The History of Psychiatry and LGBT people

HLSC 3570 - Zane Dax *University of Lethbridge*

Why I chose this topic

This topic is of a personal nature, I am part of the LGBTQ+ community and who I am is classified in the Diagnostic Statistical Manual by the American Psychology Association

Objective of this project is to educate on the issues of power, classification, pathology, and the criticisms of heteronormativity that encompass the APA, psychiatry and mental health professionals in psychology diagnostics.

Topics of this slide include

- Theories & treatment of homosexuality in the DSM
- Homosexuality classification & removal
- Transgender theories & classification under the DSM
- DSM versions, edits and criticisms of classifications

Definitions

Sex = defined by anatomical characteristics from birth as dichotomous male or female

Intersex = individuals who have congenital variations in the reproductive system that do not reflect male/ female binary

Gender Identity = distinct from the designation of biological sex, self-identification that may not correspond to sex designation at birth

Gender *expression* = refers to how an individual presents themselves with clothing, physical appearance, speech and mannerism which vary accordingly

Transgender = a person who does not identify with gender assigned at birth

Transsexual = a transgender person who seeks medical treatment (hormones and/or sex reassignment surgery) ** older term, caution in use.*

Cisgender = (from the Latin *cis-*, meaning "on the same side as") person's gender is on the same side as their birth-assigned sex

(Aultman, 2014; Belluardo-Crosby & Lillis, 2012; Carabez, Pellegrini, Mankovitz, Eliason, & Scott, 2015)

Social control
by psychological diagnosis

My introduction using the next slide, shows an example of how classifications made by psychologists are situated by place and time, superimposed mainly by European male heterosexuals determining what is an illness.

The Hysteria example is to highlight how diagnoses change through time and are not ultimate truths. This example does relate to sexual orientation, as it was seen to deviate from what was considered normal sexuality in its history of pathology.

Classification of Hysteria Disorder

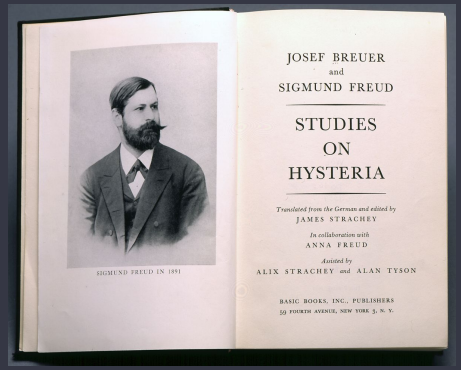
Hysteria was a diagnosis of vulnerable emotions, such as fear, ecstasy, passion, surprise, pleasure, and religious enthusiasm.

Women were thought to be especially vulnerable because of their reproductive organs and their vulnerable nervous system. Female hysteria was believed to be caused by excess pollution of the womb, with fluids that were labelled 'female sperm' as the probable cause.

Psychological thinking eventually moved from the neurological nature of hysteria (consequence of the sick womb), to sexual deviance. Although both men and women suffered from hysteria, the doctors still focused on the female genitals. No men were assessed for relations between symptoms in the genital organs and hysteria.

Western medicine linked female hysteria to levels of too much or not enough sexual energy release. Hysteria in both sexes was famously diagnosed and catalogued by Jean-Martin Charcot at the end of the nineteenth century. By the twentieth century, hysteria was also depicted as a disorder of gender as well as sexuality.

http://www.huffingtonpost.ca/entry/female-hysteria_n_4298060



https://www.nlm.nih.gov/exhibition/emotions/psychosomatic.html

(Dmytriw, 2015; Møllerhøj, 2009; Justice-Malloy, 1995)

Homo/bisexuality

Homosexuality and the theories for psychological diagnosis

Normal variation theory sees homosexuality as a natural difference and define it as neutral and as not belonging in a psychiatric diagnostic manual.

Theory of immaturity view homosexuality as immature expression of feelings or behavior, as part of a normal step towards adult heterosexuality. This theory defines homosexuality as benign.

Theory of pathology regards homosexuality as a disease, a condition that deviates from ‘normal’ heterosexual development. The theory of pathology defines homosexuality as defective or caused by an external pathogenic agent, and see it as a bad thing.

(Drescher, 2010)

Homosexuality and the theories for psychological diagnosis

Krafft-Ebing's *Psychopathia Sexualis* viewed unconventional sexual behaviors through the lens of 19th century Darwinian theory: all non-procreative sexual behaviors, now subject to medical scrutiny, were regarded as forms of psychopathology becoming a psychiatric disorder.

Note: *heterosexuals often have non-procreative sex for pleasure yet do not suffer from stigmatization and pathologization*

Before 1868 there were no heterosexuals, the word was first used in Krafft-Ebing's medical book *Psychopathia Sexualis*.

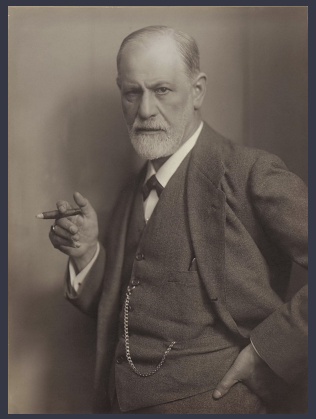
- Straight, The Surprising History of Heterosexuality, Hanne Blank

Psychopathology labels non-heterosexuals as mentally ill (using theory of pathology). This theory was used by Sigmund Freud and others to explain why people aren't heterosexual

(Drescher, 2010; Lev, 2013)

History of American Psychology Association and homosexuality

Homosexuality is often followed by homophobia in society, with one contributing cause is the department of psychology. Sigmund Freud's presiding psychoanalytic theory (1960s) which was that gay men were in arrested development, representing a fixation in the Oedipal phase of psychosexual development. This theory of homosexuality was believed to be pathological and resulted from dysfunctional parent-child relationships. Arrested development pathology wasn't strictly for gay men but also lesbian women, believing that their homosexuality is a dysfunction of a parent-child relationship and child sex abuse.



(Blackwell, 2008; Drescher, 2010; Morrow & Beckstead, 2004) (Wikipedia Image a; Wikipedia image b)

History of American Psychology Association and homosexuality

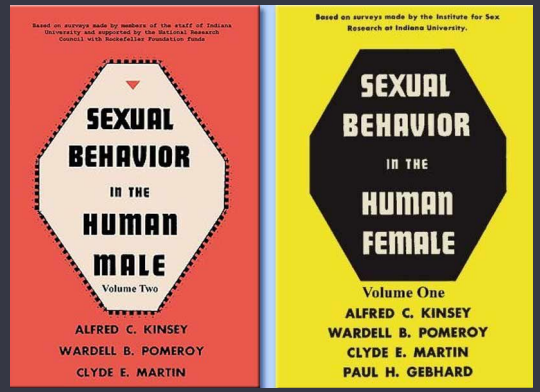
Mental health profession labelled same-sex attraction as pathological, which has led to the thinking there are cures to change an individual's sexual orientation. Converting sexual orientation methodology has used biological treatments such as cauterization of the spinal cord, castration, ovary removal or lobotomy, electric shock, and use of hormones (radiation or steroids).

Today there still continues to be 'conversion therapies' to convert LGBTQ+ individuals into cisgender heterosexuals, all based on developmental theories which have no scientific merit. These 'conversion therapies' are not supported currently by the APA (due to lack of evidence for the mental illness view of homosexuality and bisexuality) and cause significant harm to individuals. Conversion (also known as reparative) therapy studies published since 1956 to 2004, *only* ***one*** study reported a theoretical foundation for their work, which was based on grounded theory.

(Blackwell, 2008; Morrow & Beckstead, 2004; Serovich, Craft, Toviessi, Gangamma, McDowell & Grafsky, 2008)

History of American Psychology Association and homosexuality

Human sexuality research in the 1960s and 1970s started to change homosexuality perceptions. The Kinsey reports surveyed thousands of people and found homosexuality to be more common in the general population than was generally believed. Kinsey's research was at odds with psychiatric claims of the time that homosexuality was extremely rare in the general population.



(KInsey Report Image)

Prior to the removal of homosexuality as a mental disorder in the Diagnostic and Statistical Manual for Mental Disorders, the clinical discourse was full of studies aimed at changing sexual orientation based on behavior modification or aversion conditioning. After protests from gays & lesbians, in 1973 the APA Board of Trustees passed the resolution to delete homosexuality from the *DSM* **by a vote** of thirteen to zero, with two abstentions.

(Blackwell, 2008; Drescher, 2010; Pillard, 2009; Silverstein, 2009)

American Psychology Association and homosexuality DSM removal

"In 1973 [when homosexuality was removed from the DSM], in America alone, several million mentally ill persons were cured"
– Richard Green (Lev, 2013)

Dystonic refers to the subjective experience of unhappiness and is contrasted with syntonic behavior, or one's comfort with their same-sex desires

Anyone dealing with being stigmatized would find it hard to be happy. The Dystonic diagnosis was determined to be biased, and was removed.

Transvestic Fetishism was listed as a paraphilia in the DSM-IV, and the nomenclature has changed in the DSM-5 to Transvestic Disorder, with the goal of distinguishing between non- pathological cross-dressing behavior and that which causes distress to the person or harm to others. The diagnosis *only includes heterosexual men.*

Cross-dressing is not harmful to a person.
Note: Gays and Bisexuals often dress in DRAG (Dressed Resembling A Girl/Guy (for women)) which is *different than transgender* identity

Homosexuality in the DSM
DSM-1 (1952) = sociopathic personality disturbance
DSM-2 (1968) = sexual deviance
DSM-2-R (1973) = sexual orientation disturbance
DSM-3 (1980) = ego-dystonic homosexuality
DSM-3-R (1987) = sexual disorder not otherwise specified
DSM-4 (1994) = removed

(Drescher, 2010; Lev, 2013; National Center for Transgender Equality, 2018)

Transgenderism

Transgenderism

Gender is socially constructed via roles, behaviors, activities and attributes that society deems appropriate for men and women. To maintain this gender binary, most cultures traditionally insisted that every individual be assigned to the category of either man or woman at birth and that individuals conform to the category to which they have been assigned thereafter. The categories of ‘‘man’’ and ‘‘woman’’ are considered to be mutually exclusive.

Many cultures routinely conflate homosexuality with transgender identities because they rely upon several beliefs that use conventional heterosexuality and cisgender identities frame of reference. *Sexual orientation and gender are different concepts*.

(Belluardo-Crosby & Lillis, 2012; Carabez, Pellegrini, Mankovitz, Eliason & Scott, 2015; Drescher, 2010; Lev, 2013; Meyer-Bahlburg, 2010)

Transgenderism

The diagnosis of homosexuality rested on simple heteronormative assumptions about what was "natural," "healthy," "functional," "common". Based on those assumptions, psychological theories developed etiologies of "why" someone could be like "that."

Transgender people have never been subjects of an independent masculine or feminine type, and combinations of what is deemed masculine or feminine at any one time can be found within all humans, albeit performed with different intensities

(Lev, 2013; Meyer-Bahlburg, 2010)

Transgenderism

Transgender individuals face transphobia in health care professions and in education. Social, political and cultural clash from the dominant cisgender heterosexual culture cause numerous formidable challenges in daily life (depression, anxiety, trauma, substance abuse).

De-centering the cisgender assumption that normal people remain in the natal sex (cis) and that disordered people change (trans) is at the root of debate regarding gender diagnoses in the DSM and the battle for their reform.

Clinical conceptualization from gender nonconformity as "other", "mentally ill," or "disordered" to understanding that gender, as a biological fact and as a social construct, can be variable, diverse, and changeable, and existing without the specter of pathology.

(Belluardo-Crosby & Lillis, 2012; Drescher, 2010; Lev, 2013; Meyer-Bahlburg, 2010)

Transgenderism Theoretical Perspectives

Psychological theories assume and explain gender identity is the result of critical factors in psychological development influenced by social factors. This theory implies that being transgender is abnormal and unsuccessful outcome of the gender identity process.

Biological theories belief that the differences between males and females are the result of evolutionary and adaptive history. Transgenderism through this pathology perspective deems transgenderism as an abnormality.

Researchers found that the structure of the Bed nucleus of the Stria Terminalis (BSTc) brain region in trans women more closely resembles that of most women, while in trans men it resembles that of most men . Such studies do suggest that our brains may be hardwired to expect our bodies to be female or male, independent of our socialization or the appearance of our bodies

(Belluardo-Crosby & Lillis, 2012; Drescher, 2010; Zhou, et al, 1995)

Transgender DSM history

First transgender person to have sex reassignment surgery was Christine Jorgensen [1] in 1952 in Denmark

DSM-III in 1980 is when gender dysphoria and transsexualism first appeared. This later was changed in 1987 when gender identity disorder of children and transsexualism was placed under gender identity disorder (GID).

The placement of transsexualism was due to the work of John Money (psychologist & sexologist), Harry Benjamin (physician), Robert Stoller (psychologist) and Richard Green (psychiatrist)

Harry Benjamin popularized the term transsexual

2008, Sweden became the first country to remove the GIDC diagnosis from the Swedish version of the ICD-10, citing its potential, along with five other diagnoses, of being offensive and contributing to prejudice. The Swedish diagnostic manual, however, will retain the Transsexualism diagnosis in order to continued providing sex reassignment.

[1] Christine Jorgensen is the name used after the SRS, the former name is purposely being omitted

(Drescher, 2010)

Transgender classification History

The WHO in 1948 published its first version of ICD which exclusively classified mortalities (no reference to diagnosing transgenderism) (note: sexual orientation and gender identity were often conflated). ICD-6 (1949) and ICD-7 (1955) had a diagnosis for homosexuality (inclusive use). Homosexuality was moved to its own diagnostic section in ICD-8 (1968) and ICD-9 (1978), this changed for ICD-10 (1990) where it was replaced with **egodystonic sexual orientation**.

In 1980, the DSM included both transsexualism and Gender Identity Disorder in the **psychosexual** section. The DSM-II included a diagnosis for **transvestitism** under **sexual deviations**, but failed to mention any diagnostic criteria.

Despite the evidence indicating that distress is likely a result of societal discrimination, the DSM diagnostic model roots the transgender experience in a narrative of internal personal distress over gender identity and severe body dysphoria, and assumes that a narrative of distress is a core component of the transgender experience.

(Drescher, 2010; Cohen-Kettenis & Winter, 2012; Lev, 2013; Schulz, 2018)

Transgender DSM criticisms

Transgender classification criticism

There are **no scientifically based criteria** to differentiate normal and pathological gender identity.

Transgender individuals that are gender incongruent are diagnosed with a psychiatric disorder categorized under Gender Identity Disorders.

Many countries require psychiatrists and other mental health professionals to act as gatekeepers to transition services for transgender people.

The classification of mental disorder without a known etiology has a criteria of distress and impairment. This criteria is not universally experienced by all transgender or gender non-conforming people

As the term disorder it is wrong to label expressions of gender variance as symptoms of a mental disorder, the term disorder perpetuates the marginalization of trans persons

as defined in DSM-IV-TR' s and DSM-5 which furthers stigmatize and cause harm to transgender individuals.

(Belluardo-Crosby & Lillis, 2012; Drescher, 2010; Cohen-Kettenis & Winter, 2012)

Transgender classification criticism *continued*

A major problem with the requirement of formal diagnosis is that it opens the path for further medicalization and psycho pathologization, where one's life comes to be increasingly understood and controlled by medicine and psychiatry, thus defining what is "healthy" and "ill".

The psychiatric diagnosing of gender variance is akin to historical use to socially control those seen as a threat to the political, economic, and religious order of society.

Gender nonconforming bodies are medicalized even before a formal diagnosis, such as in the case of gender variant youth. The cultural need to control gender nonconformity sparks the creation of new diagnoses, where new kinds of patients are created.

Example: A girl who engaged in male-typical behavior and dress was considered a tomboy until the DSM-IV (1994) formalized a diagnostic category that pathologized such behaviors

The name change to GD is meant to destigmatize and depathologize patients by only focusing on the distress caused by gender nonconformity rather than diagnosing and stigmatizing all people who experience gender incongruence.

(Dewey & Gesbeck, 2017; Meyer-Bahlburg, 2010)

Transgender classification criticism *continued*

The diagnostic framework in the DSM-5 for all trans people continues to be underpinned by essentialist, heteronormative assumptions that situate binary sexes—male and female—with corresponding genitalia as the anchor from which Gender Dysphoria is judged. The mandated criteria in the DSM-5 propagates stereotypes about gender and not from empirical biological reasons.

With emphasis on body parts suggests that primary and secondary sex characteristics are the cornerstone underpinning the disorder, where the "disorder" relies upon concerns about anatomic dysphoria rather than GD. This leads to the situation where trans people must express "dysphoria" about their natural body and incongruent behavior and demonstrate to the psychiatrist that they have most often preferred activities that are traditionally gendered and opposite to those gender norms applied to their assigned sex at birth.

Gender behavior norms being applied to natal sex is conflating gender role performance and gender identity, which are not the same thing.

Understanding the power of being under DSM classification, by removing the stigma of "pathology" allowed not only for the coming out of gay, lesbian, and bisexual people, but also allowed for legal, political, and clinical transformations that could never have been granted a "mentally ill" population.

(Drescher, 2010; Meyer-Bahlburg, 2010)

Transgender classification criticism *continued*

The “gatekeeping” model is the focal point of power of practitioners to make treatment decisions on behalf of transgender clients, often based on assumptions about gender that do not always apply to the lived experience of transgender persons. Transgender clients receiving care under this model have reported that they feel being required to see a mental health professional is unnecessarily pathologizing.

Despite the diverse range of transgender identities, mental health practitioners practicing under the diagnostic model have played an important role in transgender identity development by enforcing the binary gender system and requiring individuals with non-binary identities to identify as “male” or “female” in order to be granted access to medical services related to the transition

The diagnosis of gender dysphoria to grant transgender clients access to medical transition services serves as a barrier for individuals due to society’s response to non-normative gender presentation

Transgender individuals do not always desire to “pass” as male or female to alleviate distress, they also do not all espouse a binary gender identity. transgender identities do not always reflect mainstream gender options

Many mental health and health care providers assume that gender variance is a mental health disorder which is rooted in inherent psychopathology.

(Schulz, 2018)

Transgender classification criticism *continued*

The classification of gender identity diagnoses as mental disorders was based more on prevailing social attitudes at the time than of available scientific evidence.

Research indicates that the diagnostic/gatekeeping model is a barrier for transgender clients due to different definitions between clients and practitioners about the goals of treatment.

Due to the gatekeeping model, transgender individuals may embrace the "distress narrative" in order to minimize barriers to treatment. Transgender individuals often will educate themselves about the standards and requirements under the diagnostic model long before making contact with a mental health or medical professional, and will enter into the health care realm ready to say what is expected of them to get the letter from the therapist granting access to health services.

The combined stigmatization of being transgender and of having a mental disorder diagnosis creates a double burden to trans persons' health status and quality of their enjoyment and attainment of human rights.

For example, transgender people are much more likely to be denied care in general medical or community-based settings given the perception that they must be treated by psychiatric specialists, even for conditions that have nothing to do with being transgender.

The relationship between psychiatric diagnosis, stigma and human rights is sharply illustrated by the history of the removal of homosexuality from the DSM-II in 1973

(Drescher, Cohen-Kettenis & Winter, 2012; Schulz, 2018)

Transgender & medicalization

Transgender medical insurance

Transgender clients often enter into the relationships with mental health practitioners as informed consumers, who are well aware that their primary goal is to obtain the letter that will grant them access to desired health services. For those who lack health insurance coverage, paying for medical and mental health services is often not possible.

Some insurance companies exclude or deny coverage for transgender related medical services that they deem “cosmetic” or “experimental,” and this raises a significant challenge for members of the transgender community who have limited financial resources to fund their transitions. This includes transgender binary individuals (trans woman/ trans man).

Access to medical services related to transition while those with transgender nonbinary identities and expressions cannot is problematic and privileges certain expressions of identity over others, further marginalizing those who do not embrace a mainstream expression of gender.

Patients are forced to appear normal and of sound mind while, simultaneously submitting to a mental health diagnosis

Medical insurance coverage requires a psychological diagnosis for approval. The fear is that no medical assistance would be provided to these individuals around sex transition in the absence of an established diagnosis.

(Belluardo-Crosby & Lillis, 2012; Dewey & Gesbeck, 2017; Schulz, 2018)

Transgender medicalization

Mental health providers view “real” transgender people as those willing to do anything to transition. (*This sets up a false dichotomy between who is a “real” trans person and who is not, which is an ongoing discourse surrounding the transgender community*). Because there is no scientific test to prove gender and because, medicine lacks a clear definition of what it means to be male or female, it is the motivation of the patient to meet culturally accepted presentations of being male or female that stand in as the test.

Medical providers are forced to describe transgender identities within a biomedical model that frames patients as disordered forcing them to use alternative diagnoses, they inadvertently deepen the cultural belief that gender nonconforming individuals are inherently mentally and/or physically disordered.

Being required to meet the DSM criteria, transgender individuals are compelled to see themselves through a strict cultural meaning around gendered embodiments and experiences.

Medicalization occurs before a formal diagnosis, where strict cultural beliefs about gender, sexual motivation, and mental stability, and competence become the proof required for the letter of recommendation to access services.

For many transgender individuals a medical diagnosis and medical treatment is key to legitimation or authenticity to their self, but they require state approval in order to gain social and economic benefits and to enter gender segregated spaces.

(Dewey & Gesbeck, 2017; Lev, 2013)

Trans medicalization criticism

Some trans advocates want to retain the diagnosis because of issues surrounding insurance payments to healthcare providers in the North American context. The rationale for the inclusion of GD seems to shift from clinical to economic reasoning, and does not justify the diagnosis for other trans advocates.

Some trans people suggest they want to self-determine their gender identity, and who are of sound mind with no dysphoria, utilizing the diagnosis of GD inevitably places them at odds with or only artificially with the DSM-5 criteria.

The majority of trans activists reject the pathologization of gender variance, some advocate complete de-medicalization, and others a diagnostic reform. These advocates suggest that the need to change gender (markers) is a form of rational self-determination, and not a mental health issue.

Advocates for self-determination framework have argued that access to transitioning technologies should be disconnected from psychiatric referrals. This advocates for the reduction in the influence of psychiatry in gatekeeping transitioning technologies, and for increased access to physicians providing medical and surgical care for transition. Some suggest placing transsexualism as a "medical" rather than a "psychiatric" diagnosis of the ICD

It is wrong to be diagnosed with a psychiatric condition because "difference is not disease, nonconformity is not pathology, and uniqueness is not illness."

(Drescher, 2010; Meyer-Bahlburg, 2010)

History of the APA and LGBT rights

Psychiatry in history has largely played a stigmatizing role of the lives of LGBTQ people. However due to much sacrifice of individuals within and outside of the APA coming out of the closet and fighting for change the DSM did eventually change.

The most significant catalyst for diagnostic change was gay activism. gay and lesbian activists, believing psychiatric theories to be a major contributor to antihomosexual social stigma, disrupted the 1970 and 1971 annual meetings of the APA. 1971 panel, entitled "Gay is Good," featured gay activists Frank Kameny and Barbara Gittings explaining to psychiatrists, many who were hearing this for the first time, the stigma caused by the "homosexuality" diagnosis.

M.D. Fryer appeared as Dr. H Anonymous, a "homosexual psychiatrist" who, given the realistic fear of adverse professional consequences for coming out at that time, disguised his true identity spoke of the discrimination gay psychiatrists faced in their own profession (1971).

1990 APA issued a statement opposing exclusion and dismissal from the armed services on the basis of sexual orientation

1992 APA urged the repeal of legislation that penalizes homosexual acts by consenting adults in private in countries

1998 APA statement opposing 'conversion' therapy, that is based on the assumption that homosexuality per se is a mental disorder or sexual orientation can change

2000 the APA recommended that ethical practitioners refrain from attempts to change individuals' sexual orientation and APA endorsed 'the legal recognition of same-sex unions and their associated legal rights, benefits and responsibilities

2002 APA called for initiatives allowing same-sex couples to adopt and co-parent children

2005 APA issued a statement supporting the legal recognition of same-sex civil marriage with all rights

2009 APA released a transgender, gender identity, and gender expression non-discrimination statement in 2009.

2012 APA issues an official position of support for Transgender civil rights, repeal of laws and policies that discriminate against transgender and gender variant individuals

(APA, 2012; Drescher, 2010; Lev, 2013)

Summary

- Hysteria was a diagnosis that focused on women then onto sexuality
- Theory of pathology is the foundation for psychopathology and 'conversion therapy', Freud being most known for advocating this position
- In 1973 the APA voted to remove homosexuality
- Transgenderism gets placed into DSM, viewing it as pathological and via psychological theory as abnormal
- Gender identity dysphoria, transsexualism, gender dysphoria all have changes made in classification
- There is no scientific test to determine normal from pathological gender identity
- Gender variance, transgender, gender non-conforming are labelled mentally ill
- Pathologization is a form of social control
- Removal of gender dysphoria would possibly result in social change like it did for homosexuality classification in the DSM
- Access and quality of care to medical services is an ongoing issue for insurance due to what is classified
- There is discourse on rejecting pathology of gender variance, switching to a medical model for services instead of psychological

References

American Psychological Association. (2012). APA official actions, position statement on discrimination against transgender and gender variant individuals. Retrieved from: https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2012-Transgender-Gender-Variant-Discrimination.pdf

Aultman, B. (2014). cisgender. Transgender Studies Quarterly, 1(1-2), 61-62. doi:10.1215/23289252-2399614

Belluardo-Crosby, M., & Lillis, P. J. (2012). Issues of diagnosis and care for the transgender patient: Is the DSM-5 on point? *Issues in Mental Health Nursing, 33*(9), 583-590. 10.3109/01612840.2012.704129

Blank, H. (2012). *Straight: The surprisingly short history of heterosexuality*. Boston: Beacon Press.

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

Drescher, J., Cohen-Kettenis, P. & Winter, S. (2012) Minding the body: Situating gender identity diagnoses in the ICD-11, *International Review of Psychiatry, 24*(6), 568-577, doi: 10.3109/09540261.2012.741575

Dewey, J. M., & Gesbeck, M. M. (2017). (dys) functional diagnosing: Mental health diagnosis, medicalization, and the making of transgender patients. *Humanity & Society, 41*(1), 37-72. doi:10.1177/0160597615604651

Kinsey report Image. Retrieved from: http://history105.libraries.wsu.edu/spring2015/wp-content/uploads/sites/4/2015/01/sexual_behavior1.jpg

Lev, A. I. (2013). Gender dysphoria: Two steps forward, one step back. *Clinical Social Work Journal, 41*(3), 288-296. doi:10.1007/s10615-013-0447-0

References *continued*

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

Morrow, S. L., & Beckstead, A. L. (2004). Conversion therapies for same-sex attracted clients in religious conflict: Context, predisposing factors, experiences, and implications for therapy. *The Counseling Psychologist, 32*(5), 641-650. 10.1177/0011000004268877

Møllerhøj, J. (2009). Encountering hysteria: Doctors' and patients' perspectives on hysteria in denmark, 1875—1918. *History of Psychiatry, 20*(2), 163-183. 10.1177/0957154X08094853

National Center for Transgender Equality. (2018). Understanding Drag. Retrieved from: https://transequality.org/issues/resources/understanding-drag

Pillard, R. (2009) From Disorder to Dystonia: DSM-II and DSM-III, *Journal of Gay & Lesbian Mental Health, 13*(2), 82-86, doi: 10.1080/19359700802690174

Silverstein, C. (2009). The implications of removing homosexuality from the DSM as a mental disorder. *Archives of Sexual Behavior, 38*(2), 161-163. doi:10.1007/s10508-008-9442-x

Schulz, S. L. (2018). The informed consent model of transgender care: An alternative to the diagnosis of gender dysphoria. *Journal of Humanistic Psychology, 58*(1), 72-92. doi:10.1177/0022167817745217

Zhou, J. N., Hofman, M. A., Gooren, L. J. G., & Swaab, D. F. (1995). A sex difference in the human brain and its relation to transsexuality. *Nature, 378*(6552), 68-70. doi:10.1038/378068a0

Wikipedia Image, a. Retrieved from: https://upload.wikimedia.org/wikipedia/commons/thumb/3/36/Sigmund_Freud%2C_by_Max_Halberstadt_%28cropped%29.jpg/1200px-Sigmund_Freud%2C_by_Max_Halberstadt_%28cropped%29.jpg

Wikipedia Image, b. Retrieved from https://upload.wikimedia.org/wikipedia/commons/thumb/e/e3/Arrested_Development.svg/2000px-Arrested_Development.svg.png