases, childhood family dynamics were responsible for "causing" adult transsexualsim. Green took the theoretical assumptions and treatment plans of his three predecessors further which resulted in the "prospective study that tracked into adulthood the development of 66 gender-atypical boys who stated a wish to be a girl. Seventy-five percent of the children Green studied grew up to be gay men" (p. 439).

With the removal of homosexuality from the DSM-II in 1973, it was a matter of time before the GID diagnoses found their way into DSM-III and now, more than 30 years later, the DSM-IV-TR is due for a review where the small but vocal trans community encapsulated in the **Lesbian, Gay, Bisexual, Transgender** (LGBT) movement have adopted "normalizing etiological theories, such as the belief that one is born gay/trans" (p. 444). Winters (2005) noted that LGBTs face social pressures and legal constraints while transsexual individuals face obstacles to sex reassignment treatment because, "by labeling a person's identity, which is discordant with her or his natal sex, as disordered, GID implies that identity and not the body is that which needs to be fixed. Indeed, by its title and diagnostic criteria, the diagnosis contradicts treatment goals that correct the body (p.72)" (p. 445). In other words, the diagnostic category of GID (essentially a psychiatric category) and the treatment goals are meant to correct the *psychological* gender dsyphoria pathology and not meant to correct the *physiological* body of perfectly healthy and functioning anatomies through SRS and hormonal treatments.

In discussing the reliability and validity of the current criteria, Cohen-Kettenis & Pfafflin (2010) maintain its importance since "one of the most drastic medical treatments, sex reassignment surgery, may ensure from this diagnosis". They noted a lack of inter-rated reliability studies in the clinical DSM assessment and diagnosis unlike the ICD-10 (International classification of diseases) where, for e.g. the German Law for Transsexual requires two independent experts to validate all applicants for a legal change of their personal status as male or female (after SRS) before the court will rule on such change (p. 500).

Among other concerns of the current diagnostic criteria, Cohen-Kettenis & Pfafflin saw that transgendered persons gave many varied terms and unusual descriptions to their transgender identity such as "in-between and beyond, shemale, bigender/two-spirit, third gender, gender neutral, and butch queen" to name a few which reflect a wide spectrum of gender variance phenomena (p. 502). Perhaps it is this kind of phenomena which remains constantly fluid and appears to seek new adaptations and permutations of identity that clinicians are increasingly confronted with treatment goals other than complete sex reassignment. For instance, they note that "natal males may want to have estrogens and breast enlargement surgery, but no vaginoplasty" (p. 503).

In a rejoinder to Cohen-Kettenis & Pfafflin's article in the same journal, Johnson & Wassersug (Letter to the Editor, 2010) cited their own study of a population which they termed as **Male-to-Eunuch** (MtE) GID who sought androgen-deprivation via drugs or castration, but do not pursue full SRS. This group does not fit the current DSM IV-TR criteria and hence lends support to the former authors' recommendation for the revised DSM to eliminate the 'A' criterion which states that they must have a desire to be, or identify with, the 'other' sex. In reality, people with GID complex are not as straightforward as the DSM made it out to be and this raises crucial questions: Is there not psychiatric comorbidity and what if the diagnosis was wrong in the first place?

It has been often noted that studies using standardized diagnostic instruments to assess psychiatric comorbidity in GID are rare. However, a study of 31 patients with GID by Hepp U, Kramer B, Schnyder U, et al. (2005) found that many met diagnostic criteria for lifetime psychiatric comorbidity, including:

- 71% for Axis I disorders (primarily mood and anxiety disorders)
- 42% for comorbid personality disorders, primarily a cluster B diagnosis
- 45% for substance-related disorders
- 6.5% for psychotic disorders
- 3.2% for eating disorders

In another study by Madeddu, Prunas, & Hartmann (2009) of 50 clients (34 biological males and 16 biological females) admitted to a GID psychiatric unit requesting SRS, they were first assessed using the SCID-II after a preliminary evaluation to exclude current major psychiatric disorders yielding the following results:

- Prevalence of any Axis II disorder (53%)
- High prevalence in cluster B **Personality Disorder** (PDs) (22%) with NOS PD (16%)
- Among Cluster B disorders, the most frequent diagnosis was narcissistic PD, followed by histrionic and borderline PDs
- No differences in the psychopathological profile and severity between MtF and FtM

The findings suggest that "some NPD diagnostic criteria (i.e., preoccupation with fantasies of unlimited beauty and the need for excessive admiration) are frequently endorsed in GID clients." Furthermore, the NOS prevalence could indicate that SRS candidates, according to some reports, "often perceive the assessment process as a hurdle that must be cleared in order to achieve their goals rather than as a useful and helpful clinical tool" may then be induced "to be reticent during assessment and to acknowledge only a moderate number of pathological traits, denying the presence and clinical relevance of more overt psychopathological manifestations" (p. 265).

Treatment Approaches to Gender Dsyphoria & Efficacy

When it comes to treatment plans, two broad approaches are taken: (1) psychological interventions to cure gender dysphoria and (2) medical interventions to eliminate gender dysphoria by adapting the sex of the body to the gender of the mind. The medical interventions of hormone treatment and surgery are offered from both a psychological and a humanistic model (Gijs & Brewaeys, 2007).

According to some case studies, "gender dsyphoria can remit sometimes with psychopharmacological (other than hormone) treatment or psychotherapy for at least 10 years". This suggests that for some, change is possible. However, "although researchers have pointed to some genetic, hormonal, and brain factors contributing to the etiology of GID, psychosocial determinants have not been identified" and "psychosocial treatments targeting the etiology or pathogenesis of gender dysphoria do not exist" (Gijs and Brewaeys).

Sex reassignment surgery (SRS) on the other hand, is a rehabilitative treatment, not a cure for a pathological condition, but a strategy to diminish the serious suffering of a transsexual person. Almost all follow-up studies that were reviewed suggest that SRS on the whole is an effective, positive and viable method of treating GID. Yet, one wonders if such general satisfaction is adequate or sufficient qualification for the overall standard of efficacy? For example, such a statement that appears to substantiate the efficacy of SRS: "Sucidality was significantly reduced postoperatively: 10% of the patients attempted suicide postoperatively, whereas preoperatively 40% reported suicidal ideation" (Gijs & Brewaeys) could also be interpreted as sobering if not alarming given the fact that human lives are at stake no matter how insignificant the statistical number is (10% in this report).

After an extensive survey of the literature on SRS in different countries, Gijs & Brewaeys concluded that a number of pertinent questions remain unanswered: "Especially disturbing is that many researchers did not directly measure gender dysphoria as the main outcome variable but instead used derivative measures, for example, satisfaction with surgery, sexual and interpersonal relationships, occupational and global functioning, or quality of life in general." In fact, in a number of reports, the "high dropout rate significantly challenges the external validity or generalizability of our follow-up studies. We do not know what the prevalence rate is of false negatives, and/or what the fate is of these patients."

In a long-term follow up study on regret after SRS, Olsson & Moller (2006) noted the following common or predictive factors for dissatisfaction and regret:

- Age over 30 years at first request for surgery
- Personality disorders, personal and social instability
- Secondary transsexualism
- A heterosexual sexual orientation
- Poor surgical results
- Poor support from the family

In their concluding remarks, Olsson & Moller noted that groups such as the HBIGDA (Harry Benjamin International Gender Dysphoria Association) which provide Standards of Care (SOC) regarding SRS have increasingly cautioned that clinicians should be "aware that not all persons with GID need or want all three elements of triadic therapy ("hormones, real-life experience, surgery")."

Cultural Beliefs, SOCE & Multi-Cultural Counselling

Living in a globalised world where borders are no longer a hindrance to the exchange of ideas through the internet, the fact remains that we each live in particular social contexts bounded by cherished notions of values, norms and beliefs. With modern technology and a world-renown financial hub, Singapore is still very much a conservative society amidst a diversity of people and multi-cultural fabric of traditions and practices, although much of it is breaking down with a younger generation who did not experience the upheavals and uncertainties in the early years of nation building. Yet, a prevailing patriarchal value system still contributes to persisting gender hierarchies amongst a majority population of society.

Mahalingam & Jackson (2007) examines the relationship between cultural-specific ideals (chastity, masculinity, caste beliefs) and self-esteem, shame and depression using an idealized, cultural model provides a viable and alternative way of looking at psychotherapeutic approaches that is relevant, culturally sensitive and could prove to be an effective treatment options to GID clients and patients living in an Asian context. They pointed out that "idealized gender identities shaped by patriarchy, such as chastity and masculinity, play a critical role in controlling women's and men's behavior. For instance, in honor cultures, chaste women are believed to be the embodiment of family honor. Hyper-masculine men are expected to be the "king" of the house, successful breadwinners, and expected to protect the family and group honor." In other words, these cultural ethoses affect one's domains and sense of well-being which in turn shape our daily mindset and behavior mostly in an unconscious rather than conscious way such that "one's self-worth is contingent upon living up to these culturally cherished ideals."

Though the study is localized in Tamil Nadu where patriarchy is manifested in the caste system, the notion that a higher caste is superior can be found in both Western and Eastern imaginations of the purest race such as the Aryans, the Persians, the Arabs and the Anglo-Saxons, as well as the Bugis, the Brahmins, the Boyanese, the Bumiputras, the Chinese, etc. Given the accepted norm of community good – this study and its findings is representative of common Asian societies generally with some cultural and social variances.

The findings by Mahalingam & Jackson in their study established a relationship between gender expectations and mental health in Tami Nadu, India:

1. The idealization of caste beliefs did positively relate to self-esteem in women but did not relate to shame for either men or women.
2. Chastity positively contributed to self-esteem in women but did not significantly relate to shame. By contrast, chastity did not significantly relate to men's self-esteem but negatively related to shame.
3. Masculinity contributed positively to men's self-esteem as well to shame. By contrast for women, masculinity positively contributed only to shame but not to self-esteem.

The results showed that both women and men appears to have accepted the norms and values of caste beliefs and notions of chastity but not for masculinity which is positively related to men's self-esteem only but positively related to both women's and men's shame. It is interesting that masculinity has both a negative and positive impact on men's shame and self-esteem respectively while it has a negative impact on women's shame only.

Further research is needed to posit hypotheses on what are the cultural norms and values of masculinity and actual correlations of the ability or inability of men to meet those

expectations, although for women, the authors postulated that "perhaps masculinity acts as a patriarchal cultural referent to regulate women's lives, leading to high levels of shame among women." Mahalingam & Jackson concluded that "endorsing idealized beliefs about gender has positive as well as negative mental health consequences." These cultural insights have important relevance to counseling GID candidates in a multi-cultural context in relation to what causes distress and impairment within the DSM IV-TR GID category.

From the above study, amidst controversial accusations of unprofessional conduct and unethical practices mostly from a Western individualistic cultural viewpoint and the aggressive promotion of self-actualization therapy in dealing with GID candidates and clients, there appear to be sufficient evidence to support the SOCE (Sexual Orientation Change Efforts) therapeutic approach at least in an Asian cultural context where both the majority of men and women subscribe to embedded cultural norms and values reflecting traditional roles and expectations of both sexes in ways that contribute positively to their personal and community mental health.

Despite the official APA position in 2009 adopting the "Resolution on Appropriate affirmative Responses to Sexual Orientation Distress and Change Efforts", that advises mental health professionals against telling clients that they can change their sexual orientation through therapy or other treatments, there are individuals who seek SOCE in order to voluntarily align to the cultural values and religious norms of their preferences and beliefs. "Thus, many people with unwanted homosexual tendencies may reject the gay lifestyle because they do not value it, and because they believe that God does not want them to pursue such a lifestyle. Given this intense conflict between their sexual and religious feelings, such individuals may seek SOCE and report having benefited from it, owing to a stronger desire or motivation to change" (Karten & Wade, 2010).

In a study of 117 men dissatisfied with their same-sex attraction who had pursued SOCE, Karten & Wade found that the most helpful sexual orientation change interventions to be "a men's weekend/retreat, a psychologist, and a mentoring relationship, and the two most helpful techniques to be understanding better the causes of one's homosexuality and one's emotional needs and issues and developing nonsexual relationships with same-sex peers, mentors, family members, and friends." Interestingly, the findings yielded two unexpected but important results. The first being that "results indicated intrinsic religiosity was associated with not reducing one's homosexual feelings and behavior" and the second being that "the more one identified as heterosexual the less change there was in one's sexual feelings and behavior toward women and one's sexual feelings and behavior toward men."

Therefore, being spiritually in tune with God and being highly religious in one's devotion and practice does not correlate nor affect one's struggle with his or her own homosexual feelings and behavior positively. Likewise, being more conscious of one's heterosexuality or becoming more heterosexual in one's feelings and behavior has no effect nor reduces one's homosexual feelings and behavior toward same-sex persons. In other words, just as enjoying sex within holy matrimony does not get rid or solve one's struggle with lust and temptation so neither does getting hitch to the opposite sex or when one becomes more pious and spiritual will it necessarily cure one's homosexual tendencies.

What the above study show is the importance of psychoeducation, having a therapeutic alliance with a counselor or psychologist, maintaining a trusting nonsexual relationship with same-sex persons, care and support within a loving and nonjudgmental

community and the acknowledgment that one is still very much a WIP (work-in-progress) is the key to finding and sustaining one's mental health in a life-long journey and struggle with one's homosexual tendencies whether one gets married or remain single.

In conclusion, the debates and controversies surrounding the DSM IV-TR and the GID category are still far from seeing any definite resolution whether now or in the future. While the LGBT camp is gaining strength and organizing themselves into powerful advocacy lobbies, a number of pertinent and practical issues still affect GID candidates and clients on a daily basis.

Firstly, from the medical and psychopathological angle: one clear possible consideration of diagnoses of GID as **Dissociative Identity Disorder** (DID) has been noticeably absent in most DSM IV-TR discourses. Colin Ross (2009) lament in his article, "Why is thinking you are a male trapped in a female body a dissociative symptom treated with psychotherapy if there is a group of identities, but a gender identity disorder treated with surgical reassignment if there is only one identity? This is inconsistent." Ross came to the conclusion that if the disorder is reclassified as DID, it would not only "threaten the turf control of specialists", and "necessitate careful evaluation of all GID cases for DID" but also "expose gender reassignment clinics to considerable legal liability for undiagnosed DID cases that have already been reassigned."

Secondly, from the therapeutic and treatment plan angle: one basic tenet of good professional attitude in practice is keeping to a high personal code of practice, regardless of whether one is bound to any legal statutes or otherwise. But to recommend that GID candidates and clients should be treated only with self-actualisation therapy approaches as the best option without due consideration of other factors such as individual personal choices, or the state of one's psychological readiness and sufficiently informed knowledge, in addition to the possibility that there are a variety of treatment options available other than SRS as well as the fact that each of us do live in specific cultural context and hold varied personal values and norms is not only preposterous and prejudicial but highly suspect.

Last, but not least, transsexual people also complain of loneliness. The challenge for counseling practitioners is to love them genuinely without condoning their lifestyle. "People in the caring professions need to provide compassionate professional support for transsexuals" (Sims). They need an accepting and open learning community who can provide them a safe place to be vulnerable without feeling condemned and marginalised, build intimate non-sexual relationships with same-sex individuals without suspicions and experience genuine love, concern and support without falsehood and superficiality.

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