

Commentary on the construction of Gender Dysphoria at *Classifying Sex: Debating DSM 5*

Zowie Davy PhD, Senior Lecturer in Community Care, University of Lincoln, UK.

Context to the commentary

On the American Psychiatric Association's (APA) website the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), is promoted as the "most comprehensive, current, and critical resource for clinical practice available to today's mental health clinicians and researchers of all orientations" (American Psychiatric Association, 2012a). The manual is 'comprehensive,' indeed; it has grown in size since its first edition to over 900 pages in its current DSM 5 incarnation. We could argue as Farley, the former president of the American Psychological Association, does that the DSM authors are contributing to an increase in "the relentless production of disorders and pathologizing of normal extremes" (Gornall, 2013: no page no.) and the facilitating of mental illnesses. In response to the publication of the DSM-5, a two-day conference at the University of Cambridge took place: *Classifying Sex: Debating DSM-5*, at which discussants debated the potential impact of the manual's criteria for pathological, paraphilic and by default 'normal' sexualities, gender identities, and psychiatric practice. The delegates considered amongst many other topics the role of power and evidence, at least that is how I understood many of the contributions to the debate.

The panel that I was invited to contribute to featured Kenneth Zucker (Chair of the Sexual and Gender Identity Disorders workgroup of DSM-5) to whom I was to critically respond. In this reflective commentary I would like to focus on power and evidence because Zucker has previously described the DSM's international influence as spreading from clinical care, clinical training to clinical research (Zucker, 2010b). Moreover, in Zucker's conference talk: *The Science and Politics of DSM-5* (Zucker, 2013) it invoked these conceptual frameworks. Zucker's intriguing first presentation slide read: "Power is the ultimate aphrodisiac (Henry Kissinger 1973)." This was followed by a slide illustrating the sum of publications Zucker and the other Chairs of the DSM-5 working groups had published accompanied by Zucker's remarks that these publications were part of the reason why they were selected by the APA's Board of Trustees (BOT) and as Chairs of their respective work groups. This generated in me a sense that power and evidence to support these tangled, conflicting positions of power were being played out in a number of domains, profiting from many tactical partnerships (Foucault, 1998 [1984]): the BOT, the

contributors to the working groups, the academe and in some cases the (parents of) patients themselves through data from the clinics.

Kissinger's quotation was not spoken to by Zucker and; thus, I understood the first slide, rightly or wrongly, simultaneously as an admittance of the *jouissance* he sustains from the relative power he has over the (gender and sexual) lives of many and an in-joke for the benefit of his colleagues and allies. For me the joke was at best veiled, banal, lascivious humour. Zucker's attempts at humour lasted throughout his talk, sometimes succeeding, sometimes failing to arouse a titter. Whilst the 'humour' flowed I was consistently drawn to the fact that we should not be laughing at these quips due to the power that is constantly asserted over people's bodies by sexologists and psychiatrists in conjunction with those influenced by and those in partnership with the DSM, such as the police, law courts, civil courts and so on. Those that laughed, to my mind, should have been more aware that the DSM in some jurisdictions can act as an agent of law, with grave potentials, as the 'warning' from psychiatrist and APA historian Zilboorg suggests:

“a medical discipline which is still young and vigorous and ambitious enough to be adventurous, and yet is already mature enough to become a factor in almost every walk of our daily life: as human beings, as citizens, as men-in-the-street and as leaders of others, as pupils at the hands of life and as teachers under the guidance of the laws of mental functioning, as prisoners of the law and judges on the bench” (Zilboorg, 1944: vi-vii).

This reminds us that those psychiatrists representing what constitutes sanity can do (symbolic) violence to the so-called insane, forcing them to fit into preconceived diagnoses, to play the patient role (Cooper, 1967) and perhaps attempt to divide feminist, queer and trans* continuities that are emerging in contemporary life.

Complex power relations

I would like to borrow Raymond Williams' (1977: 112) concept of 'lived hegemony' in which hegemony is a complex ephemeral process of “experiences, relationships and activities” to understand how 'deviant' sexualities and genders are engendered in the DSM 5. Zucker illustrated this in his paper when he attempted to shift the emphasis away purely from his and work group members' power within the authorial process and placed it firmly in the hands of the APA's BOT, their consolidated science and

expertise act as axioms upon which another group of players deliberate. Zucker in his conference paper suggested that the BOT of the APA had the final say in what was to be included in the final product. Whilst this may be true, the influence of his and his colleagues' work is visible between pages 423 and 459 of the latest edition of the DSM (American Psychiatric Association, 2013), even though there are no references cited. In a dissenting piece about the BOT not including hebephilia (sexual attraction to pubescent children) in the DSM 5, Blanchard (2013) also suggested that the power of inclusion lay at the feet of the APA's BOT. He stated: that he had to remove from any public forum an

““insider's view” of specific people, events, or APA politics connected with that decision. All members of DSM-5 Work Groups were required to sign an agreement with the APA that prohibits them from divulging any “confidential information,” which was defined so as to include group discussions, internal correspondence, or any other information about the DSM-5 development process” (Blanchard, 2013: no page number),

even though his data was scientifically ‘validated.’ Moreover, allusions to different groups, academics and researchers being represented in the ‘consultation’ process were iterated by Zucker without much substantiation. An editorial published in the *Archives of Sexual Behavior*, written by Zucker, argued that the DSM-5 produced in the internet age heralded a democratized process with improved transparency (Zucker, 2013). Notions of validity, trustworthiness and rigor are invoked here; however, we should not take this at face value and must review these contributions on the APA's website.

Paradigmatic divisions

Zucker's paper (2013) did not appear to be something new. A repetition of previously articulated sentiments (see Tosh, 2011) was evident, such as the paradigmatic division between (postmodernist/poststructuralist) philosophers and scientists (politics and science respectively). This strategy could be understood as functioning in a number of ways. Firstly, the repetition of a disciplinary divide can be seen to attempt to hide the fallacy of academic citation practices that split the objective science from subjective expert opinion. The scientific citations' value is increased through the author's, like minded colleagues' and research partners' and advocates' citation practices so much so that research evidence ‘demands’ the title of ‘expert knowledge,’ ‘science,’ and in our case, ‘evidence’ of trans* and sexual phenomena. At the same time we can ask what is not cited in a bid to keep the fallacy/narrative/discourse/fiction/paradigm alive. According to Ansara and Hegarty (2012), Zucker was

the head of a powerful network of collaborating researchers who contribute to a cisgenderist diagnostic paradigm—cisgenderism is a discriminatory ideology that delegitimizes people's own classifications of their genders and bodies. If we examine the literature reviews that have been published in a bid to reformulate the diagnosis for trans*, we can get an idea of how wide the democratized process was. Consulting the American Psychiatric Association's website (2012b) we can witness a distinct lack of attention to empirical work outside of the journal *Archives of Sexual Behavior* and a number of included papers were 'Letters to the Editor,' Zucker himself. Little work from social sciences, health sciences and the humanities was considered. Perhaps the psychiatric profession could learn a bit from the constructivists and trans* theorists Zucker summarily dismisses.

Disorder to Dysphoria

Whilst my area of concern in this commentary is with the inherent power that psychiatric diagnoses sustain over people's lives generally, I take a heightened exception to the power relations in my research area of trans*. The shift in the diagnosis that asserts that 'Gender Dysphoria'—the replacement diagnosis for Gender Identity Disorder— is a better option for trans* people has been widely contested (see TGEU, 2012). However, I would like to suggest that any attempt to draw a simple linear account of power exerted from the DSM through gender clinics, misunderstands the multiplicity of practices in gender clinics (see May, 2002; Wren, 2005) outside of North America. Nonetheless, it is widely known, at least in my circle of researchers and activists, that Zucker's 'treatment' is not accepted by a number of trans* health advocates. This stems from the rigidity of what constitutes masculinity and femininity in his view and; moreover, his appeasement of misogynistic North American gender stratification (Serano, 2007). Some organizations (Winters, 2013) have suggested that Zucker's 'reparative practices' on gender non-conforming children may well constitute cruel and inhuman treatment if read against criteria described by the United Nations. The requirement to perform particular behaviors that correspond to whether you were born with a penis or vagina in stereotypical ways, to pacify societies' bullies, undermines the Convention on the Rights of the Child (UNICEF, 2013), which states that respect for the views of the child alongside recognition of the human rights principles of equality and non-discrimination is central to the consideration of gender equality. UNICEF has warned that gender-based discrimination is one of the most ubiquitous forms of discrimination that children face. For instance, sexological diagnoses using the DSM's Gender Dysphoria would still rely on a universalized and binary understanding of behaviors and bodily aesthetics, which are theorized as "masculinity" and "femininity" to augment essentialist claims about binary sexes. Whilst this is problematic at one level of 'treatment'

because of the lack of consent from the children being treated, this clears the child's carer(s) of any part in the process. For instance, it will be more likely that parents who regard stereotypical behaviors natural rather than socially interpellated add to the 'science' of psychiatric sexology by providing the 'data' that contributes to the published materials in this area. The atypical behavior or gender distress that people may experience is situational and the result of societal standards, carers' views in collaboration with a health system that uses evidence that does not think beyond a binary framework and dated model of incongruence to 'natural' signifiers of masculinity and femininity. My research (Davy, 2008, 2010, 2011; Davy & Steinbock, 2012) and many others (Cromwell, 1999; Hines, 2011; Stone, 2006 [1991]) have illustrated that some trans* do not fit neatly into these restrictive binary 'scientific' models, which causes a problem for the diagnoses and for the purported 'cure.' Hence, my paper *Will it make a difference or is it just semantics?: Diagnosing trans people in the DSM 5* (Davy, 2013) addressed three complex questions for the APA and Zucker:

1. In what ways does changing the taxonomy in the DSM 5 lessen the already stigmatized position of trans* people?
2. Is it time for the DSM to better reflect human diversity by shifting the emphasis away from the dated two-sex model?
3. How does the trans* anti-pathologisation movement challenge DSM 5 recognition?

None of the questions were adequately addressed. On the first question, Zucker responded to the question of stigmatizing as if there was a hierarchy of shame that those diagnosed with a 'disorder' should find it more amenable with the change to Gender Dysphoria amongst a number of other changes. Reflecting the somewhat anomalous harm reduction model that asserts that 'Gender Dysphoria' somehow lessens the stigma surrounding gender identities, gender expressions or bodies that do not conform to birth-assigned gender stereotypes, while at the same time providing some kind of diagnostic coding for access to medical transition treatment for those who need it is a position that is contentious and according to legislative powers beyond the North American borders is unnecessary.

Responses from the trans* anti-pathologization movement

In an attempted shift from gatekeeper to facilitator, in contemporary models laid out in the *Standards of Care*, in its seventh version now, it stipulates that for people who desire surgical interventions

“it is important for mental health professionals to recognize that decisions about surgery are first and foremost a client’s decision – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared” (World Professional Association of Transgender Health, 2012: 27).

Myself and others have suggested that diagnostic criteria based on distress and impairment, rather than difference from cultural gender stereotypes, may offer a path toward physical transitioning goals; however, the trans* anti-pathologisation movement argue for a more radical paradigmatic shift. Self-determination, according to some trans* advocates, is another way of making recognition claims for those wanting technological interventions to change gender beyond a psychiatric frame (Cuban Multidisciplinary Society for Sexuality Studies, 2010; TGEU, 2012). Transgender Europe situates self-determination within a human rights discourse. In this literature it emphasizes that every trans* person has a right to actualize their transition, as far as they wish it should go.

Perhaps this position is more closely aligned to some groups working towards the new World Health Organization’s ICD 11 (Drescher, 2013; Drescher, Cohen-Kettenis, & Winter, 2012), which supports a name change of *Gender Incongruence* to enable medically necessary treatments based on medical rather than psychological models of care. This approach is gaining weight in the trans* anti-pathologization movement (TGEU, 2012), perhaps because of governments, such as the Argentinean one that recently legislated on, arguably, the most progressive trans* recognition law in the world. The law allows people to alter their gender on official documents without first having to receive a psychiatric diagnosis or surgery. In the New York Times online, Katrina Karkazis, a Stanford University professor of bioethics said that Argentina’s new law will “Not only [...] give you the right to self-identify, but for those who want medical intervention, [it] require[s] public and private providers to cover procedures for self-actualization” (Schmall, 2012: no page number). The self-determination frame challenges healthcare professionals to work towards supporting trans* health interventions by reducing the psychopathological framework in which trans* are viewed. In effect, these claims remove the need for psychiatric diagnoses of Gender Dysphoria. In 1991 Sandy Stone (Stone, 1991) observed that for strategic reasons a liberal transsexual politics may direct its energies towards the human rights of transsexuals rather than, for example, at psychomedical constructions of transsexuality. Here in 2013 we can see that human rights groups have refocused their energies towards transsexuality and other

trans* identities by showing that these aesthetic¹ expressions of gender are “expressions of sexual diversity” (Cuban Multidisciplinary Society for Sexuality Studies, 2010) within normal extremes, moving beyond dualist notions of trans*. As one prominent group argues: attempting to diagnose diversity is, they say, “a pointless exercise” (TGEU, 2012). Gender Dysphoria should not be classified because “difference is not disease, nonconformity is not pathology, and uniqueness is not illness” (GID Reform Advocates, 2010: no page number). This debate is couched in the discourse of human rights and self determination. The claims from these trans* advocates have started to erode the power of psychiatry over trans* bodies without implying the dualist notions of body and mind and situate trans* gendering within notions of affect. From this self-determination position they are redressing the notion of pathology for trans* and trans* politics in which people can self-actualize their gender (role) desires in whatever ways they wish.

¹ The term ‘aesthetic’ is “the *expression* of the formal qualities of sentience, like the visual, aural, tactile, and so on, which transmit aesthetic affects, and the *perception* of such; simply stated, the experience of affects” (Davy & Steinbock, 2012: 268).

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