The Informed Consent Model of Transgender Care: An Alternative to the Diagnosis of Gender Dysphoria

Sarah L. Schulz

Abstract
Historically, researchers and clinicians have viewed the transgender experience through a narrow diagnostic lens and have neglected to acknowledge the diverse experiences of those who identify as transgender. Currently, under the mainstream treatment paradigm, in order to be deemed eligible for gender transition services, transgender clients must meet criteria for a diagnosis of “gender dysphoria” as described in the DSM-5. An alternative to the diagnostic model for transgender health is the Informed Consent Model, which allows for clients who are transgender to access hormone treatments and surgical interventions without undergoing mental health evaluation or referral from a mental health specialist. This model shows promise for the treatment and understanding of the transgender experience outside of the lens of medical pathologization.

Keywords
transgender, gender dysphoria, Standards of Care, Informed Consent Model

Transgender is an umbrella term used to describe many categories of people who challenge the idea that an individual’s assigned birth sex predicts what their gender identity will be. Some transgender individuals who desire to

1Point Park University, Pittsburgh, PA, USA

Corresponding Author:
Sarah L. Schulz, Department of Psychology, Point Park University, 201 Wood Street, Pittsburgh, PA 15222, USA.
Email: sschulz@pointpark.edu
alter their physical bodies undergo “transition,” which is generally a term used to describe the process that an individual moves through to have their physical body and/or legal status align with their gender identity. While some individuals wish to medically transition through the use of cross-gender hormones and/or surgeries, the transition process also entails exploring the physical, legal, psychological, and social implications of moving from one gender category to another. Gender transition is a lengthy, costly, and often nonlinear process, and the choices about when and how to transition are complex and highly individualized (Coleman et al., 2012). In order to access gender transition services, transgender individuals must often first meet the criteria for a diagnosis of “gender dysphoria” as outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013).

The use of this diagnosis to grant access to gender transition services has been widely criticized as being a “gatekeeping” model, where the locus of power lies with 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 (Bockting, Robinson, Benner, & Scheltema, 2010). This article will discuss the barriers of the diagnostic/gatekeeping model that currently requires using the DSM diagnosis of gender dysphoria to grant access to transition-related medical services, and will discuss an alternative to the diagnostic model, an emerging treatment paradigm known as the “Informed Consent Model.” Implications for mental health practitioners and areas for future research will be discussed.

WPATH Standards of Care

The World Professional Association of Transgender Health (WPATH) is an international organization that is devoted to the understanding and treatment of transgender individuals (http://www.wpath.org/). The mission of WPATH is to promote evidence-based care, education, research advocacy, public policy, and respect in transgender health. WPATH has also set forth the Standards of Care (Coleman et al., 2012) for the provision of health and mental health services related to gender transition. The Standards of Care are the international clinical guidelines that aim to articulate professional consensus about psychiatric, psychological, medical, and surgical management of transgender individuals, with the goal of providing “clinical guidance for health professionals to assist transsexual, transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with
their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment” (Coleman et al., 2012, p. 166). It is important to note that the WPATH Standards of Care (Coleman et al., 2012) are not treatment requirements, per se, but are recommendations for best practices for determining whether a person who feels they are transgender should have access to desired medical interventions related to gender transition.

According to the current Standards of Care (Coleman et al., 2012), it is the responsibility of a qualified mental health professional to be the “first contact” with a transgender person seeking medical intervention and to ascertain an individual’s eligibility and readiness for gender-related medical interventions such as hormones and surgeries. A qualified mental health professional may come from one of a number of disciplines, including psychology, psychiatry, social work, counseling, marriage and family therapy, or nursing. According to the Standards of Care, medical treatments can be initiated with a referral from a qualified mental health professional who is responsible for providing the client’s physician or surgeon with clinical documentation (often referred to as “the letter”), supporting the person’s history, eligibility, and readiness for hormones or surgery. The current recommendations for adults seeking hormone therapy are that the client must be at least 18 years old, must be able to make informed consent about the risks and benefits of hormone therapy, and should be referred by a mental health professional. For breast/chest surgery, one referral by a mental health professional is recommended. For lower/genital surgeries, two referrals by mental health professionals who have independently assessed the patient are recommended. If the first referral is from the patient’s psychotherapist, the second referral should be from a person who has independently evaluated the client. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be submitted.

Because members of the transgender community rely on mental health professionals to determine their access to gender-related medical procedures, they are faced with significant challenges when seeking health services related to gender transition. While the authors of the Standards of Care (Coleman et al., 2012) are careful to specify that mental health professionals should recognize that health decisions about hormones and/or surgery are first and foremost a client’s decision, the use of the DSM-5 (APA, 2013) is institutionalized into the current standards of care. Specifically, the standards recommend that mental health practitioners have competence in using the DSM for diagnostic purposes (Coleman et al., 2012). The role of the mental health practitioner is to assess for and diagnose transgender individuals with gender dysphoria, and to ensure that gender dysphoria is not better accounted
for by other diagnoses. According to the Standards of Care, the master’s level clinician should also have specialized training in the assessment of psychopathology, competence in psychotherapy, and continuing education in the treatment and diagnosis of gender dysphoria (Coleman et al., 2012). The mental health practitioner may determine eligibility for gender transition services based on whether the client meets criteria for the mental health diagnosis.

As mentioned above, the Standards of Care (Coleman et al., 2012) are not treatment requirements, but professional recommendations that are commonly used to guide treatment provision for people who are seeking gender-related medical services. The Standards of Care are currently endorsed by the American Medical Association (AMA), as evidenced by a resolution passed in support of the use of the standards to guide treatment for individuals with gender dysphoria (AMA, 2008). In addition to endorsement by the AMA, the American Psychological Association endorses the WPATH Standards of Care in the Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (American Psychological Association, 2015), particularly with regard to the role of the mental health practitioner in the gender transition process. The Standards of Care (Coleman et al., 2012) have not only been embraced by professional organizations and individual practitioners, but have also been institutionalized at the policy level by managed-care insurance companies and court systems, which both play a role in the financial and legal aspects of the gender transition process. For example, for individuals seeking legal name and/or gender marker changes, courts may require them to provide documentation of engagement in long-term psychotherapy and/or a psychiatric diagnosis of gender dysphoria (American Psychological Association, 2015). Furthermore, a number of major managed care insurance providers have written medical necessity criteria policies that require individuals to first seek psychotherapy and be diagnosed with gender dysphoria in order to meet criteria for coverage of medical services such as hormones and surgeries (Aetna Inc., 2015; Blue Cross/Blue Shield of North Carolina, 2014; United Health Care, 2015). These clients often must engage with a mental health practitioner in lengthy psychotherapy (up to 12-18 months in some cases) in order for the clinician to document the client’s ability to function in the desired gender role (referred to in previous versions of the WPATH Standards of Care as the “real life experience”). A growing number of states that cover transgender health services under state Medicaid plans have similar requirements rooted in the WPATH Standards of Care; for example, New York state requires that individuals have lived 12 months in their desired gender role and have received 12 months of psychotherapy prior to accessing medical interventions (New York State Department of Health, 2015). Clearly, the reliance on the DSM diagnosis of “gender dysphoria” has been considered
a key component of access to transgender health care among many individual mental health providers as well as managed care companies and professional organizations. In the section that follows, a brief overview of the diagnosis of gender dysphoria and the rationale for its continued use will be presented.

**Gender Dysphoria: A Contested Diagnosis**

Before the Informed Consent Model is introduced, a description and critique of the diagnostic model and its reliance on the *DSM* (APA, 2013) diagnosis of gender dysphoria as a condition of being granted access to transgender health services will be offered. This critique includes three major points of discussion. One, the cause of internal distress that people who are of transgender experience is not necessarily a result of individual pathology, as is suggested by the diagnostic criteria, but is a result of societal non-acceptance and discrimination toward the transgender community. Two, the diagnostic model roots the transgender experience in a narrative of distress, while reinforcing the binary system of gender, thus potentially creating conflict about the goals of mental health treatment between the therapist and the client and overshadowing the importance of authenticity in the therapeutic alliance. Finally, the psychotherapy requirements may result in a significant and unnecessary financial burden to transgender clients seeking care under the diagnostic model.

**Overview of the Gender Dysphoria Diagnosis**

The diagnosis of gender dysphoria (APA, 2013) formerly known as “gender identity disorder” (APA, 1980) was first introduced into the *DSM-III* in 1980. It was first established as two separate diagnoses: “transexualism” for adults and adolescents, and “gender identity disorder of childhood” for children with non-normative gender presentation (Zucker & Spitzer, 2005). The diagnosis was further revised for inclusion in the *DSM-IV* (APA, 1994) with the removal of “transsexualism” and a shift toward using “gender identity disorder” with different criteria subsets for children and adults. In the most recent and fifth edition of the DSM (APA, 2013), the name of the diagnosis was changed to “gender dysphoria,” which is the current diagnosis used to initiate treatment for transgender individuals who are seeking medical care related to gender transition. To meet criteria for the diagnosis, a person must have a marked incongruence between their experienced/expressed gender and their assigned gender, for at least 6 months of duration. This incongruence is evidenced by a strong desire to be rid of current secondary sex characteristics, a strong desire for sex characteristics of another gender, and a strong desire to
be treated as an alternative gender different from one’s assigned gender. The condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. The new version of the diagnosis of gender dysphoria also includes a post-transition signifier, which is used if a client has transitioned to their desired gender category through the use of hormones or gender confirming surgeries. While the APA (2013) explains that the addition of the posttransition specifier is “used in the context of continuing treatment procedures that serve to support the new gender assignment” (p. 453), it also serves to continue to label transgender individuals with a psychiatric diagnosis even though they may no longer experience distress or impairment once they have received gender transition services.

Because the diagnosis of gender dysphoria plays such a key role in the recommendation for hormonal and surgical interventions, one rationale for continued inclusion in the DSM is to ensure access to care for transgender individuals who are seeking medical treatment services, which may include counseling, cross-sex hormones, surgeries, and social/legal transition to desired gender category. Proponents of maintaining gender dysphoria as a mental health diagnosis assert that a diagnosis is necessary to guide treatment decisions and research protocols for transgender individuals, and to determine if an individual has satisfied the standard of care requirements necessary to be eligible for gender transition services (Lev, 2004). Furthermore, proponents for the diagnosis suggest that it is necessary when seeking reimbursement from insurance companies to have a diagnosis justifying the medical interventions. However, relying on a mental health diagnosis in order to grant access to medical services has been a subject of much controversy among practitioners, researchers, and transgender individuals themselves.

Internal Distress or Societal Discrimination?

The classification of gender variance as a mental disorder and the reliance on the diagnosis of gender dysphoria to grant transgender clients access to medical transition services serves as a barrier for individuals who are seeking to determine the terms of their embodied lives outside of the lens of medical and psychiatric pathologization. The diagnostic model undervalues the possibility that those who experience distress in important areas of functioning may do so not because of an underlying psychological impairment, but due to society’s response to nonnormative gender presentation (Lev, 2004). Indeed, many transgender individuals do experience distress, and overall there are heightened rates of suicidal ideation and attempts in the transgender population: according to the National Transgender Discrimination Survey (NTDS),
suicide attempt rates were as high 46% for transgender men and 42% for transgender women, with these numbers being elevated even further for transgender individuals who reported that they were rejected by family and friends or that a doctor or health care provider had refused to treat them (Herman, Haas, & Rodgers, 2014). It is also well documented that transgender individuals experience discrimination in all areas of social life: social services, employment, health, mental health care, housing, legal, and educational settings (Sausa, 2003). Transgender individuals also report living in extreme poverty, and experiencing alarming rates of verbal and physical harassment in education, employment, and housing sectors. In a national survey of over 6,000 transgender and gender nonconforming participants, 63% of participants reported a serious act of discrimination resulting in job loss, eviction, bullying, homelessness, incarceration, or physical/sexual assault due to transgender identity or expression (Grant et al., 2011). While an increasing number of state and local institutions are beginning to recognize the need for protection from discrimination for members of the transgender community, there is currently no federal law protecting individuals from discrimination on the basis of gender identity or expression. As a result, people who are transgender and gender nonconforming are routinely fired if transitioning while employed and face discrimination on the job market, resulting in a reliance on public assistance, where they are discriminated against in welfare offices, job sites, and welfare-to-work programs (Spade, 2006). Because it is clear that transgender individuals experience discrimination across many settings, there is an open question about whether the impairment in functioning they may experience is secondary to inherent clinically significant distress (as is suggested in the diagnosis of gender dysphoria), or social stigma and discrimination resulting from the expression of a nonnormative gender identity.

**Challenging the “Distress Narrative” and Problematizing the Binary**

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. Under this model, gender dysphoria can and should be alleviated through establishing congruence between sex, gender, and gender role. However, there is evidence to suggest that transgender identity is not necessarily itself a cause of distress, but instead is a valued life experience among transgender individuals who see being transgender as a way to live a
satisfying and meaningful life (Burdge, 2014; Riggle, Rostosky, McCants, & Pascale-Hague, 2011; Waszkiewicz, 2006). In one study, more than 70% of the sample reported feeling extremely or very positive about being transgender (Riggle et al., 2011). Some transgender individuals, even after changing their bodies through medical interventions such as hormones and surgeries, may embrace and celebrate their transgender identity, which reflects the capacity for ongoing identity development outside of and beyond the medical and psychiatric realms. For others, the desired outcome of undergoing transition is not necessarily to become a “different” gender, but is a more intentional process of building a self that can be visibly queer and acknowledged as such by others in the transgender and queer communities.

As a result of the reliance on the diagnostic criteria, those who do not report a distress component to their identities or experiences in therapy may be deemed as inappropriate to receive medical services by providers who are using the DSM model of gender dysphoria. Research indicates that the diagnostic/gatekeeping model is also often a barrier for transgender clients due to disparate definitions between clients and practitioners about the goals of treatment, and 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 (Waszkiewicz, 2006). This “mismatch” between one’s true self and the personal narrative that is often portrayed to others may exist in part because “social actors know what type of story they must tell to achieve their goals” (Loseke, 2007, p. 672), which is often the case with transgender individuals who are seeking health services. It is important to emphasize that although narratives of identity may change based on the setting or situation, transgender individuals must often perpetuate a personal narrative rooted in distress and body dysphoria, particularly in therapeutic settings where they are attempting to gain access to services. For some transgender individuals, however, a more authentic experience of identity is that one can still desire to change in the absence of self-hatred, and can still celebrate the self but simultaneously require access to services.

Just as 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. While some people do transition to and identify with the binary gender category that is the “opposite” of their assigned sex at birth (i.e., male or female), transgender identities do not always reflect mainstream gender options: There is a diverse experience of nonnormative gender and variance
across the community that is not reflected in the diagnostic model of gender dysphoria. Instead, many people use various other terms to describe their identities, indicating that “male” and “female” may be limiting options to choose from when describing the specificity of the transgender experience. For example, some gender diverse individuals identify as *genderqueer*, which could mean that they identify as both male and female, neither, or somewhere in between (Nestle, Howell, & Wilchins, 2002). The diversity of the transgender community highlights that there is a wide spectrum of gender identities, and that some individuals transcend the categories of male and female completely. Bockting (2008) asked transgender respondents (*n* = 1,229) how they describe their gender identities, and in addition to the binary identities of “male” and “female,” the diverse responses included nonbinary gender options such as bi-gender, gender neutral, 3rd gender, polygendered, and gender fluid. Notably absent from a number of respondents’ gender self-descriptions are the words “male” and “female,” suggesting that some members of the transgender community identify with gender categories outside of the binary categories of male and female. Based on these findings it has been suggested that the diagnostic model be replaced with an identity-based model (Bockting, 2009), in which gender variance is seen as a valued expression of human diversity, and those with transgender identities are acknowledged as potentially experiencing gender and sexuality differently than men and women who are *cisgender*, that is, differently than those who have a match between the gender they were assigned at birth and personal gender identity (Schilt & Westbrook, 2009).

The culturally rooted notion that gender is binary influences transgender identity development directly by sending a message for those in early stages of transition to feel that they need to choose between the two mainstream gender categories in order to medically transition. 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 (Califia, 1997; Cromwell, 1999). Likewise, because some therapists and medical professionals assume that there are only two binary gender options, they may inadvertently counsel transgender clients into a binary gender category, or they may only grant access to services based on their personal assumptions and understanding of what it means to “successfully” live as male or female. Also, there is a lack of understanding among mental health providers about the complexity of transgender identities and experiences, and the differences between gender identity and sexual orientation. For example, mental health professionals may assume
that transgender clients are only eligible for hormone or surgery recommendation letters if they have a heterosexual orientation, while transgender individuals may actually identify as gay or bisexual (Bockting, Brenner, & Coleman, 2009). In this situation, the client may be denied access to medical intervention because it has been deemed that they do not meet criteria in the view of the therapist or medical provider (Coleman & Bockting, 1988). Clients who are transgender are also often encouraged by mental health practitioners to not disclose a nonbinary identity in order to “justify” the need for transition (Green, 2004). As a result, many transgender individuals do not “come out” to their health providers as transgender, or will mask nonbinary identities to fit into mainstream gender categories in order to gain necessary health services. The notion that those who embrace mainstream cultural assumptions about masculinity and femininity may access medical services related to transition while those with 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.

The Diagnostic Model as a Financial Barrier

In addition to failing to capture the complexity of the transgender experience due to its emphasis on the distress narrative of transgender identity and reinforcement of the gender binary, the diagnostic model is also a barrier for transgender clients for financial reasons. Because, according to the Standards of Care (Coleman et al., 2012), mental health practitioners share legal and ethical responsibility with medical providers for referring/authorizing a client for health services, they may be reluctant to do so after just one meeting, often requiring lengthy engagement in psychotherapy. While the diagnostic model does not specify that clients must engage in long-term psychotherapy prior to receiving a diagnosis and referral for desired health services, many of the insurance companies do require 12+ months of psychotherapy. Furthermore, mental health practitioners who are tasked with not only diagnosing gender dysphoria but ensuring that a person is ready and eligible for gender transition may not feel comfortable granting access to health services outside of the context of a longer term therapeutic relationship. Therefore, the length of therapy may range from a few sessions to months in therapy, and this length depends largely on how long the mental health practitioner deems it necessary for the client to attend therapy, and not necessarily the clients’ therapeutic goals. 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. Furthermore, many health plans offer brief and emergency
crisis intervention only, or clients may be restricted in their choice of where and from whom they can receive care. If a transgender client lives in an area where a gender specialist is not available, they may not be eligible to begin the transition process or may not receive proper care.

Currently, there is no federal law requiring private or public health insurance providers to cover medical or mental health services related to transgender care, even with a diagnosis of gender dysphoria. As a result, particularly for those who lack health insurance coverage, paying for medical and mental health services is often not possible. Additionally, a lack of access to health insurance is a significant concern for members of the transgender community, with multiple studies indicating that up to 40% to 60% of transgender individuals have reported having no health insurance (Harawa & Bingham, 2009; Xavier, Bobbin, Singer, & Budd, 2005). Even when health insurance is available through employment, transgender individuals may be reluctant to use it due to fear of being “outed” to their employer as transgender (FTM Alliance, 2004). 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. Although they do urge managed care insurance companies to cover the medically necessary health treatments, the authors of the Standards of Care (Coleman et al., 2012) make no mention of how those with limited economic resources should go about negotiating through very complicated (and often, a very costly) mental health and medical systems.

In summary, the goal of the diagnostic model is to “treat” the transgender condition, whether through therapy or medical transition services. The result of this “treatment” is often erasure of transgender identity, because under this model, by establishing congruence between body and identity, transgender individuals should blend in with mainstream ideals of gender. Therefore, some transgender individuals seeking gender services not only embrace the diagnostic narrative of distress that is required to meet criteria for the diagnosis, but may also reflect a more pronounced masculine or feminine appearance congruent with their desired gender category in order to appease the therapist with the goal of encountering fewer barriers to accessing services than those with non-conventional gender expressions. With the burden being placed on the transgender client to “prove” their identity to the mental health practitioner, this often limits the opportunities for clients to truly explore the risks, benefits, side effects, and other potential consequences of gender-related medical treatments. As a result, the engagement with a mental health practitioner is viewed as a barrier when clients have to both educate the provider about being transgender while “proving” their identity and eligibility for medical services.
Informed Consent Model of Care

Despite the barriers it creates, the diagnostic model of gender variance is the dominant lens through which transgender identity is viewed in psychiatric and psychological discourses today, and as a result, many mental health and health care providers assume that gender variance is a mental health disorder which is rooted in inherent psychopathology (Bilodeau & Renn, 2005). As a result of these barriers to receiving care under the mainstream diagnostic model, an emerging treatment paradigm has been used in which transgender clients can access desired health interventions such as hormone treatments and surgeries without undergoing a mental health intervention or referral from a mental health specialist. This alternative approach to transgender health care is the “Informed Consent Model” of transgender care (Informed Consent for Access to Trans Health, n.d.). This approach to transgender health care (a) promotes a departure from the use of the diagnosis of gender dysphoria as a prerequisite for accessing transition services and (b) attempts to impact the way that transgender individuals experience and access health care by removing the psychotherapy/gatekeeping requirement. Instead of a mental health practitioner assessing eligibility for and granting access to services, transgender patients themselves are able to decide on whether they are ready to access transition-related health services. In this model, the role of the health practitioner is to provide transgender patients with information about risks, side effects, benefits, and possible consequences of undergoing gender confirming care, and to obtain informed consent from the patient. The Informed Consent Model was developed as an alternative to the mainstream diagnostic model, in response to a growing number of transgender patients and practitioners who view the role of the mental health gatekeeper as a barrier to receiving health care. In this model, therapy is considered an option, but not a requirement or prerequisite for access to hormones and surgical interventions.

According to the Informed Consent Model, an individual who is transgender should not have to prove distress about identity in order to gain access to desired health services; instead, they have to “possess the cognitive ability to make an informed decision about health care,” including voicing an understanding of the risks, benefits, and information needed to make an informed decision about moving forward with medical services related to transition (Informed Consent for Access to Trans Health, n.d.). In the Informed Consent Model, a transgender client must attend one appointment with a counselor or medical provider to discuss the social, financial, occupational, and familial aspects and consequences of receiving medical transition services. Access to services is granted based primarily on the ability to consent to care, not whether or not the clients meets the criteria for psychiatric diagnosis.
The Informed Consent Model approach to transgender health care can be essential to the process of affirming transgender identity development outside of the lens of psychiatric labeling and pathologization. While it has been embraced by a growing number of health clinics and individual practitioners serving the transgender community, because it is so new, there is limited research highlighting transgender clients’ experiences in receiving care under this model. However, there have been a small number of studies done focusing specifically on the Informed Consent Model of care, which explore the outcomes for clients who receive transgender health services without an in-depth mental health evaluation or referral from a mental health clinician. For example, Deutsch (2011) conducted a study surveying characteristics of clinics using the Informed Consent Model to assess the legal risks of providing care under this model and to ascertain whether there were cases of regret among clients who receive care under this model. The sample included 12 unique sites/health clinics, of which only four required contact with a mental health provider prior to initiating hormone treatments. The results indicate that of 1,944 clients treated, only 17 cases of “regret” were reported, and no cases of medical malpractice claims were reported. Only 33% of sites surveyed reported any mental health involvement at all, indicating that the basic medical needs of transgender patients in some settings are being met without the diagnosis, assessment, or engagement with a mental health practitioner (Deutsch, 2011). Another recently published report provides an in-depth case study of Fenway Health, a community health center in Boston, Massachusetts, which is known for providing health services to the transgender community under the Informed Consent Model (Reisner et al., 2015). Beginning in 2007, the clinic was a pioneer in providing care to transgender individuals without requiring the involvement of a mental health professional, and removed barriers to receiving care such as mental health evaluations and requirements for psychiatric diagnosis. Between 2007, when the Informed Consent Model was implemented, and the time of the data analysis in 2013, the number of active clients increased from less than 200 to over 1,000 (Reisner et al., 2015). The widespread acceptance of this model by practitioners and clients alike signifies a shift away from viewing transgender identity as a disorder to a model of gender diversity.

**Informed Consent Model and Collaborative Decision Making**

While this model has primarily been used in health clinics, it is important to consider that individual providers may also practice under the Informed Consent Model of care. The provider’s response to the disclosure of transgender identity is important in defining whether the interaction is affirming or pathologizing to one’s identity (Eliason & Hughes, 2004). It has been shown
that decision making in health settings that is collaborative instead of authoritarian is better in terms of the health outcomes of the patient (Drake, Deegan, & Rapp, 2010; Drotar, Crawford, & Bonner, 2010; Lown, Hanson, & Clark, 2009; Politi & Street, 2011; Westberg & Jason, 1993). In the diagnostic model, clients are treated as passive recipients of care, and the practitioner is in the role of determining the client’s eligibility for further care. In clinical practice with transgender clients, this often manifests itself with providers telling patients how to transition or whether they are “eligible” for health services based on a client’s appearance or gender presentation. In the Informed Consent Model of care, clients and practitioners are viewed as partners: the practitioner is viewed as having unique skills and clinical knowledge, while the patient is viewed as having knowledge of their own beliefs, personal value systems, and individual conception of self with regard to transgender identity. Because the transgender experience is so diverse, it would be unrealistic for medical and mental health practitioners to understand a client’s individual conceptualization of their own gendered experience based on a narrow psychiatric diagnostic category rooted in a narrative of distress. In order for a patient to communicate their health needs clearly and honestly, there is a need for trust based on the expectation that practitioners will assist clients to make decisions that clients deem to be in their best interest (Katz, 2002). One challenge to this approach is that both practitioners and clients “bring their vulnerabilities to the decision-making process . . . and are authors and victims of their conflicting motivations, interests, and expectations” (Katz, 2002). Transgender clients, especially those seeking services for gender transition, do not have a choice but to bring their vulnerabilities to the “exam table.” However, they also bring motivations, interests, expectations based on past experiences, and wider-spread community narratives about how people who are transgender are treated in the health care system.

The importance of interactions between transgender patients and providers and the impact these interactions have on identity development should not be minimized. However, this dynamic is often overlooked when viewing the provider/patient relationship through the lens of the diagnostic model, which focuses on “treating the disorder” and deemphasizes the importance of the therapeutic relationship. The Informed Consent Model of transgender care takes a different approach, and may be considered a Relationship-Centered Model of Health Care (Apker, 2012).

Relationship-Centered Care is a clinical philosophy that stresses partnership, careful attention to the relational process, shared decision making between patient and provider, and self-awareness (Suchman, 2006). In this model, the emphasis is on the ways that health care provision and healing occur in the context of a relationship which includes the personhood of both
providers and transgender clients, who bring a unique set of values and perspectives to the therapeutic relationship. Relationship-Centered Care has shown to increase adherence to clinical advice and improvement in functional status, and an increase in patients’ involvement in their own care (Beach & Inui, 2006; Dimatteo, Sherbourne, & Hays, 1993). This model shows promise and compatibility with identity affirming transgender health care provision, particularly with regard to the need for a paradigm shift from the gatekeeping model to the Informed Consent Model.

**Role of the Mental Health Practitioner**

Despite the emphasis on the *DSM* and gender dysphoria diagnosis (APA, 2013) throughout the Standards of Care, the WPATH authors (Coleman et al., 2012) do in fact acknowledge the Informed Consent Model as an emerging protocol for treatment with hormone therapy for transgender clients. The Standards of Care state that the Informed Consent Model is compatible with the standards, as long as the provider obtaining informed consent ensures the client’s understanding of physical, psychological, and psychosocial risks and benefits of hormone therapy. The Standards of Care authors also emphasize that while the Informed Consent Model emphasizes consent and harm reduction, some clients may still require comprehensive mental health assessment and psychotherapy when indicated (Coleman et al., 2012).

Under the Informed Consent Model of care, transgender individuals may be encouraged, but not required, to seek services from a qualified mental health practitioner, although the role would not be to “diagnose” and “treat” gender dysphoria, but instead to support and affirm transgender identity. With the gatekeeping component being lifted, the mental health professional can be instrumental in helping a transgender client come out to family and friends, confronting internalized transphobia, finding a comfortable expression of gender, discussing gender identity versus sexual orientation, and exploring the goals and outcomes of medical interventions. Mental health professionals may be in a unique position to provide support and education, and to ensure informed consent while maximizing a client’s self-determination. There is a significant correlation between transgender client satisfaction and clients’ perceptions of their therapist’s expertise in transgender mental health (Rachlin, 2002). That is, the more knowledgeable and sensitive the mental health practitioner is to transgender health concerns, the more able and willing to engage in the therapeutic relationship a client is likely to be, thus resulting in a more effective therapeutic alliance. Overall, the involvement of a mental health practitioner in a “gatekeeping role” has been criticized because it has served as a barrier to accessing necessary services for
gender-diverse individuals, but with the proper training regarding gender diversity, mental health clinicians may serve as a much-needed support system for transgender individuals who are undergoing a significant life transition.

**Limitations and Future Directions**

More research is needed to understand the lived experience of clients receiving care under the Informed Consent Model, and to explore the practical challenges with the delivery of care under the Informed Consent Model in the context of the American health insurance system. It remains to be seen how individual providers might practice informed consent without the use of the diagnosis of gender dysphoria, particularly if the diagnosis is required by a client’s insurance company in order to gain reimbursement for gender transition services. Under the current managed care system, even plans that do not require a specific diagnosis of *gender dysphoria* still require some diagnostic code from the International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10; World Health Organization, 1992) or the *DSM-5* (APA, 2013) to justify the need for access to medical interventions. One transgender health advocacy group (Project Health, 2012) suggests that in place of “gender dysphoria,” the medical community could use diagnostic codes specific to the procedure or intervention that is being carried out. For example, instead of billing for gender dysphoria, a medical provider may use the ICD-10 diagnostic code for “unspecified endocrine disorder” (259.9) to justify the need for hormone treatments. It has also been suggested that “unspecified adjustment reaction” (309.9) could be used for billing purposes in place of gender dysphoria, although the evidence for successfully obtaining coverage for medical interventions using this approach is unclear.

Furthermore, in addition to practical concerns, the *DSM* diagnostic model of gender dysphoria (APA, 2013) is institutionalized into medical, psychology, counseling, and social work training programs. Despite the need for trans-affirming providers, current training programs lack formal, specialized training to work with transgender individuals, particularly outside of the diagnostic realm. With proper training, mental health practitioners are in a unique position to assist these clients in navigating through a very challenging health care system. Practitioners can use a holistic and strengths-based approach to working with transgender clients, and instead of focusing on treating the “disorder,” exploring the individual strengths and challenges in a way that is affirming of non-normative gender expressions and identities. The existing research lends preliminary support for the Informed Consent Model of transgender health care provision, but more research is needed to
explore the benefits and outcomes for patients receiving care using this approach.

**Conclusion**

Instead of viewing transgender identity as an individual, disordered experience of identity, it is important to acknowledge the social and cultural factors that influence transgender identity development outside of the lens of medical pathologization. To this end, a shift in the clinical approach to transgender care is necessary in order to remove the distress narrative from the center of the transgender experience, and allow for a more nuanced understanding of gender variance than what the diagnostic model offers. The Informed Consent Model of transgender care shows promise in not only alleviating barriers to accessing treatment, but also for allowing a narrative of transgender experience to emerge outside of the distress narrative that is at the core of the diagnostic model. Not only might this contribute to the depathologization of gender variance in the psychological and medical fields, but it may also help us shift toward a larger culture of equal rights and protection for individuals with nonnormative gender identities and expressions.

**Declaration of Conflicting Interests**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Funding**

The author(s) received no financial support for the research, authorship, and/or publication of this article.

**References**


Zucker, K. J., & Spitzer, R. L. (2005). Was the gender identity disorder of childhood diagnosis introduced into DSM-III as a backdoor maneuver to replace

**Author Biography**

**Sarah L. Schulz**, PhD, LSW is a licensed social worker and an assistant professor in the department of psychology at Point Park University, where she also serves as the director of the MA program in Clinical-Community Psychology. She earned her doctorate in Social Welfare with a specialization in mental health and gender studies from the University of California, Berkeley, in 2012. Since joining the Point Park faculty in 2013, her research interests have focused on the health and mental health needs of the LGBTQ community.