An Old Card in a New Game

Introduction

The diagnosis was never for the patient; it was for the society that needed one.

For twenty years after the Second World War, the psychiatric case against gay and trans people rested on an assumption so settled that it hardly needed arguing: if you would not reproduce the middle-class way, something in you must be broken. American psychiatry's diagnostic manual listed homosexuality as a *'sociopathic personality disturbance'* in 1952 and as a *'sexual deviation'* thereafter (American Psychiatric Association, 1952; 1968). Transvestism and, later, the wish to change sex were filed in the same drawer; drawers, once labelled, are hard to rename.

The clinicians of the 1950s believed they were being scientific. They were, in the main, being circular. Patients came to them in distress (because the law, the church and the family had all declared them unwell); the distress was recorded as evidence of illness; the illness explained the distress. Freud himself had escaped the trap. Replying in 1935 to an American mother who wanted her son 'cured' of homosexuality, he wrote, "*Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness; we consider it to be a variation of the sexual function*" (Freud, 1935). Freud still held the developmental theory to be regrettable. He refused the moral theory. His successors took the theory and dropped the mercy, which is the worst of all possible outcomes.

Post-war psychiatry believed gay and trans people were psychologically ill for three converging reasons. First, the era's dominant theory of mind was psychoanalytic, and psychoanalysis could explain anything: a healthy outcome was defined as heterosexual marriage, so everything else was defined as a failure to reach it. Second, the psychiatrists studied clinical populations: the people who arrived at clinics, in handcuffs or in tears, were the only homosexuals and transvestites many of them ever saw, and the sample told them what they already believed. Third, biology and arithmetic seemed to agree with them: if evolution builds bodies for reproduction, then any orientation or identity that departs from it looks, on the face of it, like an error. Add the post-war mania for normality (the house, the spouse, the 2.4 children) and the medical verdict wrote itself.

But here is the thing about card games. The psychiatric profession held a card, and played it, and won hand after hand. What nobody did for a long time was ask whether the card was in the deck at all. Or whether the game wqs being played fairly.

Development

The asking began, as it so often does, with one stubborn piece of research. Evelyn Hooker, an experimental psychologist at UCLA, tested thirty homosexual men and thirty heterosexual men who were matched for age and IQ, with both groups drawn from the ordinary (non-clinical, non-prison) population. She then asked three experts, none of whom knew whose results were whose, to identify the homosexuals from their Rorschach and other projective test scores. They could not do it better than chance (Hooker, 1957). The finding was a bomb under the circularity: whatever homosexuality was, it was not detectable madness in ordinary men. Ford and Beach's cross-cultural survey of sexual behaviour, published four years earlier, had already shown enormous variation in accepted homosexuality across human societies and even across other primates (Ford and Beach, 1951). If

homosexuality were a disease, it was a remarkably successful one, and a remarkably familiar guest in other cultures or species.

The professional argument then moved from evidence to evidence's twin sister: ethics. Activists, most visibly after the Stonewall riots of 1969, demanded that the 'illness' label answer to the growing body of data, and it could not. In December 1973 the Board of Trustees of the American Psychiatric Association voted to delete 'homosexuality' as a diagnostic category, substituting instead a category (later named ego-dystonic homosexuality) for people distressed by their own orientation; that residual label was itself deleted by DSM-III-R in 1987 (American Psychiatric Association, 1987; Wakefield, 2024). The membership confirmed the Trustees' decision by referendum in 1974. It was, in one respect, a political act; in another respect, it merely allowed the diagnosis to catch up with the extant evidence. The World Health Assembly followed in 1990, striking homosexuality out of the ICD on 17 May, a date now marked worldwide as the International Day Against Homophobia, Transphobia and Biphobia (World Health Organization, 2019).

The evidence for gay 'sanity' is now, so to speak, the settled law. The American Psychological Association has affirmed repeatedly that homosexuality is a **normal** variant of human sexuality, not a disorder; epidemiological work shows that the elevated rates of depression, anxiety and suicide among lesbians, gay men and bisexuals are strongly and specifically predicted by stigma, victimisation and concealment (the pattern Ilan Meyer named **minority stress**) rather than by anything intrinsic to sexual orientation itself (Meyer, 2003). A distressed population, produced by a hostile society, was for decades mistaken for a disordered one. The mistake is now a classic case study of how medicine can launder a prejudice by wearing a white coat.

Transgender people had to run the same race on a stiffer handicap, because a body that does not match the identity invites a different kind of scepticism: not that you are sick, exactly, but that you are mistaken; that your testimony is a symptom rather than a report.

The profession's answer came in two instalments. First, the American Psychiatric Association's DSM-5 (2013) quietly redefined the clinical problem: it is not the identity that is disordered, it is the dysphoria, the distress at the mismatch, that brings somebody to seek care (American Psychiatric Association, 2013). A person who arrives at a clinic for joint pain is not 'disordered' for having joints. Second, the World Health Organization went further in ICD-11: gender incongruence was removed from the mental disorders chapter entirely and refiled under 'sexual health conditions' (Robles et al., 2016; World Health Organization, 2019). The logic is identical to the 1973 move: the identity is a fact about the person; only **unmanaged incongruence** is a clinical matter.

Now to the question that decides the whole debate. Is there strong and solid evidence that transgender people are sane? In the strict sense of the word (sound minds, accurate perception of reality, no disordered thought), the evidence is unusually direct, because it is intervention-based. The strongest tests of a 'delusional' hypothesis are follow-up studies: if gender identity were a hallucination or a fixed delusional belief, then affirming it should make people worse (delusions and hallucinations do not improve when you agree with them).

But the opposite happens. de Vries and colleagues followed transgender adolescents through pubertal suppression, cross-sex hormones and surgery, and found psychological functioning indistinguishable from (in some respects better than) age-matched controls (de Vries et al., 2014). Telfer and colleagues found that adolescent girls given stage-appropriate gender-affirming treatment showed rapid, clinically significant reduction in dysphoria and psychological distress (Telfer et al., 2018). In the United States, Chen and colleagues reported significantly improved appearance congruence and psychosocial functioning after two years of hormones (Chen et al., 2023); Tordoff and colleagues, in a Seattle cohort, measured sixty per cent lower odds of depression and seventy-three per cent lower odds of suicidality among young people receiving gender-affirming care (Tordoff et al., 2023).

The ‘delusional’ trope fails on the definition before it fails on the data. Psychiatry’s own definition of a delusion is a fixed, false, idiosyncratic belief held against the evidence. Gender identity is not a belief about the world in that sense at all; it is a **report about oneself**. You can dispute a report about oneself, but you dispute it in the register of self-knowledge, not in the register of psychosis, and no diagnostic manual treats it as the latter. (There exists a rare, distinct phenomenon of delusional gender dysphoria occurring inside psychotic illnesses; it is vanishingly uncommon and is precisely not what the discourse of ‘delulu’ is pointing at.)

So why does the trope persist for trans people when, for gay people, it has effectively retired? Three differences stand out.

1. Transgender people are far **rarer** than gay people, so contact is rarer;
2. The meta-analytic literature is unambiguous that personal contact with a group is the most reliable known reducer of prejudice towards it (Pettigrew and Tropp, 2006). **The internet then supplies the missing ‘contact’ in a poisoned form**: people who have never met a trans person encounter a caricature of one daily, in algorithmic dosage.
3. And the trope is **politically useful**; a ‘lunatic’ needs no rights, only a diagnosis, and the old card is convenient to redeploy.

Conclusion

What, then, actually changes the minds of the ill-informed?

The evidence from the psychology of persuasion is more encouraging than the state of social media suggests.

First: conversation, not conversion. The most carefully controlled study of the last decade (a large door-to-door field experiment, run after an earlier version of it was exposed as fraudulent and then independently replicated) found that a single, roughly ten-minute, non-confrontational conversation in which a trans person spoke about their own experience and the listener was invited to take their perspective durably reduced transphobia for at least three months (Broockman and Kalla, 2016). Nobody was lectured; nobody was shamed.

Second: contact. Where ill-informed people actually know a gay or trans person, their attitudes reliably soften; the effect is one of the best-established findings in social psychology (Pettigrew and Tropp, 2006). This puts a weight of persuasion, unfairly, on the people with the least armour, which is why clinical and educational institutions (whose statements are trusted more than social media’s) need to keep stating the medical consensus plainly.

Third: patience allied to documentation. The psychiatric profession did not change in 1973 because the public suddenly became kind; it changed because a generation of careful studies made the old position empirically untenable, and the institution eventually had to choose between its card and its credibility.

The lesson of the game is not that the psychiatric profession was wicked. The psychiatrists of the 1950s were, for the most part, ordinary doctors reasoning badly with categories that no one had audited. That is the frightening part: **respectable institutions do not need villains to sustain an injustice, only an unaudited deck.**

Coda

I have a personal interest in all of this, as regular readers will know. I was born in 1956, in an England where a diagnosis like the ones described above waited for people exactly like me. I am seventy now, and the card has been re-dealt online by people who were not born when it was first played. They will

inevitably lose, and the delay is the only part worth mourning. The science is on the table; the conversations, one doorstep, one workplace, one family at a time, are the game now. It matters, as ever, only that we keep showing up to play.

Credits: by Bea Groves-McDaniel, with the ever-valued help of Sal and Faye Research Assistant and Amanuensis: FAYE-9000 Date: 21st November 2026

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