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Gender Dysphoria and the Medicalisation of Distress

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Abstract

This article investigates the controversial psychiatric diagnosis of gender dysphoria and the sociohistorical context that has led to its inclusion in the fifth edition of the *Diagnostic and statistical manual of mental disorders* (DSM-5). An outlining of the lineage of the diagnosis demonstrates psychiatry's continuation of nineteenth-century theories pertaining to sexuality and gender. The development of the psychiatric discipline and its offshoot, sexology, produced a theory of the 'third sex'. While creating legitimacy and protection for persons outside the heterosexual matrix, its unintended consequence has been to further entrench absolute differences between men and women. In an attempt to establish itself as a branch of medicine and give scientific credence to the profession, it is argued that psychiatry continues to promote the third sex theory through diagnoses that pathologise homosexuality and gender variance. As critically interrogated in the article, significant academic psychiatrists, including Robert L. Spitzer and Kenneth J. Zucker, have deployed a biomedical conception of sexuality and gender. It is proposed that their work conflates these two concepts, which stems from the cisnormative and heterosexist assumption that gender diversity should be 'corrected'.

Keywords: DSM; gender dysphoria; homosexuality; medicalisation; transgender

Introduction

A historical analysis of the concepts of gender, sex and sexuality within psychiatric discourse can challenge pervasive cultural assumptions regarding mental health and mental illness by demonstrating their cultural and historical specificity. In this article, I employ a sociohistorical analysis to examine psychiatry's role in shaping how we conceptualise gender and the treatment of gender diversity through an analysis of the current mental illness category of *gender dysphoria* (GD), formerly known as *gender identity disorder* (GID).

GD was first categorised as GID in the third edition of the American Psychiatric Association's (APA) *Diagnostic and statistical manual of mental disorders* (DSM-III; American Psychiatric Association, 1980). However, increasing pushback against the pathologisation of gender diversity led to the removal of the term 'identity' and a modification in how the diagnosis was described in the fifth edition of the manual (DSM-5), published in 2013 (American Psychiatry Association, 2013; Tosh, 2016, p. 60). The diagnostic label was reformulated to capture those persons who experienced *distress* and *dysphoria* in relation to their gender identity, as opposed to pathologising gender identity itself. GD is applied "when there is a marked incongruence between the person's expressed or experienced gender and the gender assigned to the person at birth" (Diamond, 2017, p. 92). As will be discussed in this article, even with the label change, gender diversity continues to be pathologised as a mental illness under the current diagnostic framework.

I argue here that psychiatry has further entrenched ideas around sex and gender as 'natural' categories and given scientific credence to the gender/sex binary through the treatment of gender diversity as a mental illness. Changes in the DSM relating to gender and sexuality intersect as these have been conceptually linked within psychiatry "due to the problematic assumption that sexuality, sex and gender identity are inseparable and interchangeable" (Tosh, 2016, p. 47). The conflation of sexuality and gender

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will be explored further as we consider the historical development of sexology and the creation of 'paraphilias' (Tosh, 2016, p. 51).

The first section of this article will discuss the emergence of sexology in the nineteenth century, which coincided with a shift in how we view homosexuality. German sexologist Richard von Krafft-Ebing (1840–1902) played an influential role in this change through his efforts to categorise and, in turn, medicalise persons that he considered sexual deviants. Moving into the twentieth century, I will discuss the rise of the biomedical model through the eugenics movement and the popularisation of social Darwinism. I consider the implications of this ideological strand upon professional and popular notions of sex, sexuality and gender, which led to the pursuit of biological determinants for social hierarchies—in turn, creating a biomedical model that more deeply entrenched differences between the sexes and captured gender diversity in the DSM as a mental illness.

In the latter sections of this article, I cover the work of the academic psychiatrists Robert L. Spitzer and Kenneth J. Zucker, who have both played important roles in the continued medicalisation of trans and gender diverse persons in recent editions of the DSM. As will become clear, each gained professional capital through maintaining that homosexuality and trans/gender diversities were pathologies that could be cured. Spitzer and Zucker expanded the reach of psychiatry by tapping into a heteronormative vision of sexuality and gender and maintaining psychiatry's role in defining mental illness and deviance according to this vision. In opposition to this psychiatric discourse on gender and sexuality, I use the term 'transgender and gender diverse persons' in this article to encompass the broad range of identities and ways of being that extend beyond the dichotomy of male and female. It is important to recognise that within and between gender diverse, gender nonconforming and trans people, there are important and significant differences (Lev, 2013, p. 290), each possessing their own unique experience and embodiment of their gender identity.

Sexology and the invention of paraphilias

In this section, I examine the sociohistorical context of the nineteenth century that precipitated psychiatry's concern with medicalising gender and sexuality. In doing so, we can see how current conceptualisations of gender and sexuality are reflected in the work of psychiatrists such as the German sexologist Richard von Krafft-Ebing. During the period in which Krafft-Ebing wrote his influential book *Psychopathia sexualis* (1886), a transformation was underway in European culture about how people viewed sex. In early nineteenth-century Europe, the binary between homosexuality and heterosexuality had yet to be constructed into the sexual identities that we are familiar with today (Ussher, 1997, p. 130). Prior to the development of these sexual identities, sex was more explicitly concerned with social hierarchy, power and the physical act itself (Oosterhuis, 2000, p. 241). Sexual abnormalities were attributed to overindulgence, immorality, bad parenting and excessive alcohol, sex and masturbation (Hekma, 1994, p. 214). The understanding of homosexuality changed when theories of deviancy shifted from the religious sphere to the realm of medicine.

The popularising of Darwin's *On the origin of species* (1859/1910) gave primacy to our biological existence, reshaping how the social world was understood and, in turn, governed. In doing so, Darwin's work enabled the production of a biomedical paradigm that defines the human 'biocentrically' (Wynter & McKittrick, 2015, p. 16). This biocentric understanding of personhood naturalised pre-existing social hierarchies and was used to justify a moral vision of how society should function. Physicians and early psychiatrists maintained that not only were there moral differences between men and women, but that their biological existence meant that they had different social functions. This enabled medical experts to employ biological justifications for women's inferior social standing (Ehrenreich & English, 2005, p. 129). Social Darwinist psychiatrists and medical professionals argued that the evolving capacity of men in industrial society stemmed from innate traits that enabled them to carry out a variety of roles in the public sphere.

Similarly, the same health experts considered reproduction to be women's evolutionary function, with psychiatrists such as Henry Maudsley (1835–1918) arguing that women who entered the spheres of men challenged their innate function and threatened their ability to reproduce (Collie, 1988, pp. 50–52). Thus, the 'essential' nature of women was reduced to reproduction and of men to production (Ehrenreich & English, 2005, p. 130). Accordingly, the more highly 'evolved' a society, the greater the disparity between men and women. American psychologist and evolutionary theorist Dr G. Stanley Hall argued that "as we go higher (up the evolutionary ladder) sexes diverge not only in primary and secondary sex characteristics, but in functions not associated with sex" (cited in Ehrenreich & English, 2005, p. 130). Perceived differences between men and women thus became entrenched in scientific discourse as psychiatrists argued that women were biologically inferior, lower on the evolutionary scale, and best suited to an existence within the private sphere.

In Victorian society, sexology emerged as a discipline concerned with medicalising 'deviant' sexual desires. Leading to an explosion of new terms, concepts and diagnoses (Hekma, 1994, p. 213), the gaze of the professional shifted from the act to the person (Ussher, 1997, p. 139). This attracted new attention from institutions such as the criminal justice system and the emerging psy-professionals (Hekma, 1994, p. 223). The pursuit of biological determinants led to a shift in the view of homosexuality from moral degeneracy to inborn pathology. In 1849, Claude-Francois Michea popularised the notion that deviant sexual desires were inborn perversions and the result of physio-biological failings (Hekma, 1994, p. 215). So emerged the belief that homosexual desires were part of an inborn sexual inversion, a "hermaphrodisy of the mind" (Hekma, 1994, p. 214). The argument that queer desires were inborn was used not only to pathologise but also defend these desires. Karl Heinrich Ulrich (1860) developed the theory of the 'third sex' based on his own gender inversion, which he defined as an "*anima muliebris in corpore virili inclusa*" (a female soul enclosed in a male body) (Hekma, 1994, p. 219, emphasis in original). In doing so, Ulrich provided the basis for "the mapping of transgender as an identity in the modern West" (Prosser, 1998, p. 143).

When reflecting on the historical entanglement of sexuality and gender, it is important to consider the work of queer theorist Jay Prosser (1998) who discusses the early emergence of the transgender subject. Sexologist discourse suggests that homosexuality is placed on a continuum, with 'inversion' the most 'severe' expression of homosexuality. However, Prosser challenges this literal reading of sexology's discourse and asks us to look beyond the theory that has historically cloaked transgender autobiographical narratives. For Prosser, within the case histories of 'inverts' is the creation of space for the emergence of the transgender identity. Prosser (1998, p. 10) proposes that "the discourse of inversion in turn-of-the-century sexology, its medicalization of transgender in the body, provided the significant threshold under which the transsexual as a sex-changeable and indeed sex-changed subject could make his/her [their] first appearance."

Prosser (1998, p. 136) discusses Radclyffe Hall's *The well of loneliness* (1928) and its canonisation as a lesbian novel, suggesting that, with the central protagonist identifying as a man, the story is a "blatant transgendered narrative". In critical readings of Hall's book, transgender is sublimated into homosexuality, thereby creating "the sexological discourse of sexual inversion" (Prosser, 1998, p. 137). "Through sexual inversion," argues Prosser (1998, p. 138), "sexologists sought to describe not homosexuality but a broad transgendered condition of which same-sex desire was but one symptom, and not vice versa."

According to Prosser's (1998, p. 138) reading, *The well of loneliness* becomes an example of how transgender narratives are subsumed within discourse as expression of 'severe' homosexuality and, in doing so, the subjectivity of the transgender person is erased as "homosexuality's heterocentric construct". Suggesting that the autobiographical narratives of transgender people informed the emerging field of sexology, Prosser (1998, p. 139) challenges us to look beyond the accounts of sexual inversion in sexology texts and consider how persons described as inverts constructed themselves and thereby "reconstitut[e] the invert as subject". In doing so, Prosser draws attention to the agency of transgender people in the creation

of their subjectivity within sexology—an issue which will be discussed below, with reference to the medicalisation of transgender identity.

The concept of sexual inversion was further developed in the work of Krafft-Ebing and his seminal text *Psychopathia sexualis*, which is widely described as the handbook of sexology. Krafft-Ebing's work was central to the medicalisation of queer bodies and queer desire through the creation of the *paraphilias*—meaning 'abnormal love' (Tosh, 2016, p. 51). Krafft-Ebing created categories denoting sexual psychopathology, which he believed stemmed from a neuro-psychopathic condition (Oosterhuis, 2000, p. 8). Through Krafft-Ebing and fellow German sexologist Magnus Hirschfeld (1868–1935) situating homosexuality and gender diversity on a continuum in which homosexuality was seen as an expression of gender inversion (Prosser, 1998, p. 138), 'manliness' and masculinity came to be increasingly associated with heterosexuality and, correspondingly, homosexuality became a threat to one's gender identity (Oosterhuis, 2000, p. 242).

The nineteenth century marked an important change in how we conceive sexuality and gender, which was eventually linked under theories of sexual inversion (Krafft-Ebing, 1939). During this period, European academics became increasingly concerned with coding and categorising the social world and, in doing so, defining the boundaries of "sexual deviance" (Riggs et al., 2019, p. 913). Evolutionary theory was applied to all facets of life, and gender roles and sexualities were mapped onto racial and class otherness (Cohler, 2010, p. 9). Through the creation of the paraphilias, early psy-professionals entrenched binary divisions of natural/unnatural and normal/deviant, naturalising social hierarchies within biological theory (Ehrenreich & English, 2005, p. 129). While at times used to legitimise and defend gender diversity (Eckhert, 2016, p. 241), the diagnostic labels that appeared were embedded in this binary logic and thus rooted in an understanding of gender diversity and queer bodies/desires as pathological. Moving into the twentieth century, this had important implications when queer bodies and queer desire were targeted as threats to evolutionary progression.

Anti-queer violence and eugenics in the twentieth century

Eugenics emerged as a science concerned with supporting the 'natural' progression of society and protecting it from those deemed to be a threat to this progress. It has an evaluation logic—"deeming some lives worthier than others" (Subramaniam, 2014, p. 46). Drawing on eugenics theory, medicine and psychiatry took an increasing role in the twentieth century of defining normal and social deviant behaviour under the premise of optimising the health of the nation. Persons who were identified as deviants became the target of state violence with eugenic efforts to root out degeneracy (Rose, 1996, p. 8). A core evolutionary concept, degeneracy was developed according to a theory of genetic inheritance in which pathological genes would degenerate when passed on to future generations (Shorter, 1997, p. 93). Krafft-Ebing was a proponent of this belief, theorising that "madness, when it finally breaks out, represents only the last link in the psychopathic chain of constitutional heredity, or degenerate heredity" (cited in Shorter, 1997, p. 95). Psychiatry became concerned with protecting society's evolutionary progress from those it identified as a degenerate threat. This manifested in systematic persecution, with gender diverse and queer people being targeted by the state and subjected to reorientation, sterilisation and execution. As Mildenberger (2012, p. 218) notes, during the Third Reich (1933–1945), German physicians and psychiatrists played an active role in identifying persons deemed 'undesirable', including gender diverse and queer people.

Hirschfeld was the first to compile extensive archives on sexuality and diverse gender expressions, which were subsequently ransacked and burnt by Nazi henchmen in 1933 (Bauer, 2017, p. 3). Together with his colleagues at the Institute of Sexual Science in Berlin, Hirschfeld created a space in which scientists, doctors, campaigners and people from the queer community met together and contributed to research on

sexual knowledge. For Hirschfeld, homosexuality was the result of an innate pathology, leading him to seek out its biological determinants. Bauer (2017, p. 6) delves into the lesser-known work of Hirschfeld to discuss the violence that informed the modern queer subject, "revealing that queerness was bound up in complex ways in the racialized (re)production of modern gender and social norms". Hirschfeld has been described as making major contributions to "the gay liberation movement" and a "pioneer" of "sexual freedom" (Bauer 2017, p. 8). Hirschfeld's work demonstrates a desire to know and understand the suffering of those marked by society as different. Yet as Bauer (2017, p. 9) points out, Hirschfeld's thinking was also influenced by a belief that racial hygiene and eugenics "could improve the health of the nation". Thus, he was implicated in discriminatory ideas, which at their core were formed around a binary logic that distinguished those 'selected' by evolution from those deemed to be obstacles to society's evolutionary progress (Baynton, 2016, p. 6).

Eugenic ideas were not limited to Germany; they also permeated across Europe and the United States (Subramaniam, 2014, p. 46). Baynton (2016, p. 4) describes eugenics in the United States which saw "tens of thousands of people with psychiatric or intellectual disabilities … segregated into institutions, often under horrific conditions". In Britain, a decrease in the birth rate at the turn of the twentieth century led to a concern that population decline would threaten Britain's colonial dominance. It became the social duty of the British woman to reproduce. As Cohler (2010, p. 2) concurs, "Women's roles as nurturers, child-carers, preservers of purity, could all be put to use as part of a wider imperialist project." Positivist eugenics further entrenched biological essentialism by emphasising gender roles and women's duty to reproduce the nation. Eugenics is thus rooted in a political vision that distinguishes which persons are deemed by the state to be worthy of protection versus those in need of "biological control" (Joseph, 2018, p. 60). This vision, as Joseph attests, depended on the creation of a racialised Other, who were then deemed to be a threat to the security (and 'purity') of the colonial and imperial populace.

In 1952, the APA produced its first *Diagnostic and statistical manual of mental disorders* (DSM), which included the medical classification of homosexuality as a personality disorder (American Psychiatric Association 1952; Waidzunas, 2015, p. 46). Physicians and psy-professionals would build their careers upon the theory that sexual deviancy was a disease of the body, so they researched the genitals, the glands and the brain for signs of this pathology. Psychiatry developed an extensive list of technologies to 'cure' queer people and gender diversity (Gans, 1999, p. 223). Psychiatric therapies included lobotomy, injecting patients with metrozol to induce grand mal seizures, and electroconvulsive therapy (ECT). They also attempted 'aversive conditioning', where the patient would be shown homoerotic stimuli and simultaneously made to feel physically sick either through administering an electric shock or inducing vomiting (Gans, 1999, p. 223).

Eugenic thought and the pursuit of biological justifications for social hierarchy defined the hegemonic responses to queer people and those who did not conform to heteronormativity. The work of early sexologists such as Hirschfeld was influential in the labelling, classifying and treatment of queer bodies and queer desires as biologically distinct from those who conformed to heteronormativity. Moreover, these norms became more deeply entrenched in the climate of positivist eugenics, underpinned by notions of racial superiority, which placed an increased emphasis upon reproduction to ensure the optimal health of the nation (Cohler, 2010, p. 2).

Direct action: Challenging the medicalisation of queerness

This section briefly examines the removal of the diagnosis of homosexuality from the DSM and the work of the chair of the DSM-III Committee, Robert L. Spitzer. As will become clear, this case of demedicalisation did not come about due to a changed understanding within psychiatry that homosexuality was no longer a mental illness, but rather as a result of the threat to the profession's legitimacy.

In the late 1960s, gay, lesbian and queer activists organised opposition to the medicalisation of

their identities as a form of mental illness. The Gay Liberation Front (GLF) emerged as part of a wider movement, a "loosely defined coalition of New Left, anti-war, liberation, and counterculture activists" (Kissack, 2004, p. 439). A publication from a GLF chapter founded in Lawrence, Kansas, stated:

> We are being confronted by an uptight, authoritarian, racist, sexist Amerika. So the Gay Liberation Front joins other oppressed brothers and sisters of Amerika and the Third World to struggle against the nightmare and create one world of people living together. (cited in Kissack, 2004, p. 439)

The GLF took direct action employing a strategy known as *Zap!* They disrupted conferences held by the APA to engage psychiatrists with their aim of demedicalising homosexuality (Waidzunas, 2015, p. 208). It was during one of these protests that Spitzer and the GLF met, and he appeared willing to engage with their critique, setting up a meeting between activists and psychiatrists. Spitzer's role in facilitating a dialogue between the GLF and psychiatry provided him with the professional capital that he required to head the taskforce revising the DSM-II (American Psychiatric Association, 1968) towards its third edition, the DSM-III. Against a backdrop of mounting political pressure, Spitzer facilitated a vote among the APA on the removal of homosexuality from the DSM-II, which resulted in the formal deletion of the diagnosis from the manual in 1973.

Spitzer played a pivotal role in the removal of homosexuality from the DSM. However, he also made it clear that he did not believe homosexuality was a normal expression of sexuality, stating that the declassification was "not to say that homosexuality is normal or that it is as desirable as heterosexuality" (cited in Kutchins & Kirk, 1997, p. 72). Spitzer was concerned with the nosological foundation for psychiatric diagnoses, maintaining that mental illness would "either regularly cause subjective distress or regularly be associated with some generalised impairment in social effectiveness or functioning" (cited in Waidzunas, 2015, p. 71). This enabled him to continue to problematise queer desires under the premise that they caused distress.

In 1973, Spitzer argued that while homosexuality was not a mental disorder, it was 'suboptimal' and, for those troubled by their queer sexuality, psychiatry could still be of assistance (Waidzunas, 2015, p. 68). Upon the removal of the homosexuality diagnosis from the DSM, Spitzer created a new mental disorder: *ego-dystonic homosexuality* (EDH) (Kutchins & Kirk, 1997, p. 78). Under this new diagnostic category, there was a shift from focusing on sexuality to the feelings of distress the person felt about their sexuality (Drescher, 2015). There did not exist a comparable diagnosis around heterosexuality because it was (and continues to be) understood as 'natural' (Lev, 2013, p. 290). EDH was instituted in 1980 in the DSM-III, but later removed from the DSM-III-R in 1987 (American Psychiatric Association, 1987; Drescher, 2015, p. 571), due to ongoing pressure from the public. The argument that distress warranted a psychiatric diagnosis was highly contentious. It was evident that with prejudice against queer and other marginalised groups permeating throughout society, additional distress would be present in queer communities. Lev (2013, p. 291) explains that:

> It soon became clear that living in a homophobic and heterosexist culture left few 'happy well-adjusted homosexuals,' and given the complexities of internalizing a stigmatized minority status, the diagnosis [of EDH] was determined to be bias, and was removed [from the DSM-III-R].

It must be noted that Spitzer defended the EDH diagnosis and was not opposed to conversion therapy, a practice that could continue under the diagnosis (Waidzunas, 2015, p. 68). Spitzer preferred to classify homosexuality as treatable because it caused psychological distress and impaired social functioning (Kutchins & Kirk, 1997, p. 70). This remains the dominant psychiatric rationale for treating gender identities

that do not conform to heteronormativity as forms of mental illness.

The 1980s saw the introduction of a new category of mental illness: *gender identity disorder* (GID)—a diagnosis that further pathologised transgender and queer communities. As Lev (2013, p. 291) has rhetorically asked: "Why would they [psychiatrists] want to pathologize gender identity diversity while we were finally liberating homosexuality as a diagnosis?" Cohen (2016, p. 157) has argued that psychiatric diagnoses are never truly removed from the DSM but rather the 'symptoms' are recycled and placed under a different label. We can see this process reflected in the creation of diagnostic categories in the DSM that continue to support the dominant belief that heteronormativity is natural or preferred.

The same psychiatrists (Zucker & Spitzer, 2005) who advocated for the removal of homosexuality as a diagnostic category, created diagnoses that pathologised gender diversity as disorder. This shift ties into the nosological development of the DSM and psychiatry's efforts to establish itself as a legitimate branch of medicine. This point will be considered in the discussion below, along with the increasing trends towards medicalisation and the implications of a biomedical hegemony.

Gender dysphoria in children

This section discusses how the current diagnosis of gender dysphoria (GD) has developed according to heteronormative ideals regarding the family and parenting. Described as one of the 'sexological kings', American psychoanalyst Robert J. Stoller developed the concept of *sex*—referring to one's biological anatomy—as distinct from one's *gender identity* (Tosh, 2016, p. 57). This division between sex and gender allowed people to identify with a gender identity that differed from their assigned sex. Stoller is recognised as having made an important contribution to the development of gender clinics but, as Tosh (2016, p. 57) points out, he has also been criticised for pathologising gender diversity. Stoller's theorising around the aetiology of gender diversity was informed by, and upheld, a narrative in which pathological mothers produced 'sissy boys' leading to a disordered gender identity (Ehrenreich & English, 2005, p. 269). This concern with the perceived threat of 'momism' led to studies in the late 1960s such as the aptly named 'Sissy Boy Syndrome' funded by the National Institute of Mental Health in the United States (Mackinnon, 2018, p. 85). Stoller argued that overbearing mothers were responsible for nurturing transsexualism in children, which he described as a "potentially malignant personality disorder" (Stoller, 1968, p. 193). According to Stoller (1968, p. 204), an absent or distant relationship with the father could leave a son vulnerable to the "malignant effect of his mother's excessive closeness". (Similarly, Marchiano (2021) has recently proposed that the aetiology of gender diversity and nonconformity results from a disturbed relationship with the mother.) Through his theorising around the concept of gender identity, Stoller provided persons with a much-needed gateway to surgical intervention and medical support. However, the psychiatric and psychoanalytic emphasis upon gender roles placed new emphasis upon the family unit and childhood development. This led to the inclusion of the diagnostic label 'childhood gender identity disorder' in the DSM-III in 1980, along with 'transexualism' (American Psychiatric Association 1980). Tosh (2016, p. 57) points out that this "childhood diagnosis opened the door for preventative treatments, which developed out of the failure of therapies to stop gender-nonconforming behaviour among adolescents and adults diagnosed as 'transsexual'."

In an attempt to re-condition those who do not conform to idealised gendered behaviour, Zucker continued Stoller's earlier mother-blaming narrative through pathologising gender nonconformity, focusing on children. He describes the mothers of children whom he diagnosed with gender identity disorder (GID) as having psychopathic traits, writing:

> Using the Diagnostic Interview Schedule (DIS), a highly structured method of assessing psychopathology in adults … I have found that about 50% of the mothers of GID boys had two or more DIS diagnoses and about 25% had three or more DIS diagnoses (Zucker, 2008,

p. 360).

Zucker correlates children diagnosed with GID with mentally unstable mothers. He goes on to explain that "75% of young boys with GID had an insecure attachment relationship to the mother. Unpublished data suggest that a similar percentage of girls with GID also have an insecure attachment relationship to the mother" (Zucker, 2008, p. 360). This psychiatric research continues under the premise that heteronormativity is natural/desirable, and therefore locates the pathology in the failure to adequately perform heteronormative ideals.

Zucker's work with children diagnosed with GID can be understood as an effort to eliminate gender diversity. He advises that the earlier the psychiatric intervention, the more likely it is to be successful (Zucker, 2008, p. 358). Zucker has provided the following justifications for treating gender nonconformity as mental illness: "(1) reduction of social ostracism, (2) treatment of underlying psychopathology, (3) treatment of underlying distress, (4) prevention of transsexualism in adulthood, and (5) prevention of homosexuality in adulthood" (cited in Rowland and Incrocci, 2008, p. 394). Zucker suggests that there may exist a biological predisposition for GID, but this disposition can be altered through reparative therapy.

Through the policing of children and their expressions of gender and sexuality, psychiatrists such as Zucker have gained professional capital in upholding the hegemony of heteronormativity. The central argument used by psychiatrists to justify this work is around the distress caused when a person does not fit the heteronormative model. By diagnosing children with GID, Zucker maintains his authority in producing what biological disposition and bad mothering have failed to produce—a child that conforms to their assigned gender role.

In 2013, gender identity disorder was replaced with gender dysphoria with the release of the DSM-5 (American Psychiatric Association, 2013). This diagnostic and conceptual shift can be understood as the culmination of 30 years in which GID attracted significant criticism (Tosh, 2016, p. 60). Much like the removal of the homosexuality diagnosis from the DSM, it can be understood as a change that was fought for and won by queer and trans activists challenging the pathologisation of their identities. The concept of gender dysphoria was initially developed by Fisk (1973, 1974, 1978) who had found limitations with the diagnostic label of GID, arguing that it limited his ability to help people. Through the concept of gender dysphoria, Fisk aimed to create a broader and more inclusive diagnosis to enable greater flexibility in extending surgical intervention and medical support (Tosh, 2016, p. 61). However, once this concept was taken up by other psy-professionals such as the clinical psychologist and sexologist Ray Blanchard (1990), it lost this initial objective and instead reflected earlier psychiatric theories of transsexualism. Blanchard (1990, p. 53) summarises gender dysphoria as "discontent with one's biological sex, the desire to possess the body of the opposite sex, and also to be regarded by others as a member of the opposite sex". Not only is this overly simplistic, failing to encompass the nuance and diversity of gender nonconformity, it is also heavily reliant upon biological essentialism and a binary division between sexes. Tosh (2016, p. 62) points out that the label GD "continues to frame gender nonconformity as pathological and enables the continuation of unethical therapies used on trans children with the aim of 'preventing' transsexualism".

What's the harm in a diagnostic label?

Transnormativity refers to the normative conception of what it means to be trans and the imposition of dominant social and cultural narratives for defining and categorising trans people (Riggs et al. 2019, p. 913; Vipond, 2015, pp. 22–23). Transnormativity imposes upon trans persons a set of expectations and criteria to which they must adhere in order to be granted medical care and clinical support (Vipond, 2015, p. 25). Within the dominant medicalised framework, trans people are: (a) expected to "conform to a 'wrong body narrative' when describing their gender", and hold the beliefs that (b) "all trans people require medical

treatment" and that (c) "all transgender people should seek to present and be perceived as cisgender" (Riggs et al., 2019, p. 913).

These criteria have been produced in part by early transgender activists drawing upon medical discourse in order to defend their right to align their body with their gender identity and access gender-affirming medical care and surgical interventions (Riggs et al., 2019, p. 918). The need for such interventions requires that trans people participate in their own medicalisation—as profiled above, this can be seen in the history of sexology and nineteenth-century theories of the third sex or sexual inversion (Riggs et al., 2019, pp. 914–915). Early trans activists Radclyffe Hall and Karl Ulrich both drew upon medical literature and a biological understanding of their gender identity in order to defend themselves against punitive laws, to question social mores, and bring together a community of persons who shared in their experience (Eckhert, 2016, p. 241). Historically there have been many notable examples of trans people actively challenging a lack of access to medical care; for example, the Erikson Educational Foundation (EEF) was a charitable body established in 1964 and funded by a transgender man, Reed Erickson, that financed research on transsexualism and associated medical therapies (Riggs et al., 2019, p. 918). A biological framework enabled trans activists to counter claims of moral failing, and thereby gain access to medical therapies such as hormone replacement therapy (HRT) and gender-affirming surgery, also know as sex reassignment surgery (SRS) (MacKinnon, 2018, p. 78). The medicalisation of trans people is complicated by a tension between the necessity of access to surgical interventions and the rigidity of a biomedical conception of gender.

Gender-affirming therapies have enhanced the quality of life for trans people (Mizock, 2017), but in treating gender incongruence as a medical 'condition' that must be 'fixed', the biomedical framework gives authority to the medical community in defining gender and therefore gatekeeping access to these therapies. Riggs et al. (2019, p. 913) has suggested that normative conceptions of trans identity are becoming increasingly narrow, thereby undermining the diversity and plurality of one's experience and embodiment of being trans. The current psychiatric definition of gender dysphoria fails to acknowledge that "being trans may bring joy to one's life" and restricts "the ability of trans people to self-advocate for medical interventions beyond the values and norms codified in the diagnosis" (Shuster, 2021, p. 85). Trans people are instead expected to comply with dominant medical narratives in order to meet the criteria of insurance companies (Shuster, 2021, pp. 79–80). Thus, in enabling access to gender-affirming therapies, the diagnosis of GD has been described as a double-edged sword. Shuster, (2021, p. 81) captures this idea, writing that "having a diagnostic category offers some promise that insurance companies will reimburse the expenses paid out of pocket for gender-affirming interventions, but the existence of a diagnosis suggests that being trans is an illness."

Much in the same respect as the GLF activists who campaigned for the de-pathologisation of homosexuality and its removal as a mental disorder from the DSM, there is an international movement of trans activists who are campaigning to have gender transitioning removed from the DSM (Davy et al., 2018, p. 13). This movement can be understood as the continuation of the historic struggle for self-determination of queer, gender nonconforming, gender diverse and trans people (Riggs et al., 2019, p. 916). Surgical interventions continue to be a site of struggle for trans activists. The necessity of access to medical care has led to calls for alternative models for transitioning healthcare such as the informed consent model, which draws upon a human rights framework calling for "the right to human dignity, self-determination, bodily integrity and protection from medical abuse" (Davy et al., 2018, p. 15), and thereby challenging the gatekeeping role of medical professionals.

The World Professional Association of Transgender Health (WPATH) is an important institution which manages the guidelines for the medical care of trans people (Riggs et al. 2019, p. 918). In 1979 it established the first standards of care (SOC) guidelines for trans medicine and has revised these guidelines every few years. Employing evidence-based medicine, WPATH claims to have moved beyond the extreme stigma that has historically characterised the medical community's response to trans people. It aims to create

a more-standardised and less-biased approach based on scientific evidence (Shuster, 2021, p. 78). As Shuster (2021, p. 78) suggests though, there still remains a heavy reliance upon normative understandings of gender and gender transitioning within such medical institutions. Moreover, claims of scientific objectivity often obscure the extent to which the current biomedical framework naturalises heteronormativity and thus assumes the "underlying pathological nature of queer subjects" (Eckhert, 2016, p. 242).

The inclusion of GD in the DSM continues to pathologise gender diversity and gender variance. LeFrançois and Diamond (2014, p. 39) argue that "the act of diagnosis is shown not only to categorize, but also to 'other', to make abject and to make queer". Only a diagnosis of GD enables transition; that is, to attain hormonal and surgical therapies that allow the person to physically transition to the gender they identify as. Conversely, a comorbid diagnosis—that is, another mental illness diagnosis—can be used to block persons from transitioning (Kirby & Diamond, 2014, p. 165). Trans people are placed within a double bind, where in order to access medical support, their gender identity is taken as evidence of an underlying pathology and their distress risks being labelled as mental illness. This is not to discount, undermine or negate the feelings of distress that a person may have about their body and the desire to change their physical body to align with their gender identity, but to acknowledge the impact of a bi-gender system upon the well-being of trans, gender diverse and gender nonconforming people. As the sociohistorical analysis of GD above has shown, these diagnostic categories rely heavily upon normative ideals of how a person should exist, and in the case of GD, these ideals are shaped according to homophobic and heterosexist norms. Diamond (2014, p. 201) discusses this violence using the concept of the "mythical norm":

> The 'normal' subject is always positioned at the centre, while all other subjects who deviate from this mythical norm are relegated to a 'lesser than' status. The 'normal' is left unquestioned and unscrutinised, while all other subject positions are under constant surveillance and re-evaluation.

Conclusion

It has been demonstrated in this article that psychiatric discourse on sexuality and gender has been underpinned by evolutionary thinking that conceptualises social hierarchies as biological realities. This has continued to orient psychiatry over the centuries, along with a vision of how society 'should' function. This vision has led psychiatry to reproduce cisnormative and heterosexist ideals through the medicalisation of trans people and gender diversity. Only by deferring to the psy-medical narrative—which is implicated in cisnormative and heterosexist logic—can trans, gender diverse and queer subjects gain access to support and treatment. The work of psychiatrists such as Zucker has been defended by the claim that their work is therapeutically beneficial in reducing distress by reconditioning people to the gender they were assigned. This claim operates according to a cis and heterosexist logic that gender differences between men and women are biological realities and infers that, by undermining these binary distinctions, the trans and queer subject undermines the natural organisation of society.

Far from being natural, psychiatry's conceptualisation of sexuality and gender is deeply implicated in an ideology that treats social hierarchies as evolutionary realities. By conceptualising gender diversity as a mental illness, psychiatry pathologises an expression of human diversity; as Lev (2013, p. 291) remarks, "Research from history, anthropology, and the biological sciences seem to show that non-binary gender identities, gender transformations and transpositions, are ubiquitous across human and non-human communities, throughout history and cross-culturally." More support for trans and queer people is needed; however, in order to create a more equal and just society, we must recognise the violence of cisnormativity and heterosexism. Only through their recognition can we begin to collectively address this systemic violence, learning from trans and queer people and opening new pathways of liberatory potential.

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