

Gender Dysphoria

Case Study Part 1: Jamie

Jamie Thompson is a 24-year-old transgender male who comes to the Columbus (Ohio) Community Clinic because of experiencing periods of high anxiety and feelings of rage about "not being free to be myself." Jamie, born in a rural area of the state, has lived in the city for 3 years; he works full-time as a crew supervisor for a small regional company that landscapes properties in new, high-end housing developments. His eventual goal is to become a manager or owner of such a company. Recently he has noticed that many of the new crew workers are openly hostile toward sexual minorities, and Jamie has always suspected that his supervisor is so inclined as well. He is worried that his transgender status, thus far hidden to most others, may be discovered and cost him his job. He states that he is "tired of having to live this way after so many years" and is aware that his angry temper, always a problem, may get the best of him.

Jamie was born female but has lived most of his life as a male. He is currently receiving weekly testosterone injections, a process that has been underway for 2 years, to further the process of becoming more biologically male. Jamie identifies the source of his symptoms as "fears of being found out" as a transgender male. If fired his employment does not come with any civil protections. The client is accustomed to enduring prejudicial attitudes but has been feeling less tolerant of them since coming to Columbus. He has a history of aggressive behavior and is worried that he might lash out physically at someone due to his stress. He wants help in developing coping alternatives to physical aggression.

Over the past several decades diagnoses related to gender identity have become a subject of controversy among members of the mental health professions. The understanding of gender identity has evolved and the differences between one's gender and assigned sex are now widely recognized. *Gender* refers to the physical, biological, mental, emotional, and behavioral characteristics pertaining to cultural standards of masculinity and femininity (Dragowski, Scharron-del Rio, & Sandigorsky, 2011). *Sex*, in comparison, refers to one's biological characteristics. *Gender identity* is a person's subjective sense of congruence with his or her birth sex. *Gender dysphoria*, the subject of this chapter, refers to dissatisfaction with one's birth sex, which is experienced as incongruous with, or contradictory to, one's gender identity. In the DSM-5 a previous diagnosis of gender identity disorder was re-conceptualized, relabeled, and removed from the chapter on sexual disorders, indicating a changed perspective by the American Psychiatric Association (APA, 2013). In this chapter we discuss gender dysphoria (GD) and its surrounding controversy as an example of how social workers may take a critical position with regard to the process of determining psychiatric disorders. We believe that the diagnosis should not appear in the DSM-5 because it is not a disorder, and we will comment further on this point at the end of the chapter.

Box 14.1 Assessment Guidelines for Gender Dysphoria

First, assess the behavioral and emotional nature of the client's gender dysphoria, including:

- Whether the person is troubled by, confused by, or uncomfortable with his or her gender
- Is upset by questions about gender
- Avoids social situations or stops certain desired activities due to gender concerns
- Expresses a changed gender identity
- Has thoughts of changing his or her physical sex characteristics

For those clients who are comfortable with their gender identities, gather information about their:

- Childhood gender development
- Sexual and relationship development
- Timeline and onset of gender dysphoria
- Understanding of the differences between gender identity and roles

- Knowledge about gender identity and its implications for social functioning
- Imagined or intended future gender
- Future plans and expectations
- Sense of pride in gender identity and expression
- Experience of stigma on gender nonconformity
- Any internalized transphobia
- Perceived school, occupational, and community climates, and the presence of supports in these areas
- Parent and family support, ambivalence, or rejection
- Quality of current intimate relationships
- Overall physical health
- Any relevant co-occurring conditions, including those that may complicate their understanding of gender dysphoria, be associated with gender dysphoria, or complicate their readiness for physical interventions, if desired.

The assessment may result in no diagnosis, a formal diagnosis of gender dysphoria, or other diagnoses reflecting the person's psychosocial adjustment. In any case the practitioner should have information to share with the client about community resources for gender dysphoric persons.

Case Study Part 2: Jamie

Jamie was born a white female just outside the northeastern Ohio town of Findlay to a father who worked as a plumber and a mother who was a nurse's aide in a retirement facility. He says that both parents were, and continue to be, alcohol abusers. They were "not good with money" either, a trait that kept the family in a lower-middle-class lifestyle, surviving from paycheck to paycheck. Jamie has a brother who is 10 years younger than he. They get along well but have never been close due to the age difference.

Jamie has unhappy memories of his early life because his parents argued frequently and separated when he was 14 years old. His mother became involved with a boyfriend who "rescued" her from the tense family situation and moved with her and Jamie to Springfield, Ohio, 3 hours away, for 1 year. Jamie's brother stayed with his dad. His mother returned home to Findlay without her boyfriend but soon divorced his father. Jamie continued living with his mother and had a strained relationship with his father. He recalls always feeling insecure, even prior to the emergence of his gender issues, and being prone to initiating physical fights with other kids when feeling threatened.

Jamie says that he "always wanted to be a boy," and thought of himself as a boy for as far back as he can remember. For many years he did not think this was problematic or unusual. Jamie always wore boys clothing, kept his hair short, and played "boy games" with other boys. He even joined the Cub Scout organization when he was 9 years old, but this was not unusual in his region at the time. No one else seemed to have a problem with it either, including his parents, at least during his grade school years. Jamie says that his parents were only concerned about his appearance on picture days at school, when they wanted him to dress as a girl. He did so.

It was in middle school at age 12 that Jamie began to experience ridicule from peers because of his gender orientation. When he entered sixth grade he continued participating in "masculine" activities like skateboarding, but with the emphasis on sex-role distinctions brought on by puberty

some peers began to tease, mock, and bully him. This was the first time he thought something might be wrong with him. As a result of the negativity and confusion that Jaime experienced from boys and girls alike, he decided to give in to their pressure and start dressing and behaving like a girl. This did not work out well at all; it made him extremely unhappy and angry, as it was completely inconsistent with his self-image. In response to the cruelty of others he became a bully himself, often starting fights with people who took issue with his gender identity. His aggression became such an issue that he went to a counselor for a brief period and was diagnosed with oppositional defiant disorder. Jamie does not remember anything about that experience.

When Jamie moved to Springfield with his mother and her boyfriend a few years later, he hoped that people in the new environment would be more accepting of him. He soon made a bisexual male friend there and they began dating. He came out to his mother and peers as a lesbian, and while she was accepting of the disclosure, the peer abuse continued. His mother did not tell Jamie's father about the coming out, knowing that he would be upset. Jamie could at least feel comfortable with his boyfriend and in his home.

Returning to the Findlay area in the ninth grade, Jamie learned for the first time about the existence of an LGBT community. He had not known about this because it tended to be "under the radar" but he quickly made friends with some of its members. With their encouragement he decided to live more openly as a lesbian. While the stresses due to social prejudice continued, sexual diversity was more widely accepted by that time and Jamie reports that his high school years were "easier." Still, he was a sexual minority and felt generally tense due to that fact. He began experiencing periods of depression and had panic attacks every few months.

When Jamie was in the 11th grade, he met a transgender male at his school, who was 1 year younger. He did not know much about people who identify as transgender until then but eventually became best friends with this person. Jamie began to consider where he fit on the gender spectrum and the possibility that he himself might be a transgender individual. He began to think of himself as a man from this point on.

That same year Jamie met a lesbian girl online who lived in Boulder, Colorado, and they maintained an intense long-distance relationship for a year and a half. They wrote and texted every day and were emotionally intimate with one another. Jamie decided to apply to college at Colorado State so he could be together with her. While in Colorado he became more involved in the transgender community and decided to explore the possibility of undergoing sexual confirmation procedures. He investigated hormone treatments and had one such injection, although he cannot remember the particulars of what he had to do to qualify for it. He remembers feeling good about the decision but he could not financially afford to keep up with regular treatments.

Jamie left school after 1 year due to what he admits was "irresponsible behavior" about his finances and academic responsibilities. He was homeless in Boulder for a period of time and eventually realized that he had no options but to return to Ohio. His girlfriend moved back to Findlay with him but they broke up after another few months. Jamie was working at this time at his uncle's delicatessen and was very unhappy. He remembers feeling lonely and wanting again to undergo gender confirmation procedures. He decided to move to Columbus, the state capital, to see what opportunities he might find there.

Jamie quickly found his current job, and an apartment, and became involved in the LGBT community in Columbus. Once he was able to acquire health insurance he went to a clinic that provided holistic preparation services for gender confirmation. He remembers having to "jump through a lot of hoops" before qualifying for hormone injections, including mental health counseling and living as an openly male person for a full year. The local Planned Parenthood agency provided the injections. This began 2 years ago and Jaime says that the process is intended to continue for 5 years. He states that he feels much better as a result. After 2 years his voice has changed, he has more body hair and muscle, and his facial features are "sharper." He is considering having breast surgery because he hates having to bind his breasts most days. Jamie is not sure whether he will consider additional surgical procedures in the future.

Jamie has been in a steady romantic relationship with a lesbian female for 2 years and is happy with that situation. His partner understands his challenges and shows him unqualified affection and support. He mentions, too, that this is the first relationship where the sex has been fully satisfying.

Directions Part I, Diagnosis Given the case information prepare the following: a diagnosis, the rationale for the diagnosis, and additional information you would have wanted to know in order to make a more accurate diagnosis.

Questions to Consider:

1. Is there significant incongruence between Jamie's experienced gender and birth sex?
2. Is Jamie's gender identity associated with significant distress or impairment in social or occupational functioning?
3. Are there specific ways in which Jamie experiences stigma?
4. Does Jamie experience any comorbid conditions that might account for his presenting symptoms?
5. What is the status of Jamie's physical health?
6. Does Jamie have adequate family, organizational, and personal support in his life at this time?
7. What is the nature of Jamie's closest relationships, and how do they affect his social functioning?
8. Is there evidence that Jamie experiences internalized transphobia?

See Appendix A for a template for preparing the diagnosis and Appendix B for suggested answers to the Questions to Consider.

BIOPSYCHOSOCIAL RISK AND RESILIENCE INFLUENCES

The processes of gender identity development are not yet well known; its formation is a product of complex biological, psychological, and social influences.

Onset

Biological Influences

There are believed to be three main biological pathways to atypical gender identity development—anomalous prenatal hormonal influences, genetic influences, and anatomic brain differences (see Table 14.1). Regarding hormonal influences, it is known that sex differences are programmed into the brain during intrauterine development (Bao & Schwab, 2011). During this period a testosterone surge masculinizes the fetal brain, and the absence of such a surge preserves substances that promote development of a feminine brain. This sexual differentiation of the brain takes place at a later stage of development than differentiation of the genitals, however, so these two processes can occur independently of each other, and they may not match up.

Twin studies indicate that genetic factors account for up to 80% of the variance in gender identity, which supports the heritability of the condition (Puszczyk & Czajeczny, 2017). One literature review of 69 twin sets concordant or discordant for transgender identity reported that 20% of all monozygotic twin pairs were concordant for that identity (Diamond, 2013). In another study nine of 23 monozygotic twins (39.1%) were concordant for GD, while none of the 28 dizygotic twins were concordant for the condition (Heylens et al., 2012). A study of the non-twin siblings of 995 transgender people found the probability of the condition to be about 4%, which, while low, is nonetheless elevated (Gomez-Gil et al., 2010).

Finally, a literature review of studies of brain differences between transgender persons and controls concluded that there are differences in right hemisphere and cortical structures underlying body perception, as well as differences in the cortex with regard to the amounts of gray and white

TABLE 14.1 Biopsychosocial Risk and Resilience Influences for the Onset of Gender Dysphoria

Risk Influences	Resilience Influences
Biological	
Anomalous prenatal hormonal influences	
Anatomic brain differences	Consistency of brain and gonadal sexual development
Genetic influences	
Psychological	
Insecure attachment	Secure attachment
Stereotypical gender conditioning	Broad gender conditioning
Core cognitions that promote a sense of self as deficient and vulnerable	Cognitions supporting alternative gender identification
Absence of gender confirming mirroring opportunities	Positive gender-variant mirroring
Childhood abuse or neglect	
Social	
Absence of cultural acceptance of gender incongruity	Cultural acceptance of gender incongruity
Victimization (social stigma, discrimination, transphobia)	Family support
Interpersonal conflicts	Disclosure of transgender identity
Lack of supportive peers and social groups	Availability of supportive social groups and peers

matter present (Guillamon, Junque, & Gomez-Gil, 2016). The authors point out that these findings, while significant, are inconclusive with regard to the details of anatomical differences.

Psychological Influences

A variety of psychological theories have been put forth to partially account for the onset of gender dysphoria, but most are speculative. *Psychodynamic* theories emphasize the role of early childhood experiences and identification with primary caregivers as critical in gender identity development (Fonagy, Krause, & Leuzinger-Bohleber, 2018). As examples, gender-nonconforming children may be constitutionally anxious and sensitive due to negative parental reactions to displays of nonconformity, and the development of boyhood gender nonconformity may involve a temperamental inhibition of the child coupled with strong attachments to women who encourage participation in feminine activities. One *self-psychologist* writes that the gender dysphoric child has been deprived of sufficient mirroring experiences with caregivers to develop a positive self-image (Fraser, 2009). A pair of researchers exploring adult *attachment styles* among 18 males experiencing GD who came to a clinic for assistance with related problems noted a prevalence of insecure and disorganized attachments (Vitelli & Riccardi, 2010).

Family systems theories suggest that a child's experiences of abuse or neglect can leave him or her vulnerable to poor coping skills when stress occurs, including the expected stresses that accompany gender variance (Firth, 2014). *Learning theories* emphasize the role of reinforcement, punishment, and modeling in gender development (Davis, 2012), and suggest that gender-variant behavior may be reinforced by family members but rejected by peers, which intensifies the person's negative self-esteem and further propels gender-variant behavior. *Cognitive theories* focus on children's knowledge about gender and gender-related behaviors (Simon, Zsolt, Fogd, & Czobor, 2011). Gender-variant persons are said to develop core beliefs of themselves as deficient and vulnerable.

Social Influences

Environmental influences on a child's gender development begin early, certainly in Western countries (Ellemers, 2018). On learning of the biological sex of a child, parents often begin acquiring

gender-specific clothes, toys, and nursery items. After birth, boys and girls elicit different responses from significant others. Boys are seen as stronger and girls tend to be considered delicate. Traditional gender behaviors are reinforced with inclusion and praise, and unacceptable gender behaviors are tolerated at best. Children learn that, at a fundamental level, men and women have different sets of roles, responsibilities, and expectations. For the gender-variant child these expectations create discomfort in that they do not conform to the child's own preferences (Puszczuk & Czajeczny, 2017). If the child lacks adequate caregiver support for a broad range of sex-role behaviors, he or she may develop dysphoria. The risk of dysphoria becomes more pronounced if the child experiences social oppression via bullying, stigma, and discrimination (Dhejne et al., 2016). Conversely, gender-variant persons who live in more supportive family and community systems exhibit fewer signs of psychological distress (Sanchez & Vilain, 2009).

Course and Recovery

The course of gender dysphoria is variable and depends on the person's ability to come to terms with his or her own gender identity and connect with supportive others. The presence or absence of dysphoria will depend on adjustments in lifestyle and possible biological manifestations of gender.

Adolescents who persist with GD show a greater intensity and range of gender-variant behavior in childhood and tend to be sexually attracted toward persons of the same natal sex without identifying as gay or lesbian. They also demonstrate a stronger cross-gender identification (perceiving themselves as being the desired gender versus merely wishing themselves to be). Girls who are referred for services generally present a greater level of gender-variant behavior than boys and are older in age. One group of researchers investigated the development of gender dysphoric children into adolescence and found that their persistence or desistance was related to three factors (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2010). First, between the ages of 10 and 13, the social distance between boys and girls increases. The already existing preferences for other-sex friends increased in the persisters, as did their discomfort with their assigned gender roles. The greater social distance between the sexes created a desire for the desisters to add gender-typical interests to their behavior repertoires. Second, the onset of puberty brings about changes in adolescents' feelings. For persisting boys and girls, puberty created distress, and their aversion to their bodies intensified. For desisting persons, feelings of discomfort about their bodies decreased as they became aware of the pleasant aspects of their emerging sexuality. A third factor associated with the persistence or desistance of childhood GD was the emergence of feelings of sexual attraction, which resulted either in their questioning or confirming the cross-gender identification.

Regarding dysphoria in adulthood, a qualitative study of how transgender people successfully recognize, acknowledge, and come to terms with their gender identities demonstrated that they move through the stages of (1) confusion and an increasing sense of gender difference, (2) finding an explanation and a label, (3) embracing their gender identity, and (4) identity consolidation (Pinto & Moleiro, 2015). A study of 571 transgender women in New York City found that depression was associated through the life span with being in conflict, rather than being affirmed, by significant others (Nuttbrock et al., 2011). Affirming relationships were more often found with friends than family members. Another qualitative study suggested that gender dysphoria can have a lifelong course, finding that older transgender persons (65 years or more) continued to struggle with their gender identities due to stigma internalized in their earlier lives (Silverskog, 2014).

Fewer than half of persons with GD eventually undergo sexual confirmation surgery (Sohn & Bosinski, 2007). A majority of persons who meet the diagnostic criteria aspire to live in their current bodies but without the constraints related to socially constructed sex roles. There is some evidence that the numbers of persons with GD who pursue gender confirmation surgery has been

increasing (Dhejne, Oberg, Arver, & Landen, 2014) but, on the other hand, some persons may not see those procedures as necessary because gender identity has taken on a more fluid nature, being less connected with physical characteristics.

Directions Part II, Biopsychosocial Risk and Resilience Assessment Formulate a risk and resilience assessment, both for the onset of the disorder and for the course of the disorder, including the strengths that you see for this individual and the techniques you would use to elicit them.

INTERVENTION

Psychosocial Intervention

The clinical treatment of persons with gender dysphoria is highly individualized. Those persons who are comfortable with their gender identity and presentation may only want help dealing with the related social and interpersonal challenges, while others may want to consider physical interventions. There are, as of yet, no demonstrable evidence-based interventions for the condition, but various guidelines have emerged. The American Psychiatric Association and other professional organizations have formulated standards for the treatment of persons with gender dysphoria (Byne et al., 2012; Coleman et al., 2011; Coolhart et al., 2013). These are summarized next, with additional citations included.

Psychosocial therapies focus on individual acceptance, family and peer acceptance, stress reduction, providing alternatives to binary views about gender, support during any change and coming-out processes, and education for the client. The social worker may facilitate a process whereby the client explores options for securing a more comfortable gender identity and becomes able to make informed decisions about available medical interventions (with the family, if the client is a minor). Social workers should discuss with the client the psychological, social, physical, sexual, occupational, and legal implications of any changes in gender presentation. A medical referral will of course be necessary for the client to more fully explore certain options. Other psychosocial interventions can focus on improving the person's ability to detect unsafe situations in the environment, understand the risks and benefits of self-disclosure, explore the hypothetical reactions of loved ones to any physical changes, understand how gender identity intersects with one's ethnic and cultural identity, and develop healthy coping strategies in the presence of adversity (Leibowitz & de Vries, 2016).

Treatment models are different for children compared to adolescents and adults (Ristori & Steensma, 2016). Because the gender dysphoria of children may not persist, interventions should focus on helping them and their parents deal with the uncertainty of the child's psychosexual outcome, educating them about the process of gender identity development, and helping them make decisions about gender-related behaviors and managing peer rejection and social ostracism.

The temporary delay of puberty can give a child time to explore gender concerns in a manner that is fully reversible. *Pubertal delay* may be achieved through the use of hormones, such as luteinizing hormone releasing hormone (LHRH), gonadotropin-releasing hormone (GnRH), and other substances. The benefits of suppressing puberty include reduced psychological distress, less intense comorbid disorders, and improved social functioning (Janica & Forcier, 2016). The long-term medical effects of this intervention are unknown, however, and inhibited pubertal development can have a negative effect of psychosexual development (Puszczuk & Czajeczny, 2017). A suppressed sexual drive and lack of sexual experience can disturb the formation of sexual identity and orientation as well as functioning in interpersonal relationships. Further, the capacity to make decisions to accept or reject hormone therapy may be insufficiently developed in adolescents.

Nonmedical transitions are achieved through the use of clothing, hairstyle, and changes in name, body language, and behavior. This is also known as “real life experience,” the act of fully adopting a new or evolving gender presentation in everyday life. Female-to-male persons may bind their breasts and pack their underwear, while male-to-female persons may wear makeup, wear prosthetic breasts, and heighten their vocal pitch. These types of transitions can be an end in themselves or a temporary step for those who hope to eventually engage in hormone treatments or confirmation surgery.

Use of hormones for affirmed gender involves the use of estrogens, antiandrogens, and progestins for natal males, and androgens for natal females to stimulate the secondary sex characteristics of one's affirmed gender. Natal males experience breast growth, feminine muscle and fat distribution, and softening of the skin, while natal females experience voice deepening, face and chest hair growth, masculine muscle development, and clitoral enlargement. This process is not fully reversible, and as such is generally not recommended until the person has lived for 12 months or longer as the other or an alternate gender.

A systematic review concluded that cross-sex hormonal treatments have beneficial effects on clients' well-being (Costa & Colizzi, 2016). Persons reported less anxiety, dissociation, social stress, and higher mental health-related quality of life and self-esteem. Male-to-female individuals benefited more in terms of body uneasiness and emotional functioning. In general persons experience a decrease in the psychiatric comorbidities associated with gender dysphoria. The authors emphasized that these outcomes were not biological in origin but related to psychological adjustment.

Gender confirmation surgery is a process of permanent physical change achieved by undergoing surgical procedures that alter one's natal gender to that of the affirmed gender, and includes removing breasts, testicles, hair, and perhaps constructing a vagina or penis. Practitioners might suggest a program of staged gender change in which fully reversible steps are taken first, perhaps followed by partially reversible and then irreversible steps. With adolescents, pubertal suppression can be sustained for up to several years during which time the client, with the involvement of caregivers, can decide whether it is preferable to revert to living in the birth sex or to continue the transition to the affirmed gender. If such procedures are implemented, the social worker can assess the client's readiness for suspension of puberty and cross-sex hormones and also the safety of the client's environments related to likely stigmatization.

Outcome studies indicate that gender confirmation interventions are often effective in resolving the stress that comes with gender dysphoria. In a systematic review and meta-analysis, 28 studies involving 1,833 participants with gender dysphoric persons (1,093 male-to-female, 801 female-to-male) who underwent gender confirmation procedures of various types were investigated (Murad et al., 2010). While most studies lacked controls, data showed that after gender confirmation procedures, 80% of individuals reported significant improvement in gender dysphoria, 78% reported significant improvement in psychological symptoms, 80% reported significant improvement in quality of life, and 72% reported significant improvement in sexual function. The authors concluded that while available studies are not of a high quality, gender confirmation including hormonal interventions improves gender dysphoria, psychological functioning, sexual function, and overall quality of life.

Other studies show positive but mixed results. A long-term follow-up (10–16 years) study of 104 persons who underwent gender confirmation surgery in Denmark between 1978–2010 found that mental health outcomes were improved for some but worse for others in equal parts (Simonsen, Giraldi, Kristensen, & Hald, 2016). Another long-term follow-up (10 years) study of 71 post-surgery transgender individuals in Germany found an increase in well-being among participants, but not necessarily a decrease in life challenges (Ruppin & Pfafflin, 2015). A study of Italian men, pre- and post-surgery, found that well-being was much higher after surgery, defined as living in accordance with one's true self, but this was not necessarily the same as happiness or reduced stress (Prunas et al., 2017).

A large-scale study in France of persons who had received various gender confirmation procedures (hormonal to partially physical to entirely physical) concluded that feeling “gender confirmed” can result from a variety of practices, not all of which require physical transformation.

Finally, *advocacy activities* may include such macro-level interventions as providing community education through presentations, websites, and conferences, helping to develop school-based curricula to provide education and promote acceptance of gender variance, and youth summer camps for transgender persons.

Directions Part III, Goal Setting and Treatment Planning

Given your risk and resilience assessments of the individual, your knowledge of the disorder, and evidence-based practice guidelines, formulate goals and a possible treatment plan for this individual.

CRITICAL PERSPECTIVE

The concept of gender incongruence has evolved over the past 65 years from being considered a mental disorder to being a condition that is not. During that time it has been considered a sexual deviation (APA, 1952), a sexual orientation disturbance (APA, 1968), an identity disturbance (APA, 1980), and now a source of dysphoria. The changing classifications of gender dysphoria in the DSM provides an example of how social and cultural norms may drive decisions about mental illness (Knudson, De Cuypere, & Bockting, 2010). GD as a “disorder” has been criticized on several grounds. It represents a bias that supports Western binary sex-role stereotyping as valid. There is in fact a lack of consensus about the nature of gender around the world, and some societies are more tolerant of ambiguity and variance in this regard. Proponents of GD as a disorder assume that adherence to gender stereotypes is “normal” and that the behaviors associated with it are uncommon, but there is no evidence that they represent dysfunction by themselves. The diagnosis is associated with comorbid disorders, but this is likely due to reactions to oppressive practices, similar to those experienced by persons who are gay, lesbian, or bisexual.

Because persons with gender dysphoria suffer prejudice and are at times denied civil rights, most professionals support actions that de-pathologize the condition. They agree that GD persons should have access to medical and therapeutic care reimbursed by third-party payers. Whether one can best achieve these aims by maintaining a DSM diagnosis or removing it is unclear at present. Some people think retaining the diagnosis will decrease stigma and facilitate better medical care, and others think it may do the opposite. The DSM-5 formulation of gender dysphoria seems to at least represent a step forward, removing gender as the site of the disorder and placing the focus on the associated distress. The new criteria further support recognizing an array of gender expressions by stepping out of a reliance on binary categories (Lev, 2013).

A diagnosis of gender incongruence might best exist as a medical condition (Allison, 2010). Medical doctors could treat such persons with appropriate hormone management; surgeons could perform the operations essential for a normal life in the appropriate gender; and many such treatments would be covered by health insurance. Psychiatrists and psychologists would appropriately manage the anxiety, depression, or other emotional conditions that occur in persons who experience gender incongruence.

The DSM-5 sexual disorders work group (Byne et al., 2012) stated that it wanted to avoid promoting stigma and ensure clinical care for persons with gender dysphoria, but the manual needed a diagnostic term that would protect their access to care. Replacing the term “disorder” with “dysphoria” was intended to reduce the connotation that the client is disordered. Some will be ready to address transition steps but others may have psychological conditions that they confuse

with gender dysphoria. If these persons can be identified and directed to appropriate interventions, they will be well served.

Directions Part IV, Critical Perspective Formulate a critique of the diagnosis as it relates to this case example. Questions to consider include the following: Does this diagnosis represent a valid mental disorder from the social work perspective? Is this diagnosis significantly different from other possible diagnoses? Your critique should be based on the values of the social work profession (which are incongruent in some ways with the medical model) and the validity of the specific diagnostic criteria applied to this case.

REFLECT AND APPLY

See Appendix C for the directions and templates for preparing the *Diagnosis* and the *Biopsychosocial Risk and Resilience Assessment* for the following case.

Case: Michael

Michael, a 28-year-old white transgender female, was visibly shaken, with trembling hands and a rapid pace of speech, as she explained to the social worker why she had made this first appointment at the mental health center. "My partner Matt says he's going to leave if I don't get more settled in my identity. He's really upset and I think he could actually go this time." Michael stated that she and Matt had been living together in a committed romantic relationship for 3 years. Yet Matt, a white 57-year-old philosophy professor and gay man, had always been frustrated with Michael's "fluid" gender identity. As a gay male, he considered Michael, or wanted to consider her, to be male, although Michael "usually" identified as female. Michael had received several series of hormone treatments over the years and at present presented with male genitals but female secondary sex characteristics including long hair, breasts, a soft voice, soft skin, and minimal body hair. She had never considered surgery because she did not think it mattered. "I'm female, but I don't really put myself in a box, or see myself in a rigid way. Matt wants me to stop the hormone treatments and look more male. But that's not me. I don't want that." Michael said that the pair had often discussed this issue but recently Matt had become more adamant that she make "concessions." She was not sure why.

The social worker suggested that Michael invite Matt to come in for an appointment where they might deal with this emerging point of conflict in a safe environment. Michael agreed, and the couple came together 1 week later. The social worker learned more about Michael and the partners' history together.

Michael was not eager to dwell on her personal history, given her anxiety about the present situation, but she did provide some background information. She had been born to a "hippie" couple and grew up on a "kind of commune," a shared working dairy farm that they rented with eight other adults and that included six children around her age. Michael remembered living without many rules but with a lot of nurturing supervision. Her father eventually took a high school teaching job and the three of them (she has no siblings) moved to a small town when she was 10 years old. Michael remembered being happy and getting along well with other people in her neighborhood and at school. She says her parents were loving people, and that her mother was an active Red Cross volunteer. Michael believes that she was well liked but did poorly in school, admitting that this was probably because she never had much self-discipline and focus. She remembers having good times playing outdoors with the other kids but no close friends. She never gave her gender any thought.

It was during adolescence that Michael began to consider himself (at that time) as being female, as she found herself rejecting most adolescent male behavior stereotypes and relating much more with the concerns and interests of his female friends. She thought that she might prefer being a

woman. Michael discussed these feelings with her parents and they were supportive of her talking time to "discover" who she really was. Michael also pursued new artistic inclinations at this time, especially sculpting with clay. She developed a circle of casual friends at the high school who were artistically inclined, among them a transgender male with whom she developed a friendship. This person helped Michael realize that she need not live with her assigned sex characteristics and that it was healthy to experiment with gender identity.

By age 15 Michael decided, after doing some reading, that gender was fluid, and that she did not have to "commit" to being all man or all woman. She felt comfortable with the possibility of a non-specific identity although she most closely identified with the female gender. She also realized that, while she had always been sexually attracted to men, she was not gay or lesbian. This was a great relief to Michael because she had avoided her few opportunities for romantic relationships with boys, not feeling sure that it was "right." At this time, however, Michael began presenting herself outwardly as a female, with clothing and makeup. Still, she did not want to define herself as a member of either gender. She wondered if she could "fit in" anywhere with such an identity, but her parents supported her self-discovery as representing her "genuine self." Her social life waned through the rest of high school, but Michael did not mind. She had always been a loner and felt most secure when she was by herself.

Following high school graduation Michael moved into an apartment with a male friend and began work as a clothing salesperson. Her sculpting practices persisted but never advanced beyond that of a "hobby" and she did not seriously pursue any academic or occupational goals. She was comfortable with herself gender-wise but noticed that she did not get along well with many other people, except on a formal basis. She tended to be open about her lifestyle, which was not often accepted by her peers, and she was not interested in joining any organizations related to gender diversity. Her parents were always there for her although they voiced concerns about her absence of a career focus. "They didn't care what I did except that they wanted me to do something other than sell clothes." Michael often became annoyed at what she perceived were the expectations others had for her.

During these next few years Michael came to identify more strongly as female and underwent counseling and other preparations for hormone treatments so that she could acquire female sex characteristics. She had relationships with a few men during these years but they did not last long. "The few guys I got close to wound up accusing me of being self-absorbed and flaky" she admitted. "I'm the kind of person who wants to be alone most of the time and tend to my private interests, but I'm a caring person, too. But sure, I'm not going to coddle anyone else. That's not a mature way to relate. I'm independent and I'm surprised more people I know aren't that way." Michael also grew more distant from her parents, who moved farther away after her dad's retirement to get "closer to nature again." Michael quit her job as a salesperson after 3 years without another job because she "needed time to sort things out for myself."

It was at this time that she met Matt at a party hosted by a mutual acquaintance. They "hit it off" and began seeing each other several times per week. Because Matt was employed full-time at the university, Michael felt, and Matt agreed, that she did not need to work and so she lost her motivation to do so. She became Matt's social companion and live-in partner. They shared intellectual, and artistic tastes and got along well on that basis. They also enjoyed a good sexual relationship, a first for Michael, although, as noted earlier, Matt thought of her as being male because of her genitalia. Matt worked long hours and Michael read, engaged in her art hobbies, and took care of the household in a rather traditional couple's division of labor. Michael admits that part of Matt's appeal is that he gives her "lots of space" and "alone time," but she quickly adds that they are also intellectually and emotionally compatible.

Over the years, however, Matt voiced more expectations about how Michael should present herself physically. He said in the session, "Let's face it; I'm gay, and I feel better with a male sex partner. I've gone along with Michael's way of presenting herself, and I support her fluid gender identity, as she calls it, but it would help me feel better if she looked more like a male. I don't see why this matters to her so much, because she puts herself on a continuum anyway. So why won't she do that for me?" Michael became tearful hearing these words, and said that she felt rejected by the man she loves. She did not want to be different than she was. "But I'll try to talk," she said. "I'll try to work this out with you."