

# The Notion of Gender in Psychiatry: a Focus on DSM-5

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*Abstract:* In this paper I review how the notion of gender is understood in psychiatry, specifically in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). First, I examine the contraposition between sex and gender, and argue that it is still retained by DSM-5, even though with some caveats. Second, I claim that, even if genderqueer people are not pathologized and gender pluralism is the background assumption, some diagnostic criteria still conceal a residue of gender dualism and essentialism. Third, I consider gender dysphoria, which is characterized by an incongruence between one's experienced or expressed gender and one's assigned gender; since this condition pertains to distress and disability, not to the incongruence *per se*, it does not pathologize transgender people. Still, I contend that it should be removed from DSM-5 for theoretical reasons.

*Keywords:* DSM-5, Gender, Gender dysphoria, Gender pluralism, Sex.

In this paper I critically review how the notion of gender is understood in psychiatry. More precisely, I focus on the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)<sup>1</sup> only, as at present it is the most acknowledged psychiatric nosological manual, widely used by psychiatrists all over the world.

First, I examine the contraposition between sex, which is generally taken to be a purely biological notion, and gender, which is instead used to refer to psychological, social, and cultural aspects related to biological sex. This contraposition, which has been questioned by various feminist scholars<sup>2</sup>, is still retained in DSM-5, even though with some important caveats. Second, I evaluate whether DSM-5 is committed to gender dualism or gender pluralism and argue that, even if genderqueer people are not pathologized and gender pluralism can be regarded as the background assumption, some diagnostic criteria still conceal a residue of gender dualism and gender essentialism. Third, I consider gender dysphoria, a mental disorder characterized by a marked incongruence between one's experienced or expressed gender and one's assigned gender. As this mental disorder pertains to distress and disability, not to the incongruence *per se*, transgender identities are not pathologized in themselves, but only if associated with distress and disability. However, I argue

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against the opportunity to consider gender dysphoria a mental disorder, at least from a theoretical point of view. Finally, I summarize how the notion of gender is conceived in DSM-5.

### *1. Sex and gender*

Very roughly, the term “gender” is generally used to refer to psychological, social, and cultural aspects related to sex, which is instead regarded as a biological category. In what follows, I will use male/female to refer to sex categories and man/woman to refer to gender categories. If being a male/female is considered just a biological matter, being a man/woman also depends on social, cultural, and historical practices, that may also intersect with other variables, such as “race”, social class, ethnicity, nationality, or religion<sup>3</sup>. In this sense, sex and gender are taken to be two different and, to a certain extent, independent categories. So, a particular individual may be a male/female and still identify with, experience, or express the gender woman/man<sup>4</sup>.

In popular and academic literature, especially outside philosophy, the two terms are often used interchangeably. Psychiatry is not an exception. In DSM-5, sex and gender are explicitly recognized as two different categories<sup>5</sup>, the former pertaining to the biological aspects of people, the latter to the psychological, social, and cultural ones; at the same time, however, sex and gender are frequently conflated in common psychiatric usage. Moreover, the DSM-5 taskforce has decided to use the term gender to cover not only social, cultural, and historical aspects, but also biological ones<sup>6</sup>. This, however, can be confusing. Let’s look at some DSM-5 gender-related definitions:

Gender: the public (and usually legally recognized) lived role as boy or girl, man or woman. Biological factors are seen as contributing in interaction with social and psychological factors to gender development.

Gender assignment: the initial assignment as male or female, which usually occurs at birth and is subsequently referred to as the “natal gender”.

Gender experience: the unique and personal ways in which individuals experience their gender in the context of the gender roles provided by their societies.

Gender expression: the specific ways in which individuals enact gender roles provided in their societies.

Gender identity: a category of social identity that refers to an individual’s identification as male, female or, occasionally, some category other than male or female<sup>7</sup>.

Gender experience, expression, and identity (the self-attribution of gender) clearly detail some aspects related to the notion of gender; all of them strongly depend on psychological, social, and cultural features. Gender assignment, on the contrary, somehow resembles the notion of sex, as the initial assignment as male or female is mainly related to biological features, such as chromosomes and genitalia (external and internal). Still, using “gender assignment” or “natal gender” instead of “sex” suggests that deciding what sex a particular individual is always involves not only descriptive considerations but also evaluative judgments<sup>8</sup>.

Despite the above ambiguities, DSM-5 retains a minimal contraposition between sex and gender, a contraposition that, as I have argued in previous papers<sup>9</sup>, must be maintained (at least in medicine). In fact, keeping sex and gender separated is useful to better evaluate whether relevant medical differences between individuals can be traced back to sex differences (that is, morphological, physiological, and pathophysiological differences), gender differences (cultural, historical, psychological, and social differences), or a combination of the two variables (which is the most common situation); moreover, keeping sex and gender separated is also useful to determine when and how these variables affect the clinical features and course of mental disorder, and the ways in which healthcare professionals treat their patients.

In the rest of the paper, I will endorse a minimal contraposition between sex and gender, and use “sex” with the same meaning as “assigned gender” and “natal gender”.

## ***2. Dualism and pluralism about sex and gender***

If sex and gender can be regarded as two different and, to a certain extent, independent categories, when a person is assigned a certain sex at birth (male/female), the gender (man/woman) cannot be merely inferred on a priori grounds: male/female people may self-identify with, experience, and/or express the gender woman/man. All these acknowledged variations nonetheless still assume that both the above categories come in two different and mutually exclusive forms. Even if there is still a strong and widespread presupposition in favor of a strict binary, dualistic system, such a presupposition is far from justified.

Briefly considering the notion of sex first, the prevalent opinion until the late 18<sup>th</sup> century did not embrace sex dualism but instead sex monism, that is, the idea that there is just one sex. More precisely, female genitalia were thought to be the same as male genitalia but directed inside, rather than outside, the body<sup>10</sup>. From a historical point of view sex dualism is thus a fairly recent idea.

From a biological point of view, it has been argued that sex dualism is not adequate to cover all biological variations that can be found in nature<sup>11</sup>. Focusing on intersex people, Fausto-Sterling suggests that it is wrong to think about sex in a dualistic way, as if humans were either male or female<sup>12</sup>. In order to determine whether a particular body is male or female, there are different sexual traits to consider: genetic sex (46-XY vs. 46-XX), gonadal sex (testes vs. ovaries), gametal sex (sperm vs. egg), genital sex (sperm-related vs. egg-related plumbing parts, including both internal and external genitalia), hormonal sex (more testosterone vs. more estrogen, etcetera), and somatic sex (secondary sexual characteristics, such as bodily hair or fat distribution). When the sex traits above are all aligned, we have a male body (46-XY, testes, sperm, sperm-related plumbing parts, more testosterone, etc.) or a female body (46-XX, ovaries, egg, egg-related plumbing parts, more estrogen, etc.). Nevertheless, sex traits do not necessarily go together, and a particular individual can have a varying mixture of them. In the latter case, it is possible to speak of intersex people, whose presence clearly shows that sex dualism is not a straightforward option.

In DSM-5, however, the term “intersex”, or “intersexuality”, has been substituted with the label “disorders of sex development” (DSD), indicating a “condition of significant inborn somatic deviations of the reproductive tract from the norm and/or of discrepancies among the biological indicators of male and female”<sup>13</sup>. Implying that intersex people are to be considered disordered because of their “ambiguous” genitalia (which do not conform to either of the two traditional kinds of sexed bodies) or a misalignment of their sex traits (which, again, contrasts with the dualist idea that defines an individual’s sex as either male or female), the label “disorders of sex development” still presupposes sex dualism. In previous papers<sup>14</sup> I argued that intersexuality should not be considered a disease in itself (though it might be associated with various pathological, and sometimes even life-threatening, conditions), that intersex people just fall outside strict sex dualism<sup>15</sup>, and thus that it would be important to embrace sex pluralism<sup>16</sup>, which would be an ethical, epistemological, and medical improvement. In this perspective, the DSM should adopt less pathologizing labels, such as, for instance, “divergences of sex development”<sup>17</sup> or “differences of sex development”<sup>18</sup>, which may all be compatible with sex pluralism.

Moving to the notion of gender, many cultural, sociological, and historical studies have convincingly shown that there are not just two alternative and mutually incompatible genders but instead a plurality of possible alternatives<sup>19</sup>. A considerable number of people, over time and across different cultures, identify, experience, and/or express themselves outside of the strict gender dualism that defines an individual’s gender as either man or woman. For example, there are people that:

have no gender (e.g. gender neutral, non-gendered, genderless, agender, neuter, neutrois); incorporate aspects of both man and woman (e.g. mixed gender, sometimes pangender, androgynous); are to some extent, but not completely, one gender (e.g. demi man/boy, demi woman/girl); are of a specific additional gender (either between man and woman or otherwise additional to those genders, e.g. third gender, other gender, sometimes pangender); move between genders (e.g. bigender, gender fluid, sometimes pangender); move between multiple genders (e.g. trigender, sometimes pangender); disrupt the gender binary of women and men (e.g. genderqueer, genderfuck)<sup>20</sup>.

Independently of the terminology, many people’s realities do not fall within any of the two gender categories of man and woman. For example, about one third of transgender people primarily self-identity as non-binary<sup>21</sup>. In this paper, I will use the term “genderqueer” as an umbrella term, which aims to group together all those different kinds of people who do not self-identify, experience, and/or express themselves within the traditional dualism of man and woman<sup>22</sup>.

If sex dualism is still assumed, DSM-5 formally abandoned gender dualism, which was instead implicit in DSM-IV-TR<sup>23</sup>. Examining the definition of gender identity, as well as some diagnostic criteria of gender dysphoria, it is possible to recognize that gender pluralism is officially acknowledged. For example, criterion A1 of gender dysphoria in children states: “A strong desire to be of the other gender or an insistence that one is the other gender (or *some alternative gender* different from one’s assigned gender)”<sup>24</sup>. Criteria A4, A5, and A6 of gender dysphoria in adolescents and adults contains the same specification<sup>25</sup>.

Notwithstanding these explicit admissions in favor of gender pluralism, other passages of DSM-5 still presuppose not only strict gender dualism but also gender essentialism, that is the idea that men/women have a fixed essence, that is some permanent characteristics, attributes, functions, and/or social roles shared in common by all men/women at all times. Gender essentialism generally implies that those individuals who do not share the whole essence of man/woman are not “real” men/women, thus increasing stigma and exclusion.

For instance, the following criteria of gender dysphoria in children are good examples of both gender dualism and gender essentialism (see also criterion A3 of gender dysphoria in adolescents and adults):

A2: In boys (assigned gender), a strong preference for cross-dressing or simulating female attire: or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.

A3: A strong preference for cross-gender roles in make-believe play or fantasy play.

A4: A strong preference for the toys, games, or activities stereotypically used or engaged in by *the other gender*.

A5: A strong preference for playmates of *the other gender*.

A6: In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities<sup>26</sup>.

Criteria A4 and A5 refer to “the other gender”, thus presupposing the existence of only two genders; similarly, criterion A3 refers to “cross-gender roles”, while criterion A2 mentions the opposition between masculine and feminine clothing, and criterion A6 between masculine and feminine toys as if, again, there were just two genders, man/boy and woman/girl. Criterion A6, moreover, refers to “rough-and-tumble play” as an essential feature of man/boy, with the implicit implication that someone who avoids rough-and-tumble play is not a “real” man/boy. More generally, all the criteria above seem to be based on some fixed stereotypical aesthetics and behaviors (kinds of clothing, toys, games, activities, etc.), which are supposed to be shared by all men/women or boys/girls; as a consequence, should some of these features be lacking, then the individual would not be a “real” man/boy or woman/girl.

To repeat, except some formal statements in favor of gender pluralism, the diagnostic criteria of gender dysphoria are still the expression of gender dualism and gender essentialism. DSM-5 thus seems to ignore the plethora of feminist work which criticizes the inherency of gender roles and gender identities. As such, genderqueer identities are not seriously considered or understood<sup>27</sup>.

In order to avoid the conflict between gender pluralism and gender dualism, as well as to take into account genderqueer people adequately, the DSM-5 diagnostic criteria that still conceal some residue of gender dualism and essentialism should be removed or carefully revised. Unambiguously adopting a pluralist account of gender is in fact an essential step to fully depathologize genderqueer identities and lessen the stigma that, regrettably, is still often associated with them.

### 3. *Gender dysphoria*

As already mentioned, the DSM-5 nosology contains a specific disorder directly related to the notion of gender, that is gender dysphoria, which is generally defined as a marked incongruence between one's experienced and/or expressed gender and one's assigned gender (or one's sex)<sup>28</sup>. In what follows I will use the term "transgender" as an umbrella term to refer to people who self-identify with, experience, and/or express genders different to their assigned gender.

In DSM-5 gender dysphoria substitutes the DSM-IV-TR nosological category of gender identity disorder. Some substantial changes are worth being mentioned briefly<sup>29</sup>. First, the label "dysphoria" substitutes that of "disorder" to indicate that this condition pertains to the distress and disability that *may* be associated with the incongruence between one's experienced/expressed gender and one's assigned gender, not to the incongruence *per se*. Second, gender dysphoria is no longer placed within sexual dysfunctions and paraphilias but has its own chapter. Third, gender dysphoria is described in terms of "incongruence", not "cross-gender identification", to acknowledge gender pluralism.

Let us focus on the idea that gender dysphoria pertains to distress and disability. As better specified in criterion B, the presence of distress or impairment (disability) is a necessary requirement<sup>30</sup>. Should distress or impairment be absent, no diagnosis of gender dysphoria could be made. Again, there is nothing pathological in transgender identities *per se*<sup>31</sup>. That being said, it is worth asking whether gender dysphoria should be still listed among mental disorders at all.

To a certain extent, the case of gender dysphoria seems to parallel that of homosexuality<sup>32</sup>. In 1973, the nomenclature committee of the APA concluded that homosexuality does not regularly cause subjective distress, nor is it regularly associated with generalized impairment<sup>33</sup>. On this basis, in 1974 members of the APA voted with a referendum to remove homosexuality *per se* from the manual. As a consequence, homosexuality *per se* was then replaced with sexual orientation disturbance<sup>34</sup> and, afterwards, with ego-dystonic homosexuality<sup>35</sup> to diagnose those individuals who were homosexual and harmed by their condition. As in the case of gender dysphoria, diagnoses such as sexual orientation disturbance and ego-dystonic homosexuality pertained to the distress and disability possibly associated with homosexuality, not to homosexuality *per se*. In DSM-III-R<sup>36</sup>, however, even the latter diagnosis was eventually removed, as distress and disability, if present, were clearly a consequence of the social stigma associated with homosexuality, not of homosexuality *per se*<sup>37</sup>. Such a removal represented a watershed in the struggle for reducing the stigma associated to homosexual people. Should gender dysphoria be removed too?

According to the subgroup of psychiatrists who had been appointed to revise the DSM-IV diagnosis of gender identity disorder, the new diagnosis of gender dysphoria has to be regarded as a compromise between two conflicting concerns<sup>38</sup>. On the one hand, the determination to lessen the stigma attached to a nosological category related to transgender people; such a stigma, of course, would have been lessened most if any nosological category related to transgender people had simply been removed



from DSM-5 (as happened for homosexuality). On the other hand, the need to grant access to healthcare facilities and insurance coverage for hormonal treatments and reassignment surgeries; in some countries, in fact, access to healthcare facilities and insurance coverage would only have been granted by retaining a relevant nosological category in DSM-5 (clearly, this issue did not apply to homosexuality).

A diagnostic manual like DSM-5 has to balance different and sometimes conflicting issues; thus, it is not surprising that some contradictions may eventually emerge, as in the case of gender dysphoria. However, I would argue that, from a theoretical point of view, gender dysphoria should be removed from the DSM, no longer considering it a mental disorder. Let's see it better through a review of the main arguments for and against the depathologization of gender dysphoria.

First, DSM-5 contains a general definition of mental disorder, a definition that must be met by all individual mental disorders:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability<sup>39</sup>.

Very roughly, this definition identifies a mental disorder with a harmful dysfunction, where the dysfunction requirement is taken to be a necessary one<sup>40</sup>. This means that in order to include gender dysphoria among mental disorders, one should admit that self-identifying with, experiencing, and/or expressing a different gender from the one attributed on the basis of one's sex is *per se* dysfunctional or at least a pathosuggestive symptom<sup>41</sup>. However, not only does this option have no evidential base but, clearly, it is also not in line with DSM-5's claims. On the one hand, there are no scientifically based criteria for differentiating allegedly pathological gender identities from normal ones, and the way in which *any* gender identity develops is still unknown<sup>42</sup>; on the other hand, the new diagnosis of gender dysphoria comes also from the will of avoiding the possibility to label non-distressed expressions of gender incongruence as mental disorders<sup>43</sup>. Moreover, it is rather questionable not only that transgender identity is usually associated with significant distress or disability, but also that the distress and disability that can sometimes be associated with transgender identity, and are required by criterion B, are a direct consequence of this condition and not instead of the social stigma often associated with it (as in the case of homosexuality)<sup>44</sup>. This may be especially true for children and young adolescents, who are beginning to explore their experience of gender and have to simultaneously manage any associated social stigma<sup>45</sup>. Thus, following the DSM-5 claim that "Each disorder identified in [...] the manual [...] *must meet* the definition of a mental disorder"<sup>46</sup>, gender dysphoria currently represents a contradiction in the manual and should be thus removed<sup>47</sup>.

Second, the 11<sup>th</sup> edition of the *International Classification of Diseases and Health-Related Conditions* (ICD-11) radically modified the classification of transgender identity, which in the ICD-10 was dubbed gender identity disorder and included within the chapter named Disorders of adult behavior and personality. More precisely, the ICD-11 changed the diagnostic terminology to gender incongruence, declassified this condition

as a mental disorder, and included it within a brand-new chapter named Conditions related to sexual health as a separate category. The decision to rename and move gender incongruence to a new chapter has been widely welcomed as it was evidence of the willingness to depathologize transgender identities, recognize gender variance as a normal part of life, and reduce social stigma<sup>48</sup>. This, however, leads to another theoretical problem, as people who fulfil the DSM-5 diagnostic criteria for gender dysphoria also fulfil the ICD-11 diagnostic criteria for gender incongruence, which is now regarded as a somatic condition, not as a mental disorder<sup>49</sup>. In order for the DSM to be in line with the latest edition of the ICD (and it is worth noting that harmonizing the two classifications as much as possible already was an overarching goal of the DSM-5 taskforce<sup>50</sup>), then, gender dysphoria should be totally removed from the psychiatric nosology.

From a theoretical point of view, the reasons above clearly point towards the removal of gender dysphoria from psychiatric nosology. However, could these reasons be offset by practical considerations? Removing gender dysphoria from DSM-5, thus no longer considering it a mental disorder, could make it difficult for people wishing to physically change their body to access to healthcare facilities and insurance coverage for hormonal treatment and reassignment surgeries, at least in certain countries. This could negatively impact especially on those people with lesser economic means. As I mentioned above, being able to grant adequate access to care to transgender people was probably the main reason why gender dysphoria was retained in DSM-5.

That being said, arguing to maintain a diagnostic category in the DSM, thus regarding it as a mental disorder, simply because this inclusion makes it easier to access to healthcare facilities and insurance coverage for hormonal treatment and reassignment surgeries is neither conclusive nor compelling. Of course, this does not amount to denying the importance of ensuring adequate access to care to transgender people, but rather means recognizing this problem as a social problem, which as such should be addressed independently by different means, that is, by disconnecting access to transition technologies from a psychiatric diagnosis. In general, there is in fact no reason not to grant access to medical care even for perfectly normal conditions, such as pregnancy and delivery. In some countries, transgender people are already legally recognized and have access to healthcare facilities and insurance coverage for hormonal treatment and reassignment surgeries without the need for a psychiatric diagnosis<sup>51</sup>. Moreover, if mental health professionals stop acting as gatekeepers to transition services for transgender people, access to care would also be granted to those who do not meet criterion B for gender dysphoria but still seek transition.

#### ***4. Conclusions***

In this paper, I have tried to sketch how the notion of gender is understood in psychiatry. First, in DSM-5 sex and gender are taken to be two different categories, as there is quite a clear distinction between, on the one hand, gender assignment, which is comparable to the notion of sex as it is based on chromosomes and genitalia, and, on the other, gender experience, expression, and identity, which are essentially grounded



in psychological, social, cultural, and historical features. Even though the dichotomy between sex and gender has been questioned by some feminist philosophers, I claimed that it is important that it is maintained in psychiatry. Keeping sex and gender separated may in fact help to better understand whether relevant medical differences between individuals can be traced back to biological differences, social and cultural differences, or a combination of the two variables.

Second, even if in DSM-5 gender pluralism seems to be the background assumption, some diagnostic criteria are still the manifestation of gender dualism and essentialism, as they do not take adequately into account genderqueer identities. These diagnostic criteria must be removed or better formulated. There is in fact strong evidence showing that genderqueer people are not dysfunctional and, thus, should not be pathologized at all. This is an important point that should be made even more explicit in order to lessen the stigma and discrimination that, regrettably, is often still associated with genderqueer people.

Third, in DSM-5 the incongruence between one's experienced or expressed gender and one's assigned gender is not considered a mental disorder in itself, as gender dysphoria pertains to distress and disability, not to the incongruence *per se*. Hence, transgender identities are not pathologized *per se*, but only if associated with distress or disability. At any rate, gender dysphoria is still listed among mental disorders when, from a theoretical point of view, it should simply be removed from psychiatric nosology, as happened for homosexuality. The category of gender dysphoria not only does not fit the general definition of mental disorder, thus representing a contradiction in DSM-5, but also conflicts with the ICD-11 classification, that regards gender incongruence as a somatic condition.

Genderqueer and transgender identities are probably diverse from the majority of people but "Diversity is not disease; the anomalous is not the pathological"<sup>52</sup>. We can establish what is pathological only against a background of a pre-established normal, which depends not only on biological facts, but also on our cultural values, on what we judge to be a bad or negative thing. The depathologization of genderqueer and transgender identities, and the removal of gender dysphoria from the DSM, would thus reflect inclusive and tolerant values, according to which gender diversity is accepted as a normal part of our life, values that should undoubtedly characterize our culture.

## Notes

<sup>1</sup> American Psychiatric Association, 2013.

<sup>2</sup> See, for instance, Butler, 1990; Mikkola, 2011b; Prokhovnik, 1999.

<sup>3</sup> For a detailed survey of how gender is conceived within the feminist tradition, see Mikkola, 2011a.

<sup>4</sup> What being of a certain gender amounts to is a contentious issue that cannot be addressed here.

<sup>5</sup> In the Introduction of DSM-5 it is claimed that "*sex differences* are variations attributable to an individual's reproductive organs and XX or XY chromosomal complement. *Gender differences* are variations that result from biological sex as well as an individual's self-representation that includes the psychological, behavioral, and social consequences of one's perceived gender", American Psychiatric Association, 2013, p. 15.

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- <sup>6</sup> American Psychiatric Association, 2013, p. 15.
- <sup>7</sup> American Psychiatric Association, 2013, p. 822.
- <sup>8</sup> See, for instance, Fausto-Sterling, 2000b.
- <sup>9</sup> See Amoretti, Vassallo, 2012, 2015.
- <sup>10</sup> See, for instance, Dreger, 1998b; Laqueur, 1990.
- <sup>11</sup> See, for instance, Roughgarden, 2004.
- <sup>12</sup> See Fausto-Sterling, 1993, 2000a, 2000b.
- <sup>13</sup> American Psychiatric Association, 2013, p. 820.
- <sup>14</sup> Amoretti, Vassallo, 2015.
- <sup>15</sup> See also Herdt, 1994; Roen, 2015.
- <sup>16</sup> See also Dreger, 1998a, 1998b; Roughgarden, 2004.
- <sup>17</sup> Reis, 2007.
- <sup>18</sup> Diamond & Beh, 2008.
- <sup>19</sup> See, for instance, Barker & Richards, 2015; Herdt, 1994; Heyes, 2000; Salamon, 2010; Stryker & Aizura, 2013.
- <sup>20</sup> Barker & Richards, 2015, p. 166.
- <sup>21</sup> Matsuno & Budge, 2017.
- <sup>22</sup> For a philosophical account of genderqueer identities see, for instance, Dembroff, forthcoming.
- <sup>23</sup> This decision is in line with empirical evidence, which suggests that there is nothing pathological in genderqueer identities, experiences, or expressions; see for instance Richards et al., 2016.
- <sup>24</sup> American Psychiatric Association, 2013, pp. 452, my italics.
- <sup>25</sup> American Psychiatric Association, 2013, pp. 452.
- <sup>26</sup> American Psychiatric Association, 2013, pp. 452, my italics.
- <sup>27</sup> Davy, 2015.
- <sup>28</sup> American Psychiatric Association, 2013, pp. 452, my italics.
- <sup>29</sup> For a comprehensive explanation of the differences between DSM-IV-TR diagnosis of gender identity disorder and DSM-5 category of gender dysphoria, see Zucker, 2015.
- <sup>30</sup> American Psychiatric Association, 2013, p. 452. It is worth noting that there was no requirement for distress or disability in DSM-IV.
- <sup>31</sup> See, for instance, Richards et al., 2015.
- <sup>32</sup> Drescher, 2010, 2013, 2015b.
- <sup>33</sup> Spitzer, 1981, p. 211.
- <sup>34</sup> American Psychiatric Association, 1974.
- <sup>35</sup> American Psychiatric Association, 1980.
- <sup>36</sup> American Psychiatric Association, 1987.
- <sup>37</sup> For a discussion see, for instance, Drescher, 2015a.
- <sup>38</sup> See, for instance, Drescher, 2013a, 2013b; Drescher, Cohen-Kettenis, & Winter, 2012; Karasic & Drescher, 2005; Meyer-Bahlburg, 2010; Zucker & Duschinsky, 2015.
- <sup>39</sup> American Psychiatric Association, 2013, pp. 20.
- <sup>40</sup> Cooper, 2015; Amoretti, Lalumera, 2019.
- <sup>41</sup> First and Wakefiesld, 2013.
- <sup>42</sup> Drescher, Cohen-Kettenis, & Winter, 2012.
- <sup>43</sup> Drescher et al., 2012; Drescher, 2013.
- <sup>44</sup> Zucher et al., 2002.
- <sup>45</sup> There is in fact a growing consent for the exclusion of gender incongruence in childhood even from the ICD, as children do not usually receive either medical or surgical treatment (Hill et al., 2007; Winter et al., 2019).
- <sup>46</sup> American Psychiatric Association, 2013, pp. 20, my italics.

<sup>47</sup> For a general argument, see Amoretti, Lalumera, 2019.

<sup>48</sup> In fact, the ICD already included perfectly natural and non-pathological conditions, such as single spontaneous delivery, which however may require medicalization.

<sup>49</sup> Murjan & Bouman, 2017.

<sup>50</sup> American Psychiatric Association, 2013, p. 11.

<sup>51</sup> For instance, in 2012, Argentina's Senate approved a law that makes adults reassignment surgery and hormone therapy a legal right and includes this procedure in both public and private health care plans.

<sup>52</sup> Canguilhem, 1989, p. 137.

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