

**Queer Lens of Resistance:  
A Critical Anti-Oppressive Response to the DSM-V**

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A. Background:

The *Diagnostic and Statistical Manual of Mental Disorders* is abbreviated as DSM. The DSM is a document published by the American Psychiatric Association (APA) featuring descriptions, symptoms, and other criteria that assist in the diagnosing of mental disorders. First published in 1952, the DSM has since been revised three times with the most recent revision being the 2000 DSM-IV-TR (text revision), the manual currently in use. The diagnostic criteria provide professionals (clinicians) who treat patients with mental disorders a common language and are designed to ensure accuracy and consistency in their application. Additionally, the DSM establishes criteria for diagnosis that can guide research on psychiatric disorders. The DSM is focused on diagnosis only and provides no recommendations on the course of treatment, the idea being that appropriate treatment will follow accurate diagnosis. Although based in the United States, the DSM is a powerful psychiatric tool utilized in numerous countries throughout the world by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies and policy makers. The influence of the DSM in the intersecting fields of mental health, medicine and law indicates the depth and breadth of its influence in the mental health field. Currently, the DSM is under review, and the DSM committee is conducting public consultations. This position paper is a response for the review in preparation for the next DSM edition to be published in 2013.

B. Overarching Statement/Context:

The work of the Rainbow Health Network (RHN) is premised on the optimal health and wellness of people and communities of all gender identities and sexual orientations, as well as intersex people. The RHN is premised on a philosophical perspective that is strength-based, anti-racist and anti-oppressive. The Network believes in self determination and personal agency of the communities it advocates for by holding an affirmative approach to diverse sexual orientations, gender identities and expressions of gender and sexuality. The RHN respectfully contributes this position paper as input into the APA's consultation on the updating of DSM-IV-RT towards the publication of DSM-V. The contents herein are meant to reflect a dignified approach to addressing issues of sexual orientation, gender identity and sexual and gender expression for all members of these communities whether they are experiencing mental health issues or not.

C. Theoretical Framework: A Critical Analysis

The Rainbow Health Network (RHN) Position Statement on the DSM-V Review is premised on an understanding of sexual and gender identities, behaviours and expressions as fluid and existing along a multidimensional continuum rather than being firmly located within the binary categories of 'male and 'female, 'masculine' and 'feminine', 'heterosexual' and 'homosexual' and 'normal' and 'abnormal'. We recognize a diverse range of sexual and gender identities, behaviours and expressions based on aspects of identity including race, class and ability and promote health and well-being in relationship to the expression and affirmation of diverse sexual and gender identities. This anti-oppressive, affirming, and sex positive – non-pathologizing and de-stigmatizing – understanding of diverse sexual and gender identities and expressions is an important counter balance to traditional and contemporary medical classifications that attempt to regulate sex, gender and sexuality towards the project of rendering certain bodies 'normal' and others 'abnormal'. The RHN statement is premised on an understanding that in addition to separating 'normal' and 'abnormal' behaviour, medical classifications of sex, gender and sexuality function to police racial and class hierarchies and tensions in often invisible ways. Consequently, we recognize the alignment of sex, gender, and sexuality with pathology as a

racialized, gendered, sexualized and classed endeavour that results in queer people who are differently racialized, gendered, sexualized and classed being differently pathologized in relation to expressions of sex, gender and sexuality.

The RHN Position Statement on the DSM-V Review is also premised on the belief that the requirement of a formal mental disorder diagnosis for access to health insurance coverage for expensive and scarce medical interventions for transsexual, transgender, gender queer and gender fluid people constitutes a social process of 'gate keeping' that contributes to rigid binary, heteronormative categories of sex, gender and sexuality. This exposes systemic abuses of power that impact personal identity, health services, access and equity. This is oppressive, and is counter to anti-discrimination and human rights policy and legislation in Canada related to sexual and gender identities that have been fought for over the past decades.

It is from this perspective that the Rainbow Health Network is submitting a response to the DSM-V proposed revisions to the supraordinate diagnostic category 'Sexual and Gender Identity Disorders' with a particular focus on: 'Gender Identity Disorders', 'Sexual Paraphilias' and 'Sexual Disorder Not Otherwise Specified'.

#### D. RHN Response and Recommendations

##### D1. Sexual and Gender Identity Disorders Not Currently Listed in DSM-IV

###### *Hypersexual Disorder*

The Rainbow Health Network (RHN) is concerned that Hypersexual Disorder is a diagnostic category that is open to vague generalizations and misuse due to an imposition of normative values in the assessment and evaluation of an individual's practices. Pathologizing a person's behaviour as a mental disorder through the use of a list of discrete criteria obstructs the context and meaning-making social worlds in which individuals organize an erotic life. People of all sexual orientations engage in a wide variety of lifestyle patterns and choices due to many factors, both personal and structural that we feel resists normative prescriptions about the value, meaning and the shape that erotic cultures take in the contemporary era. Thus, RHN feels that a diagnostic category that relies on a taxonomy of individual's erotic practices, as outlined in the extensive dimensional metrics, and their frequency, intensity or duration cannot account for the multiple and varied erotic cultures that exist with the likelihood that non-normative practices would disproportionately be labeled problematic behaviour and thus be considered a mental disorder.

##### D2. Gender Identity Disorders

###### *302.6 Gender Incongruence in Children*

The RHN recommends the removal of the diagnosis, Gender Incongruence (GI) in Children from the DSM-V. The proposed revisions for the DSM-V offer some improvement in the diagnostic criteria including an emphasis on gender incongruence as opposed to cross-gender identification per se as suggested by the name change from 'Gender Identity Disorder' to 'Gender Incongruence'. Yet, other proposed changes offer increased ambiguity in the diagnosing process, for example, the removal of the distress criterion (the D criterion in DSM-IV-TR) may mean that even when a child is not distressed about his or her expression of gender that a 'Gender Incongruence' diagnosis and associated treatment could be imposed. Overall,

the diagnostic category of GI in Children as presented in the proposed revisions for the DSM-V continues the tradition of the DSM-IV and DSM-IV-TR to hold the likely potential of perpetuating an oppressive gender structure characterized by presumed stable, heteronormative, dichotomized categories of 'typical' masculine and feminine behaviour and expression. This will enforce 'one or the other' thinking and gendered ways of being on children as a result of perceived violations of an assigned gender category. This is evident in the dimensional metrics of the Dimensional Assessment for GI in Children that continues to promote notions of 'typically' masculine and feminine clothing, roles and toys, games and activities and problematize cross-gendered play and friendships. In addition, the dimensional metrics adhere to a notion of 'appropriate' gendered behaviour based on the values and norms of the dominant white, middle-class and heterosexual group while failing to consider racialized and classed expressions of gender and associated roles. The RHN recognizes that steps have been taken by the DSM-5 Task Force (e.g., specific study group) to consider how gender, race and ethnicity (note: class is not addressed) affect the diagnosis of mental illness generally, and whether there are significant differences in incidence of mental illness among racialized subgroups that might indicate a bias in currently used diagnostic criteria specifically (APA, February 10, 2010). However, this approach is limited in that it continues to assume a 'white' referential norm in relation to behaviour without critically examining how institutionalized racism and classism - dominant white, middle-class norms - are perpetuated through psychiatric classification and diagnosis.

The RHN recommends the removal of "GI in Childhood" given the likely potential for children to experience surveillance at best, and pathologizing at worst, of normative, diverse developmental exploration, creativity and expression related to sexuality and gender, as well as the added potential for the diagnostic criteria to result in the surveillance and pathologizing of gender variant lesbian, gay and bisexual children.

### *302.85 Gender Incongruence in Adolescents and Adults*

The RHN is philosophically and politically aligned with calls for the removal of Gender Incongruence in Adolescents and Adults (or any similar diagnosis) in the DSM-V in that locating variant gender identities and expressions within psychiatric discourses on illness and disorder reifies rigid binary, heteronormative notions of sex, gender and sexuality while pathologizing variant and diverse expressions of sex, gender and sexuality. The DSM-V proposed changes do not shift this phenomenon in any way. However, we recognize the challenges and tensions of this position in the absence of structural change to the requirement of a formal mental disorder diagnosis for access to health insurance coverage (as described in Section C). Consequently, the RHN supports the progressive movement towards the eventual removal of 'Gender Identity Disorders' from the DSM while adopting an 'incremental reform' position in an effort to enhance equitable access to required medical procedures including sex reassignment surgery (SRS) for trans people. Within a Canadian context, this is particularly important in that existing provincial health insurance policies related to SRS eligibility (British Columbia, Nova Scotia, Manitoba and Ontario) require a DSM diagnosis of Gender Identity Disorder (e.g., an International Classification of Disorders diagnosis can not be substituted for a DSM diagnosis). It is important to note that while the RHN has adopted an 'incremental reform' position, we strongly call upon all levels of government to recognize the urgency for structural change to the requirement of a formal mental disorder diagnosis for access to health insurance coverage and in that this change is a keystone in the depathologizing of transsexual, transgender, gender queer and gender fluid people.

The RHN supports the following DSM-V proposed revisions:

- a) The name change from 'Gender Identity Disorder', which stigmatizes and pathologizes diverse gender identities and expressions, to 'Gender Incongruence', which more accurately captures the relationship between assigned and experienced gender identity for trans people. In addition, the term 'Gender Incongruence' avoids establishing a 'natural' association between discomfort/distress and one's experience of gender incongruence as might be implied or interpreted by use of the term 'Gender Dysphoria'.
- b) The removal of the 'distress/impairment' criterion as a prerequisite for the diagnosis of GI thereby, fostering eligibility for health insurance and enhancing access to medical procedures and support services for transsexual, transgender, gender queer and gender fluid people who do not report gender-related distress due to gender incongruence, and allowing for an understanding of distress as a consequence of genderism, societal transphobia and/or internalized transphobia rather than inherent to a trans identity.
- c) The addition of the specifiers, 'with a disorder of sex development' and 'without a disorder of sex development' in order to make it possible for people with a disorder of sexual development (DSD) to be given a diagnosis of GI. However, in an effort to clarify that not all people who experience incongruence between their assigned and experienced gender have a DSD, the accompanying text should note that *any* person, with or without variations of sexual physiology, may experience incongruence between their assigned and experienced gender and may desire to transition their gender, to varying degrees. Given the proposed inclusion of the specifier 'with a disorder of sex development' and 'without a disorder of sex development' in the DSM-V, the RHN calls for the development of an ongoing taskforce and research committee comprised of both intersex and trans people (including those diagnosed with GI and DSD) to examine the validity and reliability of the 'GI with a disorder of sex development' and 'GI without a disorder of sex development' subtypes.
- d) The replacement of the term 'sex' by 'gender' in order to make it possible for people who have transitioned to no longer be given a diagnosis of 'Gender Incongruence'. The 'A' criterion in the DSM-IV-TR refers to nonconformity of one's natal sex, and therefore, the diagnosis of 'Gender Incongruence' will continue to apply to post-treatment individuals (e.g., treatment does not change natal sex). The accompanying text should state that the diagnosis no longer applies to persons who have had hormonal and/surgical treatment but that the 'removal' of a 'Gender Incongruence' diagnosis should not be dependent solely on the completion of hormonal and/or surgical treatment but rather should consider the multiple ways that transgender, gender queer and gender fluid people transition.
- e) The removal of sexual orientation as a specifier of GI based on the recognized fluidity of and challenge to measuring sexual orientations.

In addition to the proposed changes, the RHN recommends:

- f) The inclusion of 'gender distress' as a specifier dimension in response to the removal of 'distress/impairment' as a required diagnostic criterion and the recognized potential need for mental health services in relation to genderism, societal transphobia and/or internalized transphobia. The accompanying text should note that an assessment of gender distress should not conflate distress that is caused by genderism, societal transphobia and/or internalized homophobia with 'mental illness' and should consider a severity threshold in an effort to limit false positive diagnosis of gender nonconforming persons.
- g) The inclusion of 'partial remission' and 'full remission' and 'previous history' as specifier dimensions in response to the effect of replacing the term 'sex' by gender (e.g., the possibility of removing a GI diagnosis) on access to medical insurance vis-à-vis the

requirement of a mental disorder diagnosis. This inclusion would offer a justification for continued medical and mental health services for postoperative transsexual people and other transitioned transgender, gender queer and gender fluid people who no longer meet the criteria for a diagnosis of GI.

### D3. Paraphilias

The RHN supports the distinction being made in the DSM-V between paraphilias and paraphilic disorders in that sexually expressed behaviour recognized in the former need not be pathologized under the category of the latter. The RHN believes that the “B” criteria, that addresses the involvement of nonconsenting persons would warrant the attention and potential intervention of psychiatry as individuals may be victimized by the expression of such sexual behaviour. Nevertheless, the APA is being cautioned to assess the dimensional metrics addressing whether the paraphilia is causing or the person is presenting as ‘distressed’ or ‘impaired’ by the paraphilia of “B” criteria with a tempered approach. Causation of signs of ‘distress’ or ‘impairment’ need to be carefully assessed as to their origins. Is such ‘distress’ or ‘impairment’ due to sincere personal concern as to the state of one’s life and the impact the paraphilia is having on it, or is such ‘distress’ or ‘impairment’ due to societal pressures of normative lifestyles that are sex negative and contribute to the repression of sexual pleasure in order to sustain normative ‘acceptable’, ‘respectable’ productivity in life? Similarly, the RHN questions including the Paraphilias as a stand alone category based upon the “A” criteria in the DSM-V with the exception of 302.89 Frotteurism, 302.2 Pedophilia and 302.3 Transvestic Fetishism. The five listed paraphilias (outside of frotteurism, pedophilia and transvestic fetishism) are merely expressions of sexual behaviour that provide sexual stimulation for individuals engaging in them and thus have no place in the DSM-V, as their mere existence within the DSM risks pathologizing effects (despite the absence of the term ‘disorder’) as such sexually expressed behaviours are termed ‘non-normative.’ Inferred are normative notions of sexual expression and behaviours based upon traditional, conventional, middle-class ideations of acceptance and respectability. The RHN recognizes and celebrates the diversity of gender identities and sexualities and their varying expressions and thus, recommends the removal of the Paraphilias ascertained by “A” criteria only, as their inclusion has the potential of contributing to a diagnostic environment of surveillance and regulation of sexual expression and behaviours that fall outside normative notions. Three exceptions to this are the categories 302.89 Frotteurism, 302.2 Pedophilia and 302.3 Transvestic Fetishism. Frotteurism is based on the involvement of ‘a non-consenting person’ in the “A” and “B” criterias, the category of pedophilia is proposed to be expanded based on highly questionable research and the absence of a non-heteronormative socio-cultural analysis, and transvestic fetishism is highly gendered and devoid of providing a definition of mental illness.

#### *302.4 Exhibitionism*

The RHN supports Exhibitionistic Disorder based on “B” criteria, provided there is a nuanced method of assessment that ascertains the difference between a sincere personal account of ‘distress’ and/or ‘impairment’ in which the existence of exhibitionism is negatively impacting their lives vs. such ‘distress’ and/or ‘impairment’ being due to societal pressures of normative lifestyles that tend toward sex negativity and contribute to the repression of sexual pleasure in order to sustain normative ‘acceptable’, ‘respectable’ productivity in life. The RHN questions whether ‘recurrent and intense sexual fantasies, sexual urges’ can be a diagnostic measure in “A” criteria as well as the effects of applying Exhibitionism as a Paraphilia based on the “A” criteria alone. Concern is also raised regarding the three specified types being based upon the concept of being ‘sexually attracted to’ as opposed to any behaviours that are enacted.

The RHN recommends the removal of Exhibitionism from the Paraphilias based upon “A” criteria alone in DSM-V and cautions that the three specified types verge on psychiatric control of sexual thoughts and feelings with potentially detrimental surveillance, regulatory and pathological effects.

### *302.81 Fetishism*

The RHN supports Fetishism Disorder based on “B” criteria, provided there is a nuanced method of assessment that ascertains the difference between a sincere personal account of ‘distress’ and/or ‘impairment’ in which the existence of fetishism is negatively impacting their lives vs. such ‘distress’ and/or ‘impairment’ being due to societal pressures of normative lifestyles that tend toward sex negativity and contribute to the repression of sexual pleasure in order to sustain normative ‘acceptable’, ‘respectable’ productivity in life. The RHN questions whether ‘recurrent and intense sexual fantasies, sexual urges, or sexual behaviours’ can be a diagnostic measure in “A” criteria as well as the effects of applying Fetishism as a Paraphilia based on the “A” and “C” criteria alone. The dimensional metrics if applied to “A” and/or “C” criteria are questionable as to why this information is being gathered and for what purposes. Doing so becomes highly suspect of contributing to a conventionally restrictive and constrictive normative approach to individuals who are sexually aroused and stimulated by fetishes. Classist notions of normative sexuality is captured in the first dimensional metric that refers to fetishes ‘that are not sexually exciting to most people’; revealing a subjective value judgment that socially constructs a pathology.

The RHN recommends the removal of Fetishism from the Paraphilias based upon “A” criteria alone in DSM-V.

### *302.89 Frotteurism*

The RHN supports Frotteurism Disorder based on both “A” and/or “B” criteria, as in this case these criteria speak to the involvement of a non-consenting person. Further to the “B” criteria, RHN cautions that a nuanced method of assessment that ascertains the difference between a sincere personal account of ‘distress’ and/or ‘impairment’ in which the existence of frotteurism is negatively impacting their lives vs. such ‘distress’ and/or ‘impairment’ being due to societal pressures of normative lifestyles that tend toward sex negativity and contribute to the repression of sexual pleasure in order to sustain normative ‘acceptable’, ‘respectable’ productivity in life. Yet, the RHN questions whether ‘recurrent and intense sexual fantasies, sexual urges’ can be a diagnostic measure in “A” criteria as these involve thoughts and internal arousings but not enactments.

### *302.2 Pedophilia*

The RHN is very sensitized to the issue of child sexual abuse and would like safeguards in place to protect children from those who would perpetrate such abuse upon them. Yet, what is being proposed in THE DSM-V for pedophilia is of concern as it raises tensions within the diverse LGBT communities who may understand this issue differently based on their alignment, or not, with varying points on the spectrum of feminist thought; life experiences re: abuse and violence; gender socialization re: sex and sexuality, etc. There has been a long history involving the regulation of LGBT communities that define homosexuality as both criminal behaviour and a mental disorder. With the removal of homosexuality as a mental disorder from the DSM in 1973, the attention of the medical community has now turned to identifying and diagnosing categories of gender difference and erotic age preference. The conflation of gay

men and pedophilia persists, despite its inaccuracy. Diagnostic categories defined by erotic age preference have intensified as the biomedical paradigm for explaining child sexual abuse has gained ascendancy in the culture. The category of pedophilia has long been part of the DSM, but new changes seek to expand this definition that would include attraction to young teenagers as a sufficient criteria for diagnosis of a mental disorder. The DSM V proposes to include a new category of mental disorder, "Hebephilia" which is an erotic age preference for young people between the ages of 11-15, or to replace the existing pedophile diagnosis with a hybrid category, "Pedohebephilia" which would expand the diagnosis of pedophilia to include contact offenses or a pattern of desire for young people up to 14 or 15 years of age.

We oppose the expansion of the category of pedophilia in the DSM for the following reasons: First, the study by Blanchard et al (2009) that proposes the increase to a diagnostic category is methodologically flawed. Blanchard et al. use a controversial and disputed device, the penile plethysmograph, for measuring an individual's desire and claims scientific objectivity for the phallometry testing they employ. This device has proven controversial, yet they claim scientific objectivity in the attribution of erotic age preferences as an identity based on measuring minute changes in blood flow in an individual's penis. We note, along with others, that volumetric plethysmography testing, based on a biomedical model, is a radically reductionistic way of "diagnosing" erotic identities as it ignores meaning-making activities tied to a complex phenomenology of desire. Highly gendered, this study does not include women in the research. Second, we maintain that this research has not been able to prove conclusively the existence of such erotic age preferences and has not developed appropriate diagnostic criteria for assessing when and if it constitutes a mental disorder. Third, with the recent changes in the sexual age of consent in Canada, where formerly, 14 and 15 year olds were considered capable of consenting relations, Blanchard's research leans too heavily on recent changes to the criminal law to buttress claims to new pathological identities. Although Blanchard claims that he is not opportunistically taking advantage of recent legal changes, prior to 2008 when the basic age of consent increased in Canada from 14 to 16, the cogency of his scientific claims would have been very difficult if not impossible to mount. And finally, we oppose the expansion of the category of pedophilia as it disregards the wide developmental expanse between 11 – 15 year olds, and the ability for young people to make informed choices about the sexual relations they may desire. Non-normative behaviour is scrutinized more in a homophobic culture and age discrepant relations are especially vulnerable to pathologization. With the increase in the age of consent, the law cannot recognize the ability for 14- and 15-year olds to consent to sexual relations. With the expansion of the diagnostic category of pedophilia, psychiatry will expand its reach in pathologizing sexual relations that the law has only recently proscribed. Once again, by raising these concerns and tensions, this does not preclude RHN's position against any form of sexual abuse, particularly of children and young people.

### *302.83 Sexual Masochism*

The RHN supports Sexual Masochism Disorder based on "B" criteria, provided there is a nuanced method of assessment that ascertains the difference between a sincere personal account of 'distress' and/or 'impairment' in which the existence of sexual masochism is negatively impacting their lives vs. such 'distress' and/or 'impairment' being due to societal pressures of normative lifestyles that tend toward sex negativity and contribute to the repression of sexual pleasure in order to sustain normative 'acceptable', 'respectable' productivity in life. The RHN questions whether 'recurrent and intense sexual fantasies, sexual urges, or sexual behaviours' can be a diagnostic measure in "A" criteria as well as the effects of applying Sexual Masochism as a Paraphilia based on "A" criteria alone. The dimensional metrics if applied to "A" criteria only are questionable as to why this information is being gathered and for what



purposes. Doing so becomes highly suspect of contributing to a conventionally restrictive and constrictive normative approach to individuals who are sexually aroused and stimulated by sexual masochism.

The RHN recommends the removal of Sexual Masochism from the Paraphilias based upon “A” criteria alone in THE DSM-V.

### *302.84 Sexual Sadism*

The RHN supports Sexual Sadism Disorder based on “B” criteria, provided there is a nuanced method of assessment that ascertains the difference between a sincere personal account of ‘distress’ and/or ‘impairment’ in which the existence of sexual sadism is negatively impacting their lives vs. such ‘distress’ and/or ‘impairment’ being due to societal pressures of normative lifestyles that tend toward sex negativity and contribute to the repression of sexual pleasure in order to sustain normative ‘acceptable’, ‘respectable’ productivity in life. The RHN questions whether ‘recurrent and intense sexual fantasies, sexual urges, or sexual behaviours’ can be a diagnostic measure in “A” criteria as well as the effects of applying Sexual Sadism as a Paraphilia based on “A” criteria alone. The “A” criteria presents as problematic as it speaks ‘of another person’ without defining whether the ‘other person’ is paired as a willing and consenting sexual masochist. The dimensional metrics appear to be applied to “B” criteria only as they variably address ‘an unwilling stranger’ and/or ‘non-consenting person’. Thus, including Sexual Sadism as a Paraphilia under “A” criteria only would be deemed inapplicable. Doing so becomes highly suspect of contributing to a conventionally restrictive and constrictive normative approach to individuals who are sexually aroused and stimulated by sexual sadism and act upon it responsibly with consensual partners.

The RHN recommends the removal of Sexual Sadism from the Paraphilias based upon “A” criteria alone in THE DSM-V.

### *302.3 Transvestic Fetishism*

The RHN takes issue with Transvestic Fetishism as a stand alone paraphilia associated with “A” criteria and as a Disorder based on “B” criteria. The RHN questions whether ‘recurrent and intense sexual fantasies, sexual urges, or sexual behaviours’ can be a diagnostic measure in “A” criteria. The “A” criteria presents as problematic due to its gendered approach. It is explicitly focused on natal males only without explanation, implying that male-to-female cross-dressing is a psychiatric issue. The problems herein are multi-leveled. The exclusion of natal females that engage in female-to-male cross-dressing presents a subtle message of acceptability (to present as male) or complete non-recognition. The targeting of natal males presents a message of unacceptability (to present as female) with misogynistic and sexist undertones, stigmatizing effects and blames victims experiencing discrimination for their oppression. Inferred is a classist contemporary westernized cultural bias. The dimensional metrics appear inconsistent with the proposed revision in “A” criteria as they speak of ‘grooming yourself as a member of the opposite sex’ presenting a broader, if binary approach to gender. Additionally, this subcategory perpetuates binary notions of gender without any recognition of gender fluidity, pathologizing those that challenge rigid gender roles by cross dressing. Also, “A” criteria sexualizes the act of cross-dressing in natal males, which may not be the case for all. “B” criteria includes both erotic and non-erotic gender expression. Furthermore, “B” criteria is in danger of completely overlooking the implications of societal prejudice towards cross dressers and the ‘distress’ and ‘impairment’ this may cause. Additionally, the two specificities are of great concern. Transvestic Disorder linked to Fetishism raises the question why the

wearing of certain 'fabrics, materials or garments' should be pathologically deemed a psychiatric disorder. And linking Transvestic Disorder to Autogynephilia is considered highly offensive to trans women as it theorizes reducing their motives to fetishistic sexual gratification rather than their attempts at achieving a harmonious gender identity. Listing Transvestic Fetishism as a Paraphilia contributes to a conventionally restrictive and constrictive normative approach to individuals who are sexually aroused and stimulated by cross dressing or in a process that may lead to transitioning their gender at some point in the future.

The RHN recommends the removal of both Transvestic Fetishism from the Paraphilias based upon "A" criteria alone and Transvestic Fetishism Disorder based upon "B" criteria in THE DSM-V.

### *302.82 Voyeurism*

The RHN supports Voyeuristic Disorder based on "B" criteria, provided there is a nuanced method of assessment that ascertains the difference between a sincere personal account of 'distress' and/or 'impairment' in which the existence of voyeurism is negatively impacting their lives vs. such 'distress' and/or 'impairment' being due to societal pressures of normative lifestyles that tend toward sex negativity and contribute to the repression of sexual pleasure in order to sustain normative 'acceptable', 'respectable' productivity in life. The RHN questions whether 'recurrent and intense sexual fantasies, sexual urges, or sexual behaviours' can be a diagnostic measure in "A" criteria as well as the effects of applying Voyeurism as a Paraphilia based on "A" criteria alone. The dimensional metrics if applied to "A" criteria are questionable as to why this information is being gathered and for what purposes. Given the general non-intrusive nature of voyeuristic behaviour and the fact many will do so in settings in which privacy is not necessarily invaded (i.e. clothing optional beaches, nudist settings, bathhouses, sex parties, etc.), measuring based on "A" criteria becomes highly suspect of contributing to a conventionally restrictive and constrictive normative approach to individuals who are sexually aroused and stimulated by voyeurism.

The RHN recommends the removal of Voyeurism from the Paraphilias based upon "A" criteria alone in THE DSM-V.

### *302.9 Paraphilia Not Otherwise Specified*

The RHN requires further development in this subcategory before commenting.

#### D4. Sexual Dysfunctions

### *302.9 Sexual Disorder Not Otherwise Specified*

The RHN calls for the removal of the statement 'persistent and marked distress about sexual orientation' under the diagnostic category, 'Sexual Disorder Not Otherwise Specified'. A diagnosis of 'Sexual Disorder Not Otherwise Specified' is used to code a sexual disturbance that does not meet the criteria for any specific Sexual Disorder and is neither a Sexual Dysfunction nor a Paraphilia. Though the generic term "sexual orientation" is used it can be presumed to refer to lesbian, gay, bisexual (non-heterosexual sexualities) since clinicians rarely – if ever - see heterosexuals who are seeking treatment related to their sexual orientation. It is possible that the diagnosis of "Sexual Disorder Not Otherwise Specified" psychologizes the effect of lesbophobia, homophobia and biphobia (i.e., distress related to sexual orientation) for lesbian, gay, and bisexual people, and in doing so, blames the victim. The inclusion of the

statement 'persistent and marked distress about sexual orientation' under the diagnostic category, 'Sexual Disorder Not Otherwise Specified stigmatizes lesbian, gay and bisexual orientation vis-à-vis psychiatric classification.

#### D5. Supraordinate Diagnostic Category of Sexual and Gender Identity Disorders

In addition to the recommended revisions proposed in this document, the Rainbow Health Network calls for the removal of Gender Identity Disorders and Sexual Paraphilias from the supraordinate Axis 1 (clinical disorders) diagnostic category 'Sexual and Gender Identity Disorders'. The continued classification of diverse sexual and gender identities and expressions as clinical disorders constitutes the ongoing surveillance, pathologizing and regulating of otherwise variant expressions of sexuality and gender (as describe in Section C). As an alternative, including Gender Identity Disorders and Sexual Paraphilias in Axis IV (psychosocial and environmental factors contributing to the disorder) would support recognition of the social, cultural and political forces related to the social construction of sexual and gender identities (without a DSD) as mental illnesses and marked distress as a result of the stigmatization of, and discrimination against, diverse sexual and gender identities that challenge heteronormative, gendered, racialized and classed notions of sex, sexuality and gender. A second, although less favourable, alternative would be to retain Gender Identity Disorders and Sexual Paraphilias as Axis I clinical disorders under 'Other Conditions that may be a Focus of Clinical Attention'. Doing so may also function to shift understanding of the cause of distress and impairment in relation to social stigma and discrimination from sexual and gender identities *per se*.

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