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Although many, if not all, of the diagnosis in the DSM present an ill-informed, stigmatizing, and potentially dangerous circumstance for LGBTQ people, I'm going to focus today on two of the most contentious, and likely most harmful diagnoses, in terms of sexuality and gender, from DSM V: Gender Dysphoria and Transvestic Disorder. I will provide some critical analysis of the diagnostic criteria as well as the research that was done by members of the Workgroup on Sexual and Gender Identity Disorders that was established by the APA for the creation of the DSM V.

First, a brief overview of the historic shifts in categorization of LGBTQ people in the DSM will itself provide a clear example of the manner in which the psychiatric establishment has used a framework rooted in dominant morals, rather than anything that could reasonably be considered science, to define the boundaries of mental illness. For instance, the status of homosexuality was changed in the DSM in 1973, officially being replaced with Sexual Orientation Disturbance. This new diagnosis regarded homosexuality as an illness only if someone experienced great distress from being gay and, presumably, wanted to change. Note that no heterosexuals could fall under that category, or be diagnosed as having a disturbance with their sexual orientation. Regardless, 1973 is heralded as the landmark year when homosexuality was "removed" from the DSM, and, as such, represents for many, inside and outside of the psychiatric establishment, a great leap of progress. However, after conceding that Sexual Orientation Disturbance was also potentially stigmatizing, in 1980 DSM III dropped Sexual Orientation Disturbance and replaced it with Ego Dystonic Homosexuality. This, in turn, was also subsequently removed in 1987's DSM III -R, after critics pointed out the troubling

nature of a focus on homosexuality when anyone can be “ego dystonic” about anything; their appearance, class status, or whatever.

In a process closely related to that which led to the gradual removal of homosexuality from the manual, Gender Identity Disorder in DSM IV has been replaced with Gender Dysphoria in DSM V, and the American Psychiatric Association is predictably applauding itself for its noble recognition and acceptance of gender non-conformity. I use the term gender non-conformity instead of gender variance or gender incongruence (two other popular terms in the literature) as it not only allows for a multiplicity of gender but also highlights the power structure of enforced gender. The idea behind this change from Gender Identity Disorder to Gender Dysphoria is that this is an acceptance of transgendered folks’ experiences as normal, or not pathological, unless there is an experience of significant distress related a sense of dissonance between one’s gender and physical sex. Again, this is clearly the same shift in diagnostic criteria that happened in 1973 regarding homosexuality.

This leads me to ask a number of questions, chief among them being: (1) Understanding the trajectory that the APA took with homosexuality over the latter half of the 20th century, what is the rationale for following a similar narrative of progress instead of just removing gender identity based diagnoses all together? And, (2) can this situation actually be described as progress at all, and if so, for whom?

An examination of some quotes from papers submitted by members of the DSM V Work Group on Sexual and Gender Identity Disorders is especially helpful in seeing more clearly what the APA’s thinking reveals about this supposed narrative of progress. Moreover, each of these quotations is revealing of ways “experts” in psychiatry maintain a position of power, and insist on themselves, and their diagnosis as essential. For example, in the paper *Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the Diagnostic and Statistical Manual*, written by Jack Drescher for the Workgroup, some of the background on the medicalization of gender non-conformity is reviewed. In discussing Dr. Harry Benjamin,

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On a similar note, in the same paper, Drescher goes even further in extolling the virtuosity and utter necessity of the psychiatric establishment in paving the way for the liberation of LGBT people. In speculating on the similar trajectories of de-stigmatization of homosexuality and gender non-conformity through incremental reclassifications in the DSM, Drescher describes the period after 1973, when homosexuality was officially removed, stating “With psychiatry no longer officially participating in stigmatization, a historically unprecedented social acceptance of gay men and women gradually ensued.” This revisionist history, which erases the decades of grass roots struggle of LGBT people, places the power of both condemning and saving in the hands of psychiatry. Perhaps even more importantly though, if Drescher believes that psychiatry had this tremendous power to improve the social conditions for lesbian and gay people, then what exactly is the justification for not completely removing gender identity diagnosis from the DSM?

Drescher explains the decision to keep a gender identity disorder in the DSM as a necessity for allowing trans folks to have access to medical treatments like hormones or transsexual

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There are a number of problems with this justification. First, it recognizes the stigma caused by diagnosis, yet retains the diagnosis for a purely strategic purpose which cannot possibly justify inclusion in what is, ostensibly, *the* scientific model of mental illness. His justification recognizes the perpetuation of stigma and social harm, while not providing an alternate model for access to treatment like a purely medical diagnosis of “transsexual,” which could be utilized for insurance purposes, but not denote a mental illness. It also valorizes one version of transgender, those seeking to physically transition, thereby tacitly perpetuating the desirability of “passing,” and the need for trans folks to adhere, at least in outward appearance, to a binary sex and gender system consisting of only male or female. Furthermore, his argument also creates an increased possibility for those found to be “dysphoric” about their gender to be prescribed psychiatric medication for depression or anxiety. And, finally, it does not at all account for the “dysphoria” that trans folks experience as a result of societal stigmatization, homophobia, transphobia, isolation, and a violently enforced gender system, and instead continues to insist that such dysphoria is a result of a treatable mental illness.

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Ray Blanchard, also a member of the Workgroup on Sexual and Gender Identity Disorders for DSM V, focused his work on the specifics of what is called “Transvestic Disorder.” A close examination of his choice of words in his paper for the Workgroup, *The DSM Diagnostic Criteria for Transvestic Fetishism*, is particularly revealing of the attitude of these psychiatrists regarding the supposed progressive changes made in DSM V. Blanchard explains that there is no need in the manual for the specifier “with Gender Dysphoria” to accompany Transvestic Disorder, but instead calls for the patients to be given the additional diagnosis of Gender Identity Disorder. He says, “If the patient has gender dysphoria in addition to Transvestic Disorder, he can simply receive the additional diagnosis of Gender Identity Disorder or Gender Identity Disorder Not Otherwise Specified (or their equivalents in the DSM V).” The key words here are “*or their equivalents in the DSM V.*” These words indicate that, as a member of the Workgroup, he understood that there was inevitability going to be a change in the diagnosis Gender Identity Disorder (and presumably he knew why), but from his perspective, and whoever reviewed these papers at the APA, GID and Gender Dysphoria are equivalents, rendering these changes mere cosmetic semantics.

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Since its inception, the DSM has presented persistent challenges to the LGBTQ communities, as well as anyone with non-normative gender, sexual desire, practices, and/or bodies, including intersex individuals, and heterosexually identified cisgendered people. Those falling within these categories have had their personhood, bodies, and consensual sexual practices pathologized and stigmatized by the medical and legal establishments, often with far reaching impact into civil rights, personal expression, and self-determination.

Although many, if not all, of the diagnosis in the DSM present an ill-informed, stigmatizing, and potentially dangerous circumstance for LGBTQ people, I'm going to focus today on two of the most contentious, and likely most harmful diagnoses, in terms of sexuality and gender, from DSM V: Gender Dysphoria and Transvestic Disorder. I will provide some critical analysis of the diagnostic criteria as well as the research that was done by members of the Workgroup on Sexual and Gender Identity Disorders that was established by the APA for the creation of the DSM V.

First, a brief overview of the historic shifts in categorization of LGBTQ people in the DSM will itself provide a clear example of the manner in which the psychiatric establishment has used a framework rooted in dominant morals, rather than anything that could reasonably be considered science, to define the boundaries of mental illness. For instance, the status of homosexuality was changed in the DSM in 1973, officially being replaced with Sexual Orientation Disturbance. This new diagnosis regarded homosexuality as an illness only if someone experienced great distress from being gay and, presumably, wanted to change. Note that no heterosexuals could fall under that category, or be diagnosed as having a disturbance with their sexual orientation. Regardless, 1973 is heralded as the landmark year when homosexuality was "removed" from the DSM, and, as such, represents for many, inside and outside of the psychiatric establishment, a great leap of progress. However, after conceding that Sexual Orientation Disturbance was also potentially stigmatizing, in 1980 DSM III dropped Sexual Orientation Disturbance and replaced it with Ego Dystonic Homosexuality. This, in turn, was also subsequently removed in 1987's DSM III -R, after critics pointed out the troubling

nature of a focus on homosexuality when anyone can be “ego dystonic” about anything; their appearance, class status, or whatever.

In a process closely related to that which led to the gradual removal of homosexuality from the manual, Gender Identity Disorder in DSM IV has been replaced with Gender Dysphoria in DSM V, and the American Psychiatric Association is predictably applauding itself for its noble recognition and acceptance of gender non-conformity. I use the term gender non-conformity instead of gender variance or gender incongruence (two other popular terms in the literature) as it not only allows for a multiplicity of gender but also highlights the power structure of enforced gender. The idea behind this change from Gender Identity Disorder to Gender Dysphoria is that this is an acceptance of transgendered folks’ experiences as normal, or not pathological, unless there is an experience of significant distress related a sense of dissonance between one’s gender and physical sex. Again, this is clearly the same shift in diagnostic criteria that happened in 1973 regarding homosexuality.

This leads me to ask a number of questions, chief among them being: (1) Understanding the trajectory that the APA took with homosexuality over the latter half of the 20th century, what is the rationale for following a similar narrative of progress instead of just removing gender identity based diagnoses all together? And, (2) can this situation actually be described as progress at all, and if so, for whom?

An examination of some quotes from papers submitted by members of the DSM V Work Group on Sexual and Gender Identity Disorders is especially helpful in seeing more clearly what the APA’s thinking reveals about this supposed narrative of progress. Moreover, each of these quotations is revealing of ways “experts” in psychiatry maintain a position of power, and insist on themselves, and their diagnosis as essential. For example, in the paper *Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the Diagnostic and Statistical Manual*, written by Jack Drescher for the Workgroup, some of the background on the medicalization of gender non-conformity is reviewed. In discussing Dr. Harry Benjamin,

the first American doctor treating thousands of transsexuals with hormones, Drescher describes Harry Benjamin as a “pioneering maverick,” and quotes from his colleague’s paper that Harry Benjamin was not only “the discoverer but also the patron saint of transsexuals.” Even though many of Benjamin’s patients, and other transsexual people of 1950s –70s, befriended Benjamin and found his standards of care in medical treatment enormously beneficial, the language in this paper reveals the elitism and ego-ism of professionals in the psychiatric field who define for the rest what is a treatable “disease” that can, with the right adventurous spirit, be “discovered.” Harry Benjamin’s standards of care became a rigid framework whereby trans folks have to submit to a medical and psychiatric examination process to seek official recognition of how they know their own bodies. That a “pioneering” medical professional can “discover” and be the “patron saint” of trans people to Drescher, re-entrenches the “otherness” of transsexuality, while understanding, a priori, the supposed stability and coherence of non-trans, cis-gendered bodies.

On a similar note, in the same paper, Drescher goes even further in extolling the virtuosity and utter necessity of the psychiatric establishment in paving the way for the liberation of LGBT people. In speculating on the similar trajectories of de-stigmatization of homosexuality and gender non-conformity through incremental reclassifications in the DSM, Drescher describes the period after 1973, when homosexuality was officially removed, stating “With psychiatry no longer officially participating in stigmatization, a historically unprecedented social acceptance of gay men and women gradually ensued.” This revisionist history, which erases the decades of grass roots struggle of LGBT people, places the power of both condemning and saving in the hands of psychiatry. Perhaps even more importantly though, if Drescher believes that psychiatry had this tremendous power to improve the social conditions for lesbian and gay people, then what exactly is the justification for not completely removing gender identity diagnosis from the DSM?

Drescher explains the decision to keep a gender identity disorder in the DSM as a necessity for allowing trans folks to have access to medical treatments like hormones or transsexual

surgeries. He states, “Presently...where either insurance or national health care systems cover these procedures, it is a psychiatric diagnosis that currently justifies ‘medical necessity’ for such care. So while removal from the DSM led to a liberating and immediate ‘cure’ for members of the gay community, a similar approach with GID could have unintended, adverse treatment consequences, particularly for the anatomically dysphoric transgender individual seeking or in need of medical transition.” He further elaborates that, “While retaining the diagnoses, even with modification, can undoubtedly contribute to perpetuating stigma (in a manner similar to being diagnosed with major depression or bipolar disorder can be stigmatizing), such an outcome would constitute a lesser harm to anatomically dysphoric members of the trans community than the denial of access to medical and surgical care likely to ensue following removal from the DSM.”

There are a number of problems with this justification. First, it recognizes the stigma caused by diagnosis, yet retains the diagnosis for a purely strategic purpose which cannot possibly justify inclusion in what is, ostensibly, *the* scientific model of mental illness. His justification recognizes the perpetuation of stigma and social harm, while not providing an alternate model for access to treatment like a purely medical diagnosis of “transsexual,” which could be utilized for insurance purposes, but not denote a mental illness. It also valorizes one version of transgender, those seeking to physically transition, thereby tacitly perpetuating the desirability of “passing,” and the need for trans folks to adhere, at least in outward appearance, to a binary sex and gender system consisting of only male or female. Furthermore, his argument also creates an increased possibility for those found to be “dysphoric” about their gender to be prescribed psychiatric medication for depression or anxiety. And, finally, it does not at all account for the “dysphoria” that trans folks experience as a result of societal stigmatization, homophobia, transphobia, isolation, and a violently enforced gender system, and instead continues to insist that such dysphoria is a result of a treatable mental illness.

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