New Zealand Sociology Special Issue: Theorising Mental Health
2023, Issue 38, No. 1, 18–28

Homosexuality in the DSM: A Critique of Depathologisation and Heteronormativity

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Abstract
This article provides a critical overview of both the historical and current diagnostic categories from the *Diagnostic and statistical manual of mental disorders* (DSM) that perpetuate heteronormativity. By drawing on critical scholars from queer theory, transfeminism and Marxist fields, I analyse two diagnostic categories (gender identity disorder of childhood and transvestic disorder) to argue that, contrary to the official narrative presented by the American Psychiatric Association, such classifications pathologise queer sexualities and gender nonconformity. The article concludes by suggesting that the American Psychiatric Association should be held to account for the historical and contemporary harm caused by the pathologisation of homosexuality and gender nonconformity, and calls for an end to psychiatric research that furthers the development of such diagnostic categories.

Keywords: DSM; heteronormativity; homosexuality; medicalisation; transgender

Introduction

The *Diagnostic and statistical manual of mental disorders* (DSM) is often referred to as the 'Bible of Psychiatry' (Geppert, 2006; Jabr, 2013; Kutchins & Kirk, 1997). It contains the American Psychiatric Association's (APA) criteria for all mental illness classifications, their diagnostic codes and various assessment measures (American Psychiatric Association, 2013). Presently in its fifth edition (DSM-5), the DSM has undergone several reformulations since its conception in 1952. The change of relevance to this analysis is the Association's removal of homosexuality from the DSM-II in 1973. With the ever-increasing expansion of the DSM's scope, it is of particular interest to investigate an instance where a diagnosis has been removed. This is because it is uncharacteristic of the medical profession to retract their control over an area of human behaviour; a trend particularly true of psychiatry (Cohen, 2016; Conrad, 2007).

The shifting language used to define the diagnosis and the negotiations surrounding homosexuality throughout its history in the DSM provide insight into the construction of psychiatric nosology, and illustrates the role of politics and professional power in the development of diagnoses and treatment alike (Conrad & Schneider, 1992; Kirk & Kutchins, 1992). Further to this, the framing of sexuality and gender in the DSM reveals the embedded heteronormative discourse in psychiatry. Upon a closer examination of related diagnoses after homosexuality's removal, it will become clear in this article that homosexuality has not been depathologised but instead recycled into other diagnoses such as the classification of gender identity disorder of childhood and transvestic disorder. To demonstrate this, I will draw on various critical perspectives, including feminism and queer theory. Ultimately, this article will argue that the DSM perpetuates heteronormativity

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through the continued pathologisation of homosexuality. It will also touch on the relationship between heteronormativity and the reproduction of social relations for the benefit of capitalism.

It should be noted that there is a significant overlap between the homophobic and transphobic rhetoric in the DSM (Tosh, 2016). The aim of this article, however, is to demonstrate that these are not mutually exclusive, but rather, rely on the very same patriarchal norms that serve the maintenance of capitalism. Furthermore, this article will critique the concepts put forward in the DSM rather than the people who use this language to describe their lived experiences. Psychiatric discourse is a totalising force that has embedded itself in almost all aspects of everyday life (see Cohen, 2016), including but not limited to sexuality and gender. It follows then that various communities—for instance, the transgender community—often take up the language imposed upon them by institutions of authority, such as psychiatry and medicine (see Pearce, 2018).

The official history of homosexuality as pathology

Pathologisation: Psychopathology and phobia

The first to suggest that homosexuality was psychopathological was German psychiatrist Richard von Krafft-Ebing. In his book *Psychopathia sexualis* (1886/2006), von Krafft-Ebing deemed all non-procreative sexual behaviour a form of psychopathology (Drescher, 2015a). This notion of homosexuality as a mental disorder stayed with the fields of psychology and psychiatry, despite Sigmund Freud's assertion that it was merely an 'arrested' form of psychosexual development which did not need to, nor could be, 'cured'. The following generation of psychoanalysts viewed homosexuality as a 'phobic' avoidance of the other sex that could be righted through psychoanalytic intervention (Drescher, 2015a). Consequently, homosexuality featured as a mental disorder in the first edition of the DSM (American Psychiatric Association, 1952, p. 39). As Fischer (2012, p. 1027) states of the appearance of this diagnosis in the manual, "pathologising homosexuality was not simply meant to reinforce social mores but was based on a real belief among psychiatrists at this time that homosexuality was symptomatic of psychological illness."

Depathologisation: Suboptimal but functioning citizens

The official story of homosexuality's departure from the DSM is one of scientific advancement, social consciousness and normalisation (Drescher, 2015a; Fischer, 2012). Between the DSM-I (American Psychiatric Association, 1952) and DSM-II (American Psychiatric Association, 1968), homosexuality was reclassified from the category of 'sociopathic personality disturbance' to the categories of 'personality disorders' and 'sexual deviation'. The continued existence of homosexuality in the DSM was eventually challenged by gay activists in the early 1970s, with "disruptive protest" at each annual meeting of the APA until 1973 (Drescher, 2015b, p. 387; Kirk & Kutchins, 1992). The protestors not only disrupted presentations but also forced the APA to schedule panels where they could present countering views on homosexuality, arguing that it was a normal variation of sexual activity rather than something abhorrent and pathological. In 1972, an anonymous psychiatrist, wearing a mask and cloak, declared at one such panel that he was a homosexual and one of over two hundred members of the Gay Psychiatric Association who met secretly during these annual meetings (Kirk & Kutchins, 1992). Robert Spitzer, a member of the APA Committee on Nomenclature and Statistics, was prompted by the protests to re-evaluate whether homosexuality was a mental disorder or merely 'suboptimal' behaviour (Spitzer, 1973). In light of Spitzer's subsequent proposal that mental disorders should be characterised by subjective distress or an impairment in social functioning (Drescher, 2015b)—a novel definition which, if taken up by the APA, would largely suggest the absence of mental illness within the gay community—the annual APA meeting in 1973 was dominated by member debate for and against the removal

of homosexuality from the DSM. Led by Spitzer, and following the consensus of the Nomenclature Committee, in December 1973 the APA Board of Trustees finally voted for homosexuality to be deleted from the DSM (Kirk & Kutchins, 1992).

This is where the presence of homosexuality per se in the DSM ends. However, even in the official history, it has been noted that queer people continued to be pathologised in the DSM (Drescher, 2015b). By way of compromise between gay activists and those in favour of homosexuality remaining a diagnosis, the APA replaced it with a new disorder known as 'sexual orientation disturbance' (SOD) in a reprint of the DSM-II (American Psychiatric Association, 1973, p. 44). SOD was defined as "individuals whose sexual interests are directed primarily toward people of the same sex and who are either disturbed by, in conflict with, or wish to change their sexual orientation" (American Psychiatric Association, 1973, p. 44). In 1980, the DSM-III (American Psychiatric Association, 1980) replaced SOD with 'ego-dystonic homosexuality' (EDH) and reclassified it under the new category of 'psychosexual disorders'. EDH had very similar criteria to SOD, except it now explicitly stated that patients with EDH wished to change their sexuality to heterosexual. The revised manual, the DSM-III-R, in 1987 did not refer to homosexuality overtly, replacing EDH with 'sexual disorder not otherwise specified' which was defined simply by "marked distress about one's sexual orientation" (American Psychiatric Association, 1987, p. 296). Fischer (2012, p. 1028) argues that this change reflected not only the acquisition of new medical information and an evolution in thought, but also "marked a step toward depathologising homosexuality". This diagnosis was, in turn, removed from the latest edition, the DSM-5 (American Psychiatric Association, 2013), without replacement.

Following the removal of homosexuality from the DSM, it has been suggested that there is no longer a medical or scientific rationale for discrimination against homosexuals within institutions (Drescher 2015a). The proposed result of this was that debates around homosexuality returned to the moral and political realm, which in turn contributed to an increase in legal rights for queer people, such as the repeal of sodomy laws, a growing number of marriage equality laws, and laws protecting the human rights of lesbian, gay, bisexual, transgender and queer (LGBTQ) people in many countries across the globe (Drescher, 2015a). As psychiatrist Jack Drescher (2015a, p. 572) rhetorically asks: "If gay people are able and prepared to function as productive citizens, then what is wrong with being gay?"

The critical history of homosexuality in the DSM

Pathologisation and theoretical frameworks

Scholars of medicalisation and social control, such as Conrad and Schneider (1992), argue that the case of homosexuality illustrates the historically complementary relationship between religious, legal and medical institutions. Conrad and Schneider (1992) demonstrate how each institution has supported the definition of homosexuality as a social deviance through general moral definitions across time. This perspective challenges the idea that the medicalisation of homosexuality was a product of scientific and social progress, and instead proposes that each 'new' iteration of thinking around homosexuality conveys the same underlying message of social and moral deviance (Conrad & Schneider 1992). While the medicalisation literature on homosexuality provides a compelling counter-perspective to the official narrative of 'progress' posed by the 'psy'-professions (such as psychiatry, psychology, psychotherapy, counselling and mental health nursing) above, it does not explain why these institutions are invested in social control. To address this, I will turn to the intersection between feminist and Marxist theory.

A critical perspective that effectively explains the emergence of homosexuality as pathology is *social reproduction theory*. Throughout Western history, the church, state and medical institutions have demonised,

criminalised and pathologised any sexual relations not for reproductive purposes, including homosexual behaviour (Conrad & Schneider, 1992). Berlant and Warner (1998) refer to this history as heteronormative; that is, the project of normalisation whereby a specific form of heterosexuality has been constructed as a part of human nature and the foundation of 'healthy' human societies (Sears, 2017). Heteronormativity is the product of social relations under capitalism, which organise production and reproduction according to the needs of capital. Specifically, the reproduction of the worker is reliant on the unpaid labour of women (see Bhattacharya, 2017). Thus, it follows that the institution of psychiatry has taken up the role of enforcing heteronormative gender roles as those that ensure the reproduction of the labour force (Cohen, 2016; Cohen & Hartmann, 2021), with all relationships falling outside of reproductive, heterosexual couplings considered a threat to capital.

While critical feminist scholarship in this area typically focuses on how women have been regulated and controlled by the psy-professions across history (see, for example, Chesler (2005) and Ussher (2011), similar critiques can be made of the construction and regulation of gender nonconformity, particularly with respect to femininity. The impact of psychiatry as an institution of patriarchal power is not limited to only women but to all people who deviate from the norm. Furthermore, although psychiatry has been critiqued for conflating gender, sex and sexuality (Tosh, 2016), queer theorist Judith Butler (2006) has argued that the social construction of 'woman' and 'man' within the heterosexual matrix does delineate certain bodies, behaviours and desires to each category. That is, heterosexuality is a defining feature of the gender roles ascribed to men and women, which places them in a binary, hierarchical relationship (Butler, 2006). By understanding sexuality and gender as culturally contingent and socially constructed in relation to one another, we cannot then ignore the relationship between the two. The role of psychiatry in maintaining and reproducing heteronormative gender roles is evident in both the historical and contemporary language used to describe gender. As the following sections will demonstrate, despite its claims of depathologisation, the DSM continues to pathologise non-heterosexual people and behaviours through heteronormative discourse in its nosology.

Depathologisation 'per se'

Critical scholars have questioned the APA's basis for depathologisation. Kirk and Kutchins (1992), for instance, examine the controversies leading up to the development of the DSM-III (American Psychiatric Association, 1980) to demonstrate that the decisions made regarding homosexuality as a diagnosis were the product of pressures and political conflicts within the APA. Although they acknowledge the role of gay activists at the time, they emphasise that it was not a decision made out of progressive social consciousness among psychiatrists but an effort to retain professional legitimacy over the field of mental pathology (Kirk & Kutchins, 1992).

Furthermore, the removal of homosexuality from the DSM has been framed by actors in the APA in such a way that they can make claims about the Association's progressive stance, with little acknowledgement of their historic contribution to pathologisation. For example, Drescher (2012) asserts that, due to the medical authority of the APA, their decision to remove homosexuality from the DSM-II (American Psychiatric Association, 1968) contributed to significant social and legal change for queer people across the globe. Despite no declaration of this in his 2012 article "The removal of homosexuality from the DSM: Its impact on today's marriage equality debate", Drescher himself was on the Task Force for the DSM-5 (American Psychiatric Association, 2013). By positioning themselves as leaders in the rise of legal rights and social change for the queer community, the APA attempts to conceal the ongoing pathologisation of homosexuality and deeply rooted heteronormativity in the subsequent editions of the DSM.

Gender identity disorder of childhood

Other critical writers, such as medicalisation scholars (see, for example, Conrad (2007)) and feminist theorists (for example, Tosh (2016)), have challenged the notion that homosexuality has been depathologised at all. Authors from these perspectives often look at the case of gender identity disorder, particularly gender identity disorder of childhood (GIDC), which emerged as a diagnosis in the DSM-III (American Psychiatric Association, 1980). GIDC is defined by the APA (2000, p. 576) in the text revised version of the DSM-IV (DSM-IV-TR) as a "strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex". To be able to make a diagnosis of GIDC, there must be evidence of persistent discomfort with one's assigned sex or the gender role associated with it, as well as clinically significant distress or impairment (American Psychiatric Association, 2000).

The earlier drafts of GIDC in the DSM-III (American Psychiatric Association, 1980) generated some internal criticism in the APA, namely from feminist mental health professionals and members of the Committee on Women (Bryant, 2007). One of their concerns was that the existing research and clinical evidence was only on children assigned male at birth (AMAB) and could not be extrapolated to children assigned female at birth (AFAB). They argued that it made sense for 'little girls' to identify as boys, given the effect of living in a sexist society where adult males tend to hold more status, privilege and power than adult women (Wolman letter to Spitzer, 30 May 1977, in Bryant, 2007). The Committee on Women also took issue with the problematisation of gender-neutral or androgynous gender roles, stating that this did not account for feminist childrearing practices that were actively trying to overcome gender stereotypes (Bernard letter to Chappell, 27 May 1977, in Bryant, 2007). These critiques informed the published definition of GIDC, removing references to gender stereotypes and focusing on gender identity, establishing separate criteria for AMAB and AFAB children, and explicitly stating that AFAB children could not be diagnosed if they identified as a boy for the "perceived advantages" (Bryant, 2007, p. 183). However, none of these critiques made note of the potential relationship between childhood gender nonconformity and homosexuality, which had been linked in previous research (see, for example, Green (1968) and Zuger (1966)).

From a medicalisation perspective, Conrad (2007) posited that homosexuality could be remedicalised through the GIDC diagnosis. He connected the relatively newer research (that is, studies that took place after the publishing of the DSM-III) on feminine boys and adult homosexuality, mainly drawing on Green's (1987) study that found that, of a group of boys diagnosed with GIDC until adolescence, 75 per cent of them developed either bisexual or homosexual desires. Conrad (2007, p. 104) concluded, based on the link between GIDC and bisexuality or homosexuality, that GIDC might have been "medicalising prehomosexual behaviour" and thus potentially remedicalising homosexuality. Although Conrad (2007) challenged the APA's assertion that homosexuality had been depathologised, he did little to expand on what 'prehomosexual behaviour' was and why that applied in this case. This perspective takes sexual orientation as something fixed, that most (if not all) queer men will engage in an innate development of their sexuality that will (most likely) involve behaviours from the GIDC criteria. Perhaps the more appropriate question to ask here is: What does the case of GIDC reveal about the psychiatric discourse on the correct performance of gender and, therefore, sexuality?

Tosh (2016) has examined the history of psychiatric constructions of gender nonconformity, looking at the emergence of GIDC from both a psychiatric and feminist perspective. She identifies that much of the research that gave rise to GIDC was not only based on the notion that feminine AMAB children might develop into homosexuals but was done in the context of treating gender nonconformity and preventing homosexuality in adulthood (see, for example, Green (1979) and Zuger (1966)). This claim to 'prevention' was rooted in the idea that homosexuality is a result of unhealthy childhood development (Stoller, 1968), which the evidence

suggested could not be 'corrected' once the person reached adulthood; thus, it was proposed that parents should be concerned and have a right to intervene (Green, 1979). That is, psychiatrists had tried and failed to stop gender nonconforming behaviour in adolescents and adults, so they shifted focus towards diagnosing children with GIDC as a way of opening the door to a range of 'preventative' psy-treatments (Tosh, 2016). Therefore, despite the supposed removal of homosexuality from the DSM-III (American Psychiatric Association, 1980), there was still an avenue to prevent it without diagnosing it. This demonstrates that rather than conflating gender nonconformity with homosexuality through scientific error, the APA continued to pathologise homosexuality by reinforcing it as an undesirable and abnormal sexuality requiring psychiatric intervention (Bryant, 2007). Following a common trend with categories of mental illness, GIDC is a clear example of a previous diagnosis being 'recycled' into another rather than being genuinely removed; "Once created," states Cohen (2016, p. 157), "psychiatric diagnoses never really disappear." GIDC also highlights the heteronormative assumptions embedded in the DSM which, through pathologisation, regulate the performance of gender roles. In this case, GIDC functioned to establish normative behaviours as early as possible to prevent the 'onset' of homosexuality; an efficient approach to securing future gender role-conforming citizens.

Transvestic disorder and autogynephilia

Another diagnostic category that reproduces the hegemonic notion of heterosexuality is the paraphilic disorders—specifically, transvestic disorder and its supporting diagnosis autogynephilia. Both these diagnoses are current examples that can be found in the DSM-5 (American Psychiatric Association, 2013). The criteria for *transvestic disorder* are "recurrent and intense sexual arousal from cross-dressing, as manifested by fantasies, urges, or behaviours" which "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (American Psychiatric Association, 2013, p. 702). The DSM emphasises that without the clinically significant distress or impairment to functioning, this would only be considered a paraphilia and *not* a disorder (American Psychiatric Association, 2013). *Autogynephilia* is "a male's paraphilic tendency to be sexually aroused by the thought or image of himself as a woman" (American Psychiatric Association, 2013, p. 703), which is reported to be common in men and AMAB people diagnosed with transvestic disorder (Blanchard, 1989b). The fantasies and behaviours that qualify as autogynephilic include the idea of possessing female anatomy or engaging in stereotypically feminine behaviour, for which the example given in the DSM-5 is "knitting" (American Psychiatric Association, 2013, p. 703). These categories have generated much controversy and criticism from various critical perspectives, including queer theory (for example, Daley & Mulé (2014)), feminism (for example, Tosh (2016)) and transfeminism (for example, Serano (2020)).

The emergence of what is now transvestic disorder, perhaps unsurprisingly, can be traced back to von Krafft-Ebing's (1886/2006) foundational text (see above) on the classification of perversions (Tosh, 2016). At the time, there was no real distinction made between homosexuality and gender nonconformity. Both were defined by von Krafft-Ebing (1886/2005) under the term 'sexual inversion', which had different degrees of severity. On the less acute end of the sexual inversion spectrum was same-sex attraction, and on the most severe end was the 'delusion' of a man believing that they were a woman (Tosh, 2015). Another perversion, according to von Krafft-Ebing (188/2006), was the 'fetishism of female attire' which was defined as men who took an 'abnormal' interest in women's clothing. This notion of the fetish was countered by Magnus Hirschfeld in his 1910 book *The transvestites*. Hirschfeld argued that transvestites and cross-dressers could not be explained purely through homosexuality (Hirschfeld, 1910; Tosh, 2016). He agreed with von Krafft-Ebing's (1886/2006) proposal that transvestites were delusional, but instead proposed that mental and physical gender existed on a

continuum. This notion is more consistent with later conceptions of gender from queer theory (see Butler, 2006). However, the DSM-II (American Psychiatric Association, 1968) did not take up Hirschfeld's (1910) interpretation and instead categorised transvestitism as a sexual deviation (American Psychiatric Association, 1968; Drescher, 2015a). The paraphilia category was introduced in the DSM-III (American Psychiatric Association, 1980), where transvestism was placed and defined by a sexual interest in women's clothing. Then, in the DSM-III-R (American Psychiatric Association, 1987), the diagnosis was renamed 'transvestic fetishism', re-invoking von Krafft-Ebing's (1886/2006) terminology. Thus, there has been a long-standing emphasis on the sexual and 'abnormal' nature of gender nonconforming behaviour in the DSM, particularly for men or AMAB people who express interest in dressing femininely and are attracted to women. That is, psychiatrists have argued that men 'should' be attracted to women, but it becomes a concern when that attraction is directed to women's clothing (Tosh, 2016).

There is a plethora of criticisms to be made of transvestic disorder, not only in light of its history, but also in the context of the evidence provided as rationale for its continued inclusion in the DSM. As noted by Tosh (2016), the premise of transvestic disorder is that men and AMAB people should not be engaging in sexual practices if they are not performing their gender correctly (namely, masculinely), because this is likely rooted in homosexual desires and may result in the dissolution of heterosexual marriage. This diagnosis implicitly (and sometimes explicitly) emphasises that homosexuality is undesirable and will lead to distress or dysfunction in men's lives if they "wish to maintain conventional marriages or romantic partnerships with women" (American Psychiatric Association, 2013, p. 704). There is a complete disregard for why an AMAB person might feel distressed at the idea that their sexual practices would interfere with heterosexual relationships, despite the well-documented evidence of homophobia—both historical and current—across a range of countries (Kantor, 2009; Poushter & Kent, 2020; Robertson, 2018). Furthermore, there is a repeated assertion by psychiatrists in this area that the prevalence of transvestic disorder in women or AFAB people is very low—indeed, until recently, it was considered to be an impossibility for such groups (Tosh, 2016). This raises the question as to whether this is a valid disorder or rather a byproduct of the devaluing of women (and by extension, femininity) in male-centric, heteronormative discourse (see Hoskin (2020)). The intense and ongoing focus on AMAB people's gender nonconformity by transvestic disorder researchers in psychiatry highlights the devaluation and regulation of femininity—understood as *femmephobia*—embedded within the profession. Hoskin (2020, p. 2328) has argued that "any femininity presented by an ostensibly male body, or not clearly female body, is grounds for dehumanization, social ridicule, and demotion." The experience of femmephobia—not only in psychiatric settings but by society at large (see Hoskin (2020))—for AMAB individuals is a more compelling explanation for the distress a person feels when they present with 'symptoms' of transvestic disorder. Considering femmephobia leads to a critical understanding of transvestic disorder as both the depoliticisation of queer and transgender distress, as well as the enforcement of heteronormative gender performance, especially (but not necessarily exclusively) for AMAB people.

Although transvestic disorder can be diagnosed regardless of sexual orientation, the supporting diagnosis of autogynephilia has been theorised to occur in heterosexual men whose attraction to women has 'gone awry', resulting in sexual arousal at the thought of oneself as a woman (Blanchard, 1989a, 1989b). The research that formed autogynephilia theory has been repeatedly criticised and proven scientifically unsound (see, for example, Moser (2010) and Serano (2010)). Transfeminist Julia Serano (2020) posited a model of 'embodied fantasies' as a counter to autogynephilia, which she argues is more in line with the contemporary evidence in sexology and psychology. She also emphasises that autogynephilia theory is gender-essentialist because it pathologises transgender people who fail to conform to gender expectations (Serano, 2020). This

gendered expectation is not only the cis-centric notion that a male gender identity should result in masculine gender presentation, but also the heteronormative assumption that women 'should' be attracted to men and vice versa. The founder of autogynephilia theory, Ray Blanchard (1989a, 1989b), proposed that there are two types of AMAB people who identify as or dress as women: 'homosexual transsexuals' and 'autogynephiles'. The homosexual transsexuals (including transvestites), by his definition, were biological men who dressed as women and were sexually attracted to men, whereas autogynephiles captured all other biological men who were not sexually attracted to men (Blanchard, 1989a, 1989b). The rationale for Blanchard's (1989a) work was that the 'homosexual type' had been well observed and documented, while the 'nonhomosexual type' was proving more challenging to categorise.

Serano (2020) suggests that the homosexual type fits nicely into the narrative that gender nonconforming AMAB people have a 'feminised brain', which is justified by their sexual attraction to men. Note that Blanchard never validated or acknowledged people's self-determination in *identifying* as female or feminine (hence the repeated use of 'biological men' in his work), but rather that the AMAB person's homosexuality could explain why they presented femininely, drawing on harmful stereotypes that gay men want to deceive heterosexual men into being sexually attracted to them (Serano, 2016, 2020). On the other hand, gender nonconforming AMAB people who are attracted to women do not fit this narrative of feminised brains and deception because Blanchard clearly could not conceive of feminine people being sexually attracted to women. Thus, the only possible explanation is that these individuals possess a 'misguided heterosexual sex drive', in which their sexual attraction to women is pathologically shifted into the thought or image of themselves as women (Serano, 2020). Because these AMAB people are 'otherwise normal' (that is, presumed by psychiatry to be heterosexual, cisgender men), there is a particular emphasis on the pathological nature of autogynephilia, much like transvestic disorder, because it conflicts with "performance in heterosexual intercourse and desires to marry and start a family" (American Psychiatric Association, 2013, p. 704). Again, this rhetoric of the interference with heterosexual relationships and reproduction is framed as a source of distress without any critical reflection on why this might be the case within the current sociocultural climate. Furthermore, this illustrates the role of the autogynephilia category in the enforcement of heteronormative behaviour, specifically in AMAB individuals, for the purpose of reproducing social relations under capitalism. Thus, I would argue that this diagnosis functions to support capital through the physical and social reproduction of workers, due to the emphasis on heterosexual reproduction and the regulation of gender roles (and, by extension, sexuality).

Rampant transphobia aside (see Serano (2020)), transvestic disorder and autogynephilia are contemporary examples of heteronormative discourse in the DSM. These diagnoses have generated significant critique, particularly from LGBTQ groups and scholars. A community-based collaboration in Toronto, Canada, for example, responded to the APA's call for commentary on the suggested revised criteria for paraphilias to be used in the DSM-5 (American Psychiatric Association, 2013) with numerous suggestions (see Daley and Mulé (2014)). Much of their criticism regarding paraphilias addresses what has already been discussed above, but they specifically take issue with the ideological nature of gender and sexuality-related disorders, arguing that the DSM relies on uniform and normalised notions of gender and sexuality (Daley & Mulé, 2014). From a critical queer perspective, they suggested that such ideologically defined disorders represent both a misogynistic attempt to prevent boys and men from acting femininely, and a way to promote compulsory heterosexuality through the prevention and/or avoidance of homosexuality. Ultimately, the collaboration argued that the continued classification of diverse sexual and gender identities as clinical disorders perpetuates the ongoing pathologisation and regulation of gender and sexuality by the DSM (Daley & Mulé, 2014, p. 1308). The scholars

also pointed out that, upon learning that Ray Blanchard was on the DSM-5 Working Group on Sexual and Gender Identity Disorders, many LGBTQ community members and groups issued formal statements and created petitions in protest. This response suggests that a significant proportion of the gender and sexually diverse community does not appreciate the sexologist's work. However, this protest evidently had no effect, as Blanchard remained on the Task Force (American Psychiatric Association, 2013) and autogynephilia is still present in the DSM-5 today (with his work being cited liberally throughout the section).

Conclusion

The general consensus across the different strands of critical scholarship is that the pathologisation of homosexual behaviour and identity is tied to the maintenance of 'correct' sexual and gender roles. Despite the dominant narrative that demedicalisation of homosexuality has occurred, I have argued here that psychiatry continues to pathologise gender nonconformity and sexual diversity through the revision of gender- and paraphilia-related categories in the DSM. Although there is no longer a pathologised identity (as a result of the removal of homosexuality per se), the construction of other diagnoses and the symptoms and behaviours that define them result in the reification of heterosexuality as the normal, nonpathological sexuality. I have also demonstrated that the psychiatric institution is motivated by the interests of capitalism, particularly regarding the reproduction of social relations through enforcing hegemonic gender roles.

It is my hope that future research in this area will further disentangle the relationship between psychiatric diagnosis, the regulation of gender performance and sexuality, and the maintenance of capitalism. The theorising that informed this article could be used to make a case for the depathologisation of gender nonconforming and queer people by reviewing and removing any reference to them in the DSM. This would also involve ceasing any further psychiatric research conducted to create or validate diagnostic categories that fall under the jurisdiction of the Sexual and Gender Identity Disorders Working Group. Until such actions are taken, the APA cannot claim to have depathologised homosexuality. They need to be held accountable for the historical harm caused by the pathologisation of homosexuality and for continuing to uphold that discourse in more recent categories of mental disorder.

References

American Psychiatric Association. (1952). *Diagnostic and statistical manual: Mental disorders*. American Psychiatric Association.

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). American Psychiatric Association.

American Psychiatric Association. (1973). *Homosexuality and sexual orientation disturbance: Proposed change in DSM-II, 6th Printing, page 44*. *POSITION STATEMENT (RETIRED)*. https://pages.uoregon.edu/eherman/teaching/texts/DSM-II_Homosexuality_Revision.pdf

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). American Psychiatric Association.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., revised). American Psychiatric Association.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., revised). American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

Berlant, L., & Warner, M. (1998). Sex in public. *Critical Inquiry*, *24*(2), 547–566. https://doi.org/10.1086/448884

Bhattacharya, T. (2017). Introduction: Mapping social reproduction theory. In T. Bhattacharya (Ed.), *Social reproduction theory: Remapping class, recentering oppression* (pp. 1–20). Pluto Press. https://doi.org/10.2307/j.ctt1vz494j.5

Blanchard, R. (1989a). The classification and labeling of nonhomosexual gender dysphorias. *Archives of Sexual Behavior*, *18*(4), 315–334. https://doi.org/10.1007/BF01541951

Blanchard, R. (1989b). The concept of autogynephilia and the typology of male gender dysphoria. *Journal of Nervous and Mental Disease, 177*(10), 616–623. https://doi.org/10.1097/00005053-198910000-00004

Bryant, K. E. (2007). *The politics of pathology and the making of gender identity disorder* [Doctoral dissertation, University of California]. ProQuest. https://www.proquest.com/openview/06f10cc9e9b63c310197fbe32694883e/1?pq-origsite=gscholar%26cbl=18750%26diss=y

Butler, J. (2006). *Gender trouble: Feminism and the subversion of identity*. Routledge. https://doi.org/10.4324/9780203824979

Chesler, P. (2005). *Women and madness* (Revised ed.). Chicago Review Press.

Cohen, B. M. Z. (2016). *Psychiatric hegemony: A Marxist theory of mental illness*. Palgrave Macmillan. https://doi.org/10.1057/978-1-137-46051-6

Cohen, B. M. Z. & Hartmann, R. (2021). The 'feminisation' of psychiatric discourse: A Marxist analysis of women's roles in neoliberal society'. *Journal of Sociology*.https://doi.org/10.1177/14407833211043570

Conrad, P. (2007). *The medicalization of society: On the transformation of human conditions into treatable disorders*. Johns Hopkins University Press.

Conrad, P. & Schneider, J. W. (1992). *Deviance and medicalisation: From badness to sickness*. Temple University Press.

Daley, A., & Mulé, N. J. (2014). LGBTQs and the DSM-5: A critical queer response. *Journal of Homosexuality*, *61*(9), 1288–1312. https://doi.org/10.1080/00918369.2014.926766

Drescher, J. (2012). The removal of homosexuality from the DSM: Its impact on today's marriage equality debate. *Journal of Gay & Lesbian Mental Health*, *16*(2), 124–135. https://doi.org/10.1080/19359705.2012.653255

Drescher, J. (2015a). Out of DSM: Depathologizing homosexuality. *Behavioral Sciences*, *5*(4), 565–575. https://doi.org/10.3390%2Fbs5040565

Drescher, J. (2015b). Queer diagnoses revisited: The past and future of homosexuality and gender diagnoses in DSM and ICD. *International Review of Psychiatry*, *27*(5), 386–395. https://doi.org/10.3109/09540261.2015.1053847

Fischer, B. A. (2012). A review of American psychiatry through its diagnoses: The history and development of the Diagnostic and Statistical Manual of Mental Disorders. *The Journal of Nervous and Mental Disease*, *200*(12), 1022–1030. http://dx.doi.org/10.1097/NMD.0b013e318275cf19

Geppert, C. M. A. (2006). Is the DSM the bible of psychiatry? *Psychiatric Times, 23*(14), 72. https://www.psychiatrictimes.com/view/dsm-bible-psychiatry

Green, R. (1979). 'Sissies' and 'tomboys'. *SIECUS Report, 7*(3), 1–15. https://siecus.org/wp-content/uploads/2015/07/7-3.pdf

Green, R. (1968). Childhood cross-gender identification. *Journal of Nervous and Mental Disease*, *147*(5), 500–509. https://psycnet.apa.org/doi/10.1097/00005053-196811000-00006

Green, R. (1987). *The 'sissy boy syndrome' and the development of homosexuality*. Yale University Press.

Hirschfeld, M. (1910/2006). The transvestites: The erotic drive to cross-dress. In S. Stryker & S. Whittle (Eds), *The transgender studies reader* (pp. 28–39). Routledge.

Hoskin, R. (2020). 'Femininity? It's the sesthetic of subordination': Examining femmephobia, the gender binary, and experiences of oppression among sexual and gender minorities. *Archives of Sexual Behavior*, *49*, 2319–2339. https://doi.org/10.1007/s10508-020-01641-x

Jabr, F. (2013, January 28). The newest edition of psychiatry's 'bible,' the DSM-5, is complete. *Scientific American*. https://www.scientificamerican.com/article/dsm-5-update/

Kantor, M. (2009). *Homophobia: The state of sexual bigotry today* (2nd ed.). Greenwood Publishing Group.

Kirk, S. A., & Kutchins, H. (1992). *The selling of DSM: The rhetoric of science in psychiatry*. Routledge. https://doi.org/10.4324/9781315134857

Kutchins, H., & Kirk, S. A. (1997). *Making us crazy: DSM: The psychiatric bible and the creation of mental disorders*. Free Press.

Moser, C. (2010). Blanchard's autogynephilia theory: A critique. *Journal of Homosexuality*, *57*(6), 790–809. https://doi.org/10.1080/00918369.2010.486241

Pearce, R. (2018). *Understanding trans health: Discourse, power and possibility*. Bristol University Press. https://doi.org/10.2307/j.ctv1wxs4v.10

Poushter, J. & Kent, N. (2020, June 25). The global divide on homosexuality persists. *Pew Research Center*. https://www.pewresearch.org/global/2020/06/25/global-divide-on-homosexuality-persists/

Robertson, D. (2018, March 12). *On Commonwealth Day, let's remember the people still suffering because of the homophobic laws we brought to their countries.* Independent. https://www.independent.co.uk/voices/commonwealth-day-2018-lgbt-homophobia-laws-empire-imperial-uk-britain-colonies-africa-a8252181.html

Sears, A. (2017). Body politics: The social reproduction of sexualities. In T. Bhattacharya (Ed.), *Social reproduction theory* (pp. 171–191). Pluto Press. https://doi.org/10.2307/j.ctt1vz494j.13

Serano, J. (2010). The case against autogynephilia. *International Journal of Transgenderism, 12*(3), 176–187. https://psycnet.apa.org/doi/10.1080/15532739.2010.514223

Serano, J. (2016). *Whipping girl: A transsexual woman on sexism and the scapegoating of femininity*. Hachette UK.

Serano, J. (2020). Autogynephilia: A scientific review, feminist analysis, and alternative 'embodiment fantasies' model. *The Sociological Review*, *68*(4), 763–778. https://doi.org/10.1177/0038026120934690

Spitzer, R. L. (1973). A proposal about homosexuality and the APA nomenclature: Homosexuality as one form of sexual behavior and sexual orientation disturbance as a psychiatric disorder. *American Journal of Psychiatry, 130*(11), 1214–1216. https://doi.org/10.1176/ajp.130.11.1207

Stoller, R. J. M. D. (1968). Male childhood transsexualism. *Journal of the American Academy of Child Psychiatry, 7*(2), 193–209. https://doi.org/10.1016/s0002-7138(09)62167-1

Tosh, J. (2015). *Perverse psychology: The pathologisation of sexual violence and transgenderism*. Routledge. https://doi.org/10.4324/9781315758190

Tosh, J. (2016). *Psychology and gender dysphoria: Feminist and transgender perspectives*. Routledge. https://doi.org/10.4324/9781315794938

Ussher, J. M. (2011). *The madness of women: Myth and experience*. Routledge. https://doi.org/10.4324/9780203806579

von Krafft-Ebing, R. (2006). Selections from Psychopathia Sexualis with special reference to contrary sexual instinct. In S. Stryker & S. Whittle (Eds.), *The transgender studies reader* (1st ed., pp. 21–27). Routledge. (Original work published 1886)

Zuger, B. (1966). Effeminate behavior present in boys from early childhood: I. The clinical syndrome and follow-up studies. *The Journal of Pediatrics*, *69*(6), 1098–1107. https://doi.org/10.1016/S0022-3476(66)80301-3