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A Precarious Policy: Executive Order 14,004 Involving U.S. Trans Military Service

Robin M. Mathy*, & Naaz Mirreghabie
School of Social Work, Tulane University, United States.

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***Corresponding Author:** Robin M. Mathy, School of Social Work, Tulane University, United States.
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Abstract

This paper addresses the history and status of policies regarding transgender people serving in the United States (U.S.) Armed Forces. We review transgender miliary policy and transitions across various administrations and their association with inclusion or exclusion of sexual and gender minorities the U.S. Armed Forces. We explore the available policy solutions and the political influences that favor action [1]. We underscore the precarious nature of the current policy, President Biden's Executive Order 14,004, permitting transgender people to serve openly in the U.S. military. We contrast this with the changing political context in which two identically worded bills are under consideration in the Armed Services Committees of the U.S. House of Representatives and U.S. Senate that are proposing bans on transgender people serving in the U.S. military. We review psychiatry's complicity in the military bans and the institutionalization of exclusion. We address problems with clinicians conflating transgender issues with the American Psychiatric Association's diagnosis of gender dysphoria. We also discuss the beneficial aspects of the U.S. military's inclusion of transgender people and how their exclusion may affect military readiness.

Keywords: Transgender, Military, Policy, Gender Dysphoria, Mental Health

Introduction

Executive Order No. 14,004 [2], titled "Enabling All Qualified Americans to Serve Their Country in Uniform," was issued by President Joseph R. Biden, Jr., on January 25, [3]. The stated intent of this policy is "to ensure that all transgender individuals who wish to serve in the United States military and can meet the appropriate standards shall be able to do so openly and free from discrimination" (para. 6). Section 2 of Executive Order No. 14,004 revoked President Trump's Memorandum of March 23, 2018, titled "Military Service by Transgender Individuals," and directed that his Presidential Memorandum of August 25, 2017, with the same title, remain revoked. The 2017 and 2018 memoranda issued by President Trump [4, 5] banned nearly all trans people from ascension or retention in the U.S. Armed Forces.

Executive Order No. 14,004 [2] is vulnerable to attempts at revocation. This policy brief addresses this vulnerability by outlining its inadequacy and the need to codify it into law. First, as explained by the Congressional Research Service (2021, para. 5):

> A President may amend, rescind, or revoke a prior executive order issued by his or an earlier Administration. Although executive orders can be flexible and powerful, they can also be impermanent because a later President can, generally, revoke or modify any previously issued executive order with which he disagrees.

Since President-elect Trump has banned trans military service in his past Administration through Memorandum 2018, he may rescind Executive Order 14,004 and reinstate the provisions of his previous ban. This would ban trans people from serving in the U.S. Armed Forces. Notably, policies regarding trans people serving in the U.S. military are, at best, capricious. Former President Trump's Memoranda [4, 5] on military service by trans individuals reversed the policy established in President Obama's Administration as expressed by Secretary of Defense Ash Carter, who announced on June 30, 2016, that trans military personnel "can no longer be discharged or otherwise separated just for being transgender" [6].

The Current Political Landscape

Executive Order 14,004 is in a precariously impermanent position. The certainty that President-elect Trump will again ban trans military personnel from serving in the U.S. Armed Forces is supported by a statement made by his former Acting Secretary of Defense Christopher Miller [7]. Miller writes in Chapter 4 (Department of Defense) of *Mandate for Leadership: The Conservative Promise* [8] that the Trump Administration will "Reverse policies that allow transgender individuals to serve in the military. Gender dysphoria is incompatible with the demands of military service, and the use of public monies for transgender surgeries or to facilitate abortion for service members should be ended" (p. 104). The *Mandate for Leadership* is a blueprint by the conservative Heritage Foundation and other right-leaning groups to quickly implement former President Trump's vision of government and eliminate the "deep state" after he regains the Presidency [9]. As Bickerton wrote, "Proposals include reintroducing legislation making it easier to fire federal workers; prosecution for distributing abortion pills by mail; and *abolishing recently established diversity, equity and inclusion initiatives at the Department of Defense*" (para. 2, italics added).

In essence, Executive Order 14,004 is a relatively fragile bureaucratic tool that does not provide sufficient stability to ensure that trans military personnel can serve openly in the U.S. Armed Forces. The application of Executive Order 14,004 as a temporary tool is an injustice to trans people relative to lesbian, gay, and bisexual service members who have been able to serve openly since the Don't Ask, Don't Tell Repeal Act took effect as Public Law 111-321 on December 22, 2010. The fickleness of policies regarding trans individuals serving openly in the U.S. military compromises the ability to recruit members of this community, which could help counter the recruiting shortage of over 40,000 people experienced by the U.S. Armed Forces [10]. Historically, trans individuals have served in the U.S. military at double to triple the rate of the general population [11]. Military service allows members of this marginalized community to escape disproportionately high unemployment [12-14] and poverty [15].

Current Legislative Landscape

Republicans are already threatening President Biden's Executive Order 14,004. Senator Marco Rubio (R-FL) introduced the Ensuring Military Readiness Act of 2023 as S.435 on February 15, 2023, with four co-sponsors. It was referred to the Senate Committee on Armed Services. Two days later, Representative Jim Banks (R-IN-3) introduced the Ensuring Military Readiness Act of 2023 to the House of Representatives as H.R. 1064, with no co-sponsors. It was then reassigned as H.R. 1112, with three co-sponsors and language identical to S. 435, to the House Committee on Armed Services on February 21, 2023. The proposed legislation would require the Department of Defense (DOD) to implement regulations that disqualify trans individuals from serving in the U.S. military if they "identify as transgender with a history or diagnosis of gender dysphoria".

There are two exceptions within the proposed legislation, including trans individuals who were (a) "stable for 36 consecutive months in their biological sex prior to accession" or (b) "diagnosed with gender dysphoria after entering into service if they do not undergo transition procedures and remain deployable within applicable retention standards for their biological sex." Moreover, S. 435 and H.R. 1112 expressed intolerance for any gender presentation incongruent with "biological sex," even requiring trans personnel who had changed their gender marker in the Defense Enrollment Eligibility Reporting System (DEERS) to serve in their "biological sex." The proposed legislation would permit trans individuals to "receive medically necessary treatment for gender dysphoria," provided it excludes any gender-affirming medical procedures.

It important to distinguish between trans individuals and people diagnosed with gender dysphoria. The term 'transgender' or 'trans' refers to individuals whose gender identity is incongruent with the sex they were assigned at birth. In contrast, gender dysphoria is a medical condition characterized by "clinically significant distress or impairment in social, occupational, or other important areas of functioning" related to the "marked incongruence between one's experienced/expressed gender and assigned gender" [16]. Not all trans individuals experience gender dysphoria, and identifying as transgender does not inherently mean an individual has gender dysphoria.

A little over a month after Representative Jim Banks (R-IN-3) introduced the Ensuring Military Readiness Act of 2023 to the House of Representatives, on March 27, 2023, Representative Sara Jacobs (D-CA-51) introduced the Ensuring Military Readiness Not Discrimination Act, with 33 Democratic co-sponsors. The bill would amend Chapter 37 of Title 10 of the United States Code by inserting Section 651a ("Members: prohibition of gender discrimination) immediately after Section 651. The new section (651a) reads:

> Any qualifications established or applied for eligibility for service in an Armed Forces shall take into account only the ability of an individual to meet occupational standards for military service generally and the military occupational specialty concerned in particular, and may not include any criteria relating to the race, color, national origin, religion, or sex (including gender identity, sexual orientation, or sex characteristics (including intersex traits) of an individual.

The conditions for passing a bill banning trans service members are present. The Ensuring Military Readiness Act of 2023 has been introduced into both the House (H.R. 1112) and Senate (S. 435), and they have been assigned to the Committee on Armed Services in their respective chambers of Congress. Moreover, H.R. 1112 and S. 435 have identical language. If both chambers of Congress pass their respective bills, there will be no need to form a committee to negotiate a compromise bill. It will not need the additional step of sending a consensus version to both chambers for a majority vote in their respective chambers before being sent to the President to be signed into law. In essence, the perfect conditions include a majority Republican presence in the House of Representatives and the Senate, a Republican President-elect, and a U.S. Supreme Court with a 9-3 conservative majority. The Ensuring Military Readiness Act of 2023 (hereafter EMRA) is primed to become law very quickly. It is unclear whether the votes in favor of passing the EMRA would have enough votes to survive a Democratic filibuster in the U.S. Senate.

The text of EMRA requires the Department of Defense (hereafter DoD) to prescribe regulations that disqualify "individuals who identify as transgender with a diagnosis of gender dysphoria" from military service, which the bill defines "as a marked incongruence between one's experienced or expressed gender and biological sex" (para. 2). Note that this definition is only the first criteria for gender dysphoria. Any two of the six criteria lasting at least six months are needed to meet the American Psychiatric Association's [16] parameters for the diagnosis specified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) [16]. In addition, the DSM-5-TR [16] requires two or more criteria to be "associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning" as noted above [16]. Mathematically, 10 potential combinations of diagnostic criteria would meet the parameters for gender dysphoria without one of them including the first criterion indicated above.

Moreover, no combination of indices would fulfill APA [16] requirements for gender dysphoria in the absence of clinically significant distress or impairment. In essence, EMRA would apply to only a small number of individuals who identify as trans, a topic to which we will return below. Regardless, related to the discussion above, EMRA requires exceptions for individuals who have been "stable for 36 consecutive months in their biological sex prior to accession, or diagnosed with gender dysphoria after entering into service if they do not undergo transition procedures and remain deployable with applicable retention standards for their biological sex" (para. 4). Trans individuals who have transitioned or intend to do so are also disqualified from military service. In contrast, they may serve in the Armed Forces in their "biological sex" if not previously diagnosed with gender dysphoria. EMRA includes "medically necessary treatment for gender dysphoria," provided it does "not include gender transition procedures" (para. 4). This effectively limits treatment to counseling or psychotherapy.

Residual Effects of Inaction with Don't Ask, Don't Tell

The precarious position of trans people serving in the U.S. military is partially attributable to their exclusion from the Don't Ask, Don't Tell Repeal Act of 2010 (hereafter "Repeal Act"), which was introduced into the 111th Congress on June 19, 2009, and enacted as Public Law 111-321 about a year and a half later on December 22, 2010 [17]. However, Frank (2013) observes that the real story of the repeal of Don't Ask, Don't Tell [17] antedated the 2008 election of President Barack Obama. Indeed, he notes that "the long-term

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strategic information campaign began at the moment DADT was born" (p. 161). Summers [18] observed that the struggle to repeal DADT began with its enactment when political activist and author David Mixner broke with President Clinton because he had failed to fulfill his commitment to end the universal prohibition on lesbian, gay, bisexual, and trans people serving in the U.S. military.

A key issue concerning trans individuals serving in the U.S. military has been that they would adversely affect military readiness. President Trump's Memorandum [4] on military service by trans individuals expressed concerns about an insufficient "basis to conclude that terminating the Departments' [Department of Defense] longstanding policy and practice would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources, and there remain meaningful concerns that further study is needed to ensure that continued implementation of last year's policy change would not have those negative effects" (2017, para. 2). When Congress was debating DADT Repeal, homosexuality was no longer classified as a mental illness, obviating any concerns that lesbian, gay, or bisexual service members had a disqualifying mental illness, a significant reason for their exclusion in the past [19].

Psychiatry's Complicity in the Military Bans

The American Psychiatric Association (APA) has formally recognized what is now known as gender dysphoria as a psychopathology since its predecessor diagnosis, transsexualism, was added to the *Diagnostic and Statistical Manual of Mental Disorders* in 1980 [20]. Notably, President Trump rebuked President Obama's authorization of funding for "sex reassignment surgical procedures" in his 2017 Memorandum, and his Memorandum [5] of the same name referenced "transgender persons with a history or diagnosis of gender dysphoria." Extrapolating from Kunzel [19], the relatively recent bans [4, 5] on trans individuals from military service due to psychopathology run parallel to those applied to sexual minorities in the past. Yet the pathologization of gender dysphoria remains a potential barrier to military service.

It is worth reviewing the trajectories of prior policies related to pathologizing homosexuality and gender dysphoria. Psychiatry, steeped at the time in psychoanalysis, became a dominant force in many areas of society, including the U.S. government and the military, as well as the criminal justice system. As noted elsewhere [19], Sullivan advocated for including homosexuality as a disqualifying condition when he developed methods of rapidly screening inductees to military service as the U.S. Armed Forces geared up for fighting in World War II. Psychiatrists also led a transformation in military policy, resulting in members of the U.S. Armed Forces being discharged for homosexuality. Notably, "From 1941 to 1945, nearly ten thousand sailors and soldiers, most, though not all, of whom were men, were hospitalized for homosexuality in psychiatric wards and discharged as 'mentally unfit' for service" [19].

Kunzel [19] notes that after World War II, the U.S. Government idealized heterosexuality and pursued homosexual individuals as a security threat. Psychoanalysts transitioned from serving as analysts and social critics to becoming outspoken advocates of American values, identities, and institutions. This was reflected in "Their diagnosis of homosexuality as mental illness, both drawing on and contributing to a more general American heteronormative project, assisted in their assimilation and acceptance" [19]. By continuing to include gender dysphoria in the DSM, the APA perpetuates a cisnormative framework that fails to respond to health inequities experienced by trans people [21]. As Drescher [22] explained, "The APA's decision to retain DSM-5 gender diagnoses had the intended effect of improving access to care" (p. 350).

However, one can see the adverse effects in Trump's Memoranda [4,5] and proposed legislation (EMRA) reaching beyond trans identity to find gender dysphoria as an excuse for excluding them from military service. The most logical solution is to remove gender dysphoria from the DSM and insist that third-party payers begin utilizing codes in the World Health Organization's [24]11th edition of the International Classification of Diseases (ICD) instead of those in the now outdated 10th edition. Beginning with ICD-11, the World Health Organization reclassified gender incongruence (roughly equivalent to the APA's gender dysphoria) as a physical health issue. WHO no longer regards gender incongruence as psychopathology. Given the U.S. Government's misuse of gender dysphoria and the adverse consequences it has on trans people, it is time to acknowledge that the costs of stigma, prejudice, discrimination, and marginalization associated with the diagnosis outweigh any intended benefit of pathologizing gender incongruence.

The civil rights movements of the 1960s and the activism of sexual minorities following *Stonewall* laid the groundwork for the APA Board to vote unanimously (with two abstentions) on December 15, 1973, to remove the diagnosis of homosexuality from the DSM [24]. In the seventh printing of its second edition of the DSM, the APA (1974) replaced homosexuality with "sexual orientation disturbance," including a proviso that same-sex attraction in and of itself is not a psychopathology. However, a significant factor affecting trans military service was the addition of transsexualism (a predecessor to gender dysphoria) to DSM-III in 1980, which the APA described as "a persistent sense of discomfort and inappropriateness about one's anatomical sex and a persistent wish to be rid of one's genitals and to live as a member of the other sex" [20]. Gender Identity of Childhood was also added to the DSM-III in 1980 [25].

The associated terminology, diagnostic criteria, and placement in the DSM have varied over the decades as research regarding gender incongruence and dysphoria increased [26]. However, these changes "were not only based on research. Social and political factors contributed to the conceptualization of gender incongruence/gender dysphoria as well" [26]. By 2013, the APA had moved the current nosology, gender dysphoria, into a separate chapter of DSM-5 and DSM-5-TR [16, 27]. Before that, the APA had renamed the condition gender identity disorder in the DSM-IV and DSM-IV-TR [28, 29].

One might argue that psychiatry officially pathologized gender nonconformity in 1980 with the publication of DSM-III [20] as a proxy for homosexuality because of its association with gender nonconformity. Many experts on the topic have contended that childhood gender nonconformity is strongly associated with adult homosexuality [30, 31], a finding consistent with a 27-year longitudinal study by Marino et al. [32]. Nonetheless, because the APA still construes gender dysphoria as a mental illness, the U.S. military may deem it a disqualifying condition so long as the APA continues to do so. In contrast, Dunlap et al.'s [33] study of active-duty service members found that diversity within military units contributes to social and institutional advancements.

The APA immediately published a position statement when it declassified homosexuality as a mental illness, noting that, as cited in Dresher [25],

> [H]omosexuality in and of itself implies no impairment in judgment, stability, reliability, or vocational capabilities, therefore be it resolved that the American Psychiatric Association deplores all public and private discrimination against homosexuals in such areas as employment, housing, public accommodations, and licensing, and declares that no burden of proof of such judgment, capacity, or reliability shall be placed on homosexuals greater than that imposed on any other persons.

The APA's Board of Trustees approved the organization's first "Position Statement on Discrimination Against Transgender and Gender Diverse Individuals" in July 2018. Despite maintaining that gender dysphoria is a mental illness [16, 27], its Position Statement articulates that "Being transgender or gender diverse implies no

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impairment in judgment, stability, reliability, or general social or vocational abilities. . . .” (para. 1). Note that, as shown in the excerpt above, the APA used wording identical to that of the position statement that accompanied the removal of homosexuality from the DSM except for inserting the words “general social” before vocational capabilities. The statement goes on to outline many forms of discrimination experienced by trans individuals and notes that “this position statement is relevant to the APA because discrimination and lack of equal civil rights are damaging to the health of transgender and gender diverse individuals” (para. 2). The statement also used language identical to that of the APA’s initial position statement about homosexuality, as also indicated in the excerpt above. Specifically, in 2018, the APA Board of Trustees [34] stated that it “declares no burden of proof of such judgment, capacity, or reliability shall be placed upon these individuals greater than that imposed on any other persons” (para. 3). We find it interesting that the APA Board of Trustees chose not to change any of the wording regarding the different populations.

The Overgeneralization of Gender Dysphoria

The aforementioned legislative proposals require members of the U.S. Armed Forces to serve only in their "birth sex" and mistakenly conflate this with a diagnosis of gender dysphoria. Even if gender dysphoria were a disqualifying condition for military service, attempts to ban trans people from military service because they are presumed to have gender dysphoria are misguided and ignore epidemiological and demographic facts. Arcelus et al. [35] conducted a meta-analysis of 21 studies and found that “the prevalence of transsexualism [i.e., gender dysphoria’s prior terminology] was 4.6 in 100,000 individuals; 6.8 for trans women and 2.6 for trans men” (p. 807). Converted to a percentage, Arcelus et al.’s estimate of 0.0046% is significantly lower than the percentage of adults in the U.S. who identify as trans. Using data from the U.S. Centers for Disease Control and Prevention, the Williams Institute [36] estimated that 1.3% of adults ages 18 to 24 identify as trans and only 0.5% of adults older than 25 do so. Jones [37] reported that a 2023 Gallup poll found that 0.9% of adults identify as trans. A Pew Research Center survey conducted in May 2022 [38] found that 0.6% of respondents identified as a transgender man or a transgender woman. Another 1% said they were nonbinary, and 0.5% said they had a different identity. In essence, even at the lowest estimate of the trans population, 0.5% for individuals over age 24 [36], there are over 326 times as many people who self-identify as trans as there are those diagnosed with transsexualism, now gender dysphoria [35].

Moreover, a survey of trans people conducted by the Kaiser Family Foundation and *Washington Post* [39] found that less than a third (31%) of self-identified trans participants used hormone therapy or puberty blockers, and only 16% had undergone some form of surgery, including gender-affirmation surgery, to alter their physical appearance. Notably, undergoing these medical-affirming treatments does not require counseling, a diagnosis of gender dysphoria, or a letter of support from any mental health or medical provider [40]. In essence, it is irrational to target trans individuals for exclusion from military service because they have a diagnosis of gender dysphoria.

A diagnosis of gender dysphoria is often made merely to provide medical justification for prescribing puberty blockers, hormone treatments, or authorizing surgery, regardless of whether the patient experiences distress or impairment related to the incongruence they experience between their gender identity and sex assigned at birth [41]. To reiterate, “The APA’s decision to retain the DSM-5 gender diagnosis had the intended effect of improving access to care” [22]. As an example, Drescher points to the U.S. Department of Health and Human Services reversing its longstanding ruling that classified gender-confirmation surgery as “experimental” and subsequently approved payments because the gender dysphoria “diagnosis represented the view of American psychiatry that they were medical conditions requiring treatment” [22].

Although 88% of trans adults reported they have begun transitioning in some way, most report they have not altered their physical appearance to align it with their gender identity [39]. Their study also found that these individuals do not use pronouns aligned with their gender identity. More than three-fourths (78%) of trans individuals indicate being “more satisfied” with their life living as a person whose gender identity is gender discordant with their birth-assigned sex, and nearly half (45%) state they are “a lot more satisfied.” In essence, it is essential to distinguish between trans individuals and those with gender dysphoria and to recognize that most trans individuals do not seek gender-affirming medical treatments to change their physical appearance. The vital policy implication here is that even if gender dysphoria is deemed a disqualifying medical condition, it applies to less than one in over 300 trans individuals seeking to serve openly in the U.S. military.

Comparison of Transgender and Cisgender Military Healthcare

It is essential to note that medical regulations concerning trans military personnel were historically inconsistent with non-transgender peers [42, 43]. Elders et al. [44] emphasized that “medical care for transgender individuals should be managed using the same standards that apply to all others” (p. 199). Despite concerns about the treatment of trans military personnel taxing resources, as expressed in President Trump’s Memorandum [4], as of June 2021, there were only 243 gender-confirmation surgeries over the prior five years, with the Pentagon spending $15 million to treat 1,892 trans military personnel. Over three-fourths of this amount (76.67% or $11.5 million) was spent on psychotherapy.

By comparison, there were nearly 2.28 million mental health encounters among 500,000 individuals in the active-duty component of the U.S. Armed Forces in 2022, accounting for about 19.2% of the almost 11.9 million medical encounters that year [45]. There was an average of 17,567 mental health hospitalizations per year in 2016, 2018, and 2020 in the active-duty component of the U.S. Armed Forces [41], with a median stay of six days. Notably, “Prolonged hospitalizations, subsequent aftercare, and early attrition because of such common disorders can harm individual and unit operational readiness” [45]. In essence, the relative cost of treating trans military personnel (< 0.4% of all treated personnel) is minuscule relative to the amount the U.S. military spends on mental health, including hospitalizations, for military personnel on active duty. These data readily rebut arguments that the expense of treating trans military personnel is too burdensome.

As noted above, policies regarding trans individuals serving in the U.S. military have been highly erratic since 2016. Despite Executive Order 14,004, trans and gender-diverse individuals in the U.S. military report instances of stigma and barriers to healthcare [46]. The term ‘gender diverse’ is used to describe individuals whose gender identity or expression does not conform to the traditional framework of society’s gender binary. Arguably, the impermanence of Executive Order 14,004 compounds this. These are significantly associated with self-reported anxiety and depressive symptoms, stress, and decreased mental health overall. Less than a fourth of the 177 trans and gender-diverse active-duty members that Johnson et al. [46] surveyed reported informing their primary care provider of their gender identity. Mental health issues related to being trans or gender diverse may adversely impact military readiness. Aligned with gender minority stress theory [47, 48], it is imperative to recognize that it is the unique stressors of trans people serving in a discriminatory environment that are mainly responsible for those issues. Johnson et al. [46] found that “Given recent changes to *military* policy, efforts may be warranted to improve access to timely, affirming care and clinician training” (p. 145, italics in original). One can readily predict that sorely needed affirming care for trans and gender-diverse troops, as well as clinical training in this area, will not occur once President Trump takes office.

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Conclusion

As a policy proposal, we recommend the retention of trans military personnel serving in the gender aligned with their gender identity. We caution against excluding trans individuals regardless of meeting criteria for gender dysphoria because of the harmful effects it would have on military readiness and the trans community. Given the U.S. military shortfall of over 40,000 military troops, the impact on the safety of American citizens cannot be underestimated. Therefore, the inclusion of medical care for trans service members is highly beneficial to the U.S. Military as well as the U.S. trans population. One must not ignore the reality that many trans military personnel have unique or specialized skills that are in high demand in the U.S. military. It would be incorrect to assume that trans service members can be easily replaced with cisgender (people living in their "birth sex") service members.

This paper confronts the harmful effects of two significant exclusions of trans people from full participation in the privileges of living in a democratic republic. The inclusion of trans individuals is a significant issue that extends beyond the military. First, the tendency of the gay rights movement to conveniently exclude trans people and issues because they pose a risk of passing their own legislative or policymaking agenda has caused significant harm to trans people and communities [49, 50]. This has led to trans people experiencing significantly greater discrimination, oppression, marginalization, and lacking legal protections afforded to sexual minorities. Second, the U.S. psychiatric community and other mental health disciplines have been complicit in perpetuating the very structural inequity that they profess to treat. That is, the stigma caused by conflating trans people with gender dysphoria and classifying the latter as having a psychopathology arguably contributes to minority stressors experienced by this community. We now recognize that mental health disparities are attributable to these minority stressors [47, 48].

Consequently, we argue that the fields of psychiatry and mental health need to eliminate the stigma that contributes to psychopathology as it did with sexual orientation. Much of the stigma is attributable to effectively classifying a minority group as mentally ill. The APA's DSM-5-TR refers explicitly to the possibility of incompatibility of gender assigned at birth with another gender identity. Thus, the psychiatric community can actively promote trans people serving in the U.S. military by acknowledging that it contributes significantly to the stressors underlying gender "dysphoria" and removing it from its official nosology. We recommend that the U.S. medical establishment advocate for transitioning to using the 11th edition of the *International Classification of Diseases* instead of the outdated 10th edition. This would make it possible to treat gender identity incongruence as strictly a sexual health condition, as does the World Health Organization's ICD-11. It would also eliminate a psychiatric basis for excluding members of a large, vibrant, contributing population seeking to live with the same opportunities and responsibilities as other Americans.

Conflicts of Interest: The authors declare no conflict of interest.

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