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Science Evolves Through Consensus: The evolution of diagnostic criteria in relation to sexual orientation and gender identity

Adam Jowett in Conversation with Jack Drescher

Jack Drescher, MD, is an American psychiatrist and psychoanalyst known for his work on the history of theorising about, diagnosing, treating and mistreating sexual minorities. Dr Drescher was a member of the American Psychiatric Association's DSM-5 expert working group on Sexual and Gender Identity Disorders, which revised the DSM- IV-TR diagnosis of gender identity disorder to the DSM-5 diagnosis of 'gender dysphoria'. He was also a member of the World Health Organization expert working group that recommended replacing ICD-10's gender identity disorder with 'gender incongruence', as well as moving the diagnosis out of the mental disorders section of the latest International Classification of Diseases (ICD-11). Dr Drescher is also an expert on sexual orientation change efforts (SOCE) and served on the American Psychological Association's Task Force on Appropriate Therapeutic Responses to Sexual Orientation. He has published a number of books in the field including Psychoanalytic Therapy and the Gay Man (Drescher, 1998a) and Sexual Conversion Therapy: Ethical, clinical and research perspectives (Shidlo et al., 2001). In February 2020, I interviewed him about his role in the recent ICD-11 revisions and his views on tackling the practice of conversion therapy. What follows is an edited version of our conversation. (Adam Jowett, Chair of the Psychology of Sexualities Section)

AJ: So, you were on the World Health Organization's (WHO) working group for the classification of sexual disorders and sexual health. Could you summarise what the key changes have been for the ICD-11 in relation to sexual orientation and explain what the rationale was behind these changes?

JD: The first changes were in relation to sexual orientation and there are parallels with the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). In the US, although homosexuality was removed from the DSM-II in 1973, it wasn't removed entirely. It was replaced with a diagnosis called 'sexual orientation disturbance', and this could apply to any person who was upset about their sexual orientation and wanted to see a psychiatrist to change it. That was the diagnosis until 1980 when it was removed from the DSM-III because there really aren't many heterosexuals seeking psychiatrists to change their sexual orientation. So in 1980 it became 'ego dystonic homosexuality' and people were very upset about that because the new DSM-III was trying to base itself on empirical research. What if people are upset about their height? You don't have an 'ego dystonic height disorder'. Or what if people were upset about their race? There's no 'ego dystonic race disorder'. Consequently, in 1987, when the next iteration of the DSM came out, DSM-III-R, ego dystonic homosexuality was removed without much resistance.

The World Health Organization's International Classification of Diseases went through a similar process. After homosexuality was removed from ICD in 1990, it was replaced in ICD-10 by what were known as the F66 diagnoses. These were 'psychological and behavioural disorders associated with sexual development and orientation'. In a manner similar to what happened in the DSM, when revising ICD-9 to ICD-10, diagnoses such as 'ego dystonic sexual orientation' and another one called 'sexual maturation disorder' were included. Those F66 diagnoses were the ones our working group looked at (Cochran et al., 2014). We further noted that these were diagnoses that had no health usage; and since the ICD is about trying to keep track of health statistics, there was no purpose in retaining these diagnoses. The decision was to remove them from ICD-11, which was mostly uncontroversial.

AJ: And how about the changes to the ICD-11 in relation to gender identity?

JD: ICD-10 had the diagnoses of 'transsexualism' and 'gender identity disorder in childhood'. The WHO working group received petitions and appeals from advocacy organisations, including the European Parliament, saying we shouldn't be classifying it as a mental disorder. However, there was a contrast here compared to what happened with the DSM.

I served on the DSM working group that changed gender identity disorder to 'gender dysphoria'. Now some people wanted gender identity diagnoses out of the DSM because it

was stigmatising in the same way that including homosexuality was stigmatising in 1973 (Drescher, 2010). However, this situation was a bit different (Drescher et al., 2012; Drescher, 2015).

One difference is that once homosexuality was taken out of DSM, you didn't need a diagnosis to help lesbians and gay men. You could diagnose them with anxiety diagnoses, for example, that apply to anybody. But the problem with removing gender identity disorder was that people need a diagnosis in order to have access to care. If you want hormones or surgery, these are medical conditions that require a diagnosis. In almost every country's healthcare system, the health-care professional needs to say what diagnosis is being treated (the diagnosis code) and care the patient received (the procedure code). Many activists know nothing about this; although there are transgender legal advocates who were telling our DSM-5 workgroup that, 'You can't take out the diagnosis because the rights of transgender people to have access to hormones in prisons has been won on the basis that this is a medical condition'. In the US, denying needed medical care is referred to as 'cruel and unusual punishment' and is unconstitutional. So those trans advocates didn't want the diagnosis taken out. Consequently, we in the APA felt that the decision boiled down to a choice between the stigma of the diagnosis versus access to care and we tried to find a balance between the two issues.

Now, with the DSM, the diagnosis was either in or out, as it's only a catalogue of mental disorders. If it was taken out completely there would be no diagnosis and no access to care. What we did in DSM-5 was keep the diagnosis but rename it 'gender dysphoria' and narrowed the diagnostic criteria, particularly in the childhood diagnosis, in a way that reduced false positives, so no one would be diagnosed just because they had some gender atypical features. Most people are happy that we've taken out the word 'disorder'. Of course, that decision was not unprecedented since not every diagnosis in the DSM has the term 'disorder' in it.

Because of my work on DSM-5, I was then invited to work on ICD-11, where things were a little bit different. The ICD is not just a catalogue of mental disorders, it's a catalogue of all health conditions and there were more options. It was possible in the ICD-11 to move the diagnosis out of the mental disorders chapter and move it into a new chapter called 'Conditions related to sexual health'. One could still have a diagnosis code and not be a mental disorder.

There were mixed reviews about that decision. The moving of the adult and adolescent diagnosis was very well received and there wasn't much resistance within WHO to making that change. Where controversy emerged was that some people were angry about the retention of a 'gender incongruence of childhood' diagnosis (see Drescher et al., 2016a; Drescher et al., 2016b; Winter et al., 2016). They argued that we'd gone from psychopathologising children to pathologising children with a medical condition. But there were others who didn't want a child diagnoses taken out, particularly in countries like Mexico. The clinicians in those countries felt that having a diagnosis helped the parents and children because parents were much more understanding when they learned this was a diagnosable condition (Robles et al., 2016). Even the World Professional Association for Transgender Health-care (WPATH) was divided about whether there should be a childhood diagnosis. So we kept it. What we explained in our rationale was that the ICD contains diagnoses like 'normal spontaneous delivery' of a child and 'menopause' that are not physical illnesses; they're normal life conditions for which medical attention is sometimes needed. In other words, we were happy to say that the child diagnosis is comparable to that; it's not a physical illness, it's just something that might require professional help and intervention.

AJ: And what would you say is the key difference between gender dysphoria in the DSM-5 and the gender incongruence category in the ICD-11?

JD: We actually used the term 'gender incongruence' in our first recommendation for changing gender identity disorder in the DSM-5. However, the feedback from clinicians was that they preferred the term 'gender dysphoria' because it was a term that was already in existence and one that people were already using in clinical practice and research. We changed the name to gender dysphoria based on that feedback.

In the ICD deliberations my colleague Peggy Cohen-Kettenis PhD, who was also on the DSM and ICD working groups, felt very strongly that we should stick with gender incongruence this time. This made a lot of sense because we were moving the diagnosis out of the mental disorders section and 'dysphoria' implies psychological disturbance, whereas gender incongruence does not.

In the US, even though we have the DSM, insurance companies require ICD codes for reimbursement. Consequently, the DSM also includes equivalent ICD codes, so gender

dysphoria and gender incongruence would be equivalent codes. They pretty much cover the same group of people who might need to access medical care.

However, there is another complication. The US healthcare system, until 2015, was still using ICD-9, which came out in 1975. It was only in 2015 that the US switched to ICD-10, which came out in 1990. It is not clear when the US will switch to ICD-11. There's a lot of resistance to doing so because it's involves a big expense for everybody – hospitals, insurance companies, etc. – to change their systems around the country. One question is 'Now that we've taken gender incongruence out of the mental disorders' chapter, why do we need gender dysphoria in the DSM?' But we do because we're still using ICD-10.

AJ: So do you foresee a time when gender dysphoria will be removed from the DSM?

JD: I don't know. I have begun giving talks to professional audiences on what I call 'The Rocky Road to Removing Gender Dysphoria from the DSM-5'. It involves a complex understanding of the US healthcare system which, I must frankly admit, is presently above my pay grade.

AJ: But do you think the diagnosis in the DSM will continue to evolve in relation to gender diversity?

JD: Oh absolutely. I often explain that the DSM is not a Bible; it's a user's manual and categories change as professionals change the way they think about the diagnoses over time. The changes in relation to homosexuality were partly a result of activists weighing in during the 1970s. Feedback from the community changed the way professionals thought about the diagnosis. Since transgender people are not invisible in the way they once were, professionals are listening to their feedback and there's a lot of serious rethinking going on. In fact, some of the transgender people providing feedback are professionals themselves. Theorising and culture are evolving, and I think that's okay. Some critics say, 'Well, that's not science'. To which I respond, 'In 2006, the International Astronomical Union voted on whether or not Pluto should be classified as a planet. Science evolves through consensus.' And how we think about these diagnoses could be different in 10 years.

AJ: And another thing you were involved in was the American Psychological Association's task force on appropriate therapeutic responses to sexual orientation (APA, 2009). Could you explain how that came about and what impact you think that's had?

JD: I became interested in the subject of conversion therapy based on experiences in my practice in Chelsea in Manhattan. I'd been seeing gay patients in my practice since the 1980s and I began seeing patients who had been through 'treatments' with clinicians who had tried to change their sexual orientation. I saw people who were harmed by those efforts.

The person delivering these 'treatments' would typically tell clients that the major factor determining success is the client's will power and motivation – or their faith if it was a religious-based treatment. Since most of these treatments failed, the patients blamed themselves rather than the person who offered them something that didn't work. Some people felt worse than when they started. They also spent a lot of time and money. Some people experienced anxiety and depression and became suicidal. Some got married as part of the treatment and had kids but came from religious backgrounds where divorce was frowned upon. These therapists created enormous messes. I wrote a paper on the subject for the *Journal of Homosexuality* (Drescher, 1998b) and a chapter in my book (Drescher, 1998a) just as the work of the so-called 'reparative therapist' Joseph Nicolosi was getting a lot of attention in the late 1990s (Nicolosi, 1991). As I became known for writing and speaking in this area, the American Psychological Association invited me to be on their task force which looked into this. As well as having experts in the area, the task force also included an expert on methodologies to determine whether the methodologies used supported the claims made about the efficacy of conversion therapies. The conclusions of the task force were that they did not. There is no real empirical basis for claiming that conversion therapies work, or that one couldn't help patients through doing other things other than trying to change their sexual orientation. It should be further noted that when professional organisations make decisions like this, they are consensus driven. Of course, there were predictable responses from those people who wanted to perform conversion therapy; some of them tried to extract quotations out of context from the report to make it sound like the APA was approving of what they were doing.

However, I think the Task Force Report might have triggered the phenomenon going on in the US right now with state and local bans on conversion therapy for minors. The APA task force report came out in 2009 and the first state to ban conversion therapy with minors was

California in 2012 (Drescher et al., 2016). Almost all the other state bans have copied the language of the California law. Although when the California ban was challenged in the courts, the American Psychological Association didn't weigh in on the court case because they didn't want to get involved in what some call a 'scope of practice' issue. There are now twenty US states with such bans, one of the latest being Utah, which is a very conservative state. Some people are wondering if other conservative states are going to pass these bans as well as a result.

However, a problem with the bans is that they are a very large hammer for a very small nail. The majority of clients seeking conversion therapy are not minors and the majority of practitioners of conversion therapy are not licensed professionals. And the bans only apply to licensed professionals. So, I see the bans mostly as symbolic gestures. Further, the system of monitoring laws like this is complaints-based. This means an individual would have to had undergone a conversion therapy and then make a complaint about it when it doesn't work.

A more effective way to stop the practice in the US is through what we call consumer protection laws. The state of New Jersey has some of the strongest consumer protection laws in the US. The advantage of consumer protection laws is that it's irrelevant whether the practitioner is licensed and it doesn't matter whether the client is an adult or a minor. There was an organisation called JONAH, which stood for Jews Offering New Alternatives to Homosexuality, that offered conversion therapy for people of the Orthodox Jewish faith. They were found to have committed fraud for claiming to be able to change their clients' sexual orientation and they had to pay thousands of dollars in damages to the plaintiffs for the harm that they'd done. But then just last year it turned out that they were still operating at the same address under another name. If the courts follow up on that violation, they may have to pay millions of dollars in damages.

AJ: So you said that the bans are a large hammer for small nail. Do you think we also need non-legislative approaches?

JD: I don't think any law is going to stop these practices entirely. There will always be people who don't want to be gay and there will always be people that will try to sell them the snake oil of possible change. For some people 'snake oil' may be a little too strong a term to describe what they are selling – their faith is genuine, and I believe they're trying to help people. But the road to hell is paved with good intentions.

It seems to me that we need more education of religious groups. We've seen that starting to happen. I've actually participated in a couple of panels in the US in which rabbis were invited to speak, and some did come to learn about this, so it is possible to educate religious communities. The notion within the Orthodox Jewish community that you might be doing harm to another Jewish person is taken very seriously, so one way to approach it is to explain that you may mean well, but you could be doing harm. If we want to be effective, it is possible to find ways to speak to religious communities because they may inadvertently be doing harm to their own members.

AJ: Yes, so 30 years after homosexuality was declassified from the ICD, and almost half a decade since it was declassified from the DSM, we've still got these pockets of society that still pathologise and think of homosexuality as being an illness.

JD: Yes, we're in a new century and some people from religious communities are still calling homosexuality a mental disorder. For example, the Catholic Church says homosexuality is 'disordered'. Other religious conservatives also say something similar and they refuse to take advice from mental health professionals that goes against their strongly held religious beliefs. That stance is hard to overcome, but I would not say it's impossible. What we're seeing in the US is that younger evangelical Christians are really not as concerned about homosexuality as their elders are, so whether this will continue to be a concern in the future remains to be seen.

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