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The DSM-5 and the Politics of Diagnosing Transpeople

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Abstract In the DSM-5, there has been a change in the diagnosis for transpeople of all ages from Gender Identity Disorder (GID) to Gender Dysphoria (GD), in part to better indicate the distress that transpeople may experience when their gender identity feels incongruent. The Workgroup for Sexual and Gender Identity Disorders, chaired by Kenneth J. Zucker, was employed by the American Psychiatric Association (APA) to update the DSM-5's GID diagnosis reflecting contemporary scientific knowledge. Additionally, in a pre-publication report to the APA, members of the Workgroup suggested that they would also be concerned with the destigmatization of transpeople while preserving a diagnosis that medical insurance companies would accept for issuing payments for transitioning treatments (Drescher, 2013). The aims of this article are, firstly, to question whether changing the diagnosis lessens the stigmatization of transpeople. I will suggest that the semantic change from GID to GD marks "inverted" gendered expressions as pathological and, thus, continues to stigmatize transpeople. Secondly, the article explores the development of the GD diagnosis, and illustrates how the scientific data this were founded on are contentious. The article then demonstrates how the trans anti-pathologization movement has challenged the perceived pathologizing effects of the DSM-5 classification of GD. The article examines a selection of Western transgender community advocates' websites, forums, and blogs. From these sources, the article then explores the different narratives of transpeople and political groups who offer details of their praxis, and evidences how the trans anti-pathologization advocates use the available science and human rights discourses to contest the role of psychiatry in the treatment of transpeople.

Keywords Gender dysphoria · DSM-5 · Transsexualism · Gender Identity Disorder · Stigma

Introduction

The Workgroup on Sexual and Gender Identity Disorders chaired by Kenneth J. Zucker was employed by the American Psychiatric Association (APA) to update the DSM-5's diagnoses surrounding gender and sexual disorders, if warranted by the scientific evidence. In this article, I introduce some of the political developments surrounding the diagnostic changes for transpeople[1] who pursue gender transitions through medical technologies under psychiatric care in gender identity clinics. According to pre-publication reports and commentaries leading up to the new diagnosis, members of the Workgroup suggested that their aims were to reduce the stigma surrounding transpeople, while proposing a diagnosis that third party funders would accept for issuing payments for transitioning treatments (Drescher, 2013).

As a result of the Workgroup members' considerations, the DSM-5 authors changed the diagnosis for transpeople of all ages from Gender Identity Disorder (GID) to Gender Dysphoria (GD), but retained similar gender identifying/expression criteria. The DSM-5 (APA, 2013: emphasis added) states:

> [i]ndividuals with gender dysphoria have a marked incongruence between the gender they have been assigned to […] and their experienced/expressed

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[1] I will use the term transpeople to refer to those people who transition to their experienced (binary or non-binary) gender socially, legally or physically, or a combination thereof. I use the terms transmen and transwomen to convey the person's experienced gender.

> gender. *This discrepancy is the core component of the diagnosis*. There must also be evidence of distress about the incongruence. (p. 453)

The diagnostic change, it was also argued, would address the gender identity formation issue apparent in the previous DSM-IV manual by highlighting the distress caused by gender incongruence rather than gender "identity per se" (APA, 2013, p. 453) as the problem. More emphasis was placed on the distress that transpeople could experience. Separate criteria were devised for children vs. adolescents and adults to reflect the typical differences in gender expressions and levels of distress. Younger children, for example, are less inclined to express extreme "anatomic dysphoria" (APA, 2013, p. 453) and less likely to communicate wishes for a body more congruent to their sense of self. For transpeople, identifying with a particular gender is not always a distressing experience, but distress can develop intermittently from an incongruence from their assigned sex/gender category in different social situations (Davy, 2010b), a point acknowledged on p. 451 of the DSM-5. Incongruence is only sometimes accompanied by marked distress.

The emphasis on distress is problematic on two levels: Firstly, transpeople often require a diagnosis from gender specialist psychiatrists to access both transitioning technologies and legal recognition. Psychiatrists may be tasked with deciding whether the patient is suffering from GD to an extent that warrants referrals for treatments or payments from insurance companies, and sometimes with providing documentation evidencing a patient's diagnosis of GD for a legal sex change. The DSM-5 states: "Although not all individuals will experience distress" (APA, 2013, p 451) as a result of gender incongruence, but one page later states: "The condition is associated with clinically significant distress," resulting in an inconsistency that may cause confusion amongst psychiatrists tasked with attempting to diagnose GD. This may potentially reduce access to treatments and legal recognition for some transpeople who do not experience chronic or intermittent GD. This inconsistency may also encourage transpeople to frame their narratives in line with the distress model in the DSM-5, to ensure that their claims of being the "other" gender are intelligible to clinicians (see Davy, 2010b). Secondly, the diagnosis of GD is perceived by many trans advocates as misrepresenting their lives—a point which will be elaborated later in the article.

Against the backdrop of the sexological portrayal of GD as a sense of unease or distress about one's (original) gender, I will explore the claims made by trans advocates in the anti-pathologization movement who argue for future healthcare pathways for transpeople to move beyond the influence of psychiatric diagnoses. To explore this challenge, I will analyze some of the international representational work that trans advocates are undertaking to counter the negativity attached to trans embodiment in medical discourse. I will show through an analysis of anti-pathologization advocates' websites, forums, and blogs that they hope for a complete removal of their transitioning desires from any mental disorder framework. They argue that the semantic change from GID to GD in the DSM-5 will not lessen the perceived harms done by what they term psychiatric pathologization and its related stigmatization (GID Reform Advocates, 2010). One arm of the movement's online materials casts trans identities within a biogenetic framework, or as an intersex condition, which I will critique as essentializing and problematic. The other arm of the movement that I consider proposes a self-determination and human rights model. More specifically, I will show that the latter group of advocates view the diagnostic use of stereotypical gendered expressions associated with boys/men and girls/women as erroneous, and that they have little to do with actual contemporary gender identity formations. Accordingly, any gendered expressions, regardless of which birth-assigned sex one is given, should not act as criteria for diagnosing transpeople. I will then illustrate how more progressive jurisdictions beyond the North American borders have removed the role of psychiatry from healthcare pathways and legal recognition.

Diagnostic and Political Shifts

Since the introduction of transsexualism as a disorder in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 1980) through to its later labels GID (APA, 1994, 2000) and now GD (APA, 2013), the controversies surrounding these diagnostic developments have emerged in various ways. The removal of homosexuality as a diagnostic category from the seventh printing of the DSM-II in July 1974 was in part accomplished in spite of complaints from psychiatrists and psychoanalysts that this exclusion would slow scientific progress in any future studies of human sexuality (Socarides, 1978). The diagnosis "Sexual Orientation Disturbance"—to describe an individual who suffers persistent distress associated with their same-sex sexual preference—remained. It was later substituted with the diagnosis "Egodystonic Homosexuality" in the 1980 DSM-III, and eventually removed in the 1987 revision DSM-III-R. Some non-clinical critics accused the 1980 DSM-IV manual's authors of replacing the void that the diagnosis of homosexuality left with Gender Identity Disorder in Children (GIDC) to help prevent adult homosexuality (Sedgwick, 1991). Although there is evidence that some clinicians and parents have offered or requested treatment for children with GID, in part, to prevent the development of homosexuality (see, for example, Nicolosi & Nicolosi, 2002), there is no clear evidence that the diagnosis of GIDC simply replaced the diagnosis of homosexuality (Zucker & Spitzer, 2005).

Transsexualism and GIDC in the DSM-IV may have been introduced because there had been an increase in people

wanting hormone therapies and sex realignment surgeries since the 1960s. Benjamin's (1966) sexological work with transpeople described an affirmative treatment pathway, and identified a typology that distinguished the "true" male-to-female transsexual from the transvestite and the homosexual, establishing a type of person who required physical changes to their bodies in order to fully express their gender identity. At this stage, Benjamin (1966) did not base his typology on those wanting to transition from female-to-male, since these were rarely seen in the clinician's office. While not directly contributing to the clinical criteria in the DSM, a similar typology to Benjamin's was used. The "true transsexual" model was widely rehearsed, and relayed in the gender clinics by many transwomen, with a slightly modified version by the rare transmen, in order to access gender realignment technologies (Davy, 2011). Utilizing the trope of the "wrong body," which requires the correction of secondary sex characteristics to match their minds, a number of transpeople who could afford the procedures and/or insurance were able to access surgical and hormonal technologies. The clinical use of the "true transsexual" model was said to be designed for people who had decided to pursue their transitioning needs through hormonal and surgical sex (genital) reassignment surgery (Bradley et al., 1991).

There were significant numbers of transpeople, however, who neither sought nor had the opportunity to pursue hormonal and surgical interventions because of medical, economic, social, or political reasons. Transpeople who had lived or intended to live a gender role more congruent with their experienced gender, but who could not be situated within the diagnostic criteria that insisted on a hatred of one's genitals and a need for sex reassignment surgery to appear as their experienced gender, could be included under the diagnosis of Gender Identity Disorder Not Otherwise Specified (GIDNOS) (Bradley et al., 1991). Therefore, extending the diagnostic idiom in the DSM-IV (APA, 1994) to GID enabled psychiatrists to diagnose those transpeople whose gender expression was not commonly associated with their assigned sex, those who did not necessarily feel incongruent to their bodies, and/or those who did not wish to pursue surgical sex reassignment. In effect, the gender expressions of these transpeople and the diagnosis of GIDNOS invalidated "true transsexualism" as the only model relevant to transgender people. Critics have argued that this extension of the diagnostic criteria served to replace a rather narrow characterization of transitioning transsexuals with a diagnosis able to absorb many more gender non-conforming individuals, who may or may not experience some form of distress. Billings and Urban (1996), for example, have claimed that diagnoses of multiple gender disorders under one overarching GID diagnosis maintained the clinical monopoly on additional forms of permanent or non-permanent gender transitioning practices.

I wish to suggest that the diagnostic framework in the DSM-5 for all transpeople continues to be underpinned by essentialist, heteronormative assumptions that situate binary sexes—male and female—with corresponding genitalia as the anchor from which GD is judged (APA, 2013, pp. 453–454). For example, in the section on children, the criteria state that gender dysphoric children have a "strong dislike of one's sexual anatomy [and] a strong desire for the primary and/or secondary sex characteristics that match one's experienced gender" (APA, 2013, p. 454). One page later, the DSM-5 also states that "[y]oung children are less likely than older children […] to express extreme anatomic dysphoria" (APA, 2013, p. 455). In the adolescent and adult section, it states that transpeople experience strong desires for, or convictions about, primary and secondary sexual characteristics of the "other gender." In adolescents, there is often "the desire to prevent the development of [secondary sex characteristics]." This emphasis on the body suggests that primary and secondary sex characteristics are the cornerstone underpinning the disorder, indeed that the "disorder" hinges upon concerns about anatomic dysphoria rather than GD. Interestingly, the clinicians Cohen-Kettenis and Pfäfflin (2010), who worked within the DSM-5 workgroup, have critically argued that the DSM has consistently assumed that psychological gender that does not match the sex assigned at birth, or the physical sex, signals a psychiatric disorder.

I would argue that the criteria proposed by the DSM-5 are derived from stereotypes applied in the gender identity clinics serving transpeople, rather than empirically developed from biological imperatives. Money (1995), in his gender constructionist research, suggested that biological imperatives are few in the human, and consist only of procreative imperatives. Other behavioral aspects such as sartorial preference, aggression, empathy, and intelligence, among a number of other characteristics, are not sex specific and are often adaptable. Some developmental psychologists, such as Maccoby and Jacklin (1974), insisted that normative gender behavior is related to sex differences (in a biological sense) alongside socialization. However, more recent research (Eagly, 2013) situates behavioral sex differences firmly within a social role model. As such, these inconsistent theories illustrate that the debate surrounding biological causation is far from settled. Moreover, this unresolved debate weakens any possibility of arguing that there is something inherent in masculine and feminine behaviors. (Trans) people have never been subjects of an independent masculine or feminine type, and combinations of what is deemed masculine or feminine at any one time can be found within all humans, albeit performed with different intensities (Bem, 1974). Nonetheless, atypical gender expressions in children continue to be depicted in the DSM-5 as a manifestation of inverted masculinity or femininity, and consequently gender. Research has also suggested that adult transpeople often think that if they do not express stereotypical masculinities and femininities and concomitantly display "distress" about their original bodies (anatomic

dysphoria), they will not fit the model that may steer them to the transitioning healthcare pathways (Davy, 2010b).

Politics of Citation

On the APA's webpage[2] *DSM-5 Development*, the authors note:

> From 2007 until the end of 2012, each work group met regularly in person and on conference calls. They reviewed DSM-IV's strengths and problems, from which research questions and hypotheses were developed, followed by thorough investigations of literature reviews and analyses of existing data. Based on their comprehensive review of scientific advancements, targeted research analyses, and clinical expertise, the work groups developed draft DSM-5 diagnostic criteria. The final, approved DSM-5 was released in May 2013 at APA's Annual Meeting.

Literature reviews and systematic analyses of existing data can often bring into focus scientific developments. However, in this case, the scientific literature that was included to form the new GD diagnosis relied heavily on a select group of sexologists who are generally supportive of each other's work (see http://www.dsm5.org/Research/Pages/Publications.aspx).

Much of the work that has been used in the DSM-5 prepublication reports, and which has clearly influenced the construction of the GD diagnosis, has linked GID to either a previous homosexual orientation or a sexualized cross-dressing fetish (Bailey, 2003; Blanchard, 1991; Lawrence, 2004). On pp. 455–456, for example, late-onset, natal male gender dysphoric people are described as frequently engaging in sexualized transvestic behavior; early-onset natal male gender dysphoric people are depicted as primarily attracted to men. The two sub-types of "male-to-female transsexuals" are referred to in Blanchard's work, who was in the DSM-5 workgroup. Blanchard's (1989; Blanchard, Clemmensen, & Steiner, 1987) contested research (Moser, 2010) depicts these sub-types as "Autogynephiles" and "Homosexual Transsexuals," respectively. According to Blanchard and his co-authors and collaborators, some transwomen are "homosexual male transsexuals" who have a "homosexual career" prior to transitioning (Bailey, 2003; Blanchard, 1991; Lawrence, 2004), and transition to make themselves sexually attractive to heterosexual men.

Autogynephiles usually have a (hetero)sexual "transvestite career" prior to transitioning. The Autogynephilia typology is included in the DSM-5 as a potential causality of gender dysphoric feelings. Although Lawrence (2011), a promoter of Autogynephilia, claims that the distinction between homosexual and non-homosexual (autogynephilic) male-to-female transpeople is fundamental to understanding the etiology of gender dysphoric people, she has also argued that it is sometimes necessary to further subdivide non-homosexual transpeople into "heterosexual, bisexual, and analloerotic or asexual subtypes" (p. 1089). Nuttbrock et al. (2011) have critiqued Lawrence's work surrounding Autogynephilia and hold that the binary construct of Autogynephilia and homosexual transsexuality is generationally out of date and manifests mainly in ethnically white transwomen. They argue that a more productive approach to understanding the etiology of gender dysphoric people would be to better understand aspects of sexuality in this population that are at odds with Autogynephilia theory.

Serano (2010) argues many people do not doubt the existence of cross-gender arousal in some pre-transitioned transwomen, but states that Autogynephilia is very similar to non-transsexual women's patterns of arousal when they fantasize about themselves having sex as women, indicating that autogynephilic fantasies are not specific to transwomen. Citing Veale, Clarke, and Lomax's (2008) research, which examined several features of transwomen's sexuality, Serano also argues that their sampling strategy avoided a number of methodological shortcomings apparent in Blanchard's and his followers work. Veale et al.'s work studied a group of transwomen who were recruited anonymously, reducing the potential bias that may come from recruiting clinic samples, which I will explore in more depth below. They concluded that even though they agree with Autogynephilia and homosexual transsexuality in principle, these are only two forms of trans sexuality amongst others. Today's trans populations are more diverse in their sexual expressions; all transpeople do not neatly fit with the theories of Autogynephilia or homosexual transsexuality (Davy & Steinbock, 2012; Pfeffer, 2014; Serano, 2010; Steinbock, 2013; Stryker, 2008; Veale et al., 2008).

It remains vague as to why only these two forms of sexualities figure in the DSM-5, or what purpose they serve within the "Development and Course" section in the DSM-5 (APA, 2013, pp. 454–456). For example, if sexuality underpins GD in terms of etiology, as the DSM-5 authors have assumed by including Autogynephilia in the manual, then it would have been prudent to also consider other available research that reflects wider knowledge about transpeople's sexualities. Although in the DSM-5's endnotes, the authors suggest that the inclusion of Autogynephilia may be of interest to researchers in the field, it seems plausible to suggest that researchers would also be interested in other published work about trans sexualities. As such, this exclusion neither takes advantage of recent sexological work (Bockting, Benner, & Coleman, 2009) nor of wider transgender studies work (Davy & Steinbock, 2012; Pfeffer, 2014; Steinbock, 2013; Stryker, 2008) which has explored a range of "sexual orientations" and which does not neglect altogether the diversity of transmen's sexualities. The controversial inclusion of only two forms of trans sexualities has needlessly (re)sexualized the new

[2] See http://www.dsm5.org/Pages/Default.aspx.

diagnosis for male-to-female transpeople by reconnecting homosexuality and a form of cross-gender fetishism that Benjamin (1966) had contested many years ago in his typology. This (re)sexualization of the GD diagnosis may exacerbate societal discrimination, and intensify the stigma that this group of people already faces (see Serano, 2010), because of its association with marginalized sexualities, thereby undermining the Workgroup's intention of reducing the stigmatizing effects of diagnosing transpeople.

Developing from Benjamin's (1966) narrow, but affirmative treatment pathway, new therapeutic approaches to trans phenomena are currently emerging (see, for example, World Professional Association for Transgender Health, 2011; Wren, 2005). Furthermore, biological research (Diamond, 2000; Kruijver et al., 2000; Zhou, Hofman, Gooren, & Swaab, 1995) and contemporary philosophical and social scientific scholarship from an emerging generation of "out and proud" transgender and genderqueer individuals and their allies are offering both novel data and empirically informed theorizations (Currah, Green, & Stryker, 2008; Davy, 2010a, 2010b, 2011; Davy & Steinbock, 2012; Stone, 2006; Stryker, 2006; Valentine, 2007). For instance, the diverse phenomenological experiences of transpeople have been explored in social science, sociological, and anthropological studies that have illustrated the agentic practices of transpeople living a gender that suits them better, whether within the binary gender system, or beyond it (Altman, 1999; Bolin, 1988; Cromwell, 1999; Ekins & King, 2006; Lewins, 1995; Rubin, 2003; Valentine, 2007). The changes in the psychiatric model in the DSM-5 (APA, 2013) seemingly ignored this research.

Rehearsing the Clinical Narrative

Several social science and transgender studies have illustrated how data from clinical encounters are limited in not fully accounting for the multiple ways that transpeople (have) live(d) their lives prior to accessing their psychiatric assessment in the gender clinic (Davy, 2010b, 2011; Speer, 2013). For example, some transpeople understand that to disclose enjoying one's penis or vagina alone or with another while claiming a feminine or masculine gender identity is considered dysfunctional by some gender clinic psychiatrists. Transpeople often feel that if they admit to this, the result may be exclusion from any form of treatment (Davy & Steinbock, 2012; Speer, 2013). Consequently, many transpeople are reluctant to relay anything to gender clinic psychiatrists that might be viewed as different from the perceived "correct" trans narrative. In previous research (Davy, 2010b), I have demonstrated that transpeople tend to tailor their clinical narratives because they realize that psychiatrists have the power to stop their transitioning process. For instance, one participant said: "In terms of doctors and psychiatrists [transpeople are] going out of their way to, in the case of transwomen who are overtly feminine, beyond what she might feel comfortable with, just to prove a point […] just to not leave doubt in people's minds." Benjamin, another participant, said: "All men have a feminine side, but I did not dare show that to the psychiatrist" (Davy, 2010b). This has obvious implications for the relevance of data derived from the gender clinics' case studies. This is an important point given the status of case study research within the systematic DSM-5 reviews which underpinned the reclassification of GD. This point also potentially weakens the significance of GD as a diagnosis for all transpeople.

The criteria used to diagnose GD help psychiatrists to determine whether someone is experiencing distress about incongruence with their experienced gender through a gender normative frame, which has little to do with experienced gender identity. Arguably, this leads to the situation where transpeople must express "dysphoria" about their natural body and incongruent behavior and demonstrate to the psychiatrist that they have most often preferred activities that are traditionally gendered and opposite to those gender norms applied to their assigned sex at birth. Within the DSM-5, these traditional gendered expressions seem to be required in spite of the lack of stark behavioral differences between the genders in Western societies today. Gender role performance and gender identity are not the same thing (Cohen-Kettenis, 2010). It is clear from feminist research that behaviors are not intrinsically masculine or feminine, but change through time and in different spaces, as Lorber (1994) also asserts. Nonetheless, transpeople retrospectively claim to have participated in stereotypically gendered play and behaviors when they have sought transitioning technologies, and have often interspersed expected gender inflections into their clinical narratives. These inflections seem inevitable because the diagnostic criteria expect cross-gendered play and behaviors to be performed prior to the granting of transitioning technologies. For example, in children "[p]repubertal natal girls [often prefer] contact sports, rough-and-tumble play, traditional boyhood games, and boys as playmates" (APA, 2013, p. 453). The clinically expected expressions of gender do not correspond well to gender role play or leisure pursuits apparent in contemporary society. Hird (2003) has previously questioned the criteria of assessment used in the DSM-IV (which have similarly appeared in the DSM-5) in relation to the bodily aesthetics and behaviors that transpeople typically ought to perform, and how different these are from the gender expressions of psychiatrists evaluating transpeople. Hird (2003) argued that:

> [most gender clinic psychiatrists] adhere to gender identity as both "real" and fixed. This adherence then facilitates the continued use of highly stereotyped notions of gender to provide the framework for assessing and treating transsex […] individuals. (p. 183)

Following her attendance at a conference in 2000, entitled *Atypical Gender Identity Development: Therapeutic Models, Philosophical and Ethical Issues*, Hird (2003) wrote a feminist commentary about the assumptions she had heard, asking: Why should boys play at rough-and-tumble and only have male friends, and why should girls only play at house and dress in skirts and dresses? And why are the majority of female psychiatrists in the room wearing trousers, with minimal use of make-up and no high heels? What Hird is rhetorically implying in her commentary is that therapeutic models are based on stereotypical aesthetics and behaviors that have become less prevalent in Western societies today. Women and girls playing rugby, martial arts, boxing, climbing or learning to fight in combat situations would perhaps be perceived as somewhat gender non-conforming, but these are just some instances of how gender expressions are changing. Is it possible to suggest, then, that there is a myth surrounding aesthetic and behavioral sex differences, which is not taken into account in the DSM-5?

As feminist research has illustrated, binary sexed behaviors are performative (Butler, 1990; Young, 1990), since genders and sexualities are both socially and clinically shaped by contemporaneous binary gender ideologies and social norms. These norms are produced through what Butler (1990) calls the "heterosexual matrix," where gender roles become naturalized through a parody of the idea of the natural and original. She states: "a sedimentation of gender norms produces the peculiar phenomenon of a 'natural sex' or a 'real woman' [or man…], which […] appear as the natural configuration of bodies into sexes existing in a binary relation to one another" (p. 178).

The DSM-5 Workgroup has disregarded the plethora of work in feminist social science which criticizes the inherency of gender roles, gender identities, and sex differences, as well as research in transgender studies that depicts non-dysphoric transpeople, desires for different embodiments, non-conventional transitioning trajectories, and sexualities. In the pre-publication reports (see Zucker, 2010 for an example), the Workgroup considered only the views and evidence derived from sexological research. A number of texts, which were taken into account, were letters to the Workgroup offering clinical opinion. As such, the review reflects a form of expert clinical consensus based on transpeople's tailored narratives and questionable ideas around masculinity and femininity.

Given the contestations surrounding the etiological basis and medical treatment of GD, inclusion of wider gender-based social science and transgender studies research would have allowed further insights into trans phenomena. A systematic review of a wide range of literature would have provided a more complex understanding of transpeople's lives. As such, there were missed opportunities, firstly, to not reproduce criteria based on stereotypical gendered behaviors and, secondly, to acknowledge the multiple ways for expressing and identifying with a particular gender identity. It may be suggested then that the latest DSM-5 manual is the outcome of expert-sexological consensus, rather than of a systematic synthesis of biogenetic, psychosocial and wider scientific evidence, despite the new diagnosis of GD having been pitched as a product of a democratized process, reflecting wider voices and knowledges (Zucker, 2013).

Against this backdrop, the following sections explore some of these wider voices and knowledges, asking in what ways changing GID to GD in the DSM-5 lessens the stigmatization of transpeople, and also how the different strands of the trans anti-pathologization movement challenge the GD classification in the DSM-5. To examine these points, I will describe some of the strategies, political praxis, and claims from transgender community organizations' and advocates' websites, forums, and blogs (which are by nature international in their scope). I wish to post a methodological caveat: I will not have reached all the internet sources available. Indeed, it is not my intention to be exhaustive. Notwithstanding these limitations, my internet source analysis arguably reaches a fair representation of the various discourses that are circulating within the trans anti-pathologization movement, particularly in relation to contestations surrounding the newly formed diagnosis in the DSM-5.

Claiming an Intersex Embodiment

"Intersex" is a general term used for a range of conditions affecting the chromosomal make-up, the reproductive, and/or sexual anatomy, of a person (Dreger, 1998). In the DSM-5, the authors have included intersex people, conceptualizing them as having a "disorder of sex development"; they can also sometimes suffer from GD. Some trans advocates have deployed the intersex category in an attempt to challenge the psychiatric understanding of GD. Transpeople have often defined their trans gender identities through a "wrong body" narrative, but some have now started to refine and adopt a more sophisticated biogenetic narrative. In particular, some of the trans advocates' claims now evoke a cerebral intersex condition (see Brain, 2012; Gender Identity Research and Education Society, 2006, 2007; Transgender London, 2011; TS-SI, 2008). Drawing on biological research, these advocates have suggested that gender identities are a product of biological dispositions, caused by hormonal influences in the fetus. These hormonal influences are claimed to have produced feminized or masculinized neurological brain structures which, subsequently, direct a post-natal desire to transition. The Gender Identity Research and Education Society (GIRES), for example, describe gender variance on their Home Page as an: "Innate, biological variation. A mismatch between brain-sex and genital-sex" (GIRES, 2010), suggesting this is why transpeople often experience their gender incongruence early in childhood, and why it persists until they pursue transitioning interventions.

This biogenetic narrative is problematic due to the reliance on fixed notions of the binary sexed brain. Neuroscientists have revealed the role of the environment and new experiences in continually re-shaping brains (Vidal, 2012). Nonetheless, trans advocates (GIRES, 2010; SameSame, 2008; Transgender London, 2011) have incorporated recent research by Hare et al. (2009), that claimed to have possibly identified gene variants responsible for undermasculinization and/or feminization in transwomen. This study argued that there was significant association between transsexualism and the AR allele gene (androgen receptor), which may cause feminization or undermasculinization in transwomen, and that gender identity *might* be partly mediated by it. Some trans advocates were quick to disseminate these findings online, and prior to the study being published. For example, one advocate's website, authored by Jade Starr, stated:

> Aussie researchers have reported finding a link between a gene and the production of testosterone in Male to Female transsexuals. After some ground breaking research on this condition which still baffles many people, there finally seems to be some light at the end of the tunnel […] Many transgender people have believed for the longest time that biology had been the cause. I myself believe this as my earliest memories were that of wanting to be a girl even before I learnt to spell. Hopefully, further studies like this will prove beyond a shadow of doubt that the phenomenon is a natural occurrence, leading to social acceptance of transgender people (SameSame, 2008).

Hare et al.'s (2009) study actually found a very weak association, contradicting the study that it tried to replicate (Henningsson et al., 2005). It has, since, failed replication in another study (Ujike et al., 2009). Moreover, the connections between neurological precursors to behavior are not well understood at present and, according to neuroscientists such as Herschkowitz (2000):

> [A] comprehensive understanding of child development requires the consideration of the constant close interaction of genome, environment and behavior. Genes code for proteins, and not directly for behavior. The proteins are a basis for metabolism, structure formation and physiological functions. Gene realization, however, is modulated by environmental factors. (p. 415)

Similarly, the neuroscientist Greenfield (2002) has mockingly suggested that researchers using depictions of brain structures determining behaviors often infer that there is an "autonomous little [wo]man lurking beyond the neurons" providing some "top-down control" (pp. 30–31), as if neurons had some form of consciousness. Greenfield's critique highlights that in some 'biological' research cultural assumptions are imported into the analysis in order to claim that genes have behavioral and expressive qualities. However, biology does not unilaterally determine human activity. The advocates' websites rarely offer any indication of what feeling like a man or a woman is like, or what gendered feelings the genes are imputed to affect. Given the precariousness of claiming a universal masculinity and femininity, highlighted above, the appeal to genetic explanations inadvertently results in essentializing particular ways to be trans, alongside a failure to take into account the multiple ways that transpeople live their lives. As a result, the diverse performances of gender, and phenomenal variation remains invisible, and the activist discourses on these sites profoundly ahistorical.

It is unclear how the biogenetic claim to be somebody with an intersexed condition will lessen the stigma surrounding transpeople or subvert psychological pathologization. I am unaware of any research, to date, that has explored the political effects of such biological strategies. The biogenetic position may also prove to be problematic in a number of other ways: For instance, the claims to a biogenetic intersex disposition and a particular gender identity simultaneously are untenable, because they are underpinned by two different logics: The notion that intersex people are inherently one gender or *the other* and compelled to transition because of an underlying biogenetic position is too simplistic. Research into multiple forms of intersex illustrates that there is more variability to gender identity outcomes than was previously assumed. Cohen-Kettenis (2010) found many prenatally testosterone-exposed individuals raised as girls continued to have an adult female gender identity. Moreover, masculine gender role behaviors in female-raised children should not be mistaken for a male gender identity. As Cohen-Kettenis has argued, it is important to distinguish between gender identity and gender role when considering intersex people. In this research, "gender identity" is characterized as a sense of oneself as male, female or indeterminate, whereas "gender role" is characterized as behaviors, personality traits, and interests that society applies to these aspects, and the way that people (are) measure(d) against stereotypical attributes.

The line of argument that suggests that GD unavoidably develops from an intersex condition logically presupposes intersex people are either male or female. While there is evidence to suggest that many intersex people do identify with a particular binary gender identity and some do wish for normative bodies, the neuroscientists above, as well as some sexologists, argue that we cannot discount postnatal psychosocial and environmental factors as immaterial to embodied experiences of gender identities (Cohen-Kettenis, 2010; Cohen-Kettenis & Pfäfflin, 2010; Diamond, 2002; Greenfield, 2002; Herschkowitz, 2000).

Intersex embodiment corresponding to a particular gender identity is not always evidenced in the literature (de Vries, Doreleijers, & Cohen-Kettenis, 2007). Connecting intersex

with a particular binary form of gender identity is problematic (Diamond, 2002; Hester, 2004; Holmes, 1995; Intersex Society of North America, 1993–2008), since some intersex people want to live beyond a binary system of gender roles, gender identities, and embodiment. As Macdonald from the UK Intersex Association states: "Given the choice of male, female or intersex I would unhesitatingly select intersex. But society does not give me that option" (cited in Phillips, 2001, p. 41). Similarly, over the last decade, Elan-Cane (2014) has been at the forefront of a non-gendered/bigendered campaign to recognize people beyond the medico-legally entrenched binary sex/gender system. Elan-Cane calls for an X on identity documents in the UK, in line with other nations (Australia, New Zealand, India, etc.), that recognizes those who experience their gender beyond male, female, and binary transgender identities.

Trans advocates' essentialist claims of GD seem to assume that society will be more accepting of transpeople if they are understood to have been "born this way." This may be because biogenetic scientists are socially legitimated experts. Given the relative power that biogenetic discourses maintain in society and particularly in medicine, this seems like a wise appropriation by advocates of the few available biological studies. However, the trans web-based materials depicting intersex embodiment and the desire to transition to a particular gender tend to mirror the simplistic dualisms from biological research, in which masculinity and femininity are regarded as natural rather than socially constructed, characteristics. This strategy neither challenges psychological notions of GD, nor subverts psychiatric power over transpeople's perceived intersex conditions. Even so, to move discursively from a psychiatric pathology narrative to a bodily pathology narrative may change the power relations that constitute the trans subject in unpredictable ways. These biogenetic arguments are not ubiquitous in trans advocacy, however, and I turn now to another arm of the anti-pathologization movement, which attempts to foster a sense of collective identity upon which claims of recognition, technological interventions, and self-determination healthcare pathways are sought.

Self-Determination as Political Praxis

Following the announcement that the DSM was to be revised, arguments emanated from both clinical and trans advocacy quarters (Burke, 2011; Drescher & Byne, 2012) with regard to how the diagnostic criteria for transpeople should be expressed. There is evidence on some trans advocates' websites confirming Vance et al.'s (2010) claim that trans welfare organizations wanted a change in taxonomy, diagnostic criteria, and language use in the DSM-5 for trans-related issues in order to better reflect the distress gender incongruence causes. In a DSM-5 prepublication report, Vance et al. also argued that some trans advocates wanted to retain the diagnosis because of issues surrounding insurance payments to healthcare providers in the North American context. This rationale for the inclusion of GD seems to shift from clinical to economic reasoning, and does not justify the diagnosis for other trans advocates (Burke, 2011). The DSM-5 affects many transpeople beyond the American borders (Hammarberg, 2009). For example, recent guidance from the British National Health Service and The Royal College of Psychiatry in England in both cases unreflectively adopted the diagnosis of GD in their policies (NHS England/medical directorate, 2013; Royal College of Psychiatrists, 2013), assuming that all transpeople who want to physically transition suffer from this condition.

The World Professional Association for Transgender Health's (WPATH) Standards of Care 7 (SOC7) (WPATH, 2011), whose membership consists of clinicians, researchers, and trans advocates, takes a different approach. WPATH have established a language which mandates a shift in trans healthcare from a gatekeeper to a collaborative model, in order to address widespread problems with access, provision, and delivery of health services for transpeople. The SOC7 stresses that it is important for healthcare professionals to recognize that transpeople's health interventions should be principally based on patients' decisions. As such, the responsibility of the professional should be to assist patients with making fully informed decisions about transitioning, situating the clinical support in a patient-centered framework. SOC7 also states that: "the distress of GD, *when present*, is the concern that might be diagnosable and for which various treatment options are available" (WPATH, 2011, p. 6, emphasis added). According to these guidelines, GD need not be present.

As the DSM-5 diagnostic criteria insist on evidence about dysphoria, it cannot function in relation to the SOC7 where dysphoria is not present. Another problem psychiatrists may have to face is that of attempting to determine whether their patients are gender dysphoric, or whether distress manifests for other reasons. This may undermine the ability to appropriate SOC7's recommendations, because of an ambiguity between gender stressors and social stressors. For example, social alienation (Newfield, Hart, Dibble, & Kohler, 2006), negative social relations, rejection, maltreatment, and victimization are all reasons given by trans youth for suicidal ideation, and are central to their experience of distress (Grossman & D'Augelli, 2006, 2007). The distress narratives that gender clinic psychiatrists encounter in their patients, thus, need to be teased out with regard to the performative functions of the GD diagnosis and other clinically important stressors. It is unclear, however, how gender clinic psychiatrists can differentiate between the two. As Zucker, Owen, Bradley, and Ameeriar (2002) have suggested, the vast majority of children and adolescents would not qualify for a diagnosis of GD on this basis in clinical observations, because it is not clear to what extent psychiatric impairments are a consequence of GD. This may result in false positive and false negative diagnoses (GID Reform Advocates, 2010).

Although the current GD diagnosis allows psychiatrists to help transpeople pursue gender transitioning technologies, there are no concessions in the DSM model of GD around transitioning as rational self-determination and agency. For those transpeople who suggest they want to self-determine their gender identity, and who are of sound mind with no dysphoria, utilizing the diagnosis of GD inevitably places them at odds with or only artificially with the DSM-5 criteria.

One other alternative approach to this dilemma leads to the final exploration this article will consider, of how some trans activists have challenged the DSM-5 classification of GD. Although the majority of trans activists reject the pathologization of gender variance (Burke, 2011), some advocate complete de-medicalization, others, diagnostic reform. Advocacy for each position is influenced by the perceived costs of access to medical procedures versus the benefits of diagnosis. Some trans advocates argue on their websites that it is erroneous for the DSM-5 to label variations of gender expression as symptomatic of a mental disorder (TGEU, 2012). For example, the slogan used in the 2014 Call to Action from Stop Trans Pathologization is *Stop Trans Pathologization—Stop Pathologizing Gender Diversity in Childhood—For the Diversity of Gender Expressions and Identities*. These advocates suggest that the need to change gender (markers) is a form of rational self-determination, and not a mental health issue (GID Reform Advocates, 2010; TGEU, 2012). Assuming an inner-self who desires such a transformation, gender transitions are thus situated in a non-essentialized experiential framework, anchored in self-determination. GID Reform Advocates (2010) argue that the only conceivable way of eventually removing the stigma surrounding transpeople is by removing the connection between psychiatry and the healthcare pathways altogether, and that transitioning should be seen as a human right within a health framework. Added to this, Drescher (2013) also argues, the retention of a psychiatric diagnosis may not lead to de-stigmatization, because any financial access is based on being pathologized. Indeed, some members of the Working Group for the proposed International Classification of Diseases 11 diagnoses regarding transsexualism have claimed that, by persevering a psychopathological model in relation to trans-specific categories, rather than relieving stigma and providing medical and social recognition, may have the opposite effect (Drescher, Cohen-Kettenis, & Winter, 2012).

In 2011, the Ministry of Health in France proclaimed that transsexualism would no longer be classified as a mental disorder. Activist circles suggested this was the beginning of a de-psychiatrization of transsexualism (Giami & Beaubatie, 2014). This policy shift has undoubtedly been influenced by the self-determination model, which challenges healthcare professionals to work towards supporting transpeople's health interventions and reducing the psychopathological framework they have historically worked with. In effect, this policy change removes the requirement of GD, or transsexualism, as a diagnosis for attaining medical and legal gender transitions. Argentina, Denmark and Malta have also removed the need for a psychiatric diagnosis prior to receiving transitioning technologies, if so desired; a reformulation of healthcare provision which is currently being debated in Norway, Sweden and elsewhere.

It is beyond the scope of this article to consider the potential negative effects of removing the psychiatric diagnosis from the healthcare pathways, and the provision of transitioning technologies for transpeople. Nonetheless, international groups of advocates regard a self-determination framework as more aligned to the diverse healthcare pathways required by transpeople, and have extensively argued that access to transitioning technologies should be disconnected from psychiatric referrals (Cuban Multidisciplinary Society for Sexuality Studies, 2010; TGEU, 2012). Since 2009, the group Stop Trans Pathologization (n.d.) have throughout the month of October coordinated demonstrations with activist groups from different world regions, demanding trans de-pathologization. Their website emphasizes within a human rights discourse that every transperson has a right to actualize their transition, as far as they wish it to go. Argentina in 2012, Denmark in 2014, and Malta in 2015 have enacted progressive trans recognition laws. As one prominent Argentinian activist wrote on Transgender Europe mailing list:

> So far, there is no law comparable with the Maltese Act when it comes to be about combining recognition with protection [of transpeople], and the introduction of sex characteristics as a legal ground extends for the first time those recognitions and protections to intersex people, which is a true legal revolution. And so far there is no law comparable with the Argentinian Law when it comes to be about combining recognition with full access to healthcare through affirming transpeople's autonomy and State obligations (Cabral, 2015).

In the *New York Times* online, 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).

The Argentinean and Maltese laws, clearly influenced by anti-pathologization advocates, are underpinned by a reframing of transpeople as non-pathological. Such legislation provides an illustration of how advocates have begun to reduce the influence of psychiatry in gatekeeping transitioning technologies, without evoking the dualist notions of body and mind, and without conflating gender role with gender identity.

Stone (1991) observed that a liberal transsexual politics should direct its energies towards the human rights of transsexuals rather

than, for example, challenging psychomedical constructions of transsexuality. Some trans advocacy such as GID Reform Advocates (2010), has focused its energies towards both challenging psychiatric constructions of transsexuality and demanding a self-determination, human rights approach to healthcare and legal recognition, arguing that expressions of gender are "expressions of sexual diversity" (Cuban Multidisciplinary Society for Sexuality Studies, 2010). Similarly, another prominent group has argued that attempting to diagnose the trans population under one idiom is "a pointless exercise" due to them having heterogeneous narratives, transitioning trajectories, and desires (TGEU, 2012). More importantly, according to GID Reform Advocates' website, transpeople should not be diagnosed with a psychiatric condition because "difference is not disease, nonconformity is not pathology, and uniqueness is not illness." It seems that some politicians in Europe have begun to listen to trans advocates by acknowledging transpeople's human rights, and creating policy that revises procedures for accessing healthcare. With an overwhelming majority, the Parliamentary Assembly of the Council of Europe (2015) has recently adopted a comprehensive resolution on transpeople's human rights. The Assembly calls upon member states to make trans-specific healthcare accessible and ensure that transpeople (including children) are not labelled as mentally ill in national or international classification manuals. Anti-pathologization advocates have been at the forefront of these developments. From a self-determination position, these advocates have helped redress the notion of transgender pathology, and questioned the assumed role that GD has in the lives of every transperson. They have also insisted that transpeople can actualize their embodied needs rationally, euphorically perhaps, and in whatever ways they desire, without the need for psychiatric gatekeeping in the form of GD diagnoses.

Conclusions

The DSM-5 diagnosis of GD is too new yet to allow us to fully understand its impact; whether it will lessen the stigma surrounding transpeople, as the authors hope, and how it will affect the clinical narratives of transpeople when they attend gender clinics requesting transitioning technologies to change their bodies. While psychiatric recognition of transpeople has undoubtedly been used to access and provide transitioning treatments in many jurisdictions, the clinical narratives expressed in psychiatric consultations are being tailored in line with the DSM criteria, and have helped to reproduce outdated stereotypes surrounding transpeople's lives. This is problematic, because the data used to support the diagnosis of GD is shaped by the frames of reference and phenomena which emerge from clinical contexts. The diagnosis of GD, rather than embracing wide ranging expressions of (trans) gender, renders invisible the complexity in transpeople's lives.

The shift in the diagnostic criteria from GID to GD has been riven by contestations about the continuing power of psychiatrists over trans embodiment and legal recognition. The semantic change from GID to GD in DSM-5 may be an attempt to rectify the mismatch between Gender Identity Disorder and the distress that *may* manifest from being a transgender person. However, the debates around perceived harms done through psychiatric pathologization are ongoing. Trans advocates have suggested that psychiatric involvement in healthcare pathways and legal assistance for those people who want to have a different body and/or corrected legal gender assignment should not be a requirement. They have succeeded in securing this in France, Denmark, Argentina, and Malta; an agenda which is being discussed elsewhere. In these countries, transpeople are legally recognized and are given access to healthcare services despite psychiatry being removed as the gatekeeper, and because of transpeople demanding healthcare and legal recognition through a self-determination model of gender variance.

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