The DSM-5 as Political Battleground: Gender Identities, Sexual Norms, and Female Desire

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The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the standard reference for the classification of mental disorders, and is seen as authoritative by clinicians, academics, drug companies and policy makers alike around the world. As the first major revision since 1994, the publication of the 5th edition of the DSM in May 2013 represented a significant and global event. The terms published in DSM-5 in 2013 will become terms through which individuals and groups know themselves, claim rights, and are offered support, insurance and psychological and pharmaceutical intervention. In the UK, the World Health Organisation's International Classification of Diseases (ICD-10) is more commonly used for assessing mental health. The DSM has nonetheless been particularly influential in the classification of disorders relating to sexuality and gender, also in the UK. The new edition is likely to influence worldwide research culture and medical practice around gender and sexuality directly, but also to have a profound indirect influence on medical practice through its impact on culture, law and identity politics. The publication of DSM-5 consequently provides an important incentive to debate the role of psychiatric labels in constructing the context within which we find and shape our identities and practices, a process which is both so pervasive and so individualised that it may otherwise often be able to pass without comment or critique at a more general level.

Psychiatric discourses have increasingly struggled with their embeddedness in culture and identity politics since the partial declassification of homosexuality from the DSM in the 1970s. This struggle for negotiating the meanings available for designating sexual and gender identities and norms has been especially salient for the DSM-5 Sexual and Gender Identity Disorders Work Group. For example, the changes to diagnostic categories suggested by this Work Group have received particular criticism from the National Institute for Mental Health in the USA (Insel 2013) and the British Psychological Society (2011). The former have criticised the DSM-5, and the sexual and gender identity disorders in particular, as unscientific, without sufficient grounding in objective laboratory testing. The British Psychological Association, by contrast, have levelled criticisms at the same diagnostic categories for neglecting relationships and social factors in the mistaken assumption that this will help, rather than hinder, the achievement of scientific neutrality. Another example of a particularly intense current battleground is that formed by the DSM-5 classifications of sexual desire and female sexuality more specifically, which have triggered critical scrutiny from feminist scholars.

This special issue brings together researchers who have led revisions to DSM-5 as part of the Sexual and Gender Identity Disorders Work Group – Ken

Zucker and Cynthia Graham – with social scientists interested in and critical of their work – Monica Greco and Alyson Spurgas. It emerges from discussions about the politics of psychological science that took place at the *Classifying Sex: Debating DSM-5* conference at the Cambridge Centre for Research in the Arts, Social Sciences and Humanities (CRASSH), Cambridge University 4-5 July 2013, organised by ourselves, and sponsored by the Wellcome Trust, CRASSH, the French Institute, the Gender Identity Research and Education Society, and the British Sociological Association Sexual Divisions Study Group. From quite different epistemological, methodological and political perspectives, the papers in this special issue analyse how psychiatric labels of sexuality, gender and desire navigate wider cultural discourses about sexual norms.

The special issue begins with Monica Greco's "What is the DSM?", which situates controversies around psychiatric classifications of sexuality and gender within the broader history of the DSM. This article is unusual and valuable in offering both an introduction to the DSM accessible to a non-specialist, and a deep and acute interrogation of the role and influence of the document to date, and thereby an important contribution to the specialist literature (see also Paris and Philips 2013). Greco undertakes a close consideration of changes in the knowledge practices the DSM formulates and enacts. She traces the roots of this ecology to the role, since DSM-III, of an unreflective commitment to an ontology that privileges the brain and biology and which, hence, considers itself atheoretical and politically neutral in distinguishing the normal from the pathological in formulating diagnostic categories. In conceptualising the specific significance of the publication of DSM-5 within this ecology of knowledge practices, Greco focuses on three keywords – polyvalence, ambivalence and participation – which help explain the manual's continuing prominence. First, as Greco emphasises, the DSM is a powerful object because it is a 'polyvalent' object: the key to its success lies in its ability to serve multiple functions for multiple, but related, interests – ranging from psychiatry as a profession, through to academic researchers, patient groups, and pharmaceutical companies. She gives the example of the failure of attempts to revise DSM from a categorical to a dimensional model of pathology to show that the document serves multiple social functions and supports embedded institutional frameworks, which makes it difficult to enact structural rather than incremental change to how it classifies.

However, Greco issues a strong warning to those commentators on the DSM who overstate the importance of formal classifications at the expense of paying attention to how the manual is used in practice, including the workarounds which get used and the opportunities made available to other stakeholders. She terms this dimension the 'ambivalence' of the DSM: the street-level power of the psychiatrist includes many ways in practice to work around the constraints imposed by the language and divisions of the DSM; likewise, different strategies also become available for policy-makers to audit and police the actions of clinicians, and for patients to present themselves and make use of the DSM in gaining access to services. Greco also makes a strong call for attention to the way wider cultural discourses of transparency, inclusiveness,

collaboration, accountability and respect for diversity have been refracted through the process of the construction of the DSM-5. She notes that while the idea of including patients and families in the revision process was dismissed by leading psychiatrists, one of the innovations associated with DSM-5 was the creation of a website through which members of the public could see some of the developments proposed by the DSM-5 Working Groups and contribute comments, questions and concerns. An expressed goal of this platform was to contribute to transparency. However, Greco points out, it was not clear at all how input from public consultations was considered, or whether any was implemented She suggests that there are indications of a process of spiralling distrust between the American Psychiatric Association and its patient stakeholders in the area of mental health.

The next article is an interview with Ken Zucker, who was the Chair of the DSM-5 Work Group on Sexual and Gender Identity Disorders. In this interview, Robbie Duschinsky questions Zucker about dilemmas encountered by the Sexual and Gender Identity Disorders Work Group. Zucker's account raises clearly the issues of polyvalence, ambivalence and relative participation from the public which Greco suggests have been so important for the DSM-5 in general. His willingness to describe the process by which the Work Group operated, and the dilemmas the Group faced also illustrates Greco's emphasis on the significance of transparency for the DSM-5 over its predecessors. The interview discusses controversies that were faced by the three sub-Work Groups (Gender Identity Disorder; Sexual Dysfunctions; and Paraphilias), coming both from debates about scientific evidence, and from the needs and expectations of different stakeholders. For instance, he illustrates both sets of concerns by giving an account of the proposal by one member of the paraphilias sub-Work Group, Martin Kafka, for a new 'Hypersexual Disorder' category within the sexual dysfunctions. In the event, this new category was not included in the DSM, but proposed for inclusion in an appendix for further study (but later rejected). Zucker also discusses the role of the Board of Trustees in rejecting the diagnostic criteria for paedophilia to include hebephilia (primary sexual preference for early adolescents), which had been proposed by the Work Group. He states that 'the decision to reject the proposal was certainly not based on scientific grounds but with regard to some other issues, political or otherwise.'

Zucker is pressed by Duschinsky on how the Work Group managed tensions between scientific and social concerns, for instance in relation to the potential use of the diagnostic categories within the paraphilias within forensic contexts. He is also asked to account further for the changes which accompanied the change in nomenclature from Gender Identity Disorder to Gender Dysphoria with the DSM-5. Zucker is Head of the Gender Identity Service for children and adolescents at the Centre for Addiction and Mental Health in Toronto, and played an integral role in this change. He acknowledges that 'the sexual dysfunctions and Gender Dysphoria certainly push the margins of what are considered mental disorders.' However, he highlights the importance of individualising discourses regarding distress and impairment in shaping perceptions of Gender Dysphoria

and the sexual dysfunctions as mental disorders by the relevant sub-Work Group. Whereas Jack Drescher on the Gender Identity Disorder sub-Work Group argued that trans people needed to be classified as having Gender Dysphoria in order to get access to medical treatment, Zucker argues that that was not the decisive consideration. He reports his own perception of Gender Dysphoria as a coherent set of signs and experiences which, clustered together, result in a kind of distress, which marks it out as distinct and discrete to some degree. This shaped his emphasis on the importance of suffering for conceptualising the purpose of classification and the boundaries of mental disorder.

One of the areas of controversy discussed by Zucker was the proposal to merge Hypoactive Sexual Desire Disorder for women and Female Sexual Arousal Disorder into one overarching category, which is now called Sexual Interest/Arousal Disorder. He notes that people who self-identify as asexual were worried that the DSM-5 was going to pathologise them, but thinks that the emphasis on distress and impairment allows for an adequate, if not good, differentiation between a sexual orientation and a mental disorder. The third article, by Cynthia Graham, relates her experiences as part of the Sexual Dysfunctions sub-Work Group, and the rationales for the changes they made to conceptualising women's sexual desire and arousal in DSM-5. She recalls conversations in this sub-Work Group which led to overarching goals in the revisions they proposed for DSM-5. These included placing more emphasis on the subjective and relational aspects of women's sexual experience and less on the genital aspects of sexual response, and giving greater acknowledgment of the variability in women's sexuality. The sub-Work Group were also intent on avoiding pathologizing normal variation in women's experiences of desire and arousal.

Graham surveys some of the relevant research literature which informed the sub-Work Group's discussions. For instance, she describes the significance of qualitative studies which had found that women often do not differentiate between sexual desire and arousal – and, when these are experienced as distinct from one another, they do not follow in a uniform sequence of phases. She also recalls the difficulties faced by the sub-Work Group in navigating definitional problems, which threatened to undermine their attempts to achieve their goals through eliding important differences between a mental disorder, a dysfunction, the experience of distress and the existence of variation between women. In line with their goals and with the available research evidence, Graham argues that in contrast to the limited, linear, mechanistic and biologistic classifications it replaced, the DSM-5's new Female Sexual Interest/Arousal Disorder is a much broader diagnosis which includes behavioural, subjective and physical aspects of sexual experience. For instance, the new diagnostic category gained severity and duration criteria compared to its predecessors, in order to avoid pathologising mild and transient experiences of lack of sexual interest and/or arousal which are not unusual in the general population. DSM-5 now contains a requirement for the diagnosis of Female Sexual Interest/Arousal Disorder that the symptoms have persisted for a minimum duration of approximately six months, and have

been experienced during almost all or all sexual encounters. The manual also includes the specification that: "if the sexual difficulties are the result of inadequate sexual stimulation…a diagnosis of sexual dysfunction would not be made." (APA 2013, p. 423) A very important further addition in Graham's eyes is that the manual now specifies that aspects of the patient's relational and social contexts, such as partner factors or cultural/religious factors, should be assessed by clinicians before making a diagnosis of Female Sexual Interest/Arousal Disorder.

Alyson Spurgas's article, which closes the special issue, argues that the Sexual Dysfunctions sub-Work Group did not go far enough, however, in emphasising the relational and social context of lack of sexual interest and/or arousal in women. One aspect of Spurgas' article is a critical commentary on the text of the DSM-5 Female Sexual Interest/Arousal Disorder. Spurgas points out that while present-day partner violence is now specified in the DSM-5 as a factor which should preclude a diagnosis of Female Sexual Interest/Arousal Disorder, past violence with a partner and relational distress below the level designated "severe" are not. Spurgas proposes that these absences epitomise a broader tendency in the formulation of the diagnostic category to carve lack of sexual interest and/or arousal out from the broader cultural context of quotidian misogyny, sexual coercion, and sexual norms in our culture which make a woman's willingness to engage in sex a requirement for perceived normality. She also criticises the sub-Work Group for maintaining the term "sexual receptivity" within one of the six criteria for the category (a diagnosis requires meeting three), suggesting an image of female sexuality which has roots in a sexist association of men with activity and women with sexual passivity.

Spurgas draws on interview research with 37 pre-menopausal women who have experienced low desire, noting her finding that nearly every one of these women had experienced sexual or gender trauma earlier in their life. She gives extracts from interviews with her participants who had been treated with Mindfulness-based Cognitive Behavioral Therapy for low sexual interest and/or arousal. Mindfulness-based Cognitive Behavioral Therapy is a therapeutic approach that incorporates the Buddhist technique of meditative mindfulness to help women stay 'focused' and 'present' during a sexual encounter, and not to get lost in associations with past sexual experiences. On the basis of these interviews, Spurgas criticises both the therapeutic approach and the diagnosis of low sexual interest and/or arousal for failing to give adequate attention to the context of these symptoms. In particular, she emphasises that both Mindfulness-based Cognitive Behavioral Therapy and Female Sexual Interest/Arousal Disorder in the DSM-5 miss something important: The symptoms of Female Sexual Interest/Arousal Disorder occur in the context of – and indeed, may be partially caused by – a sexist culture. As such, Female Sexual Interest/Arousal Disorder may have roots in the potentially violent relationship pressures on women to engage in penetrative intercourse, and the experience of a history of relational trauma and gender violence.

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