

Sexual and Gender Identity Disorders: Discussion of Questions for *DSM-V*

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SUMMARY. The author responds to Hill et al.'s "Gender Identity Disorders in Childhood and Adolescence: A Critical Inquiry" and Moser and Kleinplatz's "*DSM-IV-TR* and the Paraphilias: An Argument for Removal." The author sees the paper as raising the issue of whether there are any cases for which sexual and gender identity diagnoses are appropriate. The author believes a central issue is how does one decide that something is just unusual (normal variation) or something is disordered (pathological). The author believes the concept of "medical disorder" can be applied to human behavior and gives examples to support that view. The author supports an essentialist view that some "things" (like being human and modes of sexual expression) have properties or qualities that are invariable and represent the true essence of the "thing." From this perspective, the author finds the arguments for eliminating the categories of GID and paraphilias from the *DSM* as weak at best. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com>

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At the APA Scientific Symposium where I discussed these papers (Hill et al., Moser/Kleinplatz), when it was my turn to speak, I looked at my watch and thought, "I have an hour and half to go and I will be done with this bloody symposium." I had never wished for an end to a symposium so much. I also thought it would be interesting to have a quick vote to see how many people in the audience found the arguments of the speakers I was to discuss convincing. I think I know what the vote would be. Drs. Hill and Moser are very persuasive. Moser, in addition, is funny. He points out all kinds of little things that are wrong in the *DSM-IV* text for the paraphilias,

I am not sure the original format for this symposium was the best way to discuss the many important issues raised by the speakers. I am not going to discuss all the little details of possible problems with the *DSM-IV*, and what kind of treatment is appropriate for kids diagnosed as having Gender Identity Disorder (GID). One small point: Dr. Moser said that the defenders of the *DSM-IV* approach to the paraphilias have to show that they are "distinct." We do not have to show that at all. Almost all mental disorders are now recognized as on a continuum without clear boundaries—between different disorders and between disorders and normal functioning. I am certainly not going to argue that the particular *DSM-IV* criteria for the paraphilias and for GID are without problems and I am not going to argue that use of the diagnostic criteria by clinicians and researchers results in no false positives. I am certainly not going to argue that kids with GID are not treated badly by their peers. Furthermore, I am sure there are people with paraphilias who get into legal trouble or are denied custody because of their atypical sexual behavior and without any evidence that their sexual behavior hurts anyone.

The central issue for this symposium is Drs. Hill and Moser's remarkable proposal: that GID and all of the paraphilias should be eliminated from *DSM-V*. So the issue is not how the diagnoses of GID and the paraphilias can be better conceptualized or how the diagnostic crite-

ria can be improved. The real issue is, are there any cases of kids or adults for which these diagnoses are appropriate.

Dr. Moser seems to believe that there is no such thing as pathological sexual behavior. This is rather remarkable. It is hard to think of any other kind of behavior or function that cannot go wrong, but for Dr. Moser, paraphilias are only statistically rare. Dr. Hill tells us that he does not want to eliminate GID from the *DSM*. He is willing to keep it in the *DSM* if the diagnosis was limited to children that ask for hormone or surgical change. Since kids with GID never make such a request—in essence he also wants to get rid of the category from the *DSM*.

The central issue then is how does one decide that something is just unusual (normal variation) or something is disordered (pathological)?

Consider this. Almost everybody who has eyes can see. Yet there are some people who have eyes that cannot see. Everybody intuitively knows that in such a case there is something wrong with the eyes. Being blind is not a normal variation because we have an intuitive sense that the eyes are designed to enable the individual to see. Some people would say the eye, like all parts of the body, are designed by God to function in a particular way. Other people, like me, would say, the body has been designed by natural selection, evolution. However you understand the concept of “design,” it is clear that the eye has a certain function. When somebody has an eye that cannot see, there is some mechanism—which we may or not understand—that is not working. You can think of all kinds of other examples. Whenever you think of a medical disorder you are thinking of some biological function that is expected—that is part of being human—that is not working.

Does this concept of what is a medical disorder apply to human behavior? The answer is “yes.” There are certain human qualities or behaviors that are part of being human, that are part of normal development. Here is an example. Humans tend to be social. They are not taught to be social. Kids are naturally interested in other kids. It is not because parents tell them that you will be better off if you are interested in other kids. Something is wrong with a child who has no interest in socializing with other kids. Another example: the ability to empathize, to sense what someone else is feeling. There is something wrong with a child who does not have that capacity.

What I have been presenting is sometimes referred to as essentialism—the view that some “things” (like being human) have properties or qualities that are invariable and represent the true essence of the “thing.” As applied to human behavior, this means that there are human qualities or behaviors that are seen in all cultures, although the particular way in

which it presents itself may vary in different cultures. In contrast to essentialism is another viewpoint: social deconstructionism—that seems to be the perspective of Drs. Hill and Moser. For them, no behavior is normal or pathological since such judgments are merely social constructs. One culture says masturbation is pathological, another says it is normal. Homosexuality prior to 1973 was a mental disorder—now it is normal variation.

How does this apply to GID and the paraphilias? I'll begin with the paraphilias.

What are paraphilias all about? Dr. Moser said it is about sexual “interest.” It is not interest—it is about what we are attracted to—what we find sexually arousing. In every culture, almost all boys and girls show an interest in sex and a capacity for sexual arousal. That is part of being human. Does sexual arousal have a function? We say the heart pumps blood and the eye sees. Why do we have sexual arousal? It is obvious. Sexual arousal brings people together to have that interpersonal sex. Sexual arousal has the function of facilitating pair bonding which is facilitated by reciprocal affectionate relationships. There is a normal development of sexual arousal and sometimes it can go wrong. Dr. Moser says that paraphilic interests are not inherently different from normative interests—except in their frequency. Not true. If one turned on by undergarments, and one is more interested in undergarments than in people, I think it reasonable to assume that something has gone wrong with that individual's sexual development.

I have a fantasy. It is the year 2023 and my grandson comes up to me and says, “Grand Dad, I understand you were once a famous psychiatrist. So I've got a problem. I can have sex with Judy, my wife, but what really turns me on is 7 to 10 year-old girls and I'm so turned on by this that when I see these girls I get the thought—maybe I should really grab one of them.” What should I tell my grandson? I guess that according to Dr. Moser I should say: “We used to think that what you describe was pathological. However, we have known since *DSM-V* in 2010 that it is just normal variation. But if you give in to the impulse, that is a criminal offense. But it has nothing to do with psychology.”

That would be ridiculous. It is true that the diagnostic criteria for the paraphilias change in minor ways from time to time and the boundary with normal sexual arousal is not always clear. For example, somebody finds sex a little bit more fun if they fantasize a little rough stuff or maybe being humiliated. I do not know at what point it becomes pathological. But certainly at some point it does.

It is interesting to realize that very few men struggle with the issue of being attracted to children. It is not because of social sanctions against having sex with children. It is just that most men have no sexual interest in children. Now why is that? Evolutionary psychologists say that probably it has evolutionary significance because being interested in children is not going to have survival value. There are probably normal inhibitory mechanisms in most men against sexual attraction to children.

What are the consequences if we go the route that Drs. Moser and Kleinplatz suggest and remove the paraphilias from the *DSM*? First of all, it is not going to happen because it would be a public relations disaster for psychiatry. There was already a little disaster when the initial *DSM-IV* put in the “clinical significance” criterion that had the effect of requiring distress or impairment before pedophilia could be diagnosed. The APA wisely corrected that in *DSM-IV-TR*.

Let us now consider gender identity disorder. Dr. Hill says that, contrary to *DSM-IV*, gender is not dichotomous—we are all somewhere in between. Are we all somewhere in between? That is news to me. Biologically, we are all male or and female—with very few exceptions. Biologically, there are a very small number of intersex—so we are not all in between biologically. Are we all in between in terms of gender identity? Is it a fact that there is a small number of males who are really sure they are male and then there is large number in the middle that are not quite sure what they are and then at the extreme there are men who think they are female? The fact is that almost all males know they are male and it is self-obvious to them. There is a very small number of males who feel uncomfortable being males. Ken Zucker¹ has noted that if you look at the behaviors that are in the *DSM* “A” criteria for gender identity disorder and you do a distribution of kids referred to his clinic because of gender identity problems and compare this with the distribution among a control group matched for age and sex, there is almost no overlap.

Very few young boys want to play with young girls. They want to play with boys. In all cultures, young boys want to play with boys. Young girls want to play with girls. This is not because they are taught or encouraged to do it. Again, interest in young children seems to be part of the human condition. If you are interested in evolutionary psychology, you ask yourself could that have some survival value? The answer is yes. Thousands of years ago when men were more likely to be in hunting and women were more likely to be in the nurturing role, if you were a young boy you would do better if you spent your time with other boys with whom, when you were older, you would go to the hunt.

Dr. Hill is correct when he notes that gender roles for males and females vary from culture to culture. But in all cultures, gender is recognized as a dichotomy and there are gender specific ways of identifying gender. In our culture, for example, very few men wear lipstick. There are some women who do not wear lipstick but almost all the lipstick wearers are women. And, of course, there are cultures where no one wears lipstick.

Children normally develop a sense of gender identity. It is not taught—it just happens. I would argue that by itself, the failure to develop a gender identity that is congruent with biological gender is a dysfunction. How severe it has to be to make a diagnosis and how and if you should treat it are separate issues.

For example, Dr. Kenneth Zucker has provided me with a case that he recently evaluated at his clinic. A two year and ten month old boy was referred for assessment. When asked his name, he says he is “Snow White.” Since the age of 24 months, he has either insisted that he is a girl or that he wants to be a girl. He is adamant that he will grow up to be a mommy. When told by his parents that he will grow up to be a daddy, he bursts into tears and is inconsolable. He wants to grow up to be a mommy. He likes to wear dresses in nursery school and have his hair put into a ponytail. He only plays with girls in his school and has no male playmates on his street. He sits to urinate. For the 10 months preceding the referral, and after the onset of the cross-gender behaviors, his parents had assumed the behavior was a phase out of which he would grow. His increasing distress about being told he was a boy led them to consult their family doctor who recommended a referral to Zucker’s GID clinic.

I ask you: is this just non-conforming behavior? It seems rather obvious that there is something wrong in this child’s gender identity.

Dr. Hill sometimes used the phrase “gender choice.” This is rather naïve. For these children, it is not a question of choice at all.

In conclusion, it interesting that Dr. Moser and Hill have not presented a single case of someone—child or adult—who was harmed by being given a diagnosis of a paraphilias or gender identity disorder. Their arguments for eliminating these categories in the *DSM* are weak at best.

NOTE

1. See Zucker, K. J. & Bradley, S. (1995). *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents*. New York: Guilford Press.

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