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Should 'gender dysphoria' be classified as a mental illness?

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ABSTRACT
One's internal sense of gender, or also known as gender identity, is a complex and multi-layered construct. While most people experience a congruency between their anatomical parts and their gender identity, some do not. This exception has led to its classification as a mental illness called "gender dysphoria (GD)"in the Diagnostic and Statistical Manual of Mental Disorders (DSM), also known as the clinical bible of psychiatry.This paper will explore this issue from various perspectives. First, some cross-cultural empirical research will be presented to argue how the classification of GD as a mental illness further cements binary understandings of sex that further complicates the issue. Next, this paper will also explore how simply de-classifying it from the DSM may pose some dire consequences for those currently benefitting from corrective therapies. The aim of this paper is not to provide a concrete solution for the issue. Rather, it is to illuminate the complexity of the issue by analyzing both sides of the debate.

KEYWORDS
Gender dysphoria (GD), Diagnostic and Statistic Manual (DSM), Mental Illness, Gender Identity Disorder, Feminist Theory, Transgender Issues, Sexuality

One's internal sense of gender, or also known as gender identity, is a complex and multi-layered construct. While most people experience a congruency between their anatomical parts and their gender identity, some do not. This exception has led to its classification as a mental illness in the Diagnostic and Statistical Manual of Mental Disorders (DSM), also known as the clinical bible of psychiatry. During its first incorporation into the DSM, the disorder was named Gender Identity Disorder (GID). However, in the most recently revised version, DSM-V, the name was revised to Gender Dysphoria (GD). While the diagnostic criteria have slightly evolved since its first incorporation in the DSM as GID to its revision as GD, it nevertheless remains a mental illness inscribed into the clinical bible of psychiatry. The issue of the classification of GD in the DSM has been long contested among various critics. In this paper, I will explore both sides of the debate: those who argue against its classification and those who argue in favor of its classification. First, I will provide some background information on the issue in relation to the DSM. Second, will bring forth cross cultural research on the issue of gender identity to argue that the classification of GD may have been the unfortunate consequence of a binary model of sex and gender identity that may not necessarily be correct. Second, I will expand upon the aforementioned point by contrasting GD with the other mental illnesses outlined in the DSM. Lastly, I will explore the other side of the debate by arguing how simply declassifying it from the DSM may pose some dire consequences for those currently benefiting from corrective therapies. The aim of this paper is not to provide a solution for the two sides. Rather, my aim is to illuminate the concerns of the two sides with the ultimate conclusion that the solution of declassification from the DSM that opponents had previously argued for may not necessarily be the correct method of rectification.

One of the most influential works in the discipline was by Dr. Harry Benjamin and the publication of his work, The Transsexual Phenomenon, in 1996. In it, he rejected psychological counselling as a valid treatment method for individuals experiencing incongruity in their gender identity, and instead helped to pioneer hormonal and surgical treatment methods that are still in use today. Fourteen years after the publication of Dr. Harry Benjamin's work, the Diagnostic and Statistical Manual of Mental Disorders (DSM), also known as the clinical bible of psychiatry, introduced a new mental disorder, known as Gender Identity Disorder (GID). GID was founded on the "identity" issue – namely, the condition was

categorized as an illness because incongruity between one's anatomical parts and their gender identity was seen as a mental illness. In May of 2003, the DSM came out with its most recent version and revised GID to be named Gender Dysphoria (GD). Instead of an emphasis on incongruity as the main criterion for its classification, a new emphasis was placed on distress. That is to say, an individual may not be deemed under the criterion of the new DSM to suffer from GD unless said individual experiences significant distress stemming from the lack of congruency felt by the individual. Thus, under the new revised version of the DSM, it is no longer considered a mental illness to identify with a gender that is opposed to one's biological sex (e.g. a biological female identifying as masculine). Rather, the question becomes whether this incongruence causes one significant distress.

While the doing away of incongruity as itself a diagnostic criterion has been interpreted by some as a transition away from societal understandings of gender identity as directly linked to one's biological sex, it nevertheless does not sufficiently address the influence that societal norms regarding the link between biological sex and gender have on one's mental distress. For example, how might the state of one's mental distress differ if one were situated in a society that does not assume a direct link between one's biological sex and one's gender identity? In some cultures, gender variance is expected and celebrated (Newman, 2002). Within these cultures, cross gender identity and cross gender performativity – the performance of cross gender norms – is not only prevalent but also celebrated. As a result of the lack of negative valence placed on these cross gender instances, individuals are not distressed because of their lack of incongruity (Newman). For example, the Zuni tribe of North American Indians does not see gender as intrinsically linked to anatomical parts. Sex at birth is not assigned; instead, sex is "discovered" via the use of intricate rituals and thus, cultural practices are used to interpret biology (Newman). Within this group of individuals, the Berdaches are a group of cross-gender individuals who are seen as a "third gender" – one that transcends binary male and female or masculine and feminine categories. They are assigned high social status within their spiritual and religious hierarchal system (Newman). The implication of these findings suggest that a significant factor contributing to one's distress stemming from their experience of incongruity in North America is the binary model of gender, where one's biological sex as male or female is causally linked to one's gender identity as either masculine or

feminine, respectively. If such a binary model were to be replaced by a more flexible model, such as the one mentioned in the Zuni tribe, far less individuals may experience distress.

Distress is a criterion common to the diagnosis of almost all mental illnesses in the DSM. Likewise, such a criterion, as mentioned above, is also one involved in the classification of GD as a mental illness. However, the criterion of distress for GD differs from the criterion of distress for many of the other mental illnesses in the DSM in that the cause of distress is significantly different for the two groups. For example, if an individual is depressed or suffers from attention deficit hyperactivity disorder, then the individual is distressed as an integral part of having depression or attention deficit disorder. In contrast, I have mentioned in the previous paragraph that distress in GD is not necessarily an integral part of GD. Rather, it seems to be caused by societal understandings of gender and the valence placed on congruence or incongruence. This difference between the cause of distress for GD in comparison to the other mental illnesses listed in the DSM has been argued by some as grounds for its declassification. In particular, many have argued that since distress in the diagnosis of GD seem to be a result of a deviation from societal norms, keeping it in the DSM will only serve to pathologize those do deviate from societal norms. This argument is often made by paralleling the classification of GD with the classification of homosexuality.

Many have paralleled the classification of gender dysphoria with homosexuality, as both are deviations of societal norms and thus, should not be categorized as mental illnesses. However, the difference in the two conditions is that patients of the former condition have benefited from treatment while the latter cannot be treated. Thus, the removal of the former from the DSM can have dire consequences for individuals hoping to seek hormonal or surgical therapies. If classification of gender dysphoria as a mental illness means that treatments would be available for patients hoping to alleviate their distress, then de-classification of it would render the demise of insurance coverage of treatment options for some individuals. In a survey of 43 organizations working with gender variant individuals, 55.9% voted that gender dysphoria should be declassified from the DSM. However, of the individuals who voted for the status-quo, the main reason for doing so was for health care reimbursement needs (Vance et al., 2010). Thus, while the argument that classification of GD may pathologize individuals

who deviate from gender norms, simply declassifying it from the DSM may be too simplistic of a countermeasure.

Gender is not static. Its meanings change across cultures, across social organizations, and across historical periods. It is a fluid construct shaped by social, cultural and historical norms, reflecting the prominent themes dominate in said categories. Gender identity, then, is a multidimensional, multi-intersecting continuum that is not fixed nor anchored to anatomical parts. The distress some individual feel which prompts them to seek treatment for the condition is not a function of a disruption in their psyche. Rather, it may be the distress from nonconformity or from the internalization that they themselves are deviant for not conforming. Thus, while keeping GD in the DSM may further pathologize said individuals, simply declassifying it may not be the correct countermeasure either. Specifically, it may carry with it dire practical consequences for those hoping to seek health care reimbursements for the treatments that have helped them alleviate some of their distress.

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