

The review process of the DSM 5: is gender a cultural or diagnostic category?

Abstract

Never before has there been an intellectual production on the transgender population as observed in the last decade. Many researchers have tried to find a biological explanation for the origin of gender identity of transgender people. There is, however, a different field of research that has tried to prove that it is impossible to find a biological explanation for the diverse expressions of gender because “gender identity” is a cultural question. These two positions are not new, but the dispute between both of them has intensified due to the reviewing of the process of the Manual of Diagnostic and Statistical of Mental Disease (DSM) with its fifth edition completed in 2013. Should trans identity continue to be diagnosable? This is the question that almost all articles written in the last 10 years have tried to answer. The DSM is a manual from the American Psychiatric Association (APA), but its power is not limited to the borders of United States, generally, psychiatrists worldwide use it. The objectives of this article are the following: 1) Presenting the process of debate that resulted in the name change of diagnostic category from Gender Identity Disorders to Gender Dysphoria. The name change, as pointed out by several researchers, does not solve the problem of stigmatization or of health care; 2) Presenting the changes in the new version of the DSM-5, the chapter on “Gender Dysphoria”. For the first time, gender appears in a separate chapter of sexuality. The methodology of this research has been based on file research that happened between 2013-14 in the database of CUNY (City University of New York).

Keywords: DSM-5, gender dysphoria, access to health, stigmas

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Introduction

In May 2013, the fifth version of the Diagnostic and Statistical Manual of Mental Disorder (DSM) was published. After five years of intense debates involving experts, human rights activists, professionals psy (psychologists, psychiatrists and psychoanalysts), health practitioners, finally, we know the final resolutions adopted at the meeting of the American Psychiatric Association (APA). The DSM is a manual of the American Psychiatric Association. The characteristic of National Association, however, do not preclude there being an express desire that the clinical findings, for its alleged scientific character, have a global reach. As I will try to suggest, this universal truth-seeking can be interpreted as part of an epistemological colonizing project, since it is not possible to universalize local conceptions of gender (which in the US context straddle the medicalized and psychiatrized view of life) for a variety of gender expressions inserted in different cultures.

Ever since the DSM began to be published in 1952, five reviews were edited. Over the years, what was noted was a considerable increase of diseases diagnosed as “mental disorder”. There is a courageous literature that discusses the spoken and unspoken motivations of this inflation of psychiatric disorders, including the growing influence of the pharmaceutical industry in the decisions of the members of the Working Groups (WG) that make up the Task Forces (TF) responsible for the review.¹⁻³ The 948 pages of the DSM-5 are structured as follows: preface, section I (basic information about the DSM-5), section II (diagnostic codes and criteria), Section III (assessment tools and emerging models), appendix. Section II is the “diagnostic criteria and codes” for the 22 types of psychiatric disorders (e.g, bipolar

disorder and related disorders, depressive disorders, anxiety disorder, etc.). Only three diagnoses do not take in their titles the typification “disorder”. They are: Gender Dysphoria; Sexual dysfunction and schizophrenia spectrum; and Other psychotic disorders. The research I carried out during 2014 had an accurate cut: the diagnostic criteria for Gender Dysphoria (which in the DSM-IV was named Gender Identity Disorder).⁴ I concentrated on the following parts of the DSM-5: Preface Chapter Gender Dysphoria (section I) and part of section III (cultural formulation). The questions that guided me were: how is it possible to transform a cultural category (gender) in a diagnostic category? To answer this question, others were made: Who were the members of the Working Group (WG) responsible for the redesign of the chapter “Gender Identity Disorder”? What are the institutional linkages of these members? What literature was cited and consulted in the documents produced by the WG? I used the Foucaultian discourse analysis to read, systematize and analyze texts.

At the start of the research, I tracked the references that guided the production of the articles used by the WG “Gender Dysphoria” and organized a small table with the data:

- The language in which the article was originally written
- Institutional affiliation of the author
- Year of publication
- Position that advocates for maintaining the gender category as a psychiatric disorder
- Names as expressions of gender (gender dysphoria, gender identity disorder, gender incongruence, etc).

To survey produced articles on the DSM-5, I used as descriptors the terms “gender identity disorder”, “gender dysphoria”, “pathologization”, “transsexualism”, “transsexuality”, “transgender”. My time frame was the 2008 to May 2013 range, a period that includes the beginning of the review to the date of the launch of the new version. The analysis methodology was discourse analysis and the technique, documental analysis. I used the databases of the City University of New York (CUNY). After reading and analyzing hundreds of articles, I came to a core of four articles considered benchmarks by WG because of the recommendations they make to the new version of DSM-5.

They are:

- a. *The DSM diagnostic criteria for gender identity disorder in adolescents and adults.*⁵
- b. *Queer diagnoses: Parallels and contrasts in the history of homosexuality, gender variance, and the Diagnostic and Statistical Manual.*⁶
- c. *From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions.*⁷
- d. *The DSM diagnostic criteria for gender identity disorder in children*⁸

For this paper, however, I prioritized as corpus of analysis:

- i. DSM-5 (the parts related to gender dysphoria)

- ii. Memo Outlining Evidence Report for Chance (MOEC)
- iii. The article, quoted in MOEC, opinions about the DSM Gender Identity Disorder diagnosis: Results from an international survey administered to organizations concern with the welfare of transgender people (RS Vance et al). All working groups that suggested changes in newsrooms chapter of DSM-IV-R that they were in charge of to review, had to publish a report (MOEC) where they presented and justified the changes in diagnostic categories.

The MOEC (2013) presented the changes that happened in the chapter Gender Dysphoria and justified them. The first was to change the name of the psychological distress of “Gender Identity Disorder” to “Gender Dysphoria”, a discussion that I will make further on. Diagnostics are structured in stages of life: childhood, teenage and adulthood. Depending on the stage of life, the criteria change. Childhood will have indicators different from those presented for adolescents and adults. Among the criteria to diagnose a child as having gender dysphoria, it is necessary to note, according to the DSM-5, a desire to belong to the other gender; strong preference for cross- dressing; strong preference for playing with pairs of other genre. As for adolescents and adults, some of the criteria are: strong desire to belong to the other gender (or some other alternative gender different from the designated) strong desire for the primary and / or secondary sexual characteristics of the other gender; strong conviction of having the feelings and reactions typical of the other gender (DSM-5, 452-51) (Table 1).

Table 1 Members of the Working Group (WG) Gender Identity Disorder (that will change for Gender Dysphoria), DSM-5

Kenneth J. Zucker PH.D (Presidente)	Centre for Addiction and Mental Health-Toronto-Canada
Lori Brotto	University of British Columbia (UBC)-Department of Obstetrics & Gynaecology - Canada
Irving M. Binik	McGill University Health Center (Royal Victoria Hospital)-Canada
Ray Blanchard	University of Toronto-Canada
Peggy T. Cohen kettenis	VU University Medical Center (Amsterdam)-Department of Medical Psychology-Holanda
Jack Drescher	Columbia University-NYC-US
Cynthia Graham	University of Southampton-Reino Unido
Martin P.Kafka	McLean Hospital (Harvard Medical School Affiliate)-Belmont-US
Richard B. Krueger	New York State Psychiatric Institute-Director of the Sexual Behavior Clinic-US
Niklas Långström	Karolinska Institutet-Suécia
Heino Meyer Bahulberg	New York State Psychiatric Institute & Columbia University (Department of Psychiatry)-US
Friedemann Pfäfflin	Ulm University-Alemanha
Robert Taylor Segraves	Metro Health Medical Center & Case Western Reserve School of Medicine-US
William M.Womack (is not of the WG. Does not integrated the DSM5)	Department of Psychiatry & Behavioral Sciences, University of Washington School of Medicine, Seattle-Washington-US consultants and collaborators'group

This same proportion is maintained in the composition of the group of consultants from the WG Disorders Sexual and Gender Identity. Of the 39 consultants 32 are from North America (US=27, Canada=06); 06 in Europe (Netherlands=03, England=02, Spain=01) and in Australia=01. These data of nationalities of the WG members are important for us to verify the scope of a proposal, intended to be global, for the supposed mental disorders linked to gender. Therefore, two data are important to frame the political structure of the changes: the hegemony of the United States and English as the official language of the whole review process.

DSM-5 revision of context

Between the third (1980) and the fifth edition (2013), growth of the political organization of the collectives was noted, which aimed at protecting the interests of trans people in the United States. This growth also occurred in several other countries and was accompanied by a growing differentiation of the agenda of struggle of the gay and lesbian population. Trans activists began to demand public policies, protective legislation in the labor market, the right to legal gender identity, criminalization of transphobic violence. A strong debate on

the withdrawal of trans identities of the DSM-5 took the scene in the US and international context. A considerable part of the articles produced in this period were structured around this issue: must the trans identities remain in the DSM? Those favorable to the continuity of psychiatrization of trans identities had to structure new arguments to justify their maintenance in the Manual. There was already the historical precedent of the withdrawal of homosexuality from the DSM. Why would the gender continue as a diagnostic category in psychiatry? Trans activists, from human rights and researchers engaged in an international mobilization on the withdrawal of the expressions of trans gender and intersex, known as Stop Trans Pathologization.⁹

The setting for the integral health care of the US population in general and trans in particular happens within the framework of the relationship with the market for health insurance. For the health plan to make payment to the health professional, a code is required to report the disease, without it, there is no payment or reimbursement. This was one of the strongest arguments to justify the maintenance of trans identities in the DSM-5.^{6,10}

However, in the US meeting the specific health issues of trans population is poorly covered by health insurance. Rare are the covering costs of reassignment surgery or hormone needed to produce secondary characters in bodies socially identified as belonging to a particular gender, such as breasts in trans women and hair on the faces of trans men. Only consultations with psychiatrists are widely paid by health plans. In numerous meetings with trans people in New York I asked if they would like to do the surgeries of reassignment or/and taking hormones. The answers did not change: "I'd love to, but it's too expensive"; "impossible, I have no money"; "My health plan does not cover this type of intervention"; "between having a vagina or a small apartment, I prefer the apartment."

The continuity of psychiatrization in this context should be construed as a necessary concession to the market, it would be the only way to get the meager treatment offered by the health plans. At first sight you can arrive at the following conclusion: psychiatrization of the identities that in DSM-III and DSM-IV was supported by an understanding that gender identity was grounded in dimorphic structures of sexual bodies. Now, in the version of DSM -5, it has come to recognize that gender is not conditioned to a particular biological structure. Thus, it is understood as legitimate the existence of women with a penis and men with vagina. But this approach by DSM-5 with a despatological vision of trans identities is hasty and misleading. Although major changes happened, and they seem to suggest that there was a change in the very understanding of what gender is, a more careful reading leads us to see that the concept of gender that was present in earlier versions did not change substantially. The argument for maintaining it according to a categorical imperative of the market can be interpreted as a ruse to:

- a. Strengthen the corporatist position of psychiatrists providing them their marketing (and scientific) role to formulate answers to this kind of "disorder".
- b. The defense for maintaining the gender at DSM to ensure treatment by health plans, can be a discursive shield so as not having to openly advocate a gender conception that stamps trans people as mentally disturbed.

The lack of public health care defines the very terms in which this

whole process of discussion happened. This would be the first major difference with respect to the Brazilian context where the debate about the dispsychiatrization, rights and health care of the trans identities articulates in the relationship between social movements / Unified Health System (SUS) linked to the Ministry of Health. The state is a central actor. While in the US neoliberalism takes away any responsibility of the State with the overall health of the citizen, in Brazil, as a remnant of the state of social well being, it is the State that has a legal obligation for this responsibility. Among us, the debate on health of trans people is included in this broader debate about health / State /citizenship.

In Brazil we enter into dispute with the Ministry of Health, with the working groups articulated by SUS, we fight for reprints and enlargements of ordinances, we build channels of dialogue with public managers, we obstruct the same channels of dialogue when observing government maneuvers. Finally, the scenario in which the debate and dispute happen in Brazil is completely different. In the US context, the defense for the maintenance was to ensure treatment of trans people by health plans, in Brazil, where all the debate takes place in the context of human rights and guarantee of citizenship, being that the State has primary responsibility to fund the meager services that exist, then what's the point of continuing using the DSM as a reference to establish the parameters of discussion? And it is here that an interesting "political knot" is established. If in the US context the psychiatrization is closer to a scene game, a make-believe in which it is assumed as necessary the interpretation of a thing called "gender dysphoria", and if in the Brazilian reality it would not be necessary to reproduce this same theater, I wonder : why it is still used and gives a legitimacy to the DSM that it does not have? As I will discuss later, the DSM is a text universalizing local contexts, therefore, its *modus operandi* is as a colonizer. But the colonization thought only makes sense if it can be internalized as truth. The acceptance and reproduction of the truths of DSM is an effect of the colonized thinking. The DSM is a text that "speaks" of a social, political and specific economic context.

Sometimes we hear activists and/or researchers triggering arguments for the continuation of psychiatrization as if we were reporting to the US reality and to re-enforce, sometimes, they cite Judith Butler's texts^{11,12} to add value to the argument that one should make a strategic negotiation with psychiatrization of trans identities. In the prologue of the book *El Género Desordenado*, Butler asserts that: "(...) If to withstand and resist, with collective support, the strength of any pathological diagnosis in order to access the transition process and achieve the transformation sought and desired (2011: p.12)".

When Butler takes the DSM text as universal data and theorizes on the situation of trans people in all countries without limiting the terms of her assessment, in a way, she helps to legitimize the DSM text and transforms a particular experience (the neoliberalism relationship / health) as universal. I'm not making here any resentful criticism in accordance with Nietzsche,¹³ to this theoretical, that is so important for the reflections and struggles for human rights, or other US activists, but maybe it's my place as a researcher cucaracha activist that allows me pointing out the limits even of analyses that although do not break up with their cultural boundaries, wishes them to be recognized, reproduced, consumed, cited, adapted as valid analytical models in any and all context.

Perhaps one of the steps to produce a short circuit in this totalizing desire of the explanations is to deny analyses that announce

themselves as universal. It is necessary to accomplish what Pedro Paulo Gomes Pereira¹⁴ proposes that we do with the thought of Michel Foucault and other theorists who insist on producing interpretations of a universalizing range when, in fact, they speak of their provinces, their own realities. In dozens of articles read for this study, written by activists and / or engaged researchers I found a terrible silence on the effects of DSM in contexts outside the US, no complains whatsoever about the limits DSM and the danger that their statements are seen and treated as universal. If in the US the Manual is consumed as a resource to meet market needs, in Brazil it is credited as a scientific piece therefore unquestionable. Stuart Kirk et al.,¹ cite a survey among US mental health professionals on the DSM-III, the version known to have given this manual the bases of the scientific validation, nonexistent until then. Only half (49%) of respondents felt that the DSM-III serves the goals of their profession and 57% of them described the DSM-III as a management tool, not as a clinical tool. These results suggest that the use of DSM-III diagnostic criteria do not meet the needs of patients and therapists in the organization of treatment, but the needs of the institution in the management of the services it offers.

Looking for a name: gender identity disorder? Incongruity of gender? Gender dysphoria?

One of the recurring issues throughout the review process was the need to rename the name of the diagnosis, since “gender identity disorder”, according to the MOEC produced stigma. What authors do not consider is that the DSM as a whole is a part producer of institutionalized stigmas. That is, the name that is given will not change the fact that mental sufferings are in advance qualified as mental disorders. The quantity of names created to name the various expressions of gender is considerable. The MOEC presents some proposal of suggested identification:

Brainsex / body discrepancy syndrome, Harry Benjamin syndrome, gender variant behavior, gender variant identity, free to choice, Symptoms of transsexualism, transsexualism, multiple gender, biologic-psychological sexual disparity, gender dysphoria, incongruence between sex and gender, gender identity society-dystonic synthesis, disorders related to sex and/or gender variance, variance gender, gender expression deprivation anxiety disorder, atypical gender development, transgender our gender questioning. (MOEC, 903). What this proliferation can suggest is not an intellectual preciousness, but it presents differences in the significance attributed to the experiences of transition, change, body changes more or less intense related to gender. People who have had their gender imposed as feminine and transition to the male should be considered as trans man, male transsexual, FtM, transgender? Just to keep me in the identified field with a non-biological view of identities. There is another nomination field, represented by the hegemonic psy sciences using as a starting point for identification construction the presence of a certain genitalia. In versions 3a. and 4a. of DSM the biologist vision was hegemonic. So when one says “you are a female transsexual because you were born with a vagina” or “you are a trans man with a vagina because the gender identity is not conditioned by the genitalia” one is quoting from different conceptions for the genders.

In Brazil, outside the framework of the DSM debate, one also notes a fierce dispute in naming the experience of those who fight for social and legal recognition of a gender identity different from the one imposed. Men trans / trans women? Men (trans)/women(trans)? Transgender male / female transsexuals? Transgender? Transvestites?

Transgender women? Men transsexuals?¹⁵⁻¹⁸ The dispute intensifies when we leave the personal identification field to the definition of naming a collective identity. In each of the nominations mentioned here there are motivations and different interpretations of the relationship between body/ gender identity/subjectivity/ collective subject.

At the beginning of the chapter Gender Dysphoria, there is an introduction stating that in other cultural contexts the recurrence of gender dysphoria can also be observed. There are reports of individuals with gender dysphoria in many countries and cultures. The equivalent of gender dysphoria has also been reported in people who live in cultures with other institutionalized gender categories in addition to the male and female. (DSM-5, 458) In MOEC this idea is reinforced.

GD appears to be expressed in many cultures, including non-Western countries. In Samoa, for example, the fa'afafine constitute a kind of “third gender” category, who, from a phenomenological perspective, bear striking similarity to the Western category of transsexualism ou GD. (MOEC, 908). The text considers that “fa'afafine”,¹⁹ a gender experience that occurs in Samoa, is an interchangeable term for gender dysphoria. Rather, I argue that you cannot understand the fa'afafine existence without understanding the historical, religious, social, political context in which it consists. Subjectivities, including gender, are produced in relation to the context in which they operate. But we must recognize that at this point the DSM is consistent: as a text intended to be scientific and moving between universals, being the mental disorder identifiable independent of historical oddities. So it would make sense to “read” the experience of the fa'afafine in line of continuity with gender dysphoria.

We could follow the same line of “problematization” in relation to the way that the text gives to “transvestism”, it is present in Chapter Paraphilic disorders which included, among others, the voyeuristic disorder, exhibitionist disorder, disorder, disorder pedophile, fetishistic cross-dressing disorder and disorder. If someone takes pleasure in dressing as a woman and after a while, does not limit himself to live the fantasies in sexual context, but also uses the accessories at other times of his life, you may have a triple diagnosis due to comorbidity. He would be carrying gender dysphoria, fetishistic disorder and transvestic disorder. The manual explains it to us: Cross-dressing disorder occurs in men (rarely women) heterosexual (or bisexual) adolescents and adults for which cross-dressing behavior (cross-dressing) produces sexual arousal and cause suffering and / or losses without putting in discussion its primary gender. Occasionally, this disorder is accompanied by gender dysphoria. An individual with cross-dressing disorder who also has clinically significant gender dysphoria can receive the two diagnosis. In many cases of late-onset gender dysphoria in ginecofilicos males at birth the cross-dressing behavior with sexual arousal is a precursor. (Gender Dysphoria-DSM-5, 459 p.)

If to the Manual “transvestite” is a practice linked initially to the scene of sexual desire, in the Brazilian context the travestility takes up a another place one that negotiates senses within the trans existences and by doing so establishes a dispute within the frames of the truths for the genres. So before we insert ourselves in discussions about the multiple gender identities, there are languages that need to be translated into translation movements that seek to understand the meanings attributed by those who are included in the experiment. You can intensify the questioning of the identification even when using the same identifier, but which are set and produced in different social

and historical contexts, like the way that the meaning “transsexuality” takes in countries where people are forced by the state to undergo surgery to suit the local biopolitics prohibiting loving relationships between people of the same sex like in the documentary “homosexuals in Iran.” The estrangement should be close to that what Durkheim did when he suspected of psychological explanations for suicide. To say that a person killed himself does not reveal much of the motivations that led to “commit this extreme act”.²⁰ That is, not everyone is in existential crisis, or feeling empty. There are people who take their own lives to defend their group and do it with extreme pride.

The question that repeated itself when I was doing research in Spain was what meant, in the Brazilian context, the identity category “transvestite”, since a considerable part of the Brazilian trans women working in the sex trade of that country identify themselves as transvestite. After trying to explain, the question that unfolded was: *but would it not be transsexual? for us there is a difference between a transvestite and transsexual.* And again I tried to offer an explanation of the why of this identity demarcation that makes so much sense among us Brazilians and that cause noises in other context. In the process of depathologization of homosexualities it was necessary to remove from this experience the ahistorical character. What have sexual relationships between the disciple and the Greek master in common with contemporary homosexuality? Can it be argued that the kids of Zambia who, as part of the initiation rites of masculinity, swallow the semen of older men are inserted in homosexual relationships? Perhaps a view that looks for universals could run the risk of stating that in both instances it comes to gay experiences. However, the fact that we have two equal-sexed bodies is not sufficient, nor authorizes us to define these experiences as homosexual relationships.

Why dysphoria gender?

The MOEC justified the change of “gender identity disorder” to “gender dysphoria”, as follows:

GID was stigmatizing.⁵ Initially it was proposed to replace it with the term Gender Incongruence. (February 2010). Many commentaries by other professionals and the general public, included “consumers” of psychiatric services and transgender communities and their supporters. (MOEC: p. 902). In this quote the political desire is materialized to build a consensus on the best appointment. It’s as if WG did not want to take risks. And here the political character of this manual becomes clearer. In summary, it is our view that the proposed name change from GID to GD will 1) highlight a conceptual change in the formulation of the diagnosis (which we will amplify in the text description of the diagnosis) and 2) satisfy critics concerned about the stigmatizing use of the “disorder” term in the name of the diagnosis. The proposed name change to GD has been quite favorably received during the second round of public postings, is acceptable to WPATH experts, and is consistent with some other diagnostic terms in the DSM, such as Anorexia Nervosa... (does not have “disorder” in the diagnostic name) (...) it should be noted that the term “gender dysphoria” has a long history in clinical sexology and thus is one that is one that is quite familiar to clinicians who specialize in this area. (MOEC, 904) The term “gender dysphoria” has a long history in what context? In Brazil, it is completely unknown. Activists, experts, researchers, doctors, psychiatrists, law operators, health practitioners do not use this appointment in their daily lives. Once again, we are facing an attempt to universalize something local. How is it possible to build a scientific consensus using as legitimacy argument the argument that:

1. It is a widely used term.
2. The previous term (inconsistency) had much resistance?

The cultural issues

In DSM-IV the importance of culture as a factor to be considered at the time of making the diagnosis had already been identified. The chapter an Outline of Cultural Formulation presented a framework to assess the relationship between all mental health problems included in the manual and cultural characteristics. The 5th. edition will pay more attention to this issue. The chapter Cultural Formulation Consists of three parts:

1. Cultural formulation outline. Presented are some categories that should be taken into account before the production of diagnosis (e.g. cultural identity of the individual, cultural conceptualizations of suffering, general cultural evaluation).
2. Cultural Formulation Interview which presents 16 questions that, according to the Manual “can be used in full, or, some components can be incorporated into clinical evaluation when needed” (DSM-5, 751). It is recommended to have the interview when, for example, there is “difficulty in the diagnostic evaluation due to significant differences in cultural, religious or socioeconomic background of the clinical and of the individual” (DSM-5, 751).
3. Cultural concepts of suffering. A first reading of the chapter may suggest that there is a considerable advance in the design of the Task Force in charge of the DSM-5 revision, since the cultural dimension has been incorporated with emphasis. Some of the questions of these interviews are: “are there aspects of your origin or identity that make a difference for your [problem]?” (DSM-5, 753) or “Are there aspects of your background or identity that are causing other concerns or difficulties for you?” (DSM-5, 753). There is also a part of the Cultural Formulation Interview (EFC) aimed at the informant (which can be a family member, friend).

A second reading opens up some questions:

- 1) The concern for cultural diversity can be interpreted as one more data revealing the local character of the DSM-5 text. It may seem contradictory, but it is a mark of several American cities, the cultural diversity arising from immigration, especially in the cities where the members of the Working Group live (see table listing the members). In informal conversation with a colleague in New York, working as a translator in a hospital in the neighborhood of Harlem (Manhattan) he told me that his job is to attend medical appointments in the condition of translator of English-Spanish-English. Due to lack of communicability between doctors and patients, one of frequent results was medical errors when interpreting the patient’s symptoms. This generated a considerable amount of legal demands of patients caused by medical errors. The solution was to hire the specialized work of translators.
- 2) I would suggest a scene. A woman lives in Manhattan and she goes for a consult with a New Yorker psychiatrist. She was born in Samoa. When a woman begins to speak, her deep voice, her big hands, certainly produce a doubt about the gender identity of the woman who is before him. In her community her gender identity is respected. When she shows her identification, the psychiatrist will no longer have doubts: he is facing a ... gender dysphoric. But she is there because she wants help to overcome suffering that is not related to her gender identity.

My question is: Would this psychiatrist have cultural conditions to treat her and help her without making any comment on the gender experiences of his possible future patient? What I am trying to suggest is a reversal. As the DSM is a picture (perhaps blurred, out of focus) of US society I would say that the view of the psychiatrist will not resist speculating about issues of woman's gender experience and make synapses between the suffering that brought her there. Possibly, she will have a diagnosis of gender dysphoria, combined with other "mental disorders". The specialist's view is built for pathologizing the experiences that do not fall within what is considered culturally acceptable to the genres. What initially appeared to be a psychiatrist to patient movement will soon be shown that the path will happen in reverse? Will it be the patient who will have to subject herself to the category of knowledge and recognition of the psychiatrist's world? In her cultural context she certainly would not live through this kind of epistemological violence.

- 3) The concern with the dimension of cultural diversity would spare the criticism that the DSM-5 would be a text that does not take into account that the names of symptoms change from one context to another. In the "Cultural Concepts of Suffering" it is stated: The cultural language of sufferings are ways of expressing suffering that may not involve specific symptoms or syndromes, but provide collective and shared ways to try to talk about personal or social concerns. For example, the talk of "nerves" or "depression" can refer to widely varying forms of suffering without falling into a distinct set of symptoms, syndromes or disorders (...) The current formulation recognizes that all forms of present suffering are shaped locally, including DSM disorders. (DSM-5, 758).

I would have no objection to make to this quote, but how to articulate the cultural particularities with the wishes expressed in the DSM-5 of the obtained universality through evidence and objectivity? All the "cultural language of suffering" is not social? How to translate the language of the suffering of others? Who will be on the other side doing the listening, decoding complaints and the patient's symptoms? What is the training of psychiatrists in anthropology, sociology, history, and other humanities to help them transform the consultation scene in a moment of "cultural translation"?¹³ If we are moving in the context of cultural diversity, negotiating concepts of suffering, the first step would be to establish a symmetrical relationship of listening. How many social scientists formed the WG? "Gender Dysphoria"? None. How many people of trans? None. What are the nationalities of WG members? Only five countries (US, Canadian, Dutch, UK) who believe to exhaust the possible explanations for the "gender dysphoric" and "non-gender dysphoric".

Universalists speeches have in common the production of another, starting with the emptying of diversity. Edward Said,²¹ commented as follows on the essay entitled "The Arab World", 1972, by the psychiatrist Harold W. Glidden and published in the American Journal of Psychiatry. Thus, in four pages of double columns, for the psychological portrait of over 100 million people, covering a period of 1300 years, Glidden cites exactly four sources of his ideas (...). The article itself purports to reveal "the inner workings of Arab behavior," which from our point of view is "aberrant" but for the Arabs is "normal". After this auspicious beginning, we are told Arabs emphasize compliance; Arabs live in a shameful culture whose "prestige system" implies the ability to attract followers and clients (as an aside, we are told that "Arab society is and has always

been based on a client-patron relations system"); Arabs only function in situations of conflict ... (2015: p. 85). We can borrow the same scare Said had when it is concluded that in 10 pages, 12 researchers distributed in 5 countries, using only English as the language, can accomplish a great description of the diversity and meanings to the genders. Maybe one can argue against it that they did not dedicate themselves to the genre, but to a kind of gender expression. This is another pitfall that feminisms have to disassemble: identifying the gender dysphoric, DSM is using as measurement parameters that what is considered socially acceptable for boys and girls, it was so in DSM-III, continued in the DSM-IV, and got consolidated in the DSM-5. How to identify a child with gender dysphoria?

The obvious answer that could be directed at my consideration on the lack of plurality in the DSM (of nationalities, languages, identities, customs) is that it has no reason to be so because it is a manual of a national professional association. But this argument disappears if we ask whether the scope of the statements contained there are exclusively valid for the US context. At this time, another certainty may be asserted: no, it is valid across national borders because it is capable of verification. If listening to the other and cultural diversity was assumed to be important for the construction of all diagnostic categories (mainly in gender issues), why in the literature cited in MOEC, a total of 125 works cited (between articles and books) only 4 refer to cultural diversity of the genre? The WG could have proven that listening is an important data starting with listening to own trans activists and theorists of its own American society. The only work cited written by a trans person is cited Gender Outlaw: On Men and the rest of us, Kate Bornstein.

Perhaps throughout the construction process of the chapter Disforia Gender, the WG has held meetings with activists / theoretical trans local or international, but that simply disappeared in the final result. The construction of the framework and theoretical contributions of the WG were fundamentally endogamous: of 125 works, 59 are only 4 scientists (the same who had their papers considered as constituting the most important recommendations for reform.⁵⁻²² These names also make up the WG But there are other data that reveal the impossibility of considering diversity of analyses or of perspectives: 25 works cited are of one single author, the President of WG, KL Zucker. This total silencing reveals a profound epistemological violence. The Other has nothing important that deserves to be taken into consideration. In an act of power, the WG silences the voices and assign to a group of four researchers the task of thinking about the world of gender relations.²³

Ultimately, it is a single view, psyquiatrizing and pathologizing that continued hegomonizing the Manual. I infer that the part concerning culture, is the desire to be "politically correct", a rhetorical exercise that aims to produce mirages about the controlling character of bodies and desires in US context and colonizing towards other cultures. By pointing out the DSM-5 controlling character in the American context I add myself to the other theoretical and native activists who follow the same line. However, there is a deep silence on the second to the political-ideological dimension of a certain conception of health, mental health and structural gender of the DSM-5 text. Be they LGBT activists, researchers or professionals who have critical positions and sometimes added themselves to the voices for withdrawing gender identity as diagnosable even in this case (as far as my research led me to the present moment), I have not read a single line that points out the strength and power beyond the border of the DSM-5.²⁴

In search of scientific precision

Following the terms of this debate confronts us with an interesting dispute which is far from any objectivity. Like all the process that involved this reformulation, that which was sought was political consensus. For the first time, there was a public opening for debate. While this feature may seem interesting, it also leads us to question the scientific objectivity so vaunted.

Prior to the decision for Gender Dysphoria the WG suggested “gender incongruence”.

On the open APA website, we received many favorable comments about the proposed name change, particularly with regard to the removal of the “disorder” label from the name of the diagnosis. We also had support for this name change in an international survey of consumer organizations that we conducted.⁹ However, we also received many comments from reviewers of the open APA website, as well as from members of the World Professional Association for Transgender Health (WPATH, formerly the Association Benjamin International Gender Dysphoria Association), expressing concerns that the new descriptive term could easily be misread as applying to individuals with gender-atypical behaviors who had no gender identity problem. (MOEC, 905). The research cited,⁹ the only one held by WG (other reported studies are of secondary sources) was performed between 43 organizations that defend the rights of trans population of the United States, Europe, Africa, Oceania and Latin America, as follows:

Distribution of organizations interviewed by country

Europe (Dinamarca, Finland=2, German=1, UK=4, Netherlands=1, Spain=3 Switzerland=2, Russia=1); North America (US=8, Canada=5); Latin America (Brazil=1, Chile =1, Peru=1); Africa (=1 Nigeria=1, South Africa=1, Uganda=2); Oceania (Australia=4, New Zealand=1); International organizations (US and UK=2).

Total organizations=43.

The number of organizations in the United States is discrepant compared to other countries. It would be necessary to add organizations in Africa and Latin America to approach the US.

A total of 43 organizations, 69.8% said yes to the question:

Is the diagnosis of Gender Identity Disorder in your country used officially or for lawful purpose?

As pointed out earlier in this paper, the influence of DSM follows the same logic of power that the US has of the world. Although a provincial text, about 69.8% say it is a document that has legal power in their countries. In practical terms it means that the DSM is a document used to define the parameters of who can access the reassignment surgeries and/or taking hormones and/or request changes in documents.

Other issues and results of this survey:

a) *If the GID remains in the disorders listed in the DSM, would you prefer the name changed? [the survey uses Gender identity disorder-GID-because it was before the change to Gender Dysphoria GD]*

b) Yes=58.1; No=18.6; Unsure=18.6; No answered=4.7 (Total=43, 100%)

c) *Does your organization believe that the GID should be in the DSM?*

d) Yes=9; No=24; Unsure=10 (Total=43, 100%)

If the outer world, via the Internet was so important for the Working Group to change “gender incongruence” to “gender dysphoria”, why didn’t this large majority for the withdrawal prevail? The way I interpret the DSM, a political-ideological text marked by a particular local culture, there are non-negotiable things. The withdrawal of the psychiatric character of expressions of gender that deny dimorphism is one.

The article quotes some testimonials from people who have contributed to the survey, one of them (the only one) of a representative of a Brazilian trans organization says:

Two more questions of this Survey:

a) *If the GID stays out of the DSM, would the mental health care be reimbursed in your country?*

b) Yes=12; No=14; Uncertain=16; No answered=01

c) *If the GID stays out of the DSM, would the physical health care be reimbursed in your country?- Sim=12; Não=15; Incerto=16*

d) Yes=12; No=15; Uncertain=16

These two questions bring the cultural marks of those who formulated them. Of the nine items listed, these two were the ones that had the highest number of “not sure”,²⁵ possibly because those who responded live in a country that focuses on health issues for the state and not the market of mental health plans and physics.

The representative of an American trans organization will state:

Eliminating the diagnosis would roll back decades of legal advocacy for the rights of transgender people in the United States. Low income transgender people in the United States would literally have no way to access any form of gender affirming treatment legitimately. Attorneys who have fought for the right of transgender people arguments in these contexts, further restricting access to this necessary form of treatment only to wealthy transgender people to the dangers of using risky black market treatments or of going without any treatment at all. (U.S).⁹

Whereas most of the organizations consulted are Americans, it was to be expected that the main conclusion of the study had a closer relationship with the issues of trans population of the US. And this was the conclusion:

The major reason for wanting to keep the diagnosis in the DSM was health care reimbursement. Regardless of whether groups were for or against the removal of the diagnosis, the survey revealed a broad consensus that if the diagnosis remains in the DSM, there needs to be an overhaul of the name, criteria and language to minimize stigmatization of transgender individuals.⁹

The survey questions were not translated into the languages of the countries included. That is, the first criterion to participate in a

survey that was supposed to contribute to the changes in the Manual, according to 70% of the interviewed, has great power in their countries, was to speak the English language (“(...) all surveys were distributed in the English language.”⁹ The minimum effort of making a cultural approach and that would have been the translation of the survey was not performed.

What would be the objective, sample, measurable, repeatable data, to determine that people who demand to live in another gender suffer from gender dysphoria? I’m actioning the argument of objectivity not because I share this epistemological principle, but to dialogue with the terms of discursive rhetoric operated by DSM to build legitimacy of the text. The purpose of the DSM-5 is to be “reliable guide to diagnosis.” Although the DSM has been a landmark of substantial process with regard to reliability, both APA as well as the vast scientific community working with mental disorders recognize that earlier, science was not mature enough to produce fully valid diagnoses - that is, provide consistent, solid scientific validators and objectives for each DSM disorder (...) speculative results have no place in an official nosology, but at the same time, DSM needs to evolve in the context of other clinical research initiatives in the area.²⁶ And in the pursuit of scientific legitimacy:

The proposals for the revision of DSM-5 diagnostic criteria were developed by members of the working groups based on logic, scope changes, anticipated impact on the clinical management and public health, strength of support of research evidence, overall clarity and clinical usefulness.²⁷

For some time, the DSM has been analyzed as a part of social control, pure morality speech disguised in the skin of science. The publication of DSM-III was a milestone in this debate. The Task Force wanted to turn the manual, previously closer to the lexicon and psychoanalytic practice, into a document with scientific rigor in the manner of the exact sciences. New procedures were adopted, statistic measures invented, but in the same proportion to the desire for truth of this group of researchers came the criticism. It was in the midst of dispute that the DSM, in the debate that would give birth to the third version, had to see itself cornered by gay and lesbian activists who demanded the depathologization of homosexualities.

Who decides? APA’s structure of decision in relation to DSM

Early in the presentation of the book *El Género Desordenado*, Butler says:

Today we have an historic opportunity to critically intervene in medical discourses that govern the lives of transgender and transsexual people. The DSM is being reviewed and this implies that what is at stake now are the very terms by which trans people present themselves before medical and legal authorities and through whom they are interpreted (2011:9). Perhaps the illusion that the author expresses about the possibility of a real participation in the new directions of the DSM is coming from the great impact that the new forms of online consultation had and were carried out by the Task Force 5th. version. Who had the power to vote?

Process steps of DSM-5 review

In 1999 the first discussions about the need for a new revision of the DSM began to happen. Three years later, in 2002, the APA published a document with a work schedule.²⁸ Between the years 2003-2008

was the period dedicated to planning the conference by theme. The appointment of the President for DSM Task Force Review and the chairmen of the 13 diagnostic work groups took place in 2006. The approval of the names of the 28 members of the task force happened in 2007 and a year later 130 members of the working groups became public. The year 2010 started a new methodology and work phase: public and professional review. In two months the Task Force through the website www.dsm5.org, was open to criticism and contributions. More than 8000 contributions were received which were systematized by the working groups (DSM-5: 06). In 2011 came the second post and a year later a final publication on the web. In December 2012 the voting happened at the meeting of the APA.

In the preface of the DSM-5 there is an appreciation of how the whole process was conducted in a transparent and democratic manner. In MOEC the same rhetorical device of building text legitimacy is repeated in stating that (...) “the publication of MOEC marks transparency of the arguments for the sake of readers” (2013: 901).

Is not contradictory in the view of an objective, neutral science, using a mechanism appropriated for political associations to decide the validity of their findings? How to articulate the objectivity of “statistical” data in the production of diagnostic categories, ever so valued by the Task Force, and the thousands of “contributions” of activists, professionals and researchers? Who has the power to vote in the deliberations of the new text? The answer to these questions removes any doubt about the supposed democratic character of the revision process. What is meant by democratic? Do a consultation on the Internet?

The final approval was made by an assembly:

(...) Is a deliberative body of the APA representing the district branches and the wider membership composed of psychiatrists in the United States that provide geographic diversity, practice inclusiveness and interests. The Committee for DSM-5 is made up of a diverse group of leaders of the Assembly.²⁹ (Bold letters mine). Finally it is clear: when the DSM-5 is talking about democracy and transparency it is for the members of the association. At this point at the time of deciding, the national character of the association is recovered and is binding.

Conclusion

Throughout this paper I have tried to present arguments that show the local character (national) of the new version of D-5, specifically the chapter “Gender Dysphoria”, in detriment of the desire for universality trampled on by the supposed scientific text. As an extension, I suggest it to be a mistake to use the Manual in the Brazilian context, since, unlike the US, the leading role in the health care debate / financing is assumed by the State and not solely by the market.

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Conflict of interest

The author declares there is no conflict of interest.

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