Diagnosing Gender:

Transitivity Analysis on the Diagnostic Category of Gender Dysphoria in DSM-5

Sanna Larinkoski

MA Thesis

University of Turku

School of Languages and Translation Studies

Department of English; English Philology

February 2014

The originality of this thesis has been checked in accordance with the University of Turku quality assurance system using the Turnitin OriginalityCheck service.

TURUN YLIOPISTO
Kieli- ja käännöstieteiden laitos/ humanistinen tiedekunta
LARINKOSKI, SANNA: Diagnosing Gender: Transitivity Analysis on the Diagnostic Category of Gender Dysphoria in DSM-5
Pro gradu – tutkielma, 86s., 30 liites.
Englantilainen filologia
Helmikuu 2014

Tässä tutkielmassa analysoidaan teoksessa ’Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition’ (DSM-5) ja tarkemmin sen kappaleessa ’Gender Dysphoria’ käytettyä kieltä. DSM-5 on mielenterveydenalan ammattilaisille suunnattu luokittelu virallisesti tunnustetuista mielenterveyden häiriöistä ja se sisältää myös oireiden kuvailuun perustuvat ohjeet näiden mielenterveyshäiriöiden diagnosoimiseksi. ’Gender dysphoria’ (vapaasti suomennettuna sukupuolidysforia) on lääketieteellinen termi, joka viittaa biologisesta sukupuolesta eriävän sukupuoli-identiteetin aiheuttamaan henkiseen pahoinvointiin. Sukupuoli-identiteetin ja mielenterveysongelman yhdistäminen sisältää ideologisiin arvoihin pohjautuvia perusteluja ja tässä tutkielmassa analysoidaan ’Gender Dysphoria’ – kappaleen ideologista sisältöä kriittisestä näkökulmasta.

Tutkimuksen tarkastellaan ’Gender Dysphoria’ – kappaleessa käytetyn kielen ideologisia heijastumia ja niiden sosiaalisia vaikutuksia kolmen tutkimuskysymyksen avulla: 1) Kuinka diagnosoitu henkilö esitetään tekstissä? 2) Kuinka tekstissä rakennetaan kuvaa sukupuolidysforiasta mielenterveyshäiriönä? 3) Miten analyysin tulokset saattavat vaikuttaa käsitykseen sukupuolen yhteydestä mielenterveyteen ja sukupuolidysforian diagnosoimiseen. Analyysissä käytetään metodina M. A. K. Hallidayn transitiivisuusteoriaa ja tulosten sosiaalisia vaikutuksia analysoidaan Norman Fairclough diskurssianalyysimallin avulla. Transitiivisuusanalyysin avulla tarkastellaan kirjoittajien tekemiä valintoja kielenkäytön suhteen, jotka Hallidayn teorian mukaan heijastavat kirjoittajien henkilökohtaisia kokemuksia ympäröivästä maailmasta.

Tutkimus paljasti, että sukupuolidysforia esitetään mielenterveysongelmana erottamalla se yksilöstä erilliseksi toimijaksi, joka suorittaa erilaisia prosesseja yksilön sisällä. Yksilöistä erityisesti lapset esitetään tekstissä voimakkaasti perinteisiin sukupuolirooleihin pohjautuvan ideologian valossa, joka heijastuu oireiden kuvailuun. Analyysi osoittaa myös logiikkaongelmia lasten oireiden kuvailussa, jotka johtavat ristiriitoihin oireiden ja mielenterveysongelman yhteydessä ja kumoavat perusteet, joiden pohjalta lapset diagnosoidaan. Tutkimuksen lopussa ehdotetaan, että sukupuolidysforiaan liittyvien diagnoosiohjeiden ja – kriteerien perusteita muokataan yleisesti sukupuoli-identiteetin itsemääräämisoikeuteen pohjautuvaksi ja lasten osalta tekstiin sisällytettäisiin mahdollisia tieteellisiä perusteluja, jotka kumoaisivat diagnoosiohjeiden nykymuodossaan sisältämät ristiriidat ja perustelisivat lasten diagnosoinnin oikeellisuuden.

Asiasanat: critical discourse analysis, transitivity, gender dysphoria, DSM-5

TABLE OF CONTENTS

1. Introduction....1
2. Social Context....3
   2.1. The Diagnostic and Statistical Manual of Mental Disorders....3
   2.2. Gender Dysphoria....5
   2.3. Clinical Practice....7

3. Theoretical Framework....9
   3.1. Critical Discourse Analysis....9
      3.1.1. Discourse....10
      3.1.2. Discourse and Social Reality....12
      3.1.3. History and Core Principles of Critical Discourse Analysis....14
      3.1.4. Criticism towards Critical Discourse Analysis....17

   3.2. Medical Discourse....18
      3.2.1. Relevant Features of Medical Discourse....19
      3.2.2. Previous Analyses of the Diagnostic and Statistical Manual of Mental Disorders....21

   3.3. Social Theories on Psychiatry and Gender....23
      3.3.1. Michel Foucault and Scientific Knowledge....24
      3.3.2. Judith Butler and Performative Gender Identities....26

   3.4. Systemic Functional Grammar....29
      3.4.1. Transitivity and Process Types....31
      3.4.2. Ergativity....35
      3.4.3. Circumstantial Elements....36
      3.4.4. Modalization....37

4. Data and Methods....39
   4.1. Data....40
   4.2. Methods....41

5. Analysis....44
   5.1. Constructing Gender Dysphoria as a Mental Disorder....44
   5.2. Constructing Binary Gender....53
   5.3. Children and Gender Dysphoria....55
      5.3.1. Comparisons Between Natal Girls and Boys....57
      5.3.2. Parents, Society and a Child's Distress....65

6. Discussion....68
   6.1. The Individual, Gender Dysphoria and Self-Determination....69
   6.2. Children and Gender Dysphoria....72

7. Conclusion....79
8. References....81

9. Appendices

Appendix 1: Analysed Data
Appendix 2: Finnish Summary

LIST OF FIGURES

Table 1...33
Table 2...57
Table 3...57

1. INTRODUCTION

In May 2013, the American Psychiatry Association (APA) published the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. This manual, aimed at mental health care professionals, includes both a classification of mental disorders and the guidelines to diagnosing them. The DSM classification system includes all the mental disorders that are recognised by the health care system in the United States and it is also the standard framework employed by professionals in mental health care contexts both in the United States and worldwide (APA 2014d). As the manual is an established authority on defining the boundaries between mental health and mental disorder, the publication of the fifth edition, called *DSM-5*, was met with a great deal of interest. However, DSM-5 has also been the target of an equal amount of criticism, both during the ten-year process of revision and after its publication (Lane 2013). Much of this criticism had already been targeted at the previous editions of the manual.

One diagnostic category in the DSM system that has received heavy criticism is the diagnosis 302.6/302.85 Gender Dysphoria. *Gender dysphoria* is the clinical term for "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender" (APA 2013: 451); that is, for when an individual's gender identity does not correspond with their biological gender and this causes distress. The inclusion of this category in a classification of mental disorders has been widely contested (Ault & Brzuzy 2009; Davy 2013; Lev 2006). While the category is claimed to be based on the distress caused by the "incongruence" between experienced and physical gender, the critics argue that the inclusion of this category in the manual labels variant gender identities as mental disorders. The existence of the category is, nevertheless, a necessity for many: being diagnosed with gender dysphoria enables one to get insurance coverage for treatments in order to reassign biological gender. In consequence, an individual who identifies as transgender and wishes to start gender reassignment treatment has to, in most cases, be subjected to the diagnosis regardless of personal preference.

As the existence and use of the diagnostic category of gender dysphoria is an issue that involves a power imbalance between psychiatrists and transgender individuals, it is important to study how the diagnostic category is composed in DSM-5. The authors of the manual have significant power in determining the relationship between mental disorder and gender identity. Defining the symptoms of gender dysphoria and formulating the guidelines for its diagnosis is a process that involves ideologies. Thus, in this thesis I will analyse the language within the diagnostic category of Gender Dysphoria in the DSM-5 in order to uncover hidden ideologies and bias. I will do this with the help of three research questions:

1. How are the individuals diagnosed with gender dysphoria represented in the language of the category?
2. How is gender dysphoria constructed as a mental illness in relation to the individual?
3. What are the implications of the ideologies uncovered in the language on diagnosing gender dysphoria and pathologising variant gender identities?

I will approach the data from the perspective of Critical Discourse Analysis, as the focus of this study is on ideology and power. I will employ Halliday's (2004) transitivity model in the analysis, as the model concentrates on representations of real world happenings, which in turn are shaped by ideologies. Finally, I will use Fairclough's (2010) three dimensional model for discourse analysis to connect the findings with their social implications.

This thesis has the following structure: I will first give a more detailed introduction of the social context of this study. I will then turn to the theoretical framework, which includes sections on Critical Discourse Analysis, features of medical discourse, social theories relevant to this study, and Systemic Functional Grammar, which includes the transitivity model and other aspects of Halliday's systemic theory that will be employed in the analysis. Their practical employment will be outlined in the section on data and methods, where I will also explain how the data is narrowed down for the analysis. After the analysis, I will discuss the results, their wider implications and in the end present my final conclusions.

2. SOCIAL CONTEXT

In this section on social context I will first introduce the purpose and principles of the DSM-5 (APA 2013a), which includes the data for this thesis. The manual is published by the American Psychiatric Association (APA), which was founded in 1844 and is currently the largest organisation of psychiatrists in the world, counting 33,000 members worldwide (APA 2014a). I will then turn to the diagnostic category of Gender Dysphoria in the manual, which will be the focus of the analysis. This section will include the detailed definition of gender dysphoria, the diagnosis referring to transgender individuals in the manual. Finally, I will give a summary of the guidelines for clinical practice in the manual to clarify how the manual is employed by psychiatrists.

2.1 The Diagnostic and Statistical Manual of Mental Disorders

As explained in the Introduction, the Diagnostic and Statistical Manual of Mental Disorders (DSM) is a classification of and a guide for diagnosing mental health disorders. The classification system has been created to provide a standardised international framework for the use of mental health professionals. The manual has established itself as the normative source in the United States and is employed both by psychiatrists and other professionals in mental health care contexts (APA 2014b). The manual consists of three parts: the diagnostic classification, the sets of diagnostic criteria, and descriptive texts that accompany each classified disorder. Of these three parts, the diagnostic classification lists each mental health disorder that the DSM system includes. The diagnostic criteria sets consist of the symptoms that are connected to a particular disorder, of which a certain amount are required to occur before a diagnosis can be made. Finally, the accompanying texts give a more detailed description of different aspects of each disorder (APA 2014c). The manual includes background information covering among other things gender, culture, and age-specific features connected to the diagnoses but rules treatment suggestions outside its scope (APA 2013a: 19). The International Classification of Diseases (ICD) is a similar but broader diagnostic tool published by the World Health Organization (WHO), which uses codification compatible with the DSM in the sections regarding mental health (APA 2013a: xli). The newest

ICD manual dates back to 1994 and thus DSM-5 represents the latest information on diagnosing mental health disorders.

Five versions of the DSM exist today and the latest one, DSM-5, was published in May 2013. DSM-5 is a result of ten years of revision performed on the previous edition, which was published in 1994. The classification system has evolved over time and encountered criticism on several levels, ranging from the classification system itself to specific issues in individual diagnostic categories (see, for example, Gambrill 2013, Hyman 2010 or Zucker 2010). Much of the criticism has concerned the diagnostic categories related to sexuality and gender (Moser 2001, Hugh-Jones & Gough & Littlewood 2005, Lev 2006). In April 2013, DSM-5 faced influential criticism that questioned the scientific credibility of the whole DSM system. The critique was aimed at the method of diagnosis that the diagnostic categories are derived from. The DSM is laid on a symptoms-based diagnostic method in which diagnoses are given based on symptoms in an individual that are observed by the clinician (Insel 2013). Thomas R. Insel, the director of the National Institute of Mental Health (NIMH) in the United States, asserted that basing the diagnosis and treatment of a patient solely on symptoms is both outdated and based on inadequate empirical evidence, and thus lacking in validity (2013: n.p.). NIMH is developing their own classification system for mental disorders and has announced that the research is not based on the categories in the DSM system (ibid.). The validity of diagnosing a mental disorder solely on the basis of observed symptoms is a central topic in this thesis.

While Insel’s critique caused a reaction in the world of psychiatry (Lane 2013), DSM-5 nevertheless includes the latest guidelines on diagnosing mental health disorders between the two manuals published by the APA and the WHO. However, while medical science evolves and the diagnostic criteria evolve with it, the fact remains that the criteria invariably reflect the values of their writers (Fulford *et al.* 2005). This is especially relevant in relation to mental illness, which Foucault ([1967] 1993) and others after him (Horwitz 2002; Crowe 2000) see as a social construct that reflect cultural values. This in turn gives power to those who write manuals such as DSM-5 and those who use the manual to make diagnoses. As diagnoses affect the lives of many and the psychiatrists making them have a considerable amount of power over others, it is important to

study how the guidelines interpreted by health care professionals worldwide are composed. This study is focused on one diagnostic category in particular and this category is called Gender Dysphoria in the DSM-5.

2.2 Gender Dysphoria

> "Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and / or surgery are not available. The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se."
>
> (APA 2013a: 451)

The above quotation is the definition of gender dysphoria as can be found in the DSM -5. The key element in the definition is the concept of distress and it is stated that gender dysphoria refers specifically to the "affective / cognitive discontent" that the individual has with their *natal gender* (biological gender at birth) (APA 2013a: 451, 453). In this regard the definition is different from the previous category of *gender identity disorder* in DSM-IV. The work group responsible for updating the diagnostic category for DSM-5 stated that the name was changed both to emphasise the fundamental criteria of distress and to placate critics of the category, who opposed the use of the word "disorder" (Zucker *et al* 2013). According to this new definition in DSM-5, diagnosing an individual with gender dysphoria presupposes distress and is less concerned with the underlying gender identity. While changing the name of the category to a less stigmatising one received positive feedback from the World Professional Association for Transgender Health (WPATH) during the drafting of DSM-5 (DeCuypere & Knudson & Bockting 2010), the category itself is not without its problems.

A fundamental issue with the diagnostic category of gender dysphoria is whether it should be included in the manual at all. Critics argue that the mere existence of the category stigmatises non-conforming gender identities and pathologises an issue that is simply a matter of identification (see, for example, Winters 2006, Ault & Brzuzy 2009, Lev 2013). Lev notes the campaigns of trans-activists for the erasure of gender diagnoses from the manual and compares the depathologisation of gender variance to the prolonged removal of homosexuality from the list of mental disorders (2013: 291).

However, the dilemma lies in that without being diagnosed with gender dysphoria, an individual's access to treatments for the reassignment of biological gender is jeopardised, as getting insurance coverage for the treatment requires a diagnosis (APA 2013b). The stance of WPATH is that sex (or biological gender) reassignment treatments are a medical necessity that should be available to all transgender individuals (WPATH 2014). Thus, in the current system, the inclusion of the category in the Diagnostic and Statistical Manual of Mental Disorders is necessary for beginning the process of gender reassignment treatments.

Other problems with the category have been pointed out in studies in the field of psychiatry. Bower (2001) studied the criteria for gender identity disorder in DSM-IV and points out that despite in depth research both in biology and psychology, the aetiology of gender identity disorder remains a mystery (2001: 8). The category has been seen to be especially problematic when it is applied to children. Hill *et al* (2007) note the lack of empirical evidence as well and also problematise the validity of the diagnosis regarding children, pointing out several problems in the diagnostic criteria as well as the role of parents in categorising gender variance as a mental illness. The category has undergone several changes in the DSM-5, in addition to the change of name to gender dysphoria. For example, sexual orientation is no longer used as a basis for different subtypes of gender dysphoria (APA 2013a: 814), gender dysphoria is no longer situated in the chapter for Sexual Dysfunctions and Paraphilias but has a section of its own, and it is now required that children express "a strong desire to be of the other gender or an insistence that he or she is the other gender" (APA 2013a: 452) before they can be diagnosed with gender dysphoria (Zucker *et al* 2013). There have also been changes in wording within the whole category and the current manual uses the word 'gender' instead of 'sex' (APA 2013a: 814).

Lev (2013), while criticising both the empirical process of building DSM-5 and the binary gender categories that it upholds, gives also credit to the DSM-5 Sexual and Gender Identity Disorders Work Group for making some positive progress for equality with a very complex and sensitive issue (2013: 294-295). Davy (2013), however, argues that the changes make little difference in the big picture of transgender rights. She argues

that both the atypical gender behaviour and the distress resulting from gender incongruence are always context dependent and the evidence supporting an incongruence is based both on a binary gender model and an outdated thought of what is supposedly natural. In light of this, the change of name and taxonomy are irrelevant (2013: 5). As is apparent from all of the sources above, the category of gender dysphoria is heavily contested. The recognition of transgender identity is also regarded as a human rights issue (Amnesty International 2014). The language used in the diagnostic category makes a great difference in how transgender individuals are regarded by the professionals who make the diagnoses and also, as I will argue later, by the society in general. This is why it is important to study the language in the manual and uncover the ideologies it reflects. I will return to how language reflects ideologies, but next I will present a brief outline of how the DSM-5 is used in practice by health care professionals.

2.3 Clinical Practice

The DSM-5 includes guidelines (APA 2013a: 19-24) for clinicians on how the manual should be used. This section is a summary of those guidelines. In the guidelines (ibid.: 19), it is stated that the manual's first and foremost function is to assist clinicians as they formulate case assessments on their patients, which is the basis for a treatment plan. The manual does this by presenting diagnostic criteria sets for mental disorders as well as other text descriptions that can be used as a guideline for making the diagnosis. The symptoms that are listed in the diagnostic criteria are not meant to be seen as a comprehensive definition for the disorder in question, but rather as a summary of the characteristic signs regarding psychological, biological, environmental factors among others that indicate the existence of an underlying disorder. However, it is stated that simply checking off symptoms from the criteria lists does not offer enough justification for making a diagnosis, but the individual's clinical history as well as a thorough summary of all relevant factors relating to the diagnosis should be taken into account. Nevertheless, it is further noted that checking the list does add to the reliability of the diagnosis (ibid.).

Clinical judgement is required throughout the diagnostic process and especially when it comes to assessing the severity of the symptoms (APA 2013a: 19). This involves deciding whether all the factors that could lead to having a disorder surpass their normal manifestation ranges. The lists of symptoms represent only a limited set of human reactions. As it is not possible to include every possible aspect of a disorder in the manual, the authors state that clinical utility is the primary standard for the diagnostic criteria included in the manual (ibid.: 20). Treatment should not be denied from patients that do not show all the listed symptoms listed neither do all the symptoms need to be present for a diagnosis to be made (ibid.). The guidelines (ibid.: 21) also state that as there are no clear clinical measurements on where a mental disorder begins and ends, the generic criterion of distress is emphasised for all mental disorders. The manual also recommends the use of information from third parties, such as family members, when needed (ibid.). In the end, the final diagnosis is to be made "on the basis of the clinical interview, text descriptions, criteria, and clinician judgement" while "the diagnostic criteria are guidelines and the text descriptions such as diagnostic features are presented to support the diagnosis" (ibid.: 21). While the authors emphasise the clinician's role and the incompleteness of the criteria sets, they nevertheless state that "the diagnostic criteria [...] are well-established measures that have undergone extensive review" (ibid.: 23). Thus, while the validity of the criteria sets is assessed with the publication of all new versions of the manual, they are claimed to be tried and true and to have established their status within diagnostic practice.

Finally, any disorder in the manual (with the exception of medication induced disorders) has to meet the following definition of a mental disorder (APA 2013a: 19). This definition includes two dimensions, the individual's inner state of being as well as functioning in society. In the end, there is a disclaimer about "socially deviant behaviour" and its relation to mental disorders.

> A mental disorder is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as death of a loved one, is not a mental disorder. Socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not

> mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.
>
> (APA 2013a: 20)

Including gender dysphoria in the DSM-5 already presupposes that it is a mental disorder. However, according to the definition, what is seen as abnormal social behaviour is not indicative of a mental disorder unless it is caused by a disorder. This definition becomes problematic when a clinician is expected to decide whether an individual's behaviour is symptomatic of a disorder or simply not accepted by those around them. Horwitz (2002: 35-37) argues that the division between inner mental dysfunctions and socially deviant behaviour is the primary challenge of modern psychiatry. The definition of a mental disorder and the division between an inner disorder and behaviour that is simply disapproved of is a central theme in this thesis. Thus one focus of the analysis is how gender dysphoria is constructed as a mental disorder in relation to the individual. Next I will present the theoretical framework of this thesis.

3. THEORETICAL FRAMEWORK

This section on theory is divided into subsections reflecting four broad themes: discourse and Critical Discourse Analysis, medical discourse as a genre, social theory on psychiatry and gender, and the theory underlying the methods. In section 3.1, I will first discuss the concept of discourse and its relation to society. Then I will turn to Critical Discourse Analysis, which is the approach I will take to studying the data. In section 3.2, I will present relevant features of medical discourse. After that, in section 3.3, I will turn to social theories in connection to the core topics of this thesis, gender and mental illness. Finally, in section 3.4, I will present the relevant features of Systemic Functional Grammar from which the methods applied in the analysis are derived.

3.1 Critical Discourse Analysis

The first half of this section on discourse and its relation to social reality is based on the ideas of the philosopher Michel Foucault as presented in *The Archaeology of Knowledge* ([1972] 2009) as well as those of Norman Fairclough, a key developer of Critical Discourse Analysis. Of his works I will mainly refer to *Critical Discourse Analysis:*

the Critical Study of Language (2010) and *Discourse and Social Change* ([1992] 2002). Here I will also introduce Fairclough's three dimensional model of discourse analysis, which will be the framework connecting the analysis of the data, discourse and society in this thesis. In the latter half of this section I will present a brief history of and a broader set of approaches on Critical Discourse Analysis, including criticism.

3.1.1 Discourse

A central term in this study that requires definition is *discourse*. Norman Fairclough, who refers to Foucault's theory on discourse and society (Fairclough [1992] 2002: 3), defines discourse both in practical linguistic terms and in regard to its role in creating *relations* (Fairclough 2010: 4). On a practical level, linguists use discourse to refer to longer samples of spoken or written text (Fairclough [1992] 2002: 3). With the term relations, however, Fairclough refers to discourse as a means of creating connections between things, such as people, thoughts, different discourses, et cetera; in other words, discourse creates connections between everything that is included in *social reality* (Fairclough 2010: 3). Fairclough opposes social reality (or "social world", in this thesis I will use 'social reality') with the natural world, meaning that social reality only exists through human action (ibid.: 4). This social reality is both represented in and shaped by discourse and I will expand on this idea below.

Fairclough sees the relationships between discourse and social reality as *dialectal*, meaning that the relationships work both ways and discourse cannot be distinguished as a separate entity from the things and relations it brings to life (2010: 3-4). This dialectal relationship means that discourse is also *constructive*; that is, discourse shapes the reality it represents (ibid.: 4). Discourse can therefore be seen as being actively related to social reality rather than as simply reflecting it, which means that social reality both *construes* and constructs social relations and beings (ibid.: 4-5). The difference between the two terms is in transformative power: construing refers to discourse representing reality, while only certain representations have the power to construct social reality (ibid.: 4). The constructive power of discourse is inherently social and thus the construction of social reality happens through the interaction between participants in a discourse (ibid.: 4, 75). As a consequence of this interaction, discourse is also affected by how it is interpreted. Interpretation, in turn, is affected by the context of the

discourse (ibid: 132). For example, discussing gender identity in the context of medical discourse already affects the way gender identity is constructed in social reality. I will return to the representation and construction of social reality in sections 3.1.2 and 3.3.

Discourse can also be viewed as separate discourses for individual social situations, such as legal discourse, educational discourse, or medical discourse, which is the focus of this thesis. These different discourses contrast with one another and therefore have different ways of structuring knowledge and social relations (Fairclough [1992] 2002: 3). These discourses also show ways of using language that are particular to individual discourses. Medical discourse is no different, and the typical features of medical discourse will be introduced in section 3.2. The distinctions between separate discourses mean that they represent society in different ways and position people differently from alternative discourses (ibid. 3-4). Due to these differences, all discourses have individual effects on society. In the case of positioning individuals, in medical discourse medical practitioners are in position of authority and thus exert influence over those they treat.

I have chosen to use Fairclough's work in the theoretical framework for this study due to the applicability of his three dimensional model of discourse analysis (2010: 132). He calls these three dimensions *text*, *discourse practice*, and *sociocultural practice*. Text here comprises the dimension of linguistic analysis. Discursive practice includes the processes of producing and interpreting text as well as the interplay of different discourses. Sociocultural practice is concerned with social analysis, such as the institutions and organisations which influence discursive events and how this influence in turn shapes the discursive practice (Fairclough 2010: 132-133). In summary, sociocultural practice refers to the way in which discourse interacts with, shapes, and is shaped by society. In this thesis, the level of text in this analysis is represented by the chapter on gender dysphoria in the DSM-5 and the linguistic analysis performed on it. Discursive practice refers to the interpretation of the results of the linguistic analysis, which ties to sociocultural practice that encompasses the use of the diagnostic category of gender dysphoria and its relation to social reality. My discussion on the sociocultural practices related to the DSM-5 will draw on the theories of discourse and social reality presented in the following section.

3.1.2 Discourse and Social Reality

Fairclough draws on Foucault's theories on the relationship between discourse and social reality in the development of his model of discourse analysis. Foucault has discussed discourse and social reality extensively, including in relation to sexuality ([1978] 1990) and mental illness ([1967] 1993). According to Fairclough ([1992] 2002), Foucault's perspective on discourse analysis is often viewed as the model for social scientists and a more concrete linguistic perspective needs to be added in order for the model to work in discourse analysis. Thus Foucault's approach to discourse analysis is more of a social theory on discourse which does not concern itself with the linguistic aspect ([1992] 2002: 37). However, several of Foucault's ideas on the relationship between society and discourse as well as discourse and power need to be highlighted here. These include the ideas of *intertextuality* and *interdiscursivity* within discourse. According to Foucault ([1972] 2009: 35-36), discourse is always intertextual, as it constantly shapes and is shaped by other discourses. Fairclough, in turn, explains that interdiscursivity means that any discursive practice draws from and is defined by its relationship to other discursive practices ([1992] 2002: 55). In other words, both the contents of discourses and the discourses themselves are dependent on one another - no discourse exists as a separate, untouched entity. In the context of this thesis this means that the inclusion of gender identity in medical discourse defines gender identity in other discourses and thus the connection to mental disorder follows gender identity to all other contexts of discourse.

Another key aspect of Foucault's theory, which was already discussed above in relation to Fairclough, is that discourse both constitutes and constructs society in multiple dimensions. Foucault introduces the notion of *social objects*, which can be understood as knowledge or ideas (Foucault [1972] 2009: 44-54). For example, according to Foucault's theory, gender dysphoria as a category of mental disorder is a social object. Social objects are constituted and transformed in discourse according to the rules of that particular type of discourse (Fairclough [1992] 2002: 41). Foucault mentions the relation between norms of sexual behaviour and their use in the lists of symptoms for the perceived mental illnesses related to sexuality as an example of this phenomenon (Foucault [1972] 2009: 48). This can be compared to norms of gender behaviour and

the diagnostic criteria for gender dysphoria in the DSM-5. Social objects are construed in a very constrained way, which involves all the discourses regarding the object in question (ibid.). This means that all the discourses in society are active in forming the objects, or knowledge, but what is more relevant to this process is the order of those discourses, their relationships of power. The dominant discourses are those that have the most power in constituting social knowledge (Fairclough [1992] 2002: 51). Medical discourse defines what is perceived as healthy and ill, as in the case of gender identities, and thus the discourse has a significant impact on social reality. The position of medical discourse on gender identity as a mental health disorder can be contrasted with that of queer theory, which states that notion of gender categories is merely a cultural construct (Butler 2004: 9), but between these two discourses medical discourse is arguably the dominant one.

As with social objects, the same process applies to *social subjects*, people, which means that social identity is also affected and moulded by discourse (Foucault [1972] 2009: 55-61). Identity is not created before discourse and simply expressed through discourse, but discourse forms identity and the ways in which people express it. Following this thought, an individual's gender identity is also shaped by the discourses in the surrounding society. This is especially relevant to children and gender identity and the application of the diagnostic category of gender dysphoria to children is one of the central issues addressed in this thesis. However, Fairclough asserts that this relationship works both ways and social subjects are in turn able to mould discourse ([1992] 2002: 45). This is where the concept of power and the division between the dominant and dominated discourses are relevant. Critical Discourse Analysis is an approach to discourse analysis that can be used to reveal power imbalances in society with the objective of empowering the dominated parties (Fairclough 2010: 10-11). As the representation of gender identity as a mental disorder has an inherent power imbalance between psychiatrists and the diagnosed individuals, Critical Discourse Analysis is the relevant approach to this issue.

3.1.3 History and Core Principles of Critical Discourse Analysis

Critical Discourse Analysis (CDA) can be roughly defined as a multidisciplinary approach to studying language and power in society with a critical perspective. CDA has incorporated several theoretical approaches to discourse analyses since its foundation (Wodak & Meyer 2009: 3). Due to its eclectic background, CDA has both several names as well as a variety of definitions. The name CDA has been used quite interchangeably with Critical Linguistics (CL), while some scholars prefer to use the name Critical Discourse Studies (Wodak & Meyer 2009: 1, van Dijk 2008: 2). Van Dijk has chosen to use CDS due to objecting the word 'analysis' in the name, as he feels it implies a more methodological meaning than what CDA actually is (2008: 2). I have chosen to use the term CDA after Fairclough as I will be mainly drawing on his work in regard to CDA. Rather than a method, CDA is an approach that can include an unlimited amount of multidisciplinary methodologies that can be in turn applied to different social issues. Van Dijk's definition is even looser: he calls CDA (or CDS) "at most a shared perspective on doing linguistic, semiotic or discourse analysis" (1993: 131). All of the different perspectives on CDA share certain principles and a basis on which research is founded. The fundamental premise is that language is a social phenomenon and that it both affects and is affected by society (Fairclough 2010: 3-4). In other words, CDA researchers focus on what language does, not simply as a way to express reality, but as a force that modifies it.

The critical aspect in Critical Discourse Analysis can be followed back to earlier Marxist and later Frankfurt School Critical Theory (Fairclough et al 2011: 358). CDA concerns itself with how power is distributed in society and takes an explicit stance in defending those who are dominated by the powerful. Wodak and Meyer formulate the objectives of CDA as a critical theory below:

> Critical theories, thus also CDA, want to produce and convey critical knowledge that enables human beings to emancipate themselves from forms of domination through self-reflection. So they are aimed at producing 'enlightenment and emancipation'.
>
> (Wodak & Meyer 2009: 7)

Resisting domination that is caused by power imbalance in society is the goal that brings the 'critical' into CDA. However, lately, while struggles for power and the liberation of the dominated remain the focal point of CDA research, the concept of critique

has acquired a broader meaning. According to Wodak & Meyer (2009), 'critical' is not synonymous with 'negative' and the investigated objects "do not have to be related to negative or exceptionally 'serious' social or political experiences or events" (Wodak & Meyer 2009: 2). CDA can thus be used to investigate any social event or construct that is taken for granted (ibid.). Fairclough (2010: 11), however, does not share this view and defines CDA in terms of addressing social wrongs, which is the objective of this study as well.

CDA approaches language in relation to society and considers the context to be as important as the language itself (Wodak & Meyer 2009: 5). Social issues can be studied in multiple ways in CDA, but the broad perspective is the same as defined by Fairclough below. In this extract, Fairclough explains that the interplay of language and society is the crucial point of interest.

> "These approaches have in common a concern with how language and/or semiosis interconnect with other elements of social life, and especially a concern with how language and/or semiosis figure in unequal relations of power, in processes of exploitation and domination of some people by others."
>
> (Fairclough 2001: 25)

As referred to by Fairclough above, *power* and *domination* are the key terms that separate Critical Discourse Analysis from Discourse Analysis. Scholars using CDA as an approach to social issues focus on the relations of power and the domination created by power imbalance. Power incorporates a multitude of forms and operations, but critical discourse analysts study the role of discourse in the production of power and social inequality (Fairclough 2010: 8). Discourse reproduces power and thus also reflects the networks of power in society, which can be uncovered via linguistic analysis (ibid.: 4,7). I will return to this, but first I will elaborate on the concept of power.

The concept of power in discourse includes control over the content of discourse but also the access to discourse. According to van Dijk, control over discourse is a link to controlling people's minds (van Dijk 2008: 9-10). However, he continues that power is not in itself inherently a negative thing, but the consequences of power depend on how it is used. There are both legitimate and illegitimate uses of power, and their qualifications require standards for legitimacy. Those standards are relative, fluctuating and dependent on time and culture, no matter how universal they seem (van Dijk

2008: 17-19). Thus, for example, the authoritative position of psychiatrists in the Western world is culturally dependent. *Ideologies* influence the ways that people in positions of authority choose to use their power. Fairclough defines ideologies as identities or representations of the world that are connected to establishing or sustaining unequal power relations (2010: 8). Dominant ideologies often exist unnoticed, as they are taken for granted by those under their influence and thus the manipulation of contemporary social ideologies is a covert way of gaining power and directing social change into desired paths (Wodak & Meyer 2009: 8). The binary division of gender is an example of a dominant ideology that usually goes unnoticed and reflections of this ideology in the DSM-5 will be uncovered in the analysis.

Analysing ideologies is a central task of a critical discourse analyst, but, according to van Dijk (2008), choosing the ideologies for critical study is a complicated issue, similar to defining the legitimacy of power. A traditional approach is to measure the negative social consequences of particular ideologies, but even those are dependent on contemporary standards of justice (van Dijk 2008: 19-20). Therefore, in order to perform a credible critical analysis, the researcher must always explicate their own ideological perspective towards their object of study. I will define my position as a researcher at the end of this section.

CDA neither attempts to supply any specific theory nor to promote any singular methodology as the best one to use for a Critical Discourse Analysis. Fairclough, Mulderrig & Wodak state that CDA always starts with the topic and the choice of methodology depends on what is analysed (2011: 358-359). The fact that CDA is a problem oriented approach makes it unavoidably eclectic and interdisciplinary (Wodak & Meyer 2009: 5). This is also the case with the grammatical approaches applied in the linguistic analysis. However, regardless of the chosen methodology there are certain principles that are generally relevant in linguistic analysis. According to Fairclough (1995: 4), texts are exceptionally sensitive to social processes and therefore they are invaluable material if one wants to study social relations. As discourse constructs and constitutes the world, the manner in which the world is represented in the text reveals an abundance of things about the author, even when this is not intended. Instead of concentrating simply on the content, one must pay attention to “the texture of texts, their form and or-

ganization" (Fairclough 1995: 4). The textural properties are the ones that indicate the implicit content of texts, the ideologies that are behind it. According to Fairclough, mere analysis of the content is an incomplete analysis. What is left unsaid in the text can also be just as significant as the presence of text (1995: 4-6).

As the interpretation of discourse for its part shapes social reality (Fairclough 2010: 132), the interpretative aspect needs to be taken into account in this analysis as well. A Critical Discourse Analysis is subjective in nature and therefore the analysis of the data will also reflect my subjective point of view. The choice of CDA as the approach and the category for gender dysphoria in the DSM-5 as the data already indicate my position as a researcher, but I will explicate it more thoroughly here. CDA has been chosen as the approach as I view the pathologising of gender identity as an unfair repression of a minority (transgender individuals) by a dominant social group (psychiatrists as a medical authority). This study aims to give concrete evidence of how this power imbalance between the transgender individuals and the psychiatrists behind the manual is reflected in the data. This is done by revealing the underlying ideologies in how the individual are represented in the data through a linguistic analysis. However, while my subjective point of view has guided me to study this issue, the analytical methods I have chosen to employ are closely grounded in grammar. Thus the results presented in this analysis are produced by well-established methods of linguistic analysis that will be introduced in section 3.4. Therefore, while my point of view in regard to the social issue may be subjective, my argumentation will be supported by concrete evidence.

3.1.4 Criticism towards Critical Discourse Analysis

The eclectic and interdisciplinary nature of CDA discussed above has also been at the receiving end of criticism (Wodak & Meyer 2009: 3). The variety of the applications of CDA has also produced a similar variety of definitions of key terms such as power and ideology, which has caused confusion (ibid.: 5). Widdowson (2004), however, focuses his criticism on the relationship between text and meaning, which is a fundamental aspect of both Systemic Functional Grammar (introduced in section 3.4) and Fairclough's three level model of discourse analysis. Widdowson argues that the relationship between meaning and text as a linguistic object is not as straightforward as it is understood in CDA and Systemic Functional Grammar. This misunderstanding, accord-

ing to Widdowson, is in the assumption that the grammar of a text encodes social meanings and those encoded meanings can then be analysed from the perspective of social injustice (2004: 19-20). Widdowson argues that such assumptions on meaning cannot be drawn from linguistic analysis alone: linguistic analysis of a text necessarily isolates it from the context of its production, and thus the link between text and social meaning is severed (ibid.). He continues that meanings are not encoded in the grammar of the text, but are in fact read into the text, and thus critical discourse analysts confuse analysis with interpretation (ibid.: 96).

While I recognise that the connection between text, analysis and social meaning is far from simple (Fairclough [1992] 2002: 75 & 2010: 9), I nevertheless argue that combined with suitable and thorough methods of linguistic analysis, CDA and Fairclough's framework are good tools for analysing both text, discourse and the social practices they reflect. This is true especially in regard to the data of this analysis. The DSM-5 and the diagnostic category of gender dysphoria are texts that serve a practical purpose. The guidelines and criteria in the text are interpreted by psychiatrists, who then apply their interpretation of them when they diagnose an individual with gender dysphoria. Thus the link between the text and sociocultural practice is very concrete in this data. I will briefly return to Widdowson's critique of Systemic Functional Grammar in section 3.4, but next I will focus on the features of medical discourse

3.2 Medical Discourse

In this section I will first briefly introduce medical discourse as a genre, give some examples on the trends in medical discourse analysis, then turn to the features of medical discourse that are relevant to this study, and finally discuss some findings that have been made in previous analyses on the edition of DSM that preceded DSM-5. According to Wilce (2009), since the 1960's, medical discourse has been studied from two different perspectives: the microanalytic and macroanalytic (2009: 200). The latter perspective has been much inspired by the work of Michel Foucault (ibid.), whose theories on mental illness as a socially constructed phenomenon I will elaborate on in section 3.3.1. Wilce laments that the majority of the research on medical discourse focuses on biomedical doctor/patient interaction and continues that this narrow focus

leaves much of the social and ideological aspect of medical discourse unanalysed, even though medical discourse can be used to maintain hegemonic ideologies (2009: 201, 202). In this study I will argue that the DSM-5 maintains a binary gender ideology by representing gender variance as a mental disorder.

The microanalytic approach to medical discourse encompasses the Conversation Analysis (CA) of doctor/patient encounters. Bowles (2006) credits much of the emphasis on oral discourse in medical discourse analysis to the popularity of CA as a research method (2006: 44). CA can be used to study the power division between patients and practitioners and for example Ainsworth-Vaughn (1992) has analysed how this is reflected in topic transitions during medical interviews. The analysis of written medical discourse includes analyses of research articles, leaflets and medical textbooks, which have been analysed with methods such as corpus analysis (Ferguson 2001), narrative analysis (Davis 2008), and Systemic Functional Grammar, the origin of the method applied in this thesis (Macdonald 2002). Linguistic analyses of medical discourse have revealed features that are characteristic to medical discourse. As the data of this study is a medical text, I will introduce the features that are relevant below.

3.2.1 Relevant Features of Medical Discourse

The data of this thesis represents the field of psychiatric medicine. As stated by Wilce (2009) above, medical discourse analysis leans towards biomedicine, as do the studies discussed below. Nevertheless, many of the linguistic features identified by the authors are similar to what I have observed in this particular data, even though biomedicine concentrates on physical symptoms in particular parts of the body and the DSM-5 category of gender dysphoria is behaviourally oriented (see section 5. Analysis). One of the notable features is presented by Fleischmann in her essay published in the Journal of Medical Humanities (1999: 5). Fleischmann discusses illness in general as a linguistic construct and the language with which being ill is expressed. She observes that an individual with an illness can be either “a suffering individual, possessor of a disease object, or experiencer of a state of ill health” and continues that cultures create different connections between individuals and disease and that these differences are language

related (ibid: 8). The idea of mental illness as a separate entity is observed by Crowe (2000) and the concept of possessing as illness will be addressed in the analysis.

Adams Smith (1984) studied what she coined "author's comments" in medical journal articles, which refers to the way the authors insert personal commentary in their texts. She found out that the authors use personal commentary mostly to assess the probability of their statements (in other words, to alter the degree of modal responsibility) and that this was chiefly done with the help of modal auxiliaries, of which 'may' was the most common (1984: 33). Adverbs (or Mood Adjuncts) were also used for this purpose. These research articles also included evaluation, which was done via a variety of *attitudinal markers*, various ways of expressing evaluation, including the use between active vs. passive voice, the reporting verbs the author has chosen and the quality of other lexical items (ibid: 34). Rundblad (2007) studied different ways of achieving *impersonalisation* (the obscuring of the agent, usually the author) in medical research articles and notes that using the passive voice is a well-known method for this in medical discourse and scientific discourse in general (2007: 253). Another feature common to medical discourse is *nominalisation*, which is the expression of a process with the help of a noun instead of a verb (Gao 2012: 87). 'Pathologisation', frequently used in this study as well, is an example of a nominalized verb.

MacDonald (2002) has studied the *recontextualisation* of medical discourse in three genres: research articles, doctor/patient interviews and medical textbooks. Recontextualisation refers to how the features of medical texts change when they are moved from one context to another (ibid: 452). Of these three genres, the DSM manuals are closest to the textbooks, as it includes instructions for clinicians on how to perform their profession and it also includes a smaller amount of rhetorical features than the other genres, which is typical of the textbook genre (2002: 458). However, there are differences as well, as medical textbooks are chiefly written in the past tense (2002: 461), while the data for this study is mostly written in the present tense. MacDonald argues that the lack of overt rhetorical devices indicates that the content of the text is taken as self-evident and thus the validity of what is stated in the text is not questioned. Consequently, what is being said in the other genres turns into the common

truth when it is recontextualised in the textbook genre (2002: 458). The claim of validity that is implied in the DSM-5 will be discussed later in this study.

MacDonald also examined the author's comments in the three genres under study, referring to Adams Smith (1984). He found that the authors of medical textbooks use evaluative (or attitudinal) markers with approximately the same frequency as in research articles, which is around every five lines (2002: 460). Thus, while medical textbooks are quite devoid of rhetorical measures and consequently different from other genres of medical discourse, this does not necessarily affect the amount of evaluation in the texts. MacDonald studied the division of different process types in medical textbooks and found that two process types dominated over other: the authors made the most use of relational processes in the texts (ca. 45%) and almost the same amount of material processes (ca. 40%). He argues that the choice of these process types adds to the image of the unchallenged validity of medical textbooks (2002: 463). Systemic Functional Grammar and the significance of different process types will be introduced in section 3.4 that includes the theory related to the methods of this study. Other researchers, who have studied medical discourse with the help of Systemic Functional Grammar include Gao (2012) and Fryer (2012), who finds the method very applicable for medical discourse analysis (2012: 32).

3.2.2 Previous Analyses on the Diagnostic and Statistical Manual of Mental Disorders

In this section I will introduce the critical discourse analysis by Crowe (2000) on the previous version of the DSM manual, DSM-IV and the discussion by Butler (2004) regarding the category of Gender Identity Disorder in the same edition. However, I will begin by Wilce's observation on the textual quality of the DSM manuals in general, which moves along the same path as MacDonald's argument of the validity claim inherent in the language of the textbook genre. Wilce (2009) talks about the "denotational textuality" (term by Silverstein 2004) or quotability of the DSM manuals, which is created by patterns of denotative meaning in the text. These patterns make the text memorable, which in turn enables it to circulate and thus strengthens its authority. The patterns refer to the way the manual and the disorders are organised to form a coherent whole. This coherence is then reproduced in psychiatric conferences, as the

DSM sets the boundaries of argumentation (Wilce 2009: 208). This can be connected to MacDonald's arguments on the power of the recontextualisation of knowledge, as what is produced by research is validated in the textbook, which is then validated again every time the textbook is used as the basis for defining the current knowledge.

Crowe (2000) has performed a critical discourse analysis on DSM-IV, the previous version of the manual. She notes the power imbalance between mental health professionals and patients and the manual's role in constructing the understanding of mental disorders as well as normality in the society (2001: 70). The analysis itself is performed from the Foucaultian perspective of language as social practice, but otherwise no specific theoretical framework is employed in regard to methodology. The data covers the whole manual and Crowe approaches it from a thematic starting point with the object of finding out how mental disorder is constructed in the data and how the criteria for specific disorders are chosen. She divides the diagnostic criteria into four sections on the basis of what the criteria expect from the individual in relation to functioning in the society. The four categories are productivity, unitariness (having a consistent identity that can be distinguished from others), rationality and moderation (Crowe 2000: 72). She states that the symptoms for mental disorders in the manual originate from problems regarding these four societal expectations. The study does not clarify how these categories are divided between specific disorders nor is it specified from which chapters the examples are taken from, and thus the results constitute a very general picture of the manual's role in constructing mental disorder.

Mental disorder itself is, according to Crowe (2000), constructed with the help of dividing normal and abnormal behaviour from a social point of view. She also defines the fundamental basis for a mental disorder to be that there is a syndrome occurring within an individual and that the syndrome originates form a fault in the said individual. The possibility of external events and environmental causes are thus excused from responsibility (Crowe 2000: 71-72). This aetiology problem in regard to mental disorders has been recognised also by researchers in the field of psychiatry (see, for example, the critical study by Bower (2001) on the category in gender identity disorder in children in DSM-IV). Finally, Crowe talks about the role of distress as a tool in diagnosing a mental disorder. In the manual, distress is regarded to originate from the mental

disorder and the subjective experience of distress is used to identify a disorder (2000: 71-72). Central topics in this study are the origin of distress and mental disorder as a separate entity that performs actions within an individual.

Butler (2004), to whom I will refer in more detail in section 3.3.2, discusses the language used in the category of gender identity disorder in DSM-IV. In regard to methodology, Butler's analysis is not a linguistic analysis per se, but more of an examination of the causal relations between the different aspects of the diagnosis. She argues that in listing the criteria for diagnosing gender identity disorder, the authors form a very strict image of gender norms. The authors rely on these norms in attempting to form guidelines to identifying a person with gender identity disorder while at the same time they do not explain how these norms are related to gender identity. Consequently the authors unintentionally confirm gender identity as being a cultural category that each individual personally constructs (Butler 2004: 95-98). This ties to the results of Crowe's (2000) analysis of the construction of mental disorders in general in DSM-IV. I will return to Butler's discussion of the language in DSM-IV category in my own discussion of the results of this study. Butler's theories on gender and society are introduced in the following section, along with the relevant social theories by Foucault.

3.3 Social Theories on Psychiatry and Gender

In this section I will introduce theories relating to society, gender and mental illness. This section is divided into two parts. First I will focus on the relevant social theories by Michel Foucault, most of which can be found in his works *The History of Sexuality Volume I: An Introduction* ([1978] 1990) and *The Archaeology of Knowledge* ([1972] 2009). These theories concern on one hand the birth of psychiatry as a discipline and thus the birth of mental illness and on the other hand the construction of "illegitimate sexualities" ([1978] 1990: 4) as categories of mental illness. Judith Butler uses Foucault's ideas as a basis in her theory of the performativity of sexual and gender identities, which she describes in *Undoing gender* (2004). This theory will be discussed in connection to the results of this study in the Discussion, where Foucault's work will also be taken into account. The social aspect of Foucault's theories is intertwined with his view of discourse as a constructive force.

3.3.1 Michel Foucault and Scientific Knowledge

In *The Archaeology of Knowledge*, Foucault ([1972] 2009) summarises the creation of modern psychiatric discipline and its spread through relations to other social institutions and concepts. According to Foucault (ibid.: 199), psychiatry had no discipline prior to its formation where its scientific force and central concepts were derived from. Instead, psychiatry gained strength as a discipline through relations to morality, hospitalisation, work and social exclusion; in other words, psychiatry permeated through other areas of social life. This happened through discursive formation of relations that involved many separate discourses other than scientific, including legal discourse, politics and literature. Through these discourses psychiatry started operating in the daily life of people and spread well beyond the boundaries of its own discipline (Foucault [1972] 2009: 198). Foucault claims that psychopathology is a pseudoscience that is purely based on discursive formation but holds its position as a scientific authority by being represented as scientific knowledge (ibid. 198, 203). The inclusion of gender dysphoria in the DSM system has been criticised for lacking empirical evidence (Bower 2001, Hill *et al* 2006) and this can be argued to be a case of validating a psychiatric diagnosis by merely presenting it as scientific knowledge.

Foucault ties together the concepts of knowledge and power, in particular the power over controlling human existence. He calls this *biopower*, the power of knowledge used to reconstruct human life ([1978] 1990: 139). This power is used to control the body with the object of controlling aspects of life, in other words, controlling “the body as a machine”, which is tied to productiveness, and also the “bio-politics of the population”, concerning biological processes such as birth and maintaining health from the perspective of population control (ibid.). Thus human biology was connected to political life and from this connection the moralities concerning body and biology were born (ibid.: 140). The result of this “technology of power centered on life” is a society that imposes normalities on its subjects (Ibid.: 144). This normalisation is today reflected in the idea of binary gender as the norm, which also reflects a close relationship to biological categories. These categories are imposed by authorities such as psychiatrists, but are also inherent in all social life; namely, they are considered normal.

During his discussion of sexual identities ([1978] 1990: 10-11), Foucault introduces his "repressive hypothesis" and theorises that repression is the common denominator between power, knowledge, and sexuality. This repression is used by authorities in various ways to control both people's sexual behaviour and the discourse on sexuality. The authorities that Foucault refers to are the moral gatekeepers, political institutions and economic powers of different historical times. This connection can also be made between power, knowledge and gender. Variant gender identities are repressed by psychopathological discourse, which represents scientific "knowledge" and also holds the keys to gender corrective treatment. Here another of Foucault's ideas is relevant, namely the "incitement to discourse" ([1978] 1990: 34). By this Foucault refers to repression through controlling the flow of discourse and encouraging the desired forms of discourse. In regard to sexuality, Foucault uses the example of Christian confession (ibid.: 35): all sexual activity and thought had to be verbalised and thus the thoughts were controlled by the authorities. This can be compared to the way that one gets the keys to gender corrective treatment: gender identity needs to be expressed and verbalised to a psychiatric authority, who in turn decides whether one qualifies for treatment. The qualifications (the diagnostic criteria for gender dysphoria) are the gate and the psychiatrist is the gatekeeper (Lev 2006: 54). All of this involves discourse and is connected to networks of power.

Foucault sees all social subjects as products of networks of power, which constantly affect reality in ways that cannot be predetermined ([1978] 1990: 101, 96). Thus identity categories are the products of these networks as well (Jagose [1996] 2008: 82). However, Foucault does not view power as inherently negative, but also as a source of resistance. The same networks of power that set the limits to possible identities cannot exist without resistant power ([1978] 1990: 101). He continues that there are never only two sides of power in discourse, but several discourses that work simultaneously and for different purposes. What makes a difference within the networks of power is the strategy that is employed by these discourses towards achieving their goals, be it resistance or something else (ibid.: 101-102). CDA can be viewed as this type of a discursive strategy with the goal of resisting domination. The idea of resistance in identity politics is also one of the key concepts of queer theory (Jagose [1996]

2008: 82). In the following section I will introduce theories of Judith Butler, one of the key developers of queer theory, and discuss them with regard to gender identities, while recognising that her ideas concern both identities of sexuality and gender.

3.3.2 Judith Butler and Performative Gender Identities

Judith Butler, a key developer of queer theory (Jagose [1996] 2008: 83), builds on Foucault's ideas in her theory of *performativity*. With performativity Butler means, in rough summary, that all sexuality and gender roles are performed in relation to social expectations of normal (1993 [2011]: xii). Butler discusses the reciprocal relationship between human beings as individuals and as parts of society and states that neither can exist separate from the other:

> We are not our own persons, our "personhood" is built out of social norms. And, paradoxically, only these social norms enable us to realize ourselves as individual persons.
>
> Butler (2004: 2)

Such is subsequently the case with people as gendered and sexual beings. Butler (2004) argues that gender categories are fully social constructions and not representative of any sort of inner natural states. The notion of natural gender itself is constructed through repetitive performances of gender in our everyday lives (2004: 48). This is a contested idea (Boucher 2006, Nelson 1999), but while I recognise that the theory of performativity may have its limitations, I find it applicable in the context of gender dysphoria and behaviourally based symptoms. I will return to this topic in the Discussion. Nevertheless, the terms *masculine* and *feminine* are an especially strong example of cultural constructions: they are bound by space and time as "their meanings change radically depending upon geopolitical boundaries and cultural constraints on who is imagining whom, and for what purpose" (Butler 2004: 10). The notion of representing one's gender in a stereotypical way is a key ingredient in the diagnostic category of gender dysphoria in DSM-5, as I will show in the analysis.

The idea of gender and sexuality as purely social creations has significant consequences to the autonomy of our individual identities. Butler claims that we have no true autonomy over our public and private gender, sexuality, body or identity and generalises that "the terms by which we are recognized as human are socially articulated and changeable" (Butler 2004: 2). Regardless of our position in the society, we all in-

herently require recognition as human beings and social norms result in some of us being recognised as less than human. Butler argues that this is the ground for potential power abuse, as the recognition by those around us is necessary for viable life.

> "But if the schemes of recognition that are available to us are those that "undo" the person by conferring recognition, or "undo" the person by withholding recognition, then recognition becomes a site of power by which the human is differently produced".
>
> Butler (2004:2)

By "undoing" Butler refers to the fact that being acknowledged as an equal human being validates our existence and not being acknowledged can make existence unbearable. Society thus has at the very least a transformative effect on all humans, but the effect can also be destructive if the human is not looked upon as socially acceptable. Butler refers to Foucault with what she calls "regulative discourses" which create socially acceptable expressions of gender (2004: 41). Diagnosing mental illness is one way to regulate social norms and deny recognition as a fully capable human being.

The diagnostic category of gender dysphoria enables this lack of recognition. Through this category, gender identities that do not conform to what is generally accepted as normal is reduced to mental illness and left outside of recognition. This is based on a sense normalcy that is related to the physical body and it imposes a narrow view on gender as made natural only by physical attributes, explained by Butler below.

> "A concurrent operation of gender norms can be seen in the DSM-IV's Gender Identity Disorder diagnosis. This diagnosis that has, for the most part, taken over the role of monitoring signs of incipient homosexuality in children assumes that "gender dysphoria" is a psychological disorder simply because someone of a given gender manifests attributes of another gender or a desire to live as another gender. This imposes a model of coherent gendered life that demeans the complex ways in which gendered lives are crafted and lived."
>
> (Butler 2004: 5)

The issue is deeply paradoxical as one must be diagnosed with gender dysphoria to be able to start the treatment to correct one's biological gender. As Butler states above, the pathologisation of the transgender identity must therefore be endured to realise the changes that may be necessary for viable life. Butler ties this to the larger scheme of interacting with social norms and self-determination. The norms are created before and during we make our individual choices. Therefore our choices, such as choosing our bodies, are dependent on social conditions. We rely on social institutions to sup-

port our individual choices but, conversely, we need to change those institutions to allow us the freedom of self-determination (2004: 7).

The Foucaultian perspective on power and resistance allows for the changes in the socially acceptable norms. Butler describes the possibilities of change as maintaining a "critical and transformative relation" to the norms that constitute us and on which we are dependent (2004: 3). Norms are dependent on repetition if they are to continue to remain dominant and therefore acquiring recognition for an identity creates a less limited norm for a human being when it is reproduced (2004: 3-4). We reproduce gender norms by performing ourselves within societal constraints that we, paradoxically, create ourselves. By stretching those constraints we make room for performing our gender identities in more flexible conditions, thus transforming social reality (ibid.). Psychiatric discourse and the DSM system lay down powerful constraints by pathologising certain experiences of gender. As a consequence, selected understandings of gender are imposed on us. These constraints can be stretched as well by questioning the sociocultural practice of pathologising gender identity.

The DSM is extremely influential as the voice of medical authority. The manual enforces polarising categories such as natural/unnatural, healthy/sick and functional/dysfunctional that reflect on those who are diagnosed by psychiatrists following the manual's guidelines. I argue that categorising different gender identities as mental disorders is based on culturally constructed ideals of gender and that it can be considered power abuse. Psychiatrists around the world hold the keys to gender reassignment treatments, as the diagnosis for gender dysphoria is required of a person who wishes to have insurance coverage and undergo treatment. These psychiatrists use the manual to make the diagnosis and therefore reinforce all the notions of normality regarding gender every time the diagnosis is made.

The paradox is that the diagnosis is essential to starting gender reassignment treatment. With the system being as it is, some sort of diagnostic guidelines are required to enable the psychiatrists make the necessary diagnosis. However, as at this time a diagnostic category for those who wish to start reassignment treatment is needed, I argue that this category should be written as neutrally as possible and with intense scrutiny

as to what the consequences of such a category are. Gender dysphoria as a diagnostic category or, as Foucault argues ([1972] 2009), all categories of mental disorders are representative of the views of the authors. Therefore it is necessary to analyse the discourse used in DSM-5 and reveal all possible biases. In this thesis, a transitivity analysis is performed on text included in the diagnostic category of Gender Dysphoria in DSM-5. The analysis of the text can be viewed as a part of the resistant discourses as discussed by Foucault ([1978] 1990: 101-102) and as an attempt to stretch the societal constraints laid the pathologisation of gender identity (Butler 2004). The sociocultural practice of using the manual for both diagnosing gender dysphoria and enabling gender reassignment treatment cannot be stopped by analysis alone, but if enough voices raise the resistant discourse, eventually the pressure may change the system.

Before moving on to the theory underlying the methods of this analysis, it must be stated that medical issues are necessarily beyond the scope of this thesis and therefore I can discuss the justification for the diagnostic categories themselves only from a non-medical perspective. As has been argued extensively above, the medical and the discursive are at the very least overlapping concepts and, in the case of psychopathology, essentially the same. Nevertheless, both my lack of background in medicine as well as my position as a researcher using CDA as an approach needs to be taken into account. While it is already clear that the existence of the diagnostic categories are based on social norms, what has not yet been studied in the recent and revised DSM-5 is how much these norms are reflected in the language. The theoretical framework for the linguistic analysis, which is Systemic Functional Grammar, is introduced below.

3.4 Systemic Functional Grammar

In *An Introduction to Functional Grammar*, Halliday and Matthiessen lay out the "architecture of language" from its basic functions to the grammatical structures with which language is realised (2004). Systemic Functional Grammar (SFG) is a comprehensive description of the language system, covering everything from the fundamental reasons for the existence of language to the practical realisations of language either in spoken or written form, down to the last phoneme and morpheme. In this section I will briefly introduce the principles of Systemic Functional Grammar, the basic functions, or *meta-*

functions of language as formulated by Halliday, and I will then turn to the structural dimensions of language that are relevant to this thesis. When introducing the more specific systems in SFG, I will refer to both Halliday as the creator of SFG (Halliday & Matthiessen 2004) and to Thompson (2004). I will follow some of Thompson's ideas in the analysis, especially with regard to labelling material processes and performing ergativity analysis. But first I will turn to the main features of SFG.

According to Halliday, there are two main perspectives for studying language: one is to view text (in this case any instance of language use) as an object and the other is to view it as an instrument. *Systemic Functional Grammar* takes the latter approach and regards language as a means of communication, placing function over structure and focusing on how language is used to create meaning. Systemic Functional Grammar is a systematic and comprehensive way of describing the meaning-making possibilities in the English language (Halliday & Matthiessen 2004: 3-4). How meaning is constructed depends on the choices that we make when we use language, on how we choose from the meaning making resources that language offers (ibid.: 10, 19). The choices we make *represent* our experience of reality. In Systemic Functional Grammar, language is understood to have the primary role as the constructor of reality. As Krizsán formulates it, "people build mental pictures of reality through language (2011: 10)". As discourse is a social phenomenon, it does not only construct our own individual representations of reality, but those of everyone within its sphere of effect, which in turn is the way ideologies are reproduced (Krizsán 2011: 8). When we create meaning through language we consequently create reality. This relationship was also recognised by Foucault, as discussed above in section 3.1.2. In Systemic Functional Grammar (from here on SFG), representing reality is related to the *ideational metafunction*, which will be introduced below along with the two other metafunctions.

According to Systemic Functional Grammar, meaning in language is organised under three metafunctions, which are the highest ranking dimensions of language as a meaning-making system (Halliday & Matthiessen 2004: 20). Each metafunction is concerned with a different dimension of meaning creation and each metafunction embodies different grammatical systems. The *interpersonal metafunction* relates to language as a means of exchanging meanings. According to Halliday, all exchanges are related to two

types of speech roles: giving and demanding either goods and services or information (ibid.: 107). These meanings are expressed in the Mood element of the clause (ibid.: 111), which in turn includes the systems of polarity and modality, which will be introduced below. The *textual metafunction* is concerned with how text is constructed. According to Halliday and Matthiessen, it can be seen as a facilitating metafunction to the other two, as the textual metafunction deals with the cohesion, continuity and organisation of the message, features that the two other metafunctions depend on (ibid.: 30). However, for this thesis, the most relevant metafunction is the ideational metafunction.

The ideational metafunction is related to how we experience the world around us and how those experiences are reflected in language, as Halliday and Matthiessen summarise below. They talk about language as a "theory of human experience", a notion that can be connected to the idea of language as representation discussed above.

> "In other words, language provides a theory of human experience, and certain of the resources of the lexicogrammar of every language are dedicated to that function. We call it the ideational metafunction, and distinguish it into two components, the experiential and the logical."
>
> (Halliday & Matthiessen 2004: 29)

As explained here, the ideational metafunction is divided into the *experiential* and the *logical* metafunctions, of which the experiential deals with representing experiences and the logical with how we connect different messages (Thompson 2004: 39). In this thesis the focus is on the experiential metafunction and especially on the underlying grammatical system of *transitivity*.

3.4.1 Transitivity and Process Types

Transitivity is the main grammatical system in Systemic Functional Grammar that is employed in this analysis. Transitivity is a system concerned with experiential meaning, that is, with how the world and what is going on around us is represented in the language. My objective in this thesis is to find out how gender dysphoria and the individuals diagnosed with gender dysphoria are represented in the DSM-5. Transitivity focuses on verbs (or *processes*) and transitivity analysis is the analysis of processes and the related participants. In DSM-5, the symptoms of gender dysphoria are described through action, behaviour, expressions of feelings by an individual; that is, the symp-

toms are presented as performances of different kinds of processes. Therefore transitivity analysis is an ideal choice of method for this thesis, as the choices that the authors make regarding the processes and the individuals form the picture of how they are represented. Below I will introduce transitivity as a system and analytic method in more detail.

In simplified terms, transitivity in Systemic Functional Grammar (as opposed generative grammar where it refers to whether a verb has an object or not) is a way of finding out "who did what to whom" (Thompson 2004: 86). These relationships are reflected in the grammar of a *clause*, the "central processing unit" in SFG (Halliday and Matthiessen 2004: 10). Halliday and Matthiessen summarise the system of transitivity and the components involved below:

> "Our most powerful impression of experience is that it consists of a flow of events, or 'goings-on'. This flow of events is chunked into quanta of change by the grammar of the clause: each quantum of change is modelled as a **figure** – a figure of happening, doing, sensing, saying, being or having. All figures consist of a process unfolding through time and of participants being directly involved in this process in some way; and in addition there may be circumstances of time, space, cause, manner or one of a few other types. The circumstances are not directly involved in the process; rather they are attendant on it. All such figures are sorted out in the grammar of the clause."
>
> (Halliday & Matthiessen 2004: 170)

In other words, there are three components in a clause that can be studied with the help of transitivity: processes*, participants* and *circumstances*. Processes are the actions taking place as expressed with a verbal group and *participants* are those somehow involved in the action (Thompson 2004: 87). The type of participants a clause can have is determined by the process type and therefore transitivity is strongly focused on the verbal groups in the clauses (ibid.: 89). Circumstantial elements will be introduced in a separate section.

In the table below I have presented some examples of each of the process types and their participants with examples taken from the data. The different types of processes include material processes that refer to happenings in the world around us, mental processes that refer to our inner experiences, and relational processes which we use to make links between different parts of experience, to classify and identify. In addition to these main process types there are behavioural processes, which "represent the

outer manifestations of inner workings" (Halliday & Matthiessen 2004: 171) (e.g. 'watching' instead of 'seeing'), verbal processes, which include processes of exchanging information, and existential processes, which refer to things simply being (e.g. 'There is…') (ibid.: 170-171).

Participant	**Process**	**Participant**
1. They	avoid	rough-and-tumble play and competitive sports
Actor	**Process: material**	**Goal**
2. Others	do not recall	any signs of childhood gender dysphoria
Senser	**Process: mental**	**Phenomenon**
3. The majority of these individuals	are	gynephilic or sexually attracted to other posttransition natal males with late-onset gender dysphoria
Identified	**Process: relational, identifying**	**Identifier**
4. Prepubertal natal girls with gender dysphoria	may express	the wish to be a boy
Sayer	**Process: verbal**	**Verbiage**
5. Adolescents and adults with late-onset gender dysphoria	frequently engage	in transvestic behavior
Behaver	**Process: behavioural**	**Behaviour**
6.	there are	two broad trajectories for development of gender dysphoria: early onset and late onset
	Process: existential	**Existent**

Table 1. Participants and Process Types in Transitivity Analysis with Examples

All the examples in the table have two participants and a process. The first participant in a material process (Example 1 in the table) is the Actor, the doer of the process. The second participant is the Goal, the one the action is done to. In similar vein, the first participants such as the Sayer in a verbal process (Example 4) or the Senser in mental processes (Example 2) are the ones performing the process, while the second participants Verbiage and Phenomenon are what is respectively expressed or sensed by the first participant. In behavioural processes, the Behaver performs a process which is

specified in the Behaviour, which is not a real participant in the sense as the other second participants above (Thompson 2004: 104). Behavioural processes are a rather ambiguous category that overlaps with material and mental processes (ibid.) and these two process types narrow the presence of behavioural processes in the analysis. Existential processes have only one participant, as they are solely used to denote the existence of something, as in Example 6.

Relational processes, however, are used to identify and characterise the participants involved in the process (Halliday & Matthiessen 2004: 210). The subtypes of relational processes are a more complex system compared to the other processes, but for this analysis, the relevant types of relational processes are the *attributive*, *identifying* and *possessive* ones. Attributive relational processes are used to characterise: the first participant is called the Carrier, who 'carries' the Attribute, which is the second participant in the process (Thompson 2004: 96). The identifying relational processes are, just as transparently, used to identify typically the first participant (the Identified) with the second participant (the Identifier) as in example 3 (Thompson 2004: 118-120). The possessive relational processes are used to indicate possession with the participants Carrier: possessor and Attribute: possessed. As the labels imply, this type of possessive relational process is a subtype of the attributive relational process, with the Carrier: possessor being in possession of the Attribute: possessed (Halliday & Matthiessen 2004: 245). The possessive relational processes can be a subtype of both attributive and relational processes (Halliday & Matthiessen 2004: 246), but in this study, the identifying attributive processes are of little relevance.

Identifying relational processes are used to label the first participant of the process (Thompson 2004: 118) and the labelling done with the help of identifying relational processes in the DSM-5 is an important aspect in analysing the ideologies reflected in the data. Another type of identifying relational clause could also be found in the data and that is the Token/Value structure. This structure is used to identify a specific example of a general category, or vice versa and these choices of what is presented as specific in relation to general can be revealing of the authors' ideological beliefs (ibid.: 98). Choices in general made by the authors of the data are the crux of this study; tran-

sitivity analysis is concerned with the choices that the authors make when they represent their experiences in language.

As transitivity analysis is connected to verbs, the method focuses on the choices that the author makes in relation to processes and participants in the clause. For example, in the following extract from the data, the author has decided to present the 'symptoms' as the doer of the action instead of the child, which conveys a different meaning had the choice been different.

(1) For some preschool-age children **[Circumstance: Matter]**, both pervasive cross-gender behaviors and the expressed desire to be the other gender **[Carrier]** may **[Modalization: low, implicit, subjective]** be **[Process: relational, attributive]** present **[Attribute]**, or, more rarely **[Circumstance: Extent, frequency]**, labeling oneself as a member of the other gender **[Actor]** may **[Modalization: low, implicit, subjective]** occur **[Process: material, transformative, involuntary]**.

In Example 1, there is first an attributive relational clause and then a material clause. In both clauses, the symptoms are the first participants in the processes: instead of the children behaving in a certain manner, the symptoms "are present" and "occur" for them. Therefore the children are not represented as responsible for their own actions. The position of the first participant places the symptoms in power over the processes and the meaning conveyed would have been completely different had the authors chosen to place the children as the performers of the process. These differences, among others, will be pointed out with the help of transitivity analysis. However, transitivity can be misleading in regard to some clauses and therefore another perspective on the relationship between processes and participants will be employed in parts of the analysis. This perspective is called *ergativity*.

3.4.2 Ergativity

The ergative model is a system within transitivity that is also concerned with processes and participants, but offers a different angle to the transitive model (Halliday & Matthiessen 2004: 283). Thompson (2004) summarises that transitivity focuses on who does the process and to whom, while ergativity prioritises whether the action happens on its own or is caused to happen (Thompson 2004: 135). In a material clause analysed with the transitive model the participants are called Actor and Goal, but within the

ergative model they are called Agent and Medium. The Agent is the one causing the process and the Medium can be viewed as the "host" of the process (Thompson 2004: 136). In an *ergative* clause, the Agent is the "external cause" of the process that is realised through the Medium (Halliday & Matthiessen 2004: 285). In a *non-ergative* clause, the process is not caused externally, there is no Agent and the Medium takes the position of the first participant (Thompson 2004: 136). The difference is in the causation.

The difference between clauses analysed with the transitive and ergative model can be seen in the second clause in Example 1. Below, the clause is first analysed with the transitive and then the ergative model. The transitive model shows "labeling oneself as a member of the other gender" as the Actor of the process, but the ergative model labels it as the Medium. Thus the process of "occurring" is not caused by the Actor/Medium, but simply happens.

(2) labeling oneself as a member of the other gender **[Actor]** may **[Modalization: low, implicit, subjective]** occur **[Process: material, transformative, involuntary]**

(3) labeling oneself as a member of the other gender **[Medium]** may **[Modalization: low, implicit, subjective]** occur **[Process: material]**

The transitivity analysis leaves these differences in causation unanalysed, but these differences are significant especially in relation to the role of gender dysphoria and the symptoms listed in the data. Thus ergativity analysis is employed as well, however only in relevant places. According to Halliday and Matthiessen (2004: 334), the ergative perspective can be used to analyse all clauses with any process types, but Thompson (2004: 137) argues that, in practice, the most worthwhile application of ergativity analysis is on material processes. As I find that in the data, the role of causation is significant when it comes to gender dysphoria and symptoms being represented as the doers of different actions, I will follow Thompson's example in the analysis. However, two other aspects of SFG need to be taken into account in the analysis. The first one is also transitivity related, namely the circumstantial elements that appear in clauses along with processes and participants.

3.4.3 Circumstantial Elements

Halliday and Matthiessen (2004) summarise circumstantial elements to be the circumstances that are connected to the process. While circumstantial elements are not

obligatory, they give more detail to the clause, specifying, for example, time, place, cause, or the manner with which the process is performed. Circumstantial elements are usually expressed with an adverbial group or a prepositional phrase (Halliday & Matthiessen 2004: 175-176). For example, the beginning of Example 1, "[f]or some preschool-age children", is a circumstance of Matter, specifying who the following clause is concerned with. Halliday and Matthiessen (2004: 262-263) list nine categories of circumstantial elements with their respective subcategories, but the circumstances that are most relevant to this thesis are those of Location and Extent.

Circumstances of Location can be divided into those specifying place and time, while circumstances of extent can be further categorised to distance, duration and frequency. Of the subcategories of Location, place is of importance here. The individuals portrayed in the data often appear as the Location in which a process takes place. Other circumstantial elements that the individuals appear in include Matter, as in the example above, and subcategory of Angle: viewpoint. These categories are important in analysing the role of the individual in the processes within the data. Of circumstances of Extent, the subcategory further discussed in the analysis is that of frequency, which specifies how often a process is thought to take occur. This category is especially relevant to the portrayal of children in the data and closely related to *modalization*, which is a system realised in the Mood structure of the Interpersonal metafunction (Thompson 2004: 45-72) that will be explained more thoroughly below. Modalization is the final aspect of SFG introduced in this section and I will return to the more specific analysis of the circumstantial elements in the Data and Methods section.

3.4.4 Modalization

As mentioned above, modalization is located within the Interpersonal metafunction in the Systemic Functional Grammar. As Widdowson (2004: 26) points out, the way SFG divides language into different systems based on functions makes it hard to apply in the analysis of practical language use. I recognise this criticism and to get a fuller picture of the data, an interpersonal perspective is added to the analysis. The different metafunctions of transitivity and modalization is demonstrated by the fact that modalization is concerned with elements in clauses that the transitivity system completely

disregards (Thompson 2004: 87). Elements in a clause that are irrelevant from a transitivity perspective include the Finite (or auxiliary verb in generative grammar terms) which either expresses the *primary tense* (the tense at the moment of speaking) or *modality* (the likelihood or desirability of what is stated) in a clause (Thompson 2004: 49, 67, Halliday & Matthiessen 2004: 115-116). Modalization is a subtype of modality and it deals with the degree of certainty in a proposal (Halliday & Matthiessen 2004: 147). This degree can be controlled in terms of *probability* (the likelihood of the statement being true) and *usuality* (how frequently the statement is true) (Thompson 2004: 67). Analysing modalization is a way of finding out the degree of commitment behind a statement and also how much responsibility the author is willing to take over the validity of the statement (Thompson 2004: 69). The levels of *modal commitment* and *modal responsibility* in the data affects the strength of the message that the authors wish to send about gender dysphoria and the individuals diagnosed with it; therefore analysing modalization is important.

As the degree of modalization can be controlled in a statement, it is therefore also somewhat gradable. This gradability works only to an extent, but the scales are nevertheless a useful analytic tool (Thompson 2004: 69). Halliday and Matthiessen present a three-ladder grading scale for the *values* of modal commitment: high, median and low (2004: 620). Probability and usuality can be thus graded with these values. Modalization can also be categorised in terms of *orientation*, referring to whether the modalization expressed by the author is *subjective* or *objective* and also whether it is *explicit* or *implicit* (ibid.). The former division refers to whether the author presents a subjective point of view or attempts to objectivise the statement (Thompson 2004: 70). The latter, in turn, refers to whether the point of view of the author is presented in a separate clause from the main statement, which puts it out in the open, or whether the modalization is incorporated within the main statement, thus making it more difficult to trace back to the author (Halliday & Matthiessen 2004: 615). This is related to the level of modal responsibility. I will return to analysing the levels of modal commitment and responsibility in Methods. In the following paragraph I will present some relevant ways in which modalization can be expressed, before moving on to introducing the data.

There are three ways of expressing modalization in a statement: by using a *modal operator*, by using a *modal Adjunct* or by using them both (Halliday & Matthiessen 2004: 147, Thompson 2004: 68). Modal operators are a part of the Finite and include verbs such as 'must', 'will' and 'may', which respectively represent the categories of high, median and low values of modalization (ibid: 116). Modal Adjuncts of probability and usuality (such as 'probably' and 'sometimes') are also used to express modalization (ibid: 147). Of these Adjuncts the important ones here are the ones expressing usuality, which are comparable to the circumstantial elements of Extent: frequency in the transitivity system. Halliday and Matthiessen (2004: 264) draw a line between the interpersonal category denoting usuality as modal assessment and the circumstantial element of frequency as denoting the repetition of a process. While I note this distinction, for the sake of clarity all of the Adjuncts that are analysed in relation to modalization will be labelled as circumstantial elements in the data. I will expand on the specifics of the analysis in Methods, but first I will turn to the data.

4. DATA AND METHODS

In this section I will present the data and the methods used in the analysis. The section on data contains a more detailed description of the diagnostic category of Gender Dysphoria in the DSM-5 that I will analyse in this thesis. In the following section on methods I will explain how the analytical tools introduced above have been applied in practice. The complete analysed data can be found in Appendix I at the end of this thesis. The aim of this analysis is to answer the three research questions presented in the introduction: how are the individuals diagnosed with gender dysphoria represented in the data, how is gender dysphoria is constructed as a mental illness in relation to the individual, and what are the possible implications of the results on the sociocultural practices of diagnosing gender dysphoria and pathologising variant gender identities. In the analysis, the first two research questions overlap one another, as the representation of the individual is affected by the way gender dysphoria is constructed and vice versa. The data and methods have been chosen accordingly.

4.1 Data

The data analysed in this thesis is included in the chapter on gender dysphoria in DSM-5. The reason for choosing this particular manual over other possible ones, namely the ICD (cf. section 2.1), is that DSM-5 is the most recently published manual on diagnosing mental disorders and therefore has the most current information on the topic and diagnostic guidelines produced in the field of psychiatry. Although the credibility of the latest version of the DSM may have suffered from the criticism it has received since before and after publication in May 2013 (Insel 2013, Lane 2013), it does take precedence over the similar manual published by the World Health Organization. The most recent version of this manual, ICD-10, was published in 1994 and is thus severely outdated, which makes DSM-5 the most relevant data for this study. The manual as a whole includes 991 pages and analysing it in its entirety is outside the scope of this thesis. Partly due to this, the data has been narrowed down to one chapter in the manual, the one on gender dysphoria. I will justify the choice of this particular chapter at the end of this section.

The chapter on gender dysphoria is nine pages long and starts with a foreword outlining the relevant terminology. This is followed by twelve sections: Diagnostic Criteria for children and combined ones for adolescents and adults, Specifiers, Diagnostic Features, Associated Features Supporting Diagnosis, Prevalence, Development and Course, Risk and Prognostic Factors, Culture-Related Diagnostic Issues, Diagnostic Markers, Functional Consequences of Gender Dysphoria, Differential Diagnoses and Comorbidity. The chapter ends in two short subcategories called Other Specified Gender Dysphoria and Unspecified Gender Dysphoria. Within these sections, the authors separate different groups of individuals based on age and natal gender (such as children/adolescents/adults, girls/boys, males/females) and the symptoms are often (but not always systematically) described separately for each group. The transitivity analysis of the data starts from the beginning of the running text, which is at the beginning of Diagnostic Features. The previous sections, especially Diagnostic Criteria, will be referred to in the analysis and discussion, but as they do not include full clauses, analysing them through transitivity would not be fruitful. The two final subcategories are similarly constructed and thus left out as well. The more specific ways the data has

been narrowed down involve the methods of this analysis and will thus be presented in the following section.

The chapter on gender dysphoria was chosen as it has been and remains today one of the most controversial chapters in the manual (refer to section 2.2). As previously discussed, the pathologising of gender identity is both a deeply contested issue within the scientific community (see section 2.) and considered a human rights issue (Amnesty 2014). Consequently, the formulation of the actual diagnostic category in the manual was a highly sensitive issue and the results bear studying. According to Foucault ([1976] 1990), Fairclough (2003) and Halliday (2004), language does not simply represent reality but also shapes it and the unconscious, value-based linguistic choices we make are reflected in the language we use. As the chapter on gender dysphoria is held as a guideline by psychiatrists worldwide, the language and thus the authors' values become highly influential. Therefore it is important to analyse the chapter on gender dysphoria and reveal the ideologies that are reflected in the text. Because this particular diagnostic category is central to this human rights issue, I have decided that a detailed analysis on this chapter is more worthwhile than a more quantitatively oriented analysis on a wider stretch of data from other chapters in the manual which could also be included for similar reasons.

4.2 Methods

The data is analysed qualitatively, as I wish to find out how the diagnosed individuals and gender dysphoria are represented and constructed in the diagnostic category. From these representations I will draw conclusions on the ideologies reflected in the text and then discuss the impacts of these representations and ideologies on sociocultural practice in the Discussion. These purposes demand a close analysis of the text, but I will support my argumentation with quantitative means in relevant places. Transitivity analysis was chosen as the main method as it is a useful tool in analysing representations, the way the authors of the manual view the subjects that they discuss. The data consists largely of clauses where the individual, gender dysphoria or its symptoms are participants in different processes. Thus, with its focus on processes and participants, transitivity analysis is the ideal choice of method to analyse the way the authors

represent their world views through different process choices. Analysing the processes and the participants will form an overall picture of how the individual and gender dysphoria are represented in relation to one another and to the society in general.

As the method I have chosen produces a detailed analysis, the focus of this study has been narrowed down to the most prominent findings in the data. The analysis section includes a set of general analytic categories that reflect those findings. These categories are the construction of gender dysphoria as a mental disorder, the construction of binary gender categories, children and gender dysphoria, and the role of distress as the central symptom in the diagnosis. The section on children and gender dysphoria includes a closer comparative analysis of how natal girls and boys are treated in the data. These analytic categories are based on the most prominent issues that arose from the data during the analysis, but are also justified by earlier research, such as the research on the linguistic construction of mental disorders (see, for example Crowe 2000) the problems regarding the application of the diagnosis on children (Hill *et al* 2006). Distress is emphasised as the prerequisite for making the diagnosis in the manual and thus focusing on it is both reasonable and important. The role of society will also be noted throughout the analysis and included in the Discussion.

The data has also been narrowed down to reflect the research questions. As the primary research question is concerned with the representation of the individual, all of the clauses that have been analysed include the individual as one of the participants or the individual is included within a circumstantial element connected to the clause. This means that gender dysphoria is also analysed from the perspective of the individual. There are some clauses in the diagnostic category where only gender dysphoria is one of the participants, but they are few in comparison and mostly found in the Risk and Prognostic Factors section under a subheading Genetic and physiological (APA 2013a: 457), where the authors discuss inconclusive evidence of possible biological factors increasing the likelihood of gender dysphoria. How individuals are included in the circumstantial elements will be explained in more detail in the analysis, but this often involves the presentation of the individual as a type of a stage where gender dysphoria or symptoms perform a process. However, circumstantial elements are not otherwise

central in the analysis and will additionally be discussed only in relation to modalization in the closer analysis of children in the data. Passive constructs have also been taken into account when the implied participant is either the individual or gender dysphoria/symptoms.

While transitivity is a suitable method for this analysis, it does have some limitations, as described in section 3.4.2. Modalization has thus been noted in the analysis, but will be discussed only in connection to the clauses about children. As noted in section 3.4.4, relevant Mood Adjuncts have been labelled as the related circumstantial elements. Ergativity analysis is performed on the material clauses where either gender dysphoria or symptoms are the first participant to reveal the causal relationships between the participants and the process. I will also note some lexical choices that I found relevant to the analysis. The transitivity labels used in the analysis are from Thompson (2004) and they differ slightly form those used by Halliday and Matthiessen (2004). The most notable difference is in the labelling of material processes, as Halliday and Matthiessen use 'transitive/intransitive' to refer to clauses that represent 'doing' and 'happening' respectively (200: 180). I have chosen to use Thompson's division of 'intentional/involuntary' simply because I find these labels more transparent. These labels also make the distinction between processes that are caused and happen on their own, but ergativity analysis is added to support the findings. For the sake of clarity, I will also analyse lower ranking clauses separately below the main clause complex instead of using the notational conventions from Halliday & Matthiessen (2004: 10) where all different levels of clauses are analysed within the clause complex. Finally, it needs to be noted that while I discuss the "behavioural" basis of the symptoms in several places in the Analysis, I am not referring to the amount of behavioural processes in the data. My style of analysis, which can be examined in Appendix 1, merges behavioural processes with material and mental processes in almost all cases (see section 3.4.1).

5. ANALYSIS

In this section I will present the results of and highlight examples from the analysis. As mentioned above, this section is divided into four thematic sections based on relevant findings and previous research. These sections are Constructing Gender Dysphoria as a Mental Disorder (5.1), Constructing Binary Gender (5.2) and Children and Gender Dysphoria (5.3). The latter has two subsections: Comparisons between Natal Girls and Boys (5.3.1) and Parents, Society and a Child's Distress (5.3.2). While much of the analysis focuses on the representation of children, these sections highlight problems that are present in the other sections of the manual. This focus is due to both time and space limitations and the contested application of the diagnostic category on children (see section 2.2). As mentioned in Data and Methods, the research questions are in practice intertwined and thus the first two analytical categories, despite their names, include analysis on the representation of the individual as well. The relevant features of medical discourse will be taken into account in the Discussion, where the results will also be further discussed in light of the theories of Foucault, Fairclough and Butler introduced earlier (refer to section 3.). Finally, I use the word 'manual' to refer to the category of gender dysphoria for the sake of readability and when I discuss girls and boys as a necessary division in the analysis, I refer to natal girls and boys.

5.1 Constructing Gender Dysphoria as a Mental Disorder

One of the main topics in this analysis is the way in which gender dysphoria is constructed as a mental disorder in data. In the following I will argue that gender dysphoria is seen as a separate entity that performs processes within the individual, which has been identified in relation to mental illness in general by (Crowe 2000). I will analyse different process types in the text and present examples to support my argumentation. The separation between the individuals natural state of being and the functions of mental illness is made clear in the grammar and one of the most common ways this is done is by making either gender dysphoria or its symptoms the first participant in a clause. In the following example, the individuals with gender dysphoria appear in the circumstantial element attached to the clause, while one of the clinical features of gender dysphoria is the first participant in a material process:

(4) Also in adolescents and adults **[Circumstance: Location, place]**, preoccupation with cross-gender wishes **[Actor]** often **[Circumstance: Extent, frequency]** interferes with **[Process: material, transformative, intentional]** daily activities **[Goal]**.

In the above example, the individual is seen as a stage where gender dysphoria or its symptoms perform different processes. This construction indicates that gender dysphoria is seen as a separate entity that has the power to change and individual's behaviour. The individual themselves is in no position of power in this type of a clause and commonly appears as the Circumstance of Location, Matter or Angle or as Range in the data. This structure is especially prevalent with material and relational processes in the text. However, an ergativity analysis performed on the material processes with gender dysphoria or symptoms as the first participant shows that the transitivity analysis can be misleading in some cases, especially regarding the position of the Actor in the clause.

As explained in section 3.4.2, transitivity analysis is concerned with the doers of the action and the ones the actions are done to, while ergativity focuses on whether the process happens on its own or is being caused to happen. In an ergativity analysis, the Agent is the one causing the process, while the Medium is a 'host' in which the process is caused to happen (Thompson 2004: 136). In the majority of the material processes in the manual, gender dysphoria or the symptoms are identified as the doers of the action or the Actors by the transitivity analysis, but in ergativity analysis they appear as Mediums, as in the extract below:

(5) […] more rarely **[Circumstance: Extent, frequency]**, labeling oneself as a member of the other gender **[Medium]** may **[Modalization: low, implicit, subjective]** occur **[Process]**.

Here, the Medium "labelling oneself as a member of the other gender" is not the cause of the process, but something that occurs without the Medium's influence. From the total of 21 material clauses in the data that had gender dysphoria or its symptoms (including more general features, such as the "persistence" of gender dysphoria), in only four clauses was one of the actors listed above also the Agent from the ergativity perspective. This mean that only 19 % of the clauses were *ergative*, that is, the process in the clause was caused by gender dysphoria or its symptoms.

Below is an example from the data of an ergative clause. In this clause "a high degree of atypicality" is the agent that causes the likelihood of the persistence of gender dysphoria to increase. However, even in this clause where the symptom is in the position of the Agent, the Medium that is affected by the process is not the individual, but another feature of gender dysphoria.

(6) […] that a high degree of atypicality **[Agent]** makes **[Process: material]** the development of gender dysphoria and its persistence into adolescence and adulthood **[Medium]** more likely **[Circumstance: Manner, quality]**.

As in the example above, the relationship between the Agent and the Medium in the three other clauses with the similar ergativity structure is not between gender dysphoria and the individual. This means that in none of the material processes in the data does gender dysphoria or its symptoms have grammatically a direct causal role in the processes affecting the individual. However, this does not eradicate the separation between the symptoms and the natural state of the individual, which is nevertheless apparent in the grammar. The ergativity analysis merely reveals that the power of the symptoms is portrayed to be more limited in the material processes than what the transitivity analysis alone implies. In any case, the construction of gender dysphoria as mental illness does not happen only through material processes in the text, but is also visible in the mental and relational processes used by the authors.

The power of gender dysphoria as a separately acting entity is also limited in three cases of mental processes that are about the development of gender dysphoria in the text. In these three cases, the individuals themselves are responsible of the development of gender dysphoria, which is expressed with a mental process as in the example below:

(7) Many individuals with disorders of sex development and markedly gender-atypical behaviour **[Senser]** do not **[Polarity: negative]** develop **[Process: mental, cognition]** gender dysphoria **[Phenomenon]**.

In this example, gender dysphoria is not the entity developing within the individual, but the Phenomenon that the individual is responsible of creating as the Senser in a cognitive mental process. This removes gender dysphoria from the position of power as a separate entity that operates within the individual in its own accord. This grammatical structure consolidates Crowe's (2000) conclusion that mental illness, while a

separate entity, is the result from a defect within the diagnosed individual rather that outside circumstances. The structure above does clearly place the "blame" on the individual. I will return to this in the discussion.

Relational processes, processes of identifying, having an attribute or possessing something, are prominent in the text. All of the relational process subcategories are used in a way that separates gender dysphoria from an individual's natural state. The individuals may possess symptoms, or symptoms themselves either carry attributes or are identified as acting within the individual. In the next few paragraphs I will give examples and analyse some of the relational processes in the text. Here, in the two extracts below, gender dysphoria and symptoms are participants in identifying relational processes:

(8) In both adolescent and adult natal females **[Circumstance: Location, place]**, the most common course **[Identified]** is **[Process: relational, identifying]** the early-onset form of gender dysphoria **[Identifier]**.

(9) In many cases of late-onset gender dysphoria in gynephilic natal males **[Circumstance: Location, place]**, transvestic behavior with sexual excitement **[Identifier]** is **[Process: relational, identifying]** a precursor **[Identified]**.

In Example 8, a type of gender dysphoria is identified as the most common in a group of individuals. In Example 9, "transvestic behaviour" is identified as one of the symptoms that precede the full onset of another type of gender dysphoria. Here the individual is again the stage for the processes while gender dysphoria and the symptoms are the participants realising the process.

Below are two examples of possessive relational processes in the text. Here relational processes are used slightly differently from the other examples. In Example 10, the individual is the first participant in these processes, being the possessor of something. Most of the time what is being possessed is a symptom, as in the first extract. However, as Example 11 shows, relational processes are also used in connection to feelings in the text.

(10) Natal females with the late-onset form **[Possessor]** do not **[Polarity: negative]** have **[Process: relational, attributive]** co-occurring transvestic behaviors with sexual excitement **[Possessed]**.

(11) Some adults **[Carrier: possessor]** may **[Modalization: low, implicit, subjective]** have **[Process: relational, attributive]** a strong desire to be of a different gender and treated as such **[Attribute: possessed]**, and they **[Carrier: possessor]** may **[Modalization: low, implicit, subjective]** have **[Process: relational, attributive]** an inner certainty to feel and respond as the experienced gender without seeking medical treatment to alter body characteristics **[Attribute: possessed]**.

The process choice in Example 10 identifies the symptom as behaviour that is possessed instead of simply done. Thereby a division is made between what is considered normal behaviour and behaviour that is seen to not originate from the individual themselves but rather from the perceived illness. A similar practice is exemplified in Example 11, where the individual, instead of feeling something, is in possession of a feeling that seems detached from the individual. If the relational processes in the latter example would be replaced by mental processes, the individual would be portrayed in more control of their feelings and the feelings themselves would appear more natural. The relational processes used in connection to symptoms and feelings demonstrate the authors' uncompromising position towards the individual's own experience of their state – they clearly feel that the individual's behaviour and emotions originate from mental illness. A similar effect is achieved when the relational processes are used to label the individual, which I will turn to next.

Below is an example of two ways in which the individual is identified as something in the manual. There are two clauses in this clause complex and in the first one, an identifying relational process is used to indicate that the individual is "androphilic" (meaning sexually attracted to men) and in the latter clause roughly the same meaning is repeated with a mental process.

(12) Adolescents and adults with late-onset gender dysphoria **[Identified]** are **[Process: relational, identifying]** usually **[Circumstance: Extent, frequency]** androphilic **[Identifier]** and after gender transition **[Circumstance: Location, time]** self-identify **[Process: mental, cognition]** as gay men **[Phenomenon]**.

An identifying relational process gives the individual a clear label and the effect is enhanced by the use of the medical term *androphilic*. The relational process makes the meaning behind the clause significantly more clinical and creates distance between the individual and their own experience on their sexual orientation. In the former clause, sexual orientation is something observed by a medical practitioner. In the latter clause, however, the meaning is created with the use of a mental process that gives straight-

forward credit to the individual. Here the individual "self-identifies" as being something and therefore respect is being given to their own experience.

In the clauses where the authors discuss homosexuality in the manual, the process types used are almost equally divided between relational and material processes. From the total of twelve clauses, 42 percent are identifying relational processes, 42 percent mental processes and 17 percent attributive relational processes. The attributive relational processes are used in constructions such as the one below:

> (13) For both natal male and female children showing persistence **[Range]**, almost all **[Carrier]** are **[Process: relational, attributive]** sexually attracted to individuals of their natal sex **[Attribute]**.

If the relational processes are counted together, they outweigh slightly the amount of mental processes in clauses that refer to homosexual identity. In addition to processes, there is an instance where using a mental process is avoided with the construction "of self-identity as gay or homosexual", which will be analysed in section 5.3.1. Also, in Example 9, where the authors talk about "transvestic behaviour", they use the label "gynephilic" in the circumstantial element where they define the individuals in question. While not all the processes connected to the topic of homosexuality are relational, it is clear that homosexuality is also seen as a medically relevant label and not solely as an identity determined by the individual themselves.

Other ways with which gender dysphoria is constructed as a mental illness include the use of verbal, material and behavioural processes in creating distance between the individual and their outward behaviour. The types of behaviour that the authors view as symptoms of gender dysphoria are often 'displayed', 'demonstrated' or 'adopted' in the data. The authors choose to use these processes to imply that the individual performs certain behaviour instead of portraying the individual simply behaving in a certain manner. This is also done by making the behaviour a participant in a clause. In Example 14, a behavioural process is used in this manner and in Example 15, the individual's behaviour is the first participant in a material process.

> (14) To varying degrees **[Circumstance: Manner, degree]**, adults with gender dysphoria **[Behaver]** may **[Modalization: low, implicit, subjective]** adopt **[Process: behavioural]** the behavior, clothing, and mannerisms of the experienced gender **[Behaviour]**.

(15) For individuals with gender dysphoria without a disorder of sex development **[Circumstance: Angle, viewpoint]**, atypical gender behavior **[Actor]** among individuals with early-onset gender dysphoria **[Circumstance: Location, space]** develops **[Process: material, creative, intentional]** in early preschool age **[Circumstance: Location, time]**, and it **[Carrier]** is **[Process: relational, attributive]** possible **[Attribute]** that a high degree of atypicality makes the development of gender dysphoria and its persistence into adolescence and adulthood more likely **[Projection]**.

In the former extract, non-conforming gender behaviour is adopted by the individual with gender dysphoria and the implication is that adopting said behaviour is symptomatic of gender dysphoria. In the latter one, atypical gender behaviour is placed as the Actor in a material process, separating it as an entity that develops on its own, instead of expressing the same meaning with the individuals as the first participant and thus responsible for their behaviour. Next, I will summarise with an example how a type of behaviour is constructed as a symptom in the text.

In Examples 9 and 10 above and in Example 16 in the following paragraph, "transvestic behaviour" appears in relation to gender dysphoria and is constructed as one of the symptoms. There are several measures that the authors use to construct a symptom and in this case it is done namely with identifying relational process, possessive relational process and finally by labelling the behaviour with a medical term. In Example 9, the authors identify "transvestic behaviour" as one of the precursors of what is regarded as a fully developed mental disorder. In Example 10, "transvestic behaviour" is something to be possessed, which separates it from normal behaviour and transforms it into a separate entity that functions independently.

Lastly, in the example included fully in the following paragraph, the authors talk about supposed predisposing factors for gender dysphoria and coin the medical term *autogynephilia* for sexual arousal related to imagining oneself as a woman. This is a very outright way of transferring this in the area of mental illness, as the authors create a category for it, thus creating a social object, a concept discussed by Foucault and Fairclough introduced in section 3.1.2. "Autogynephilia" thus represents "sexual arousal associated with the thought or image of oneself as a woman" in the category of mental illness, which could be seen as a thought among others without this label. Similar labels, those of "androphilia" and "gynephilia", have been created for homosexuality in the category of mental illness. "Transvestic disorder" is also listed as a separate disor-

der in the manual and as a subsection in the Differential Diagnosis section of the chapter on gender dysphoria (APA 2013a: 702, 458).

One manner of constructing gender dysphoria as a mental illness that is not directly related to process types is the presentation of certain feelings and types of behaviour outright as problems. In this example already mentioned above, the authors state that “sexual arousal associated with the thought or image of oneself as a woman” is a “social, psychological, or developmental” problem that is likely to lead to gender dysphoria.

(16) Additional predisposing factors under consideration **[Value]**, especially in individuals with late onset gender dysphoria (adolescence, adulthood) **[Circumstance: Location, space]** include **[Process: relational, identifying]** habitual fetishistic transvestism developing into autogynephilia (i.e., sexual arousal associated with the thought or image of oneself as a woman) and other forms of more general social, psychological, or developmental problems **[Token]**.

The Value/Token construct is used to identify more specific instances of a larger category (Thompson 2004: 98). Here the larger category, Value, is the group of predisposing factors and the Tokens are problems that could lead to gender dysphoria. Thus the behaviour or the individual is identified as problematic and, according to the authors, the problematic behaviour is likely to lead to gender dysphoria. There are plenty of other instances in the text where gender dysphoria is plainly associated with problems or listed with “comorbid” or “coexisting” mental disorders, such as anxiety and depression (APA 2013: 458-459). Non-conforming gender behaviour is also presented as a problem from a societal point of view, which I will turn to next.

When the symptoms of gender dysphoria are presented in the manual, the authors use the reactions of society to justify the labelling a behaviour or a preference as a symptom. The social basis in the construction of mental illness has been widely recognised (Foucault [1967] 1993; Crowe 2000; Horwitz 2002). Sometimes actors in the society are given an overt role in defining the symptoms of gender dysphoria. In the following example, the perceptions of strangers about the individual are given the same weight as other supposedly symptomatic features in an individual:

(17) They **[Senser]** prefer **[Process: mental, emotion]** boys’ clothing and hairstyles **[Phenomenon]**, are **[Process…]** often **[Circumstance: Extent, frequency]** perceived **[Process: mental,**

perception] by strangers **[Senser]** as boys **[Phenomenon]**, and may **[Modalization: low, implicit, subjective]** ask **[Process: verbal]** to be called by a boy's name **[Verbiage]**.

Here, among the mental and verbal process where the girl in question is the first participant, there is a mental process in which a stranger categorises the girls as belonging to a gender. The role of the strangers appears out of place in a clause construct that otherwise deals with the personal preferences and desires of the individual. Using people that come into random contact with the individual as a basis for diagnosis seems like an attempt to transfer responsibility to actors other than the authors, who are otherwise contextually presented as the authority on diagnosing gender dysphoria.

Sometimes the views of the authors and what they claim to be the views of the society are hard to separate from one another. Here the authors list things that are, according to them, associated with gender dysphoria. The source of the association, however, is left unclear, as the authors choose to use a passive construct and thus leave the performers of the process obscure.

(18) Gender dysphoria, along with atypical gender expression, **[Carrier]** is associated with **[Process: relational, attributive]** high levels of stigmatization, discrimination, and victimization, leading to negative self-concept, increased rates of mental disorder comorbidity, school dropout, and economic marginalization, including unemployment, with attendant social and mental health risks **[Attribute]**, especially in individuals from resource-poor family backgrounds **[Circumstance: Location, place]**.

The list above is not openly credited to any studies, but the passive structure and the relational process used to list the attributes gives the impression that the listed things are commonly accepted. However, without a proper source, this list may just as well be a list of what the authors themselves associate with gender dysphoria. The list itself can be quite influential as it dictates to the medical practitioners using the manual a clear picture of the society's regard towards individuals diagnosed with gender dysphoria. As the list contains undeniably negative things, the individuals are represented in a very negative light. We can assume that none would want to be associated with the circumstances above and thus the society is represented as very judgmental in the text and non-conforming gender identities as a deviation from societal norms. Next, I will continue the analysis with a closer look at how the idea of binary gender is created and supported in the data.

5.2 Constructing Binary Gender

It is clear that gender dysphoria is seen as a mental disorder that has the power to alter an individual's behaviour. This is evident in the way that gender dysphoria and its symptoms are the performers of different processes in the text and those processes often happen within the individual and seemingly without their consent. Non-conforming gender behaviour is regarded as symptomatic and thus the text gives higher priority for an individual's natal gender over their own experience on the matter. This can also be seen in the way gender in general and gender in relation to society is represented in the text. Here I will present some observations on how society and the ideal of binary gender are put forth in the data. The following extract contains the authors' general definition of gender dysphoria that starts the chapter in DSM-5. Here, gender is said to be a category to which one is assigned, which Butler (2004: 97) also noted in regard to DSM-IV.

(19) Individuals with gender dysphoria **[Carrier: possessor]** have **[Process: relational, attributive]** a marked incongruence between the gender they have been assigned to (usually at birth, referred to as *natal gender*) and their experienced/expressed gender **[Attribute: possessed]**.

between the gender they **[Goal…]** have been assigned **[Process: material, transformative, intentional]** to **[…Goal]**

The authors state that the individual (and presumably everyone) is assigned to a gender and gender dysphoria creates incongruence between the "assigned" gender and the experienced one. The incongruence is expressed with a possessive relational process and thus it is something that is "had" while the natal gender is something that has been assigned by an unknown entity which is omitted in the passive structure. The choice of the verb "assigned" and the omitted Actor in the passive structure suggests that gender is in the hands of a higher power and the individual's own perception is secondary to the original assignment. The original assignment thus represents the correct or mentally healthy way of being. Biology is therefore seen to override the mind and the original assignment of the two gender possibilities is seen as the natural state of things.

This extract includes a disclaimer by the authors about the use of the diagnostic guidelines but it also simultaneously reveals the authors' attitude towards non-stereotypical

gender role behaviour. Here the attitude is not marked by the process type in the clause but rather word choices that are placed between quotations marks.

(20) The diagnosis **[Phenomenon]** is not **[Polarity: negative]** meant to merely describe **[Process: mental, cognition]** nonconformity to stereotypical gender role behavior (e.g., "tomboyism" in girls, "girly-boy" behavior in boys, occasional cross-dressing in adult men **[Circumstance: Location, place]**) **[Range]**.

The choice to use informal words such as "tomboyism" and "girly-boy" in an official medical text reveals a strong attitude towards the subject. The terms are undeniably loaded and outside of the register that is otherwise predominant in the text. Here, the authors are quite openly judgmental towards the behaviour they regard symptomatic, but their views on gender atypical behaviour can also be seen in the lists of normal things for a girl or a boy to do that can be found in the text.

In the diagnostic guidelines for children, the authors list activities that they feel are typical for either gender. The lists include stereotypical toys and games that boys and girls should prefer and if the child prefers the toys and activities of the other gender it is considered a symptom of gender dysphoria. These two examples below are from the section about girls with gender dysphoria that discuss the girls' preferences and expressions of interest.

(21) Contact sports, rough-and-tumble play, traditional boyhood games, and boys as playmates **[Phenomenon]** are **[Process…]** most often **[Circumstance: Extent, frequency]** preferred **[Process: mental, emotion]**.

(22) They **[Sayer]** show little interest **[Process: verbal]** in stereotypically feminine toys (e.g., dolls) or activities (e.g., feminine dress-up or role-play) **[Target]**.

In Example 21, contact sports and "rough-and-tumble play" are declared to be typical past times of boys and having boys as playmates should arouse suspicions about the girls' gender identity. Then again, if the girl does not like to play with dolls or engage in "feminine dress-up or role play", this could be considered conspicuous from a mental health perspective. All in all, the authors are quite open about their view on how a girl should behave.

Below is an example from the sections discussing boys with gender dysphoria. Here the authors use the Value/Token construct to identify "stereotypically female-type

dolls” as he favourite toys and girls as the favoured playmates of boys with gender dysphoria.

(23) Stereotypical female-type dolls (e.g., Barbie) **[Identified]** are **[Process: relational, identifying]** often **[Circumstance: Extent]** favorite toys **[Identifier]**, and girls **[Identified]** are **[Process: relational, identifying]** their preferred playmates **[Identifier]**.

The meaning about preferred toys and playmates expressed in this example is roughly the same as in the first example in the previous paragraph. However, the Value/Token construct (as well as the modal adjunct “most often” in the former example) creates a difference in the level of certainty behind the statement. With this construct, the authors firmly identify the favourites of boys with gender dysphoria and leave no room for argument, while with the girls, the toys and friends listed are “most often preferred”. Consequently, the authors both state that these preferences are certain in boys with gender dysphoria and also imply that these preferences are quite certain indicators of gender dysphoria. In the following section, I will continue the analysis by studying the way that children are treated in the text.

5.3 Children and Gender Dysphoria

As previously mentioned, individuals are divided into groups based on natal gender and age in the text. The groups are children, children divided into girls and boys, adolescents, adolescent boys and girls, and finally adults and adult males and females. All age groups are discussed in general as well as separately in the data; however, the divisions are not systematic and not all groups are discussed to the same extent. In the total of 213 clauses in the data, approximately 38 % discussed children specifically, 19 % discussed adolescents and 28 % concerned the adults. Females were discussed in roughly 21 % and males in 27 % of all the clauses. The figures have some overlap, as some of the clauses discussed more than one group at the same time. The clearest division is made between boys and girls: their symptoms are discussed in a very detailed and comparative manner and also from a distinctly behavioural perspective. There is a clear contrast in how girls and boys are regarded by the authors and that contrast can be observed from the amount of different process types used when the two groups are discussed. There are also clear differences in the way that children are portrayed in comparison to other age groups; however, time and space limitations do

not allow an in-depth analysis and comparison of every group in this study. As the parts concerning children include the most variation and are also contested when it comes to diagnosing gender dysphoria (Hill *et al.* 2007), those parts have been chosen for this analysis.

While it is not possible to compare the age groups in any great detail, in general it can be said that there is a clear continuum from children to adults on how much value the text places on cognitive abilities and emotions. Both this and the fact that the descriptive diagnostic guidelines on children have been constructed from a behavioural basis have also been acknowledged by the authors of the manual (APA 2013a: 454-455). As a result of this, the adults are treated in a seemingly more respectful manner, as the process types and participants used in connection to them have a more individual oriented basis. However, clauses about all the groups also have common features, such as that atypical gender behaviour is 'adopted', 'demonstrated' or 'displayed', a process choice that was already introduced above and also appears in the following examples on children.

Below I will analyse clauses that describe children in the text. The first part of this analysis will consist of comparisons on how natal girls and boys are portrayed as this division is very prominent in the data. The second part will focus on children in general and the relationship between society and children's distress. In most clauses in the data, words 'girl' and 'boy' refer to children as an age group, but there are a couple of instances where the age referred to is early adolescence and these instances have been included in this analysis. The examples in the first part of this section include clauses where girls or boys are first participant in a process, including passive structures when the implied agent is a boy or a girl; however clauses that refer to statistical issues (such as sex ratios) have been left out here. More specifically, clauses tallied in the tables presented below include only those that are about gender dysphoria or its symptoms in relation to the boys and girls. Two clauses that deal with statistics in relation to children who identify themselves as homosexual are analysed separately. Along with the examples, I will also present some figures to support my findings on how boys and girls are portrayed in the manual.

5.3.1 Comparisons between Natal Girls and Boys

First, I counted and compared the different process types that are used in clauses describing boys and girls in the data. The results show clear differences between the two groups and these differences appear to follow the traditional stereotypes regarding girls and boys. As can be seen from the tables below, with girls the authors have chosen to use verbal processes in the majority of the clauses. The girls are thus portrayed to be generally expressive about their feelings and cognitively active. Most of the clauses about boys are divided between material processes and different relational processes. Consequently, they are represented as having features or symptoms and performing actions instead of expressing their thoughts. The tables below show the amounts of all different process types used to describe girls and boys respectively. Relational processes are divided into their three subcategories, as the use of the different subcategories is relevant to the analysis.

Process type	Amount	% of all Clauses
Verbal	10	48
Material	7	33
Mental	3	14
Rel., identifying	1	8
Total	21	100

Table 2. Process Types in Clauses about Girls

Process Type	Amount	% of all Clauses
Material	7	35
Total rel. processes	5	25
Rel., possessive	3	
Rel., identifying	1	
Rel., attributive	1	
Mental	4	20
Verbal	4	20
Total	20	100

Table 3. Process Types in Clauses about Boys

There are a total of 41 clauses in the data where girls or boys are the first participant in a process and 51 % of them discuss girls and 49 % are about boys. The total number of

clauses is thus divided quite evenly. In the clauses about girls, aside from verbal processes, the second most common process type is material and the third mental. The authors use only four different process types when they describe girls (as only one subtype of relational process is used). The most obvious difference in comparison to the boys is in the amounts of verbal and relational processes. The clauses about boys have 20 % verbal processes while girls have 48 %, which is over twice as much. Then again, the clauses describing boys have 25 % relational processes in total, representing all subcategories, while girls have only one identifying relational process, which amounts to 8 %. The majority of the 20 clauses about boys have material and relational processes, with mental and verbal processes being tied for second place. The uneven amounts of different process types are evidence of the contrast between girls and boys in the manual, which I will expand on below.

60 % of the clauses about boys have a material or a relational process and therefore the boys are in general represented either as doing something or identified as something, having an attribute or possessing something. Below there is an extract from the Diagnostic guidelines where in the first clause there is a possessive relational process and in the second a material process. Thus it is a typical description of a boy with gender dysphoria in the manual.

(24) They **[Carrier: possessor]** have **[Process: relational, attributive]** a preference for dressing in girls' or women's' clothes **[Attribute: possessed]** or may **[Modalization: low, implicit, subjective]** improvise **[Process: material, transformative, intentional]** clothing **[Goal]** from available materials (e.g., using towels, aprons, and scarves for long hair or skirts) **[Circumstance: Manner, means]**.

In the first clause, the boys are portrayed as having a preference, instead of expressing a preference for or simply preferring something. Choosing a relational process instead of a mental process to express this meaning both creates distance between the reader and the subject and makes the boys seem less capable of expressing their preferences and disconnected from their feelings. The material process in the clause complex describes the boy performing an action in a very detailed manner. I will return to the amount of detail the authors use later in the analysis. In general, the amounts of material processes are equally divided between the boys and the girls and there is only a

slight difference in favour of the girls regarding mental processes. The clearest difference is in the amount of relational and verbal processes.

The girls are clearly represented as more verbal and expressive in comparison to the boys. The example below describes preferences just as the above example on boys, but the difference is in the process types that the authors choose to use. The girls' preferences are portrayed through a mental process in the first clause and in the final one, they express a desire through a verbal process.

(25) They **[Senser]** prefer **[Process: mental, emotion]** boys' clothing and hairstyles **[Phenomenon]**, are **[Process…]** often **[Circumstance: Extent, frequency]** perceived **[Process: mental, perception]** by strangers **[Senser]** as boys **[Phenomenon]**, and may **[Modalization: low, implicit, subjective]** ask **[Process: verbal]** to be called by a boy's name **[Verbiage]**.

With the use of the mental process, the girls' feelings and mental capacity in general are given more respect than if the same meaning would be expressed with a relational process. The girls are thus represented as more connected to their feelings than boys in these two examples. The verbal process in the final clause adds to the image of girls being more expressive and communicative with their environment.

In both of the above examples, the boys and girls are described to prefer something and in both instances the most straightforward way of expressing this would have been by using a mental process. Nevertheless, the authors chose to use a relational process for boys and a mental and a verbal one for girls. This choice brings the reader closer to the girls while creating a distance from the boys, as the girls in the text are communicating with their environment and the boys' state of being and feelings seem to be merely observed rather than communicated. The observant standpoint makes the authors appear to be quite absolute in regard to their views on the boys. The authors most of the time state that the boys do, are or have something and their interpretation is presented as the truth. With the girls there seems to be more uncertainty, as a great deal of the symptomatic emotions and actions are credited to the girls themselves with the use of verbal processes. Then again, in the clauses where the topic is emotions and verbal processes are used, the processes merely portray the girls' expressing emotions rather than feeling them and thus the authors still take a some-

what observant point of view. Mental processes are shared quite evenly between girls and boys. Next, I will briefly move to data that has not been included in the tables at the beginning of this section.

In the section called Development and course, the authors discuss homosexuality in relation to boys and girls diagnosed with gender dysphoria. Here the children appear in the circumstantial elements connected to the clauses and thus act as 'stages' for the processes. Again there is evidence of the authors' different attitude towards girls and boys, which is realised in the use of relational and verbal processes. In the following examples, the reader is presented with figures of how many percentages of both boys and girls identify as homosexual. The difference can be seen in the process types, as girls are described with both relational and mental process while boys only get a relational process.

(26) For natal male children whose gender dysphoria does not persist **[Range]**, the majority **[Identified]** are **[Process: relational, identifying]** *androphilic* (sexually attracted to males) and of self-identity as gay or homosexual (ranging from 63% to 100%) **[Identifier]**.

(27) In natal female children whose gender dysphoria does not persist **[Circumstance: Location, place]**, the percentage who **[Identified]** are **[Process: relational, identifying]** *gynephilic* (sexually attracted to females) **[Identifier]** and self-identify as lesbian is **[Process: relational, attributive]** lower (ranging from 32% to 50%) **[Attribute]**.

whose gender dysphoria **[Actor]** does not **[Polarity: negative]** persist **[Process: material, transformative, intentional]**

self-identify **[Process: mental, cognition**] as lesbian **[Phenomenon: circumstantial prepositional phrase]**

In Example 27, girls are labelled with the identifying relational process, but they are also described to "self-identify as lesbian". The addition of the mental process means that the girls' own feelings and perception are given credit and they are presented as being able to formulate their own identities. With the boys in Example 26, however, there is only one process in the clause, which is an identifying relational process. In the Identifier part of the clause, the authors have added another label after *androphilic*, which is that the boys are "of self-identity as gay". This construction could have just as easily been replaced by a mental process similar to the girls' and the clumsiness of the expression seems to point towards an attempt to avoid using the labelling mental

process. The boys, therefore, are not credited with the same ability to determine their own identity as the girls.

While there is little or no difference in the amounts of mental and material processes between the two natal genders, the contrast between boys and girls can be seen in these examples and many other instances in the data. This is shown by the way the other process types are divided, but also in the way that the two groups are described outside process type choices. For one, when the girls are portrayed as doing or feeling something in the manual, the processes are described in a more general manner and the second participants and circumstantial elements include less detail (such as lists of games and objects). In the clauses about boys, the processes are described more thoroughly with longer second participants and circumstantial elements. Below are two easily comparable examples of mental processes that are used in similar contexts, the first discussing girls and the second boys.

(28) Contact sports, rough-and-tumble play, traditional boyhood games, and boys as playmates **[Phenomenon]** are **[Process…]** most often **[Circumstance: Extent, frequency]** preferred **[Process: mental, emotion]**.

(29) Traditional feminine activities, stereotypical games, and pastimes (e.g., "playing house"; drawing feminine pictures; watching television or videos of favorite female characters) **[Phenomenon]** are **[Process…]** most often **[Circumstance: Extent, frequency]** preferred **[Process: mental, emotion]**.

Both clauses list the preferences of girls and boys with identical grammatical constructs. The difference between these two examples can be found in the lengths of the second participants, the Phenomenons that in this case appear at the beginning of the clauses. The list of preferred things is clearly longer in the latter example about boys.

Lists such as the one in the first example are common in connection to boys. I compared the lists of specific examples of actions and objects that the authors listed in parenthesis in relation to boys and girls respectively, similarly as in Example 29 above. The authors listed eight examples when discussing boys and two when discussing girls. With boys, these lists appeared in connection to material and relational processes and, in one instance, a mental process referring to preference. With girls the two examples listen in connection to a verbal process. This emphasises the boys' role as doers and

havers who are observed. Also, the authors are generally very careful to address the two groups as 'natal girls/boys' or with the pronoun 'they', emphasising the premise of natal gender and separate symptoms. However, the authors address the girls simply as 'girls' in two instances (APA 2013a: 453, 454), while nothing similar is done with boys. The boys are merely once called 'these children' (APA 2013a: 453). I will discuss the implications of these findings along with the implications of how the use of modalization is divided between boys and girls. I will present the findings on modalization in the next few paragraphs.

Modalization is a common feature of medical discourse (Adams Smith 1984) and is also used by the authors throughout the whole section on gender dysphoria in the manual. The authors use it to modify the level of probability in the statement, namely to express that there is a possibility of a symptom occurring but it does not necessarily do so. In the data as a whole, modalization is chiefly expressed with the finite modal operator 'may'. According to Halliday's categories (2004: 622), using the Finite 'may' means that the level of modal commitment is low, modalization is implicitly expressed (meaning that it appears in the same clause as the rest of the statement) and that the modalization is subjective instead of attempting to objectivise the statement (Thompson 2004: 69-71). The low level of modal commitment towards what is stated means that the authors take a low level of responsibility over what is said. As only one type of Finite is used when the authors express modalization with the help of a modal operator (or when they use *verbal modalization* (Adams Smith 1984)), the level of modalization is fixed. Therefore, instead of the level, the amount of modalization is the matter of importance. I compared the amounts of verbal modalization in the clauses about girls and boys and found a difference: there is more verbal modalization in the clauses that describe the girls in the text. The girls have twelve instances of verbal modalization in 21 clauses, which comprises 57 % of the clauses. The boys have verbal modalization in seven out of 20 clauses, which means that it is found in 35 % of the clauses.

Modalization can also be expressed with the help of circumstantial elements (Thompson 2004: 71), in this case notably with mood adjuncts such as 'sometimes' or 'rarely'.

These elements were also analysed to see if there was any difference. Circumstantial elements were used to express modalization in four clauses with the boys and three with the girls. in addition, two times with both groups “some” was the first participant in the process, softening the statement, and again there were two times in both sets of clauses when the clauses were doubly modalized with both ‘may’ and either a mood adjunct or ‘some’ as the first participant. In the end, three or 15 % of the clauses regarding boys were left completely unmodalized and two or 10 % of the clauses regarding the girls. It can be therefore concluded that the only notable difference between the two groups is in the amount of verbal modalization.

Below there are two examples, the former of which is taken from the set of clauses about girls and the latter from the set about boys. The clause describing girls includes modalization, while the one on boys does not. As can be seen, the level of certainty between the two clauses is clearly different.

(30) These girls **[Sayer]** may **[Modalization: low, implicit, subjective]** demonstrate **[Process: verbal]** marked cross-gender identification **[Verbiage]** in role-playing, dreams, and fantasies **[Circumstance: Location, place]**.

(31) They **[Actor]** avoid **[Process: material, transformative, intentional]** rough-and-tumble play and competitive sports **[Goal]** and have **[Process: relational, attributive]** little interest in stereotypically masculine toys (e.g., cars, trucks) **[Attribute: possessed]**.

In the first clause, the authors avoid taking the full responsibility of the statement, while in the second clause complex they are quite certain about what they are saying. This second carries two of the three clauses about boys that are left unmodalized. These clauses include two possessive relational processes and one material process, while the unmodalized clauses regarding girls include a mental process and a verbal process. The clauses that have no modalization in them are important when it comes to analysing how the individuals are portrayed, as they represent the things that the authors are most certain about regarding their subjects.

Examples 32 and 33 below include the unmodalized clauses about boys. In Example 32, the authors declare that the boys have a preference for dressing in feminine clothing and both the choice of relational process and the lack of modalization indicate strong

certainty on what is stated. Similar structure is used in the second clause in Example 33, while the first clause has a material process.

(32) They **[Carrier: possessor]** have **[Process: relational, attributive]** a preference for dressing in girls' or women's' clothes **[Attribute: possessed]** […]

(33) They **[Actor]** avoid **[Process: material, transformative, intentional]** rough-and-tumble play and competitive sports **[Goal]** and have **[Process: relational, attributive]** little interest in stereotypically masculine toys (e.g., cars, trucks) **[Attribute: possessed]**.

Again, in Examples 34 and 35 below are the unmodalized clauses about girls. In contrast to the clauses about boys above, these clauses have a mental process and a verbal process. Of all the "symptoms" regarding girls, the authors are thus most certain that the girls prefer masculine clothing and hairstyles and show little interest towards feminine toys.

(34) They **[Senser]** prefer **[Process: mental, emotion]** boys' clothing and hairstyles **[Phenomenon]**

(35) They **[Sayer]** show little interest **[Process: verbal]** in stereotypically feminine toys (e.g., dolls) or activities (e.g., feminine dress-up or role-play) **[Target]**.

The process types in these unmodalized clauses are representative of the division of all process types between boys and girls. I argue that as these clauses are the ones that have the highest modal commitment in the clauses that have girls or boys as the first participant, they are important in analysing how the girls and boys are represented in the data. I will return to these clauses and their implications in the Discussion.

Comparatively speaking, however, the results regarding modalization are speculative at best. As the only notable difference between boys and girls is in the amount of verbal modalization and there are only a few clauses that are completely unmodalized in the end, no set conclusions can be drawn on the basis of modalization. If the differences in verbal modalization are indicative of something, there are several ways the interpretation could go. The larger amount of modalization in clauses about girls could imply that the authors are more uncertain when it comes to describing gender dysphoria in girls, while in general they appear more decided about their view on boys. Another interpretation could be linked to the difference in process types used for girls

and boys, which seem to follow stereotypical gender roles of girls as verbal and emotional and boys as doers. The stereotypical derivative would be that the girls appear as more tentative than boys in the text. I will discuss the overall representation of boys and girls in section 6.2.

While the unmodalized clauses are revealing about the authors' attitudes, many of the clauses that could arguably be viewed as pivotal to diagnosing both girls and boys with gender dysphoria are modalized in the data. This could be problematic especially in instances such as the one below. This clause construct starts the section of the data that discusses boys specifically and a similar construct starts the section on girls. Thus plenty of weight is placed on their meaning in the text. This example discusses the boys stating that they wish to be a girl.

(36) Prepubertal natal boys with gender dysphoria **[Sayer]** may **[Modalization: low, implicit, subjective]** express **[Process: verbal]** the wish to be a girl **[Verbiage]** or assert **[Process: verbal]** that they are a girl or that they will grow up to be a woman **[Projected]**.

Here the authors state that the boy "may express the wish to be a girl" and the whole clause complex is modalized. Thus it is not necessary for the child to express anything regarding their gender and the diagnosis can still be made purely on the basis of behavioural analysis. As stated above, almost all of the clauses describing supposedly symptomatic behaviour include modalization and I will discuss the implications in the Discussion. Another problem with the modalization appears in connection to clauses that deal with distress. Distress, as stated before (see section 2.2), is a prerequisites for the diagnosis. If there is plenty of modalization used in clauses that deal with the individual's personal experience of distress, then it is questionable if the manual clearly requires that the criterion of distress is met. I will return to the consequences of modalization on the power imbalance between the child, parents and the clinician in the Discussion and move on to analyse the role of distress in relation children.

5.3.2 Parents, Society and a Child's Distress

This second part of the analysis focuses on the role of distress in relation to children in the manual. As was stated previously in the section on clinical practice (section 2.3),

the guidelines on how to use the manual instructs the clinician to use third party information whenever required to make the diagnosis. Societal norms and the perceptions of family and strangers are thus included in the diagnostic guidelines of gender dysphoria as well. This is especially relevant in regard to the diagnostic guidelines for children with gender dysphoria. While the role of society is evident when the symptoms of other age groups are discussed, with the children the role of parents and peers is pivotal. Below is an extract that talks about the signs of distress in the child when the parents tell the child that they do not belong to their experienced gender.

(37) A very young child **[Sayer]** may **[Modalization: low, implicit, subjective]** show **[Process: verbal]** signs of distress (e.g., intense crying) **[Verbiage]** only when **[Circumstance: Contingency, condition]** parents **[Sayer]** tell **[Process: verbal]** the child **[Receiver]** that he or she is "really" not a member of the other gender but only "desires" to be **[Projection]**.

that he or she **[Identified]** is **[Process: relational, identifying]** "really" not **[Polarity: negative]** a member of the other gender **[Identifying]** but only "desires" **[Process: mental, desideration]** to be **[Phenomenon]**.

To start with the process types chosen here, in the first clause the child "shows" distress instead of feeling it. This distances the reader from the child's emotions and gives primacy to the parents' observation of the child's emotional distress. The parents are then described "telling" the child the (perceived) truth about the child's gender and this telling is the action that causes the distress. In the projection, the authors use an identifying relational process to state that the child's natal gender is the correct one, stating this as the truth instead of as a differing perspective. The quotation marks around the words "really" and "desire" could be interpreted in several ways: either they are used to soften the statement and give room to the child's feelings on the matter (especially in the case of "really") or they could be used to question the validity of the child's emotions (particularly with "desire").

Here the parents are clearly the ones defining the child's gender. The child is labelled as a member of the other gender by a relational process, indicating that a belief that this gender is the relevant and true one. Again, the child's distress is "shown" instead of felt, which makes the parental perception even more powerful. All in all, both the binary gender view and the correct gender are clearly imposed by the parents and this

imposition is the one causing the distress. This puts the parents in a position of power with the diagnosis, as their actions cause symptomatic behaviour in the child. Distress is also the key prerequisite for diagnosing gender dysphoria and here it is rather unclear whether the sources of distress are the parents or gender dysphoria. The criterion of distress is especially problematic in light of what the authors state in the beginning of the example: the child may appear distressed only when the parents impose their view on gender upon them.

The origin of the child's distress is also ambiguous in other parts of the data where the child's position in relation to their peers is discussed. In the following examples, taken from the section called Functional Consequences of Gender Dysphoria, refusal to attend school as well as behavioural and emotional problems are listed as consequences of gender dysphoria. However, in both cases, the responsibility is credited to the child's peers.

(38) Some children **[Actor]** may **[Modalization: low, implicit, subjective]** refuse to attend **[Process: material, transformative, intentional]** school **[Goal]** because of teasing and harassment or pressure to dress in attire associated with their assigned sex **[Circumstance: Cause, reason]**.

(39) In prepubertal children **[Circumstance: Location, time]**, increasing age **[Carrier]** is associated with **[Process: relational, attributive]** having more behavioral or emotional problems **[Attribute]**; this **[Carrier]** is related to **[Process: relational, attributive]** the increasing nonacceptance of gender-variant behavior by others **[Attribute]**.

In the former example, the child refuses to go to school because of harassment and pressure originating from their surrounding environment. The cause of the distress is given openly in the circumstantial element. The latter example states with the help of two attributive relational processes that as the child ages, the possible accumulating problems are associated with increasing intolerance by the environment. These functional consequences are not represented as being caused by gender dysphoria itself, but the actions of those around the diagnosed individual. Thus the perception of society is in a deciding position when it comes to diagnosing gender dysphoria in children and the authors clearly believe that even though the unaccepting society is the cause of these functional issues, the problem does not lie within the society but within the child.

Even though the origin of the distress can be traced back to sources other than gende dysphoria in the data, the authors emphasise the importance of the distress criterion when making the diagnosis. Here the authors acknowledge the range of gender identities beyond the binary model that is the basis of the gender dysphoria as a mental illness and draw the limits on how the clinical diagnosis should be applied.

(40) Given the increased openness of atypical gender expressions by individuals across the entire range of the transgender spectrum **[Circumstance: Cause, reason]**, it **[Carrier]** is **[Process: relational, attributive]** important **[Attribute]** that the clinical diagnosis be limited to those individuals whose distress and impairment meet the specific criteria **[Projection]**.

> that the clinical diagnosis **[Carrier]** be **[Process: relational, attributive]** limited **[Attribute]** to those individuals whose distress and impairment **[Actor]** meet **[Process: material, transformative, intentional]** the specific criteria **[Goal]**

The allowance towards the non-conforming gender identities is compressed into the circumstantial element at the start of the extract, making it appear more of a side note than it would have if the same meaning was expressed by using processes. Nevertheless, the authors state that due to the increased openness, the distress criterion is especially important. This, however, is logically problematic as the source of the distress seems to be often something other than gender dysphoria in the manual. Society appears to play a significant part in creating the distress and I will continue to analyse the relationship between society and gender dysphoria in the discussion.

6. DISCUSSION

This discussion will focus on the choices that the authors make on process types and participants when they discuss the individual and gender dysphoria in the data. These choices will be discussed within two themes: first I will examine the representations of the individual and gender dysphoria in general and after that I will focus more closely on children and gender dysphoria in particular. My arguments will be based on the findings of the analysis and I will show that the process type choices have major implications on how the authors represent their subjects. I will argue that these choices reflect particular ideologies that the authors have regarding gender identities.

Throughout the discussion I will tie the findings to the sociocultural practices related to the manual and discuss the possible effects that the representations of the individual and gender dysphoria have on those practices. The sociocultural practices are considered in the light of the theories by Foucault and Butler introduced in section 3.3.

6.1 The Individual, Gender Dysphoria and Self-Determination

As was shown during the first half of the analysis, the authors have chosen to place both gender dysphoria and the diagnosed individual as first participants within clauses. Moreover, gender dysphoria or its symptoms act as the first participant in clauses where the individual appears in the circumstantial elements as a type of a 'stage' for the process. This indicates that gender dysphoria is seen as an entity that can act on its own, and this already has major implications on how it is viewed by the authors. The fact that gender dysphoria and the symptoms are able to perform processes within the individual gives it autonomous power. The authors choose to separate gender dysphoria and its symptoms from the individual's normal state of being and give it power to change the individual's behaviour by placing it as a performer of processes and through these measures the authors are representing gender dysphoria as a mental disorder. This conclusion is not overridden by the ergativity analysis that was performed on the material processes: while it was shown that gender dysphoria and its symptoms do not have causative power in regard to the processes, gender dysphoria nevertheless has the status of a separate participant and a performer of processes, whether they are the Agent or Medium in the ergativity analysis.

What the ergativity analysis does seem to indicate is the same phenomenon that Crowe (2001) found in her analysis of mental disorders in general: mental disorders are seen as separate entities that are caused by a fault within the individual. Gender dysphoria and the symptoms do not cause processes within the individual, but rather happen within them and thus appear to originate from where they occur. This is supported by the material processes in the data where the individual is presented as "developing" gender dysphoria, clearly indicating the origin to be the individual themselves. In these clauses the individual is also the Agent and therefore the cause behind

the process of development. Thus the authors place the responsibility for causing the "disorder" on the diagnosed individual. Still, this does not affect gender dysphoria's representation as a separate entity: the perceived disorder is still explicitly separated from an individual's natural state. The findings of Crowe's (2001) study support this conclusion. In her discussion of gender dysphoria in DSM-5, Davy (2013: 5) reaches the conclusion that the name change from 'identity disorder' to 'dysphoria' does not cause any changes in the presentation of variant gender identities as mental disorders. In light of the representation of gender dysphoria described above as well as the construction of binary gender categories as described in the analysis, I concur and argue this point further when I discuss the representation of children in the data.

Aside from material processes, another process type that is used to construct gender dysphoria as a mental disorder is the relational process. The relational processes are used to indicate the possession of gender dysphoria or symptoms in the data, again presenting it as a separate entity. In regard to illnesses in general, Fleischmann (1999) has pointed out that they are often represented as objects to be possessed. Relational processes are also used to identify symptoms or features of gender dysphoria. However, more notably, the authors use identifying relational processes to label the diagnosed individual. This is usually done in relation to homosexuality. Already discussing the individual's sexual orientation in the context of diagnostic guidelines equals it as a symptom. This is enhanced both by the labelling done by the identifying relational process and by referring to homosexuality with medical terms, such as 'androphilic' and 'gynephilic'. The construction of 'transvestic behaviour' as a symptom and the term 'autogynephilia' were already discussed in the analysis; I view all of the above as cases of creating social objects (Foucault [1972] 2009). The creation of a category with a specific name in medical terminology is a way to connect both homosexuality and 'transvestic behaviour' to mental disorders. Through the creation of these categories, homosexuality and 'transvestic behaviour' are then included in the scientific knowledge which supposedly underlies the category of gender dysphoria within DSM-5. While homosexuality is no longer classified as a mental disorder in the DSM system,

within the scientific knowledge that the system is claimed to be based on it is nonetheless related to symptoms of another disorder.

However, the authors also make use of mental processes in connection to homosexuality and introduce the verb 'self-identify'. In some of the clauses that concern homosexuality in the data, the individual self-identifies as homosexual, instead of being labelled so by the authors. This indicates two things: homosexuality is also seen as an identity and thus not merely a symptom (or symptomatic), and also in certain instances in the data, the authors give the individual power over determining their own identity. This mental process of self-identification does not appear very often, but I argue that it shows the direction towards which the language in this category should be taken. At the moment, the symptoms are largely represented as processes observed by the psychiatrist in the data. While the individuals are at times represented as expressing feelings and verbalising their desires, at other times the authors choose to both represent gender dysphoria as the performer of processes and to use relational processes to state their perceptions of the individual. If the authors would choose to present the symptoms solely through mental and verbal processes with the individual as the first participant, this would validate the individual's personal experience of gender and represent the individual as capable of determining their own gender identity.

The premise of self-determination is also demanded by Amnesty International (2014) in their report over the judicial position of transgender individuals in Europe. Amnesty argues that both gender identities in the eyes of the law and the related medical procedures should be a matter of individual choice (2014). Individually determined gender identities have limited place in the DSM-5 and the current sociocultural practice of diagnosis-before-treatment. This is shown in the representations of the individual and gender dysphoria: when gender dysphoria performs processes within the individual, the individual, who is simply represented as the circumstances of the process, has no power. The grammar in the data reflects the authors' view that gender dysphoria is a mental disorder and the individual cannot be made responsible for determining their own gender identity. This way the revised category of gender dysphoria in DSM-5 still

“undoes” the diagnosed individuals (Butler 2004: 2), represents them as mentally ill and thus does not validate their existence as equal members of society. Emphasising the key requirement of distress makes no difference in the light of the representations found in the grammar of the data.

If the category of gender dysphoria only existed to facilitate access to treatment with no intention to label or diagnose, the diagnostic guidelines would be presented through mental and verbal processes with the individual as the first participant. This would give credit to the individual’s cognitive abilities and right of self-determination and also acknowledge that variant gender identities are exactly what they are called, instead of being symptoms of a mental disorder. I argue that should the sociocultural practice of diagnosing gender dysphoria to facilitate the entry to treatment continue, the diagnosis and thus the language within the diagnostic guidelines should be premised on the individual’s self-determination. As the DSM-5 has significant influence on both diagnostic practice and medical discourse, I argue that basing the linguistic formulation and thus the diagnostic practice on self-determination would have a positive impact on the overall representation of transgender individuals and variant gender identities in social reality. The impact of this change, however, would be small in comparison to the one produced by the abolition of the whole sociocultural practice of diagnosis-before-treatment and pathologisation of gender identities, which is the only justified ending in terms of equality and human rights.

6.2 Children and Gender Dysphoria

In this section I will talk about three interconnected problems with the representation of children and their relation to gender dysphoria, parents and society. These problems can be pointed out in the grammar of the data. They are the observation of behaviour that is the basis of the symptoms; the overlapping roles of parents, society and psychiatrists in making the diagnosis; and the origin of the required symptom of distress. I argue that the aforementioned problems question whether the diagnostic category of gender dysphoria as written in the DSM-5 should be applied to children. This has also been questioned in previous studies and analyses on the category in

DSM-IV (Butler 2004; Davy 2013; Hill *et al.* 2007). I will also discuss the individual representations of girls and boys in the data and what this implies in terms of the authors' ideologies, and also what the implications of these ideologies are on the validity of the diagnostic guidelines in connection to children. I will start with discussing the symptoms of gender dysphoria in children.

The authors themselves acknowledge that the guidelines for diagnosing a child with gender dysphoria in DSM-5 are written from a behavioural basis (APA 2013a: 454-455). While this is understandable to a certain extent, as a child's cognitive abilities are still developing, this behavioural perspective nevertheless creates problems. The grammar mostly places the reader (the psychiatrist) in the implied position of the observer while the child performs processes that are interpreted as symptomatic. I will discuss the percentual extent to which this is done when I discuss natal girls and boys individually. These behaviours and preferences are connected to binary gender stereotypes that include lists of toys and games a typical girl or boy is supposed to enjoy. Butler (2004: 95-96) already notes this problem with regard to the category of gender identity disorder in the DSM-IV and the analysis carried out in this thesis shows that this has not changed in the newest edition of the manual. If one questions the traditional binary gender stereotypes as a premise for healthy gender identity, many of these symptoms, such as natal boys liking Barbies, are made irrelevant.

These behavioural premise for the symptoms in children can also be observed through Judith Butler's (2004) theory of performative identities. As summarised in section 3.3.2, Butler argues that gender categories are social constructs that are upheld by repetitive performances of gendered behaviour (2004: 48). This is fitting in light of the findings of the analysis: the symptoms of gender dysphoria, especially those related to children, are presented as behaviours that are observed and then compared to "healthy" gender behaviours. The gender performances that do not conform to the socially accepted categories are diagnosed as disordered. An individual with socially acceptable gender identity performs their own gender, while those with non-conforming identities are at times reduced as the 'stages', or circumstantial elements in the grammar, on which the

symptomatic behaviours are acted out by the disorder. The idea of gender performance is especially fitting in relation to children, whose diagnoses, I argue, are almost completely based on non-conforming gender performances.

The behavioural basis of the symptoms which is reflected in the use of material and relational processes also problematises the clinical practice: as many of the symptomatic behaviours are related to the child's environment, such as the refusal to go to school or problems with making friends, it is highly unlikely that a clinician would be able to observe all of these behaviours themselves. A certain amount of symptoms need to occur before the diagnosis can be made and thus the clinician may need third party information to complete the diagnosis. The guidelines for clinical practice in the DSM-5 endorse the use of third party information when needed (APA 2013a: 21). The producers of this information are likely to be the child's parents, who then give their own account of the child's behaviour. This creates a link between the child and the maker of the diagnosis that is problematic in terms of diagnostic validity: in addition to the psychiatrist's own interpretation of the symptoms that the child 'displays', the parents' interpretation is added to the formation of the diagnosis. The parents' interpretation is necessarily value based and this adds to the interplay of values and ideologies related to the diagnosis. The central issue is that these values do not originate from the child but from the parents and the psychiatrist, while the child is the one receiving the diagnosis. This problem was also recognised in DSM-IV by Hill *et al.* (2007), and in light of the analysis I argue that this has not changed in the DSM-5.

The problems with the behavioural basis for the symptoms could in theory be countered by the precondition of distress. This, however, brings us to the problem of the origin of the distress, which was also pointed out in DSM-IV (Butler 2004; Hill *et al.* 2007). In Example 33 in the analysis, the child shows signs of distress when the parents determine the child's gender for them according to purely biological standards. Similarly in Examples 34 and 35, the child's refusal to go to school and emotional problems are caused by harassment and rejection from peers. In Example 33, the authors use an identifying relational process to state the parents' belief that the child is not "really" of

the gender that they identify themselves to be, indicating the primacy of the parents' perception through this labelling process type. Therefore the child's distress is caused by the values that their parents explicitly impose on them; in consequence, the cause of distress is the parents, not gender dysphoria. This causes a very obvious logical problem: if the origin of the distress is not gender dysphoria, it is completely baseless to use it as a key requirement for making the diagnosis.

In the data, the authors fail to show gender dysphoria to be the source of distress. Instead, the distress is a by-product of the dominant ideology of binary gender that is intertwined in sociocultural practice and enforced by the DSM-5. This is shown in the grammar: the participants that are responsible for the distress and related behaviour are parents, peers and society that impose this binary gender ideology. As the category of gender dysphoria in DSM-5 is based on this dominant ideology, it can be concluded that the sociocultural practice of using the manual can also be the cause of distress. The same conclusion was reached by Butler in relation to gender identity disorder in DSM-IV (2004: 99). The role of distress is emphasised in the revised category of gender dysphoria in DSM-5, but, similarly to DSM-IV (ibid.), this logical fallacy cancels the relevance of both distress as a symptom and as a key requirement for the diagnosis. This is especially relevant in regard to children and the behavioural basis of their symptoms. The symptoms presented in the diagnostic guidelines for children rely on the observation of processes performed by the child. The representations of these behaviours and preferences as symptoms is based on socially constructed stereotypes of binary gender. Finally, analysis of the grammar indicates that the symptom of distress is not caused by a supposed mental disorder, but by environmental factors. Thus, so far the analysis brings little support for the existence of the diagnostic criteria and guidelines for gender dysphoria in children in the DSM-5.

The logical problem with the behavioural symptoms is related to the lack of cognitive ability that the children are credited with in the data. There is a distinct lack of mental processes in the clauses about children compared to the other process types, and even those mental processes that are used often refer to preferences of playmates and toys.

In the clauses that discuss girls and boys separately, emotions are usually conveyed through a verbal process: the children 'express', 'demonstrate', or 'show' emotions. Choosing verbal processes to convey this meaning relies on the observation of the psychiatrist; had the feeling of these emotions been expressed with a mental process in the data, the personal origin and the validity of the children's emotions would be acknowledged. Here was also a notable difference between girls and boys in the data: the girls had markedly more verbal processes than the boys. This shows show a clear difference in their representations; the authors portray the girls as more expressive than boys. What this means in terms of diagnosis is that the diagnostic guidelines pay more attention on the expressions of emotions, preferences and desires by the girls, while the boys remain observed on a behavioural level.

The boys are represented as doers through material processes and through relational processes they are portrayed as being in possession of or identified with the same things that the girls were expressing through verbal processes. This indicates that the authors have less faith in the boys' cognitive abilities than those of girls. While the psychiatrist takes an observant position towards the girls as well, which shown by the choice of verbal processes instead of mental ones, the boys are observed from a longer distance. The use of relational processes, where boys are in possession of emotions and preferences without actually expressing or feeling them distances the reader from the boys. Using relational and material processes also make the authors appear very certain about what the boys are going through; so much so that it can be observed through behaviour alone. MacDonald (2002) argues that a similar validation of information is achieved through the use of these processes in medical textbooks.

The communicative capabilities of girls are given more credit and thus their personal experiences are represented as more relevant in the data; placing the girls as first participants in verbal processes connects the reader to their thoughts. In the data this representation through verbal processes could also appear as a sign of hesitation from the authors, as the verbal processes diminish the power and responsibility of the observing psychiatrist. With the boys, the predominance of material and relational proc-

esses indicates a higher level of certainty. However, in terms of the validity of the diagnosis, it could be said that based on the representation of girls in the data their diagnoses would be made from a less behavioural basis than those of the boys. The girls' personal experiences have more relevance when they are diagnosed. However, modalization also needs to be taken into account when analysing the individual representations of girls and boys as well as the overall representation of children in the data.

All but 15 % of the clauses about boys and 10% of the clauses about girls had no modalization in the data. This means that respectively 85 % and 90 % of the processes in the data included expressions of lower modal commitment from the authors. Lowering the degree of probability through modalization is common in medical discourse (Adams Smith 1984), but in clauses that are representative of symptomatic behaviours and preferences which, in turn, are the only indicators of a supposed underlying disorder, the amount of modalization becomes problematic. This is especially enhanced when combined with the fact that diagnosing children is likely to require third party information. The diagnostic criteria for gender dysphoria in children include eight criteria, of which six need to occur before the diagnosis can be made. These criteria are included in the data as the symptomatic behaviours and preferences that are observed. However, as the occurrence of the vast majority of the symptoms is expressed as uncertain and the parents may have to be trusted to report some of them, the psychiatrist is left with a great deal of responsibility and, ergo, power. What the psychiatrist does with this power is left to their professional discretion, but, more importantly, in this combination the child receiving the diagnosis is left with very little say about their personal experience, let alone with the possibility of determining their own identity. There is a marked power imbalance between the child and the psychiatrist, which is reflected in the grammar through the process types that represent the child as something to be observed as well as through modalization, which gives the psychiatrist a great deal of interpretative freedom. When it comes to the individual representations of boys and girls in the data, the few unmodalized clauses are of importance.

Three clauses with boys as the first participant and two clauses with girls were left completely unmodalized in the data. The clauses about boys included two possessive relational processes and a material process, and the clauses about girls had a mental and a verbal process, and they can be found as Examples 32-35 in the analysis. These clauses represent the symptoms that the authors are certain about and they reflect the general division of process types between girls and boys. The authors are certain of the boys as 'possessors' and 'doers', while they are certain of the girls as 'feelers' and 'expressers'. This follows the stereotypical gender roles which are clearly the basis for the diagnostic criteria and guidelines for children. These stereotypes are overtly expressed in the things and activities girls and boys are supposed to prefer, but also implicitly in the process types that the authors choose to employ. This, I argue, reveals a strong binary gender ideology through which the authors view their subjects, which is not only found on the surface of the guidelines, appearing as "helpful" generalisations that enhance their clinical utility, but also within the deeper experiental meanings that are reflected in grammar.

The findings of the analysis of the representations of children and gender dysphoria in the data can be summarised in three points: the symptoms in the diagnostic guidelines are based on observed behaviours reflecting a stereotypical model of binary gender, which causes a marked imbalance of power between the child and the psychiatrist; the key symptom of distress is caused by sociocultural practice rather than an inherent disorder in the data; and the representations of girls and boys in the diagnostic guidelines reveals a deeper ideological bias towards binary gender stereotypes. In light of these findings, I argue that the grammar in the diagnostic guidelines and criteria for gender dysphoria in children in the DSM-5 does not support the premise that an inner disorder causes distress and symptomatic behaviour in children. The grammar rather reflects an underlying ideology through which the behaviour is made symptomatic, which is in turn validated by the presence of distress whose true origin is disregarded. This ideology underlying the authors' representations of their subjects is that variant gender identities are, simply, a type of mental disorder.

7. CONCLUSION

This study set out to examine the representations of the individuals and the construction of gender dysphoria as a mental disorder in the DSM-5 diagnostic category of Gender Dysphoria. These representations and patterns of construction were identified through the transitivity choices made by the authors. With the help of the critical approach and Fairclough's three dimensional model of discourse analysis, the results of the transitivity analysis were connected to and discussed from the perspective of sociocultural practice. As the representations and their ideological implications could be uncovered with the help of the transitivity model and discussed with the help of Fairclough's discourse analytic model, the methods proved to be useful for the analysis carried out in this study.

In light of the results of the analysis, I argue that the sociocultural practice of diagnosing an individual with gender dysphoria to enable them to enter reassignment treatments is unjust and includes an inherent power imbalance between the individual and the psychiatrist. Should this practice continue as a part of the treatment system, the basis of the diagnosis and thus the language in the diagnostic category should be changed to premise individual self-determination of gender identity. With regard to children, the language in the diagnostic category reflects a marked imbalance of power between the child and the psychiatrist as well as a strong binary gender ideology which is used to justify the diagnostic criteria. The results of this study question the validity of applying the diagnostic category on children. Thus, I argue that at the very least the language regarding children within the diagnostic category of Gender Dysphoria should be changed to reflect any possible scientific evidence that the primary symptom of distress is caused by a mental disorder. Otherwise there is no justifiable basis for the existence of the diagnostic criteria and guidelines for children in their current form as can be deduced from the analysis carried out in this study.

The results of this analysis are naturally biased themselves as they depend on my interpretation. However, as I have openly stated my position as a researcher, and the results are also supported by previous research performed on the DSM manuals in the

fields of both linguistics and psychiatry they are valid interpretations of the ideological representations in the data. However, due to the limited scope of this study, further research is needed to get a full sense of the ways in which the authors' ideologies are reflected in the grammar. While this study has revealed a general picture of the representation of the individual and a more detailed picture of the representation of the children in the data, there are several possible focuses for future research. Among these are the comparative analysis between the different groups of individuals in the data and the comparative analysis of the use of more observantly based material and relational processes against the more individual oriented mental and verbal processes. One avenue of study could also be the effects that the use of different methods of expressing modalization have on the representations, on which the results were inconclusive in this analysis. The full effects of both the results and the category of Gender Dysphoria in DSM-5 on sociocultural practice and social reality are also topics for a much wider discussion.

8. REFERENCES

Primary Sources

American Psychiatric Association 2013a. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Arlington, VA: American Psychiatric Association.

Secondary Sources

Adams Smith Diana E. 1984. Medical discourse: Aspects of author's comment. *The ESP Journal* 3: 25-36.

Ainsworth-Vaughn Nancy 1992. Topic transitions in physician-patient interviews: Power, gender, and discourse change. *Language in Society* 21 (3): 409-426.

American Psychiatric Association 2013b. Gender dysphoria [online]. Available: http://www.dsm5.org/Documents/Gender%20Dysphoria%20Fact%20Sheet.pdf (26 January 2014).

American Psychiatric Association 2014a. About APA & psychiatry [online]. Available: http://www.psychiatry.org/about-apa--psychiatry (26 January 2014).

American Psychiatric Association 2014b. About DSM-5 [online]. Available: http://www.dsm5.org/about/Pages/Default.aspx (11 February 2014).

American Psychiatric Association 2014c. DSM [online]. Available: http://www.psychiatry.org/practice/dsm (26 January 2014).

American Psychiatric Association 2014d. Frequently Asked Questions [online]. Available: http://www.dsm5.org/about/Pages/faq.aspx (13 February 2014).

Amnesty International 2014. The state decides who I am: Lack of legal gender recognition for transgender people in Europe [online]. Available: http://www.amnesty.org/en/library/info/EUR01/001/2014/en (11 February 2014)

Ault Amber & Brzuzy Stephanie 2009. Removing gender identity disorder from the diagnostic and statistical manual of mental disorders: A call for action. *Social Work* 54 (2): 187-189.

Boucher Geoff 2006. The politics of performativity: A critique of Judith Butler. *Parrhesia* (1): 112-141.

Bower Herbert 2001. The gender identity disorder in the DSM-IV classification: A critical evaluation. *Australian and New Zealand Journal of Psychiatry* 35 (1): 1–8.

Bowles Hugo 2006. Conversation analysis and health communication: Updating a developing relationship. In Gotti & Salager-Meyer (eds.): 43-64.

Butler Judith [1993] 2011. *Bodies That Matter*. New York: Routledge.

Butler Judith 2004. *Undoing Gender*. New York: Routledge.

Crowe M. 2000. Constructing normality: A discourse analysis of the DSM-IV. *Journal of Psychiatric and Mental Health Nursing* 7: 69–77.

Davis Elizabeth M. 2008. Risky business: Medical discourse, breast cancer, and narrative. *Qualitative Health Research* 18 (1): 65-76.

Davy Zowie 2013. Commentary - The construction of gender dysphoria at 'Classifying Sex: Debating DSM-5'. *Psychology of Women Section Review* 15 (2). Available: http://eprints.lincoln.ac.uk/

DeCuypere G., Knudson G. & Bockting, W. 2010. Response of the World Professional Association for Transgender Health to the proposed DSM 5 criteria for gender incongruence. *International Journal of Transgenderism* 12 (2) 54-59. Available: http://www.wpath.org/

Fairclough Norman [1992] 2002. *Discourse and Social Change*. Cambridge: Polity Press.

Fairclough Norman 1995. *Critical Discourse Analysis*. London: Longman Group Limited.

Fairclough Norman 2001. Critical discourse analysis. In McHoul & Rapley (eds.): 25-40.

Fairclough Norman [2003] 2004. *Analysing Discourse: Textual Analysis for Social Research*. London: Routledge.

Fairclough Norman 2010. *Critical Discourse Analysis: the Critical Study of Language*. Harlow: Pearson Education Limited.

Fairclough Norman, Mulderrig Jane & Wodak Ruth 2011. Critical discourse analysis. In van Dijk (ed.): 357-379.

Ferguson Gibson 2001. If you pop over there: A corpus-based study of conditionals in medical discourse. *English for Specific Purposes* 20 (1): 61–82.

Fleischman Suzanne 1999. I am ... , I have ... , I suffer from ... :A linguist reflects on the language of illness and disease. *Journal of Medical Humanities* 20 (1): 3-32.

Foucault Michel [1967] 1993. *Histoire de la Folie*. (Madness and Civilization: a History of Insanity in the Age of Reason) Transl. Howard Richard. London: Routledge.

Foucault Michel [1972] 2009. *L'Archéologie du Savoir* (The Archaeology of Knowledge) Transl. Sheridan Smith A. M.. London: Routledge.

Foucault Michel [1978] 1990. *Histoire de la sexualité Vol I: La Volonté de savoir*. (The History of Sexuality Volume I: An Introduction) Transl. Hurley Robert. London: Penguin Group.

Fryer Daniel Lees 2012. Analysis of the generic discourse features of the English-language medical research article: A systemic-functional approach. *Functions of Language (FunL)* 19 (1): 5-37.

Fulford Kenneth W.M., Broome Matthew, Stanghellini Giovanni & Thornton Tim 2005. Looking with both eyes open: Fact and value in psychiatric diagnosis? *World Psychiatry* 4 (2): 78–86.

Gambrill Eileen 2014. The diagnostic and statistical manual of mental disorders as a major form of dehumanization in the modern world. *Research on Social Work Practice* 24 (1): 13-36.

Gao Wenyan 2012. Nominalization in medical papers: A comparative study. *Studies in Literature and Language* 4 (1):86-93

Gotti Maurizio & Salager-Meyer Françoise (eds.) 2006. *Linguistic Insights, Volume 45: Advances in Medical Discourse Analysis: Oral and Written Contexts.* Bern: Peter Lang.

Halliday M. A. K. & Matthiessen Christian 2004. *An Introduction to Functional Grammar*. London: Arnold Publishers.

Hill Darryl B., Rozanski Christina, Carfagnini Jessica & Willoughby Brian 2007. Gender identity disorders in childhood and adolescence: A critical inquiry. *International Journal of Sexual Health* 19 (1): 57-75.

Horwitz Alan V. 2002. *Creating Mental Illness*. Chicago: The University of Chicago Press.

Hugh-Jones Siobhan, Gough Brendan & Littlewood Annie 2005. Sexual exhibitionism as 'sexuality and individuality': A critique of psycho-medical discourse from the perspectives of women who exhibit. *Sexualities* 8 (3): 259-281.

Hyman Steven E. 2010. The diagnosis of mental disorders: The problem of reification. *Annual Review of Clinical Psychology* 6: 155-179.

Insel Thomas R. 2013. Director's blog: Transforming diagnosis [online]. Available: http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml (26 January 2014).

Jagose Annamarie [1996] 2008. *Queer Theory: An Introduction*. New York: New York University Press.

Kleinplatz (ed.) 2001. *New Directions in Sex Therapy: Innovations and Alternatives*. Philadelphia: Brunner-Routledge

Krizsán Attila 2011. *"The EU is Not Them, But Us!": The First Person Plural and the Articulation of Collective Identities in European Political Discourse.* Newcastle: Cambridge Scholars Publishing.

Lane Christopher 2013. The NIMH withdraws support for DSM-5 [online]. Available: http://www.psychologytoday.com/blog/side-effects/201305/the-nimh-withdraws-support-dsm-5 (26 January 2014).

Lev Arlene Istar 2006. Disordering gender identity: Gender identity disorder in the DSM-IV-TR. *Journal of Psychology & Human Sexuality* 17 (3-4): 35-69.

Lev Arlene Istar 2013. Gender dysphoria: Two steps forward, one step back. *Clinical Social Work Journal* 41: 288–296.

Macdonald Malcolm N. 2002. Pedagogy, pathology and ideology: The production, transmission and reproduction of medical discourse. *Discourse & Society* 13 (4): 447-467.

McHoul Alec & Rapley Mark (eds.) 2001. *How to Analyze Talk in Institutional Settings: A Casebook of Methods*. London: Continuum.

Moser Charles 2001. Paraphilia: A critique of a confused concept. In Kleinplatz (ed.) 91-108.

Nelson Lise 1999. Bodies (and spaces) do matter: The limits of performativity. *Gender, Place & Culture: A Journal of Feminist Geography* 6 (4): 331-353.

Rundblad Gabriella 2007. Impersonal, general, and social: The use of metonymy versus passive voice in medical discourse. *Written Communication* 24 (3) 250-277.

Silverstein Michael 2004. "Cultural" concepts and the language-culture nexus. *Current Anthropology* 45 (5): 621-652.

Thompson Geoff 2004. *Introducing Functional Grammar*. London: Hodder Education.

van Dijk Teun 1993. *Elite Discourse and Racism*. London: Sage.

van Dijk Teun A. 2008. *Discourse & Power.* New York: Palgrave.

Widdowson H.G. 2004. *Text, Context, Pretext: 3.3cal Issues in Discourse Analysis*. Malden, MA & Oxford: Blackwell Publishing.

Wilce James M. 2009. Medical discourse. *Annual Review of Anthropology* 38: 199-215.

Winters Kelley 2006. Gender dissonance. *Journal of Psychology & Human Sexuality* 17 (3-4): 71-89.

Wodak Ruth & Meyer Michael (eds.) 2009. *Methods for Critical Discourse Analysis*. London: Sage.

Wodak Ruth & Meyer Michael 2009. Critical discourse analysis: History, agenda, theory, and methodology. In Wodak &Meyer (eds.): 1-33.

World Health Organization 2014. International Classification of Diseases (ICD) [online]. Available: http://www.who.int/classifications/icd/en/ (26 January 2014).

World Professional Association for Transgender Health (WPATH) 2014. WPATH clarification on medical necessity of treatment, sex reassignment, and insurance coverage for transgender and transsexual people worldwide [online]. Available: http://www.wpath.org/ (3 February 2014).

Zucker Kenneth J. 2010. The DSM diagnostic criteria for gender identity disorder in children. *Archives of Sexual Behavior* 39 (2): 477-498.

Zucker Kenneth J., Cohen-Kettenis Peggy T., Drescher Jack, Meyer-Bahlburg Heino F. L., Pfäfflin Friedemann & Womack William M. 2013. Memo outlining evidence for change for gender identity disorder in the DSM-5. *Archives of Sexual Behavior* 42: 901–914.

APPENDIX 1:

Analysed Data

Diagnostic Features

Individuals with gender dysphoria **[Carrier: possessor]** have **[Process: relational, attributive]** a marked incongruence between the gender they have been assigned to (usually at birth, referred to as *natal gender*) and their experienced/expressed gender **[Attribute: possessed]**.

> between the gender they **[Goal…]** have been assigned **[Process: material, transformative, intentional]** to **[…Goal]**

Prepubertal natal girls with gender dysphoria **[Sayer]** may **[Modalization: low, implicit, subjective]** express **[Process: verbal]** the wish to be a boy **[Verbiage]**, assert **[Process: verbal]** that they are a boy **[Projected]**, or assert **[Process: verbal]** that they will grow up to be a man **[Projected]**.

> that they **[Identified]** are **[Process: relational, identifying]** a boy **[Identified]**
>
> that they **[Actor]** will grow up to be **[Process: material, transformative, intentional]** a man **[Goal]**

They **[Senser]** prefer **[Process: mental, emotion]** boys' clothing and hairstyles **[Phenomenon]**, are **[Process…]** often **[Circumstance: Extent, frequency]** perceived **[Process: mental, perception]** by strangers **[Senser]** as boys **[Phenomenon]**, and may **[Modalization: low, implicit, subjective]** ask **[Process: verbal]** to be called by a boy's name **[Verbiage]**.

Usually **[Circumstance: Extent, frequency]**, they **[Sayer]** display **[Process: verbal]** intense negative reactions **[Verbiage]** to parental attempts to have them wear dresses or other feminine attire **[Target]**.

Some **[Actor]** may **[Modalization: low, implicit, subjective]** refuse to attend **[Process: material, transformative, intentional]** school or social events where such clothes are required **[Goal]**.

These girls **[Sayer]** may **[Modalization: low, implicit, subjective]** demonstrate **[Process: verbal]** marked cross-gender identification **[Verbiage]** in role-playing, dreams, and fantasies **[Circumstance: Location, place]**.

Contact sports, rough-and-tumble play, traditional boyhood games, and boys as play-mates **[Phenomenon]** are **[Process…]** most often **[Circumstance: Extent, frequency]** preferred **[Process: mental, emotion]**.

They **[Sayer]** show little interest **[Process: verbal]** in stereotypically feminine toys (e.g., dolls) or activities (e.g., feminine dress-up or role-play) **[Target]**.

Occasionally **[Circumstance: Extent, frequency]**, they **[Actor]** refuse **[Process: material, transformative, intentional]** to urinate in a sitting position **[Goal]**.

Some natal girls **[Sayer]** may **[Modalization: low, implicit, subjective]** express **[Process: verbal]** a desire to have a penis **[Verbiage]** or claim **[Process: verbal]** to have a penis **[Verbiage]** or that they will grow one when older **[Projection]**.

> that they **[Actor]** will grow **[Process: material, creative, intentional]** one **[Goal]** when older **[Circumstance: Location, time]**

They **[Sayer]** may **[Modalization: low, implicit, subjective]** also state **[Process: verbal]** that they do not want to develop breasts or menstruate **[Projected]**.

> that they **[Senser]** do not **[Polarity: negative]** want to **[Process: mental, desid-eration]** develop breasts or menstruate **[Phenomenon]**

Prepubertal natal boys with gender dysphoria **[Sayer]** may **[Modalization: low, implicit, subjective]** express **[Process: verbal]** the wish to be a girl **[Verbiage]** or assert **[Process: verbal]** that they are a girl or that they will grow up to be a woman **[Projected]**.

> that they **[Identified]** are **[Process: relational, identifying]** a girl **[Identifier]**

> that they **[Actor]** will grow up to be **[Process: material, transformative, inten-tional]** a woman **[Goal]**

They **[Carrier: possessor]** have **[Process: relational, attributive]** a preference for dress-ing in girls' or women's' clothes **[Attribute: possessed]** or may **[Modalization: low,**

implicit, subjective] improvise **[Process: material, transformative, intentional]** clothing **[Goal]** from available materials (e.g., using towels, aprons, and scarves for long hair or skirts) **[Circumstance: Manner, means]**.

These children **[Actor]** may **[Modalization: low, implicit, subjective]** role-play **[Process: material, transformative, intentional]** female figures (e.g., playing "mother") **[Goal]** and often **[Circumstance: Extent, frequency]** are **[Process: relational, attributive]** intensely **[Circumstance: Manner, degree]** interested in female fantasy figures **[Attribute]**.''

Traditional feminine activities, stereotypical games, and pastimes (e.g., "playing house"; drawing feminine pictures; watching television or videos of favorite female characters) **[Phenomenon]** are **[Process…]** most often **[Circumstance: Extent, frequency]** preferred **[Process: mental, emotion]**.

Stereotypical female-type dolls (e.g., Barbie) **[Identified]** are **[Process: relational, identifying]** often **[Circumstance: Extent, frequency]** favorite toys **[Identifier]**, and girls **[Identified]** are **[Process: relational, identifying]** their preferred playmates **[Identifier]**.

They **[Actor]** avoid **[Process: material, transformative, intentional]** rough-and-tumble play and competitive sports **[Goal]** and have **[Process: relational, attributive]** little interest in stereotypically masculine toys (e.g., cars, trucks) **[Attribute: possessed]**.

Some **[Actor]** may **[Modalization: low, implicit, subjective]** pretend not **[Polarity: negative]** to have **[Process: material, transformative, intentional]** a penis **[Goal]** and insist on **[Process: verbal]** sitting to urinate **[verbiage]**.

More rarely **[Circumstance: Extent, frequency]**, they **[Sayer]** may **[Modalization: low, implicit, subjective]** state **[Process: verbal]** that they find their penis or testes disgusting, that they wish them removed, or that they have, or wish to have, a vagina **[Projected]**.

> that they **[Senser]** find **[Process: mental, emotion]** their penis or testes disgusting **[Phenomenon]**

that they **[Senser]** wish **[Process: mental, desideration]** them removed **[Phenomenon]**

that they **[Carrier: possessor]** have **[Process: relational, attributive]**, or wish to have **[Process: mental, desideration]**, a vagina **[Carrier: possessed/Phenomenon]**.

In young adolescents with gender dysphoria **[Circumstance: Location, place]**, clinical features **[Carrier]** may **[Modalization: low, implicit, subjective]** resemble **[Process: relational, attributive]** those of children or adults with the condition **[Attribute]**, depending on development level **[Circumstance: Contingency, condition]**.

As secondary sex characteristics of young adolescents **[Carrier]** are **[Process: relational, attributive]** not **[Polarity: negative]** yet fully developed **[Attribute]**, these individuals **[Sayer]** may **[Modalization: low, implicit, subjective]** not **[Polarity: negative]** state **[Process: verbal]** dislike of them **[Verbiage]**, but they **[Carrier]** are **[Process: relational, attributive]** concerned **[Attribute]** about imminent physical changes **[Circumstance: Matter]**.

In adults with gender dysphoria **[Circumstance: Location, place]**, the discrepancy between experienced gender and physical sex characteristics **[Carrier]** is **[Process: relational, attributive]** often, but not always **[Circumstance: Extent, frequency]**, accompanied by a desire to be rid of primary and / or secondary sex characteristics and / or a strong desire to acquire some primary and / or secondary sex characteristics of the other gender **[Attribute]**.

To varying degrees **[Circumstance: Manner, degree]**, adults with gender dysphoria **[Behaver]** may **[Modalization: low, implicit, subjective]** adopt **[Process: behavioural]** the behavior, clothing, and mannerisms of the experienced gender **[Behaviour]**.

They **[Senser]** feel **[Process: mental, emotion]** uncomfortable being regarded by others, or functioning in society, as members of their assigned gender **[Phenomenon]**.

Some adults **[Carrier: possessor]** may **[Modalization: low, implicit, subjective]** have **[Process: relational, attributive]** a strong desire to be of a different gender and

treated as such **[Attribute: possessed]**, and they **[Carrier: possessor]** may **[Modalization: low, implicit, subjective]** have **[Process: relational, attributive]** an inner certainty to feel and respond as the experienced gender without seeking medical treatment to alter body characteristics **[Attribute: possessed]**.

They **[Senser]** may **[Modalization: low, implicit, subjective]** find **[Process: mental, cognitive]** other ways to resolve the incongruence between experienced/expressed and assigned gender **[Phenomenon]** by partially living in the desired role or by adopting a gender role neither conventionally male not conventionally female **[Circumstance: Manner, means]**.

> by partially living **[Process: material, transformative, intentional]** in the desired role **[Circumstance: Role, guise]** or by adopting **[Process: mental, cognition]** a gender role neither conventionally male not conventionally female

Associated Features Supporting Diagnosis

When visible signs of puberty **[Actor]** develop **[Process: material, transformative, involuntary]**, natal boys **[Actor]** may **[Modalization: low, implicit, subjective]** shave **[Process: material, transformative, intentional]** their legs **[Goal]** at the first signs of hair growth **[Circumstance: Location, time]**.

- ❖ When visible signs of puberty **[Medium]** develop **[Process: material]**

They **[Actor]** sometimes **[Circumstance: Extent, frequency]** bind **[Process: material, transformative, intentional]** their genitals **[Goal]** to make erections less visible **[Circumstance: Cause, purpose]**.
Girls **[Actor]** may **[Modalization: low, implicit, subjective]** bind **[Process: material, transformative, intentional]** their breasts **[Goal]**, walk **[Process: material, transformative, intentional]** with a stoop **[Circumstance: Manner, quality]**, or use **[Process: material, transformative, intentional]** loose sweaters **[Goal]** to make breasts less visible **[Circumstance: Cause, purpose]**.

Increasingly **[Circumstance: Manner, degree]**, adolescents **[Sayer]** request **[Process: verbal]**, or may **[Modalization: low, implicit, subjective]** obtain **[Process: material, transformative, intentional]** without medical prescription and supervision **[Circumstance: manner]**, hormonal suppressors ("blockers") of gonadal steroids (e.g., gonadotropin-releasing hormone [GnRH] analog, spironolactone) **[Goal]**.

Clinically referred adolescents **[Senser]** often **[Circumstance: Extent, frequency]** want **[Process: mental, desideration]** hormone treatment **[Phenomenon]** and many **[Senser]** also wish **[Process: mental, desideration]** for gender reassignment surgery **[Phenomenon]**.

Adolescents living in an accepting environment **[Sayer]** may **[Modalization: low, implicit, subjective]** openly **[Circumstance: Manner, quality]** express **[Process: verbal]** the desire to be and be treated as the experienced gender **[Verbiage]** and dress **[Process: material, transformative, intentional]** partly or completely **[Circumstance: Manner, degree]** as the experienced gender **[Circumstance: Role, guise]**, have **[Process: relational, attributive]** hairstyles typical of the experienced gender **[Possessed]**, preferentially **[Circumstance: Manner, quality]** seek **[Process: material, transformative, intentional]** friendships **[Goal]** with peers of the other gender **[Circumstance: Accompaniment]**, and/or adopt **[Process: mental, cognition]** a new first name consistent with the experienced gender **[Goal]**.

Older adolescents **[Actor]**, when sexually active **[Circumstance: Location, time]**, usually **[Circumstance: Extent, frequency]** do not **[Polarity: negative]** show **[Process: material, transformative, intentional]** or allow **[Process: mental, cognitive]** partners **[Actor 2]** to touch **[Process: material, transformative, intentional]** their sexual organs **[Goal]**.

For adults with an aversion toward their genitals **[Circumstance: Angle, viewpoint]**, sexual activity **[Carrier]** is **[Process: relational, attributive]** constrained **[Attribute]** by the preference that their genitals not be seen or touched by their partners **[Circumstance: Cause]**.

their genitals **[Phenomenon/Goal]** not **[Polarity: negative]** be seen **[Process: mental, cognition]** or touched **[Process: material, transformative, intentional]** by their partners **[Senser/Actor]**

Some adults **[Actor]** may **[Modalization: low, implicit, subjective]** seek **[Process: material, transformative, intentional]** hormone treatment (sometimes **[Circumstance: Extent, frequency]** without medical prescription and supervision **[Circumstance: Accompaniment]**) and gender reassignment surgery **[Goal].**

Others **[Carrier]** are **[Process: relational, attributive]** satisfied **[Attribute]** with either hormone treatment or surgery alone **[Circumstance: Accompaniment]**.

Adolescents and adults with gender dysphoria **[Carrier]** before gender reassignment **[Circumstance: Location, time]** are **[Process: relational, attributive]** at an increased risk of suicidal ideation, suicide attempts, and suicides **[Attribute: circumstantial prepositional phrase]**.

Prevalence

For natal adult males **[Range]**, prevalence **[Actor]** ranges **[Process: material, transformative, intentional]** from 0.005% to 0.014% **[Circumstance: Extent]**, and for natal females, from 0.002% to 0.003%.

Since **[Circumstance: Cause, reason]** not all adults seeking hormone treatment and surgical reassignment **[Actor]** attend **[Process: material, transformative, intentional]** specialty clinics **[Goal]**, these rates **[Identified]** are **[Process: relational, identifying]** likely **[Circumstance: Manner, quality]** modest underestimates **[Identifier]**.

In children **[Circumstance: location, place]**, sex ratios of natal boys to girls **[Actor]** range **[Process: material, transformative, intentional]** from 2:1 to 4.5:1 **[Circumstance: Extent]**.

In adolescents **[Circumstance: Location, place]**, the sex ratio **[Carrier]** is **[Process: relational, attributive]** close to parity **[Attribute]**; in adults **[Circumstance: Location, place]**, the sex ratio **[Senser]** favors **[Process: mental, emotion]** natal males **[Phenomenon]**, with ratios ranging from 1:1 to 6.1:1.

In two countries **[Circumstance: Location, place]**, the sex ratio **[Senser]** appears to favor **[Process: mental, emotion]** natal females **[Phenomenon]** (Japan 2.2:1; Poland 3.4:1).

Development and course

Because expression of gender dysphoria varies with age, there are separate criteria sets for children versus adolescents and adults. Criteria for children are defined in a more concrete, behavioral manner than those for adolescents and adults. Many of the core criteria draw on well-documented behavioral gender differences between typically developing boys and girls.

Young children **[Carrier]** are **[Process: relational, attributive]** less likely than older children, adolescents, and adults to express extreme and persistent anatomic dysphoria **[Attribute]**.

> to express **[Process: verbal]** extreme and persistent anatomic dysphoria **[Verbiage]**

In adolescents and adults **[Circumstance: Location, place]**, incongruence between experienced gender and somatic sex **[Identified]** is **[Process: relational, identifying]** a central feature of the diagnosis **[Identified]**.

A very young child **[Sayer]** may **[Modalization: low, implicit, subjective]** show **[Process: verbal]** signs of distress (e.g., intense crying) **[Verbiage]** only when **[Circumstance: Contingency, condition]** parents **[Sayer]** tell **[Process: verbal]** the child **[Receiver]** that he or she is “really” not **[Polarity: negative]** a member of the other gender but only “desires” to be **[Projection]**.

> that he or she **[Identified]** is **[Process: relational, identifying]** “really” not **[Polarity: negative]** a member of the other gender **[Identifier]** but only “desires” to be **[Process: mental, desideration]**

In adolescents and adults **[Circumstance: Location, place]**, distress **[Actor]** may **[Modalization: low, implicit, subjective]** manifest **[Process: material, creative, involuntary]**

because of a strong incongruence between experienced gender and somatic sex **[Circumstance: Cause, reason]**.

- In adolescents and adults **[Circumstance: Location, place]**, distress **[Medium]** may **[Modalization: low, implicit, subjective]** manifest **[Process: material]** because of a strong incongruence between experienced gender and somatic sex **[Circumstance: Cause, reason]**.

Gender Dysphoria without a disorder of sex development.

For clinic-referred children **[Circumstance: Matter]**, onset of cross-gender behaviors **[Identified]** is **[Process: relational, identifying]** usually **[Circumstance: Extent, frequency]** between ages 2 and 4 years **[Identified]**.

This **[Carrier]** corresponds **[Process: relational, attributive]** to the developmental time period in which most typically developing children begin expressing gendered behaviors and interests **[Attribute]**.

in which **[Circumstance: Location, time]** most typically developing children **[Sayer]** begin expressing **[Process: verbal]** gendered behaviors and interests **[Verbiage].**

For some preschool-age children **[Circumstance: Matter]**, both pervasive cross-gender behaviors and the expressed desire to be the other gender **[Carrier]** may **[Modalization: low, implicit, subjective]** be **[Process: relational, attributive]** present **[Attribute]**, or, more rarely **[Circumstance: Extent, frequency]**, labeling oneself as a member of the other gender **[Actor]** may **[Modalization: low, implicit, subjective]** occur **[Process: material, transformative, involuntary]**.

- more rarely **[Circumstance: Extent, frequency]**, labeling oneself as a member of the other gender **[Medium]** may **[Modalization: low, implicit, subjective]** occur **[Process: material]**.

A small minority of children **[Sayer]** express **[Process: verbal]** discomfort with their sexual anatomy **[Verbiage]** or will state **[Process: verbal]** the desire to have sexual anatomy corresponding to the experienced gender ("anatomic dysphoria") **[Verbiage]**.

Expressions of anatomic dysphoria **[Actor]** become more common **[Process: material, transformative, involuntary]** as children with gender dysphoria approach and anticipate puberty **[Circumstance: Location, time]**.

as children with gender dysphoria **[Actor/Senser]** approach **[Process: material, transformative, intentional]** and anticipate **[Process: mental, emotion]** puberty **[Goal/Phenomenon]**

- ❖ Expressions of anatomic dysphoria **[Medium]** become more common **[Process]** as children with gender dysphoria approach and anticipate puberty **[Circumstance: Location, time]**.

Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary. In natal males **[Circumstance: Location, place]**, persistence **[Actor]** has ranged **[Process: material, transformative, involuntary]** from 2.2% to 30% **[Goal]**.

- ❖ In natal males **[Circumstance: Location, place]**, persistence **[Medium]** has ranged **[Process: material]** from 2.2% to 30% **[Circumstance: Extent]**.

In natal females **[Circumstance: Location, place]**, persistence **[Actor]** has ranged **[Process: material, transformative, involuntary]** from 12% to 50% **[Attribute]**.

- ❖ In natal females **[Circumstance: Location, place]**, persistence **[Medium]** has ranged **[Process: material]** from 12% to 50% **[Circumstance: Extent]**.

In one sample of natal males **[Circumstance: Location, place]**, lower socioeconomic background **[Carrier]** was **[Process…]** also modestly **[Circumstance: Manner, quality]** correlated **[Process: relational, attributive]** with persistence **[Attribute]**.

Extant follow-up samples **[Carrier]** consisted of **[Process: relational, attributive]** children receiving no formal therapeutic intervention or receiving therapeutic interventions of various types **[Attribute]**, ranging **[Process: material, transformative, intentional]** from active efforts to reduce gender dysphoria to a more neutral, “watchful waiting” approach **[Circumstance: Extent]**.

It **[Carrier]** is **[Process: relational, attributive]** unclear **[Attribute]** if children "encouraged" or supported to live socially in the desired gender will show higher rates of persistence **[Projection]**, since such children have not yet been followed longitudinally in a systemic manner **[Circumstance: Cause, reason]**.

> children "encouraged" or supported to live socially in the desired gender **[Sayer]** will show **[Process: verbal]** higher rates of persistence **[Verbiage]**
>
> such children **[Goal]** have not **[Polarity: negative]** yet been followed **[Process: material, transformative, intentional]** longitudinally in a systemic manner **[Circumstance: Manner, quality]**

For both natal male and female children showing persistence **[Range]**, almost all **[Carrier]** are **[Process: relational, attributive]** sexually attracted to individuals of their natal sex **[Attribute]**.

For natal male children whose gender dysphoria does not persist **[Range]**, the majority **[Identified]** are **[Process: relational, identifying]** *androphilic* (sexually attracted to males) and of self-identity as gay or homosexual (ranging from 63% to 100%) **[Identifier]**.

> whose gender dysphoria **[Actor]** does not **[Polarity: negative]** persist **[Process: material, transformative, involuntary]**
>
> - ❖ whose gender dysphoria **[Medium]** does not **[Polarity: negative]** persist **[Process: material]**

In natal female children whose gender dysphoria does not persist **[Circumstance: Location, place]**, the percentage who **[Identified]** are **[Process: relational, identifying]** *gynephilic* (sexually attracted to females) **[Identifier]** and self-identify as lesbian is **[Process: relational, attributive]** lower (ranging from 32% to 50%) **[Attribute]**.

> whose gender dysphoria **[Actor]** does not **[Polarity: negative]** persist **[Process: material, transformative, involuntary]**
>
> - ❖ whose gender dysphoria **[Medium]** does not **[Polarity: negative]** persist **[Process: material]**

self-identify **[Process: mental, cognition**] as lesbian **[Phenomenon: circumstantial prepositional phrase]**

In adolescent and adult natal males **[Circumstance: Location, place]**, there are **[Process: existential]** two broad trajectories for development of gender dysphoria: early onset and late onset **[Existent]**.

Early-onset gender dysphoria **[Actor]** starts **[Process: material, creative, involuntary]** in childhood **[Circumstance: Location, time]** and continues **[Process: material, transformative, involuntary]** into adolescence and adulthood **[Circumstance: Extent, duration]**; or, there is **[Process: existential]** an intermittent period **[Existent/Goal]** in which the gender dysphoria desists and these individuals self-identify as gay or homosexual **[Circumstance: Location, time]**, followed **[Process: material, transformative, intentional]** by recurrence of gender dysphoria **[Actor]**.

in which the gender dysphoria **[Actor]** desists **[Process: material, transformative, intentional]** and these individuals **[Senser]** self-identify **[Process: mental, cognition]** as gay or homosexual **[Phenomenon]**

- ❖ *Early-onset gender dysphoria* **[Medium]** starts **[Process: material]** in childhood **[Circumstance: Location, time]** and continues **[Process: material, transformative, intentional]** into adolescence and adulthood **[Circumstance: Extent]**
- ❖ in which the gender dysphoria **[Medium]** desists **[Process: material]**
- ❖ followed **[Process: material]** by recurrence of gender dysphoria **[Agent]**.

Some of these individuals **[Sayer]** report **[Process: Verbal]** having had a desire to be of the other gender in childhood that was not expressed verbally to others **[Verbiage]**.

in childhood **[Circumstance: Location, time]** that **[Verbiage]** was not **[Polarity: negative]** expressed **[Process: verbal]** verbally **[Circumstance: Manner]** to others **[Receiver]**

Others **[Senser]** do not **[Polarity: negative]** recall **[Process: mental, cognition]** any signs of childhood gender dysphoria **[Phenomenon]**.

For adolescent males with late-onset gender dysphoria **[Circumstance: Angle, viewpoint]**, parents **[Sayer]** often **[Circumstance: Extent, frequency]** report **[Process: verbal]** surprise **[Verbiage]** because they did not see signs of gender dysphoria during childhood **[Circumstance: Cause, reason]**.

> because they **[Senser]** did not **[Polarity: negative]** see **[Process: mental, perception]** signs of gender dysphoria **[Phenomenon]** during childhood **[Circumstance: Location, time]**

Expressions of anatomic dysphoria **[Carrier]** are **[Process: relational, attributive]** more common and salient **[Attribute]** in adolescents and adults **[Circumstance: Location, place]** once **[Circumstance: Location, time]** secondary sex characteristics **[Actor]** have developed **[Process: material, transformative, involuntary]**.

- once **[Circumstance: Location, time]** secondary sex characteristics **[Medium]** have developed **[Process: material]**.

Adolescents and adult natal males with early-onset gender dysphoria **[Carrier]** are **[Process: relational, attributive]** almost always **[Circumstance: Extent, frequency]** sexually attracted to men (androphilic) **[Attribute]**.

Adolescents and adults with late-onset gender dysphoria **[Behaver]** frequently **[Circumstance: Extent, frequency]** engage **[Process: behavioral]** in transvestic behavior **[Behavior]** with sexual excitement **[Circumstance: accompaniment]**.

The majority of these individuals **[Identified]** are **[Process: relational, identifying]** gynephilic or sexually attracted to other posttransition natal males with late-onset gender dysphoria **[Identified]**.

A substantial percentage of adult males with late-onset gender dysphoria **[Actor]** cohabit with **[Process: material, transformative, intentional]** or are **[Process: relational, attributive]** married to <u>natal females</u> **[<u>Goal</u>/Attribute]**.

After gender transition **[Circumstance: Location, time]**, many **[Senser]** self-identify **[Process: mental, cognition]** as lesbian **[Phenomenon]**.

Among adult natal males with gender dysphoria **[Circumstance: Location, place]**, the early-onset group **[Actor]** seeks out **[Process: material, transformative, intentional]** clinical care for hormone treatment and reassignment surgery **[Goal]** at an earlier age than does the late-onset group **[Circumstance: Location, time]**.

The late-onset group **[Possessor]** may **[Modalization: low, implicit, subjective]** have **[Process: relational, attributive]** more fluctuations in the degree of gender dysphoria **[Possessed]** and be **[Process: relational, attributive]** more ambivalent about and less likely satisfied after gender reassignment surgery **[Attribute]**.

In both adolescent and adult natal females **[Circumstance: Location, place]**, the most common course **[Identified]** is **[Process: relational, identifying]** the early-onset form of gender dysphoria **[Identifier]**.

The late onset form **[Carrier]** is **[Process: relational, attributive]** much less common **[Attribute]** in natal females compared with natal males **[Circumstance: Location, place]**.

As in natal males with gender dysphoria **[Circumstance: Location, place]**, there may **[Modalization: low, implicit, subjective]** have been **[Process: existential]** a period in which the gender dysphoria desisted **[Existent]** and these individuals **[Senser]** self-identified **[Process: mental, cognition]** as lesbian **[Phenomenon]**; however, with recurrence of gender dysphoria **[Circumstance: Cause, reason]**, clinical consultation **[Goal]** is sought **[Process: material, transformative, intentional]**, often **[Circumstance: Extent, frequency]** with the desire for hormone treatment and gender-reassignment surgery **[Circumstance: Accompaniment]**.

Expressions of anatomic dysphoria **[Carrier]** are **[Process: relational, attributive]** much more common and salient **[Attribute]** in adolescents and adults than in children **[Circumstance: Location, place]**.

Adolescent and adult natal females with early-onset gender dysphoria **[Identified]** are **[Process: relational, identifying]** almost always **[Circumstance: Extent, frequency]** gynephilic **[Identifier]**.

Adolescents and adults with late-onset gender dysphoria **[Identified]** are **[Process: relational, identifying]** usually **[Circumstance: Extent, frequency]** androphilic **[Identifier]** and after gender transition **[Circumstance: Location, time]** self-identify **[Process: mental, cognition]** as gay men **[Phenomenon]**.

Natal females with the late-onset form **[Possessor]** do not **[Polarity: negative]** have **[Process: relational, attributive]** co-occurring transvestic behaviors with sexual excitement **[Possessed]**.

Gender dysphoria in association with a disorder of sex development.

Most individuals with a disorder of sex development who develop gender dysphoria **[Actor]** have already come **[Process: material, transformative, involuntary]** to medical attention **[Goal]** at an early age **[Circumstance: Location, time]**.

> who **[Senser]** develop **[Process: mental, cognition]** gender dysphoria **[Phenomenon]**

For many **[Circumstance: Manner, quality]**, starting at birth, issues of gender assignment **[Verbiage]** were raised **[Process: verbal]** by parents and physicians **[Sayer]**.

Moreover, as infertility is quite common for this group **[Circumstance: Cause, result]**, physicians **[Carrier]** are **[Process: relational, attributive]** more willing to perform cross-sex hormone treatments and genital surgery before adulthood **[Attribute]**.

As individuals with a disorder of sex development become aware of their medical history and condition **[Circumstance: Location, time]**, many **[Senser]** experience **[Process: mental, emotion]** uncertainty about their gender, as opposed to developing a firm conviction that they are another gender **[Phenomenon]**.

> As individuals with a disorder of sex development **[Senser]** become aware **[Process: mental, cognition]** of their medical history and condition **[Phenomenon]**

However, most **[Actor]** do not **[Polarity: negative]** progress **[Process: material, transformative, intentional]** to gender transition **[Goal]**.

Risk and Prognostic Factors

Temperamental. For individuals with gender dysphoria without a disorder of sex development **[Circumstance: Angle, viewpoint]**, atypical gender behavior **[Actor]** among individuals with early-onset gender dysphoria **[Circumstance: Location, space]** develops **[Process: material, creative, involuntary]** in early preschool age **[Circumstance: Location, time]**, and it **[Carrier]** is **[Process: relational, attributive]** possible **[Attribute]** that a high degree of atypicality makes the development of gender dysphoria and its persistence into adolescence and adulthood more likely **[Projection]**.

> that a high degree of atypicality **[Actor]** makes **[Process: material, transformative, intentional]** the development of gender dysphoria and its persistence into adolescence and adulthood **[Goal]** more likely **[Circumstance: Manner, quality]**.

- ❖ atypical gender behavior **[Medium]** among individuals with early-onset gender dysphoria **[Circumstance: Location, space]** develops **[Process: material]** in early preschool age **[Circumstance: Location, time]**
- ❖ that a high degree of atypicality **[Agent]** makes **[Process: material]** the development of gender dysphoria and its persistence into adolescence and adulthood **[Medium]** more likely **[Circumstance: Manner, quality]**.

Environmental. Among individuals with gender dysphoria without a disorder of sex development **[Circumstance: Location, place]**, males with gender dysphoria **[Possessor]** (in both childhood and adolescence **[Circumstance: Location, time]**) more commonly **[Circumstance: Extent, frequency]** have **[Process: relational, attributive]** older brothers **[Possessed]** than do males without the condition.

Additional predisposing factors under consideration **[Value]**, especially in individuals with late onset gender dysphoria (adolescence, adulthood) **[Circumstance: Location, space]** include **[Process: relational, identifying]** habitual fetishistic transvestism developing into autogynephilia (i.e., sexual arousal associated with the thought or image of oneself as a woman) and other forms of more general social, psychological, or developmental problems **[Token]**.

Genetic and physiological. For individuals with gender dysphoria without a disorder of sex development **[Circumstance: Cause, behalf]**, some genetic contribution **[Verbiage]** is suggested **[Process: verbal]** by evidence for (weak) familiality of transsexualism among nontwin siblings, increased concordance for transsexualism in monozygotic compares with dizygotic same-sex twins, and some degree of heritability of gender dysphoria **[Sayer]**.

As to endocrine findings, no **[Polarity: negative]** endogenous systemic abnormalities in sex-hormone levels **[Goal]** have been found **[Process: material, transformative, intentional]** in 46,XY individuals **[Circumstance: Location, place]**, whereas there appear to be **[Process: existential]** increased androgen levels **[Existent]** (in the range found in hirsute women but far below normal male levels) in 46,XY individuals **[Circumstance: Location, place]**.

Examples **[Value]** include **[Process: relational, identifying]** 46,XY individuals with a history of normal male prenatal hormone milieu but inborn nonhormonal genital defects (as in cloacal bladder exstrophy or penile agenesis) and who have been assigned to the female gender **[Token]**.

> who **[Goal]** have been assigned **[Process: material, transformative, intentional]** to the female gender **[Scope]**

The likelihood of gender dysphoria **[Goal]** is further enhanced **[Process: material, transformative, intentional]** by additional, prolonged, highly gender-atypical postnatal androgen exposure with somatic virilization **[Actor]** as may **[Modalization: low, implicit, subjective]** occur **[Process: material, transformative, involuntary]** in female-raised and non-castrated 46,XY individuals with 5-alpha reductase-2 deficiency or 17-beta-hydroxysteroid dehydrogenase-3 deficiency or in female-raised 46,XX individuals with classical congenital adrenal hyperplasia with prolonged periods of non-adherence to glucocorticoid therapy **[Circumstance: Location, place]**.

- The likelihood of gender dysphoria **[Medium]** is further enhanced **[Process: material]** by additional, prolonged, highly gender-atypical postnatal androgen exposure with somatic virilization **[Agent]** as may

[Modalization: low, implicit, subjective] occur **[Process: material]** in female-raised and non-castrated 46,XY individuals with 5-alpha reductase-2 deficiency or 17-beta-hydroxysteroid dehydrogenase-3 deficiency or in female-raised 46,XX individuals with classical congenital adrenal hyperplasia with prolonged periods of non-adherence to glucocorticoid therapy **[Circumstance: Location, place]**.

Many individuals with disorders of sex development and markedly gender-atypical behavior **[Senser]** do not **[Polarity: negative]** develop **[Process: mental, cognition]** gender dysphoria **[Phenomenon]**.

There appears to be **[Process: existential]** a higher rate of gender dysphoria and patient-initiated gender change from assigned female to male than from assigned male to female **[Existent]** in 46,XY individuals with a disorder of sex development **[Circumstance: Location, place]**.

Culture-Related Diagnostic Issues

Individuals with gender dysphoria **[Verbiage]** have been reported **[Process: verbal]** across many countries and cultures **[Circumstance: Location, place]**.

The equivalent of gender dysphoria **[Verbiage]** has also been reported **[Process: verbal]** in individuals living in cultures with institutionalized gender categories other than male or female **[Circumstance: Location, place]**.

It **[Carrier]** is **[Process: relational, attributive]** unclear **[Attribute]** whether with these individuals the diagnostic criteria for gender dysphoria would be met **[Projection]**.

whether with these individuals **[Circumstance: Accompaniment]** the diagnostic criteria for gender dysphoria **[Goal]** would be met **[Process: material, transformative, involuntary]**.

Diagnostic Markers

Individuals with a somatic disorder of sex development **[Sayer]** show **[Process: verbal]** some correlation of final gender identity outcome with the degree of prenatal androgen production and utilization **[Verbiage]**.

Functional Consequences of Gender Dysphoria

In older children **[Circumstance: Location, place]**, failure to develop age-typical same-sex peer relationships and skills **[Actor]** may **[Modalization: low, implicit, subjective]** lead **[Process: material, transformative, involuntary]** to isolation from peer groups and distress **[Circumstance: Location, place]**.

- ❖ In older children **[Circumstance: Location, place]**, failure to develop age-typical same-sex peer relationships and skills **[Medium]** may **[Modalization: low, implicit, subjective]** lead **[Process: material]** to isolation from peer groups and distress **[Circumstance: Location, place]**.

Some children **[Actor]** may **[Modalization: low, implicit, subjective]** refuse to attend **[Process: material, transformative, intentional]** school **[Goal]** because of teasing and harassment or pressure to dress in attire associated with their assigned sex **[Circumstance: Cause, reason]**.

Also in adolescents and adults **[Circumstance: Location, place]**, preoccupation with cross-gender wishes **[Actor]** often **[Circumstance: Extent, frequency]** interferes with **[Process: material, transformative, intentional]** daily activities **[Goal]**.

- ❖ Also in adolescents and adults **[Circumstance: Location, place]**, preoccupation with cross-gender wishes **[Agent]** often **[Circumstance: Extent, frequency]** interferes with **[Process: material]** daily activities **[Medium]**.

Gender dysphoria, along with atypical gender expression, **[Carrier]** is associated with **[Process: relational, attributive]** high levels of stigmatization, discrimination, and victimization, leading to negative self-concept, increased rates of mental disorder comorbidity, school dropout, and economic marginalization, including unemployment, with attendant social and mental health risks **[Attribute]**, especially in individuals from resource-poor family backgrounds **[Circumstance: Location, place]**.

Differential Diagnosis

The diagnosis **[Phenomenon]** is not **[Polarity: negative]** meant to merely describe **[Process: mental, cognition]** nonconformity to stereotypical gender role behavior (e.g.,

“tomboyism” in girls, “girly-boy” behavior in boys, occasional cross-dressing in adult men **[Circumstance: Location, place]**) **[Range]**.

Given the increased openness of atypical gender expressions by individuals across the entire range of the transgender spectrum **[Circumstance: Cause, reason]**, it **[Carrier]** is **[Process: relational, attributive]** important **[Attribute]** that the clinical diagnosis be limited to those individuals whose distress and impairment meet the specific criteria **[Projection]**.

> that the clinical diagnosis **[Carrier]** be **[Process: relational, attributive]** limited **[Attribute]** to those individuals whose distress and impairment **[Actor]** meet **[Process: material, transformative, involuntary]** the specific criteria **[Scope]**
>
> - ❖ whose distress and impairment **[Medium]** meet **[Process: material]** the specific criteria **[Range]**

Transvestic disorder. Transvestic disorder **[Actor]** occurs **[Process: material, transformative, involuntary]** in heterosexual (or bisexual) adolescent and adult males (rarely in females) **[Circumstance: Location, place]** for whom cross-dressing behavior generates sexual excitement and causes distress and / or impairment **[Circumstance: Cause, behalf]** without drawing their primary gender in question **[Circumstance: Contingency, default]**.

- ❖ Transvestic disorder **[Medium]** occurs **[Process: material]** in heterosexual (or bisexual) adolescent and adult males (rarely in females) **[Circumstance: Location, place]** for whom cross-dressing behavior generates sexual excitement and causes distress and / or impairment **[Circumstance: Cause, behalf]** without drawing their primary gender in question **[Circumstance: Contingency, default]**.

An individual with transvestic disorder who also has clinically significant gender dysphoria **[Beneficiary]** can be given **[Process: material, transformative, intentional]** both diagnoses **[Goal]**.

> who **[Possessor]** also has **[Process: relational, attributive]** clinically significant gender dysphoria **[Possessed]**

In many cases of late-onset gender dysphoria in gynephilic natal males **[Circumstance: Location, place]**, transvestic behavior with sexual excitement **[Identifier]** is **[Process: relational, identifying]** a precursor **[Identified]**.

Body dysmorphic disorder. An individual with body dysmorphic disorder **[Senser]** focuses on **[Process: mental, cognition]** the alteration or removal of a specific body part **[Phenomenon]** because it is perceived as abnormally formed, not **[Polarity: negative]** because it represents a repudiated assigned gender **[Circumstance: Cause, reason]**.

> because it **[Carrier]** is perceived as **[Process: relational, attributive]** abnormally formed **[Attribute]**
>
> because it **[Token]** represents **[Process: relational, identifying]** a repudiated assigned gender **[Value]**

When an individual's presentation **[Actor]** meets **[Process: material, transformative, involuntary]** criteria for both gender dysphoria and body dysmorphic disorder **[Scope]**, both diagnoses **[Scope]** can be given **[Process: material, transformative, intentional]**.

- When an individual's presentation **[Medium]** meets **[Process: material]** criteria for both gender dysphoria and body dysmorphic disorder **[Range]**, both diagnoses **[Range]** can be given **[Process]**.

Individuals wishing to have a healthy limb amputated **[Senser]** (termed by some *body identity integrity disorder*) because it makes them feel more "complete" **[Circumstance: Cause, reason]** usually **[Circumstance: Extent, frequency]** do not **[Polarity: negative]** wish **[Process: mental, desideration]** to change gender **[Phenomenon]**, but rather desire **[Process: mental, desideration]** to live as an amputee or a disabled person **[Phenomenon]**.

Schizophrenia and other psychotic disorders. In the absence of psychotic symptoms **[Circumstance: Contingency, condition]**, insistence by an individual with gender dysphoria that he or she is of some other gender **[Identified]** is not **[Polarity: negative]** considered **[Process: relational, identifying]** a delusion **[Identified]**.

that he or she **[identified]** is **[Process: relational, identifying]** of some other gender **[Identifier]**

Other clinical presentations. Some individuals with an emasculinization desire who develop an alternative, nonmale / nonfemale gender identity **[Possessor]** do have **[Process: relational, attributive]** a presentation that meets criteria for gender dysphoria **[Possessed]**.

who **[Senser]** develop **[Process: mental, cognition]** an alternative, nonmale / nonfemale gender identity **[Phenomenon]**

a presentation that **[Actor]** meets **[Process: material, transformative, involuntary]** criteria for gender dysphoria **[Scope]**

- ❖ a presentation that **[Medium]** meets **[Process: material]** criteria for gender dysphoria **[Range]**

However, some males **[Actor]** seek **[Process: material, transformative, intentional]** castration and / or penectomy **[Goal]** for aesthetic reasons **[Circumstance: Cause, reason]** or to remove psychological effects of androgens without changing male identity **[Circumstance: Cause, purpose]**; in these cases, the criteria for gender dysphoria **[Goal]** are not **[Polarity: negative]** met **[Process: material, transformative, involuntary]**.

Comorbidity

Clinically referred children with gender dysphoria **[Sayer]** show **[Process: verbal]** elevated levels of emotional and behavioral problems– most commonly, anxiety, disruptive and impulse-control, and depressive disorders **[Verbiage]**.

In prepubertal children **[Circumstance: Location, time]**, increasing age **[Carrier]** is associated with **[Process: relational, attributive]** having more behavioral or emotional problems **[Attribute]**; this **[Carrier]** is related to **[Process: relational, attributive]** the increasing non-acceptance of gender-variant behavior by others **[Attribute]**.

However, also in some non-Western cultures **[Circumstance: Location, place]**, anxiety **[Carrier]** has been found to be **[Process: relational, attributive]** relatively common **[Attribute]** in individuals with gender dysphoria **[Circumstance: Location, place]**, even

in cultures with accepting attitudes toward gender-variant behavior **[Circumstance: Location, place]**.

Autism spectrum disorder **[Carrier]** is **[Process: relational, attributive]** more prevalent **[Attribute]** in clinically-referred children with gender dysphoria than in the general population **[Circumstance: Location, place]**.

Clinically referred adolescents with gender dysphoria **[Possessor]** appear to have **[Process: relational, attributive]** comorbid mental disorders **[Possessed]**, with anxiety and depressive disorders **[Identified]** being **[Process: relational, identifying]** the most common **[Identifier]**.

As in children **[Circumstance: Location, place]**, autism spectrum disorder **[Carrier]** is **[Process: relational, attributive]** more prevalent **[Attribute]** in clinically referred adolescents with gender dysphoria than in the general population **[Circumstance: Location, place]**.

Clinically referred adults with gender dysphoria **[Possessor]** may **[Modalization: low, implicit, subjective]** have **[Process: relational, attributive]** coexisting mental health problems, most commonly **[Circumstance: Extent, frequency]** anxiety and depressive disorders **[Possessed]**.

APPENDIX 2

Finnish Summary

JOHDANTO

Toukokuussa 2013 Yhdysvaltain Psykiatriyhdistys (American Psychiatric Association, APA) julkaisi viidennen painoksen DSM – diagnoosijärjestelmästä, *the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*. DSM-5 on mielenterveydenalan ammattilaisille suunnattu luokittelu virallisesti tunnustetuista mielenterveyden häiriöistä ja se sisältää myös oireiden kuvailuun perustuvat ohjeet näiden mielenterveyshäiriöiden diagnosoimiseksi. Tässä tutkielmassa analysoidaan DSM diagnoosijärjestelmän viidennen painoksen ja tarkemmin sen kappaleessa *Gender Dysphoria* käytettyä kieltä. *Gender dysphoria* (epävirallisesti suomennettuna *sukupuolidysforia*) on lääketieteellinen termi, joka viittaa biologisesta sukupuolesta eriävän sukupuoli-identiteetin aiheuttamaan henkiseen pahoinvointiin. Sukupuoli-identiteetin ja mielenterveysongelman yhdistäminen sisältää ideologisiin arvoihin pohjautuvia perusteluja ja sukupuolidysforian sisällyttäminen DSM järjestelmään on kiistanalainen asia. Koska sukupuolidysforian diagnosoimiseen liittyy myös vallankäyttöä psykiatrin suunnalta ja DSM manuaalien edustama lääketieteellinen diskurssi määrittää rajat sukupuoli-identiteetin ja mielenterveysongelman välillä, on diagnoosikriteereiden ja ohjeiden kieli tärkeä tutkimuskohde. Tässä tutkielmassa analysoidaan 'Gender Dysphoria' – kappaleen ideologista sisältöä kriittisestä näkökulmasta.

TAUSTA

Viidettä DSM-manuaalia valmisteltiin kymmenen vuotta, jonka aikana transsukupuolisuuteen viittaavan diagnoosikategorian nimi vaihdettiin *Gender Identity Disorderista* (sukupuoli-identiteetin häiriö) nimeen *Gender Dysphoria*, millä teoksen kirjoittajat halusivat korostaa henkisen pahoinvoinnin (dysforia) merkitystä diagnoosin tekemiselle. Tämän henkisen pahoinvoinnin esiintymistä edellytetään ennen diagnoosin tekemistä. Muutoksesta huolimatta sukupuolidysforiaa on diagnoosikategoriana arvosteltu laajas-

ti, aivan kuin sitä edeltäviä kategorioita DSM-manuaalin edellisissä painoksissa (Ault & Brzuzy 2009; Davy 2013; Lev 2006). Kriitikoiden mukaan sukupuoli-identiteetin yhdistäminen mielenterveysongelmaan leimaa transsukupuolisuuden ja muut biologista kaksijakoa karttavat sukupuoli-identiteetit mielenterveysongelmiksi. Kriitikot ovat lisäksi osoittaneet ongelmia käyttäytymiseen perustuvissa oireissa, joiden mukaan sukupuolidysforia diagnosoidaan. Nämä ongelmat ovat erityisen voimakkaita lapsiin kohdistuvissa diagnoosikriteereissä ja oirekuvauksissa (Bower 2001; Hill *et al.* 2007). Kuitenkin sukupuolidysforian diagnosoimisella on erityisasema sukupuolen korjaukseen liittyvissä lääketieteellisissä hoidoissa, joissa transsukupuolisen henkilön kehoa korjataan vastaamaan koettua sukupuoli-identiteettiä. Vakuutusyhtiöt vaativat yleensä virallista diagnoosia, ennen kuin hoitokuluja voidaan kattaa vakuutuksesta. Sukupuolenkorjaushoitoihin ja sukupuoli-identiteetin viralliseen tunnustamiseen liittyy myös paljon erilaisia lakeja ympäri maailmaa, joiden vaikutukset ovat tämän tutkimuksen ulottumattomissa. Kuitenkin Amnesty International (2014) lukee sukupuoli-identiteettiin, lakiin ja hoitoihin liittyvät kysymykset ihmisoikeusasioiksi.

TEOREETTINEN VIITEKEHYS

Tämä tutkimus on *kriittinen diskurssianalyysi*, jossa tutkitaan kieltä sukupuolidysforian diagnoosikategoriassa diskurssianalyysin keinoin kriittisestä näkökulmasta. Kriittinen diskurssianalyysi on lähestymistapa, jota voidaan hyödyntää laajasti eri tieteenaloilla ja joka ei sisällä suosituksia tarkemmista metodeista (Wodak & Meyer 2009). Lähtökohtana on kuitenkin Foucault'n ([1972] 2009) ajatus siitä, että *diskurssi* on sosiaalinen ilmiö, joka sekä *selittää* että *rakentaa* käsitystämme sosiaalisesta todellisuudesta, joka muodostuu ihmisten välisessä kanssakäymisessä (Fairclough 2010). Diskurssi heijastaa kokemustamme todellisuudesta, joten yhteiskunnan valtarakenteita ja ideologioita voidaan analysoida kriittisen diskurssianalyysin avulla. Tutkimuksessa keskeisiä termejä ovat *valta*, jonka epätasapainoon eri yhteiskuntaryhmien välillä kriittinen diskurssianalyysi pyrkii kiinnittämään huomiota, sekä *ideologiat*, jotka Norman Fairclough (2010) määrittää identiteettiin liittyviksi käsityksiksi sosiaalisesta todellisuudesta, jotka heijastuvat vallankäyttöön.

Analyysin tuloksia tarkastellaan Fairclough'n kolmitasoisen diskurssianalyysimallin avulla, joka yhdistää tekstin, diskurssin ja niihin liittyvät sosiaaliset rakenteet. Tuloksia tarkastellaan myös Michel Foucault'n ([1972] 2009, [1978] 1990) yhteiskuntateorioiden sekä Judith Butlerin (2004) performatiivisuusteorian valossa. Analyysissä otetaan huomioon *lääketieteellisen diskurssin* erityispiirteet, joihin kuuluu muun muassa todennäköisyyksien ilmaisu *modalisaation* keinoin. Aikaisemmissa lääketieteellisen diskurssin ja DSM-manuaalien analyyseissa on myös huomattu, että mielenterveysongelmat kuvataan usein omistettavina objekteina, joilla on valtaa toimia itsenäisesti yksilön sisällä.

Itse analyysi hyödyntää M. A. K Hallidayn (2004) *transitiivisuusteoriaa*, joka on osa *systeemis-funktionaalista kielioppia* (Systemic Functional Grammar). Teorian mukaan kielen tehtävä on ennen kaikkea palvella erilaisia tarkoituksia, minkä puitteissa kielellä luodaan merkityksiä. Kielen rakenne perustuu merkitysten luomiseen eri olosuhteissa. Nämä merkitykset ovat seurauksia kielen käyttäjien tekemistä valinnoista ja näiden valintojen ansiosta kielessä myös heijastuu sen käyttäjän maailmankatsomus ja ideologiat. Kielen eri käyttötarkoitukset jakautuvat kolmeen *metafunktioon* (metafunction) *ideationaaliseen* (ideational) *interpersonaaliseen* (interpersonal) sekä *tekstuaalisen* (textual), joista ideationaalinen sisältää kokemuksemme ympäröivästä maailmasta. Transitiivisuus on teoria siitä, kuinka ilmaisemme näitä kokemuksia kielen avulla.

Transitiivisuusteoria keskittyy *prosesseihin*, jotka ilmaistaan verbien avulla sekä prosessien osanottajiin ja olosuhteisiin. Hallidayn (2004) mukaan tekemämme valinnat prosessien, niiden osanottajien ja olosuhteiden suhteen muodostavat *representaatioita*, jotka edustavat näkemyksiämme ympäröivästä todellisuudesta. Analysoimalla kielen käyttäjän valintoja voidaan saada käsitys siitä, millaisia representaatioita he muodostavat käsiteltävästä asiasta. Koska kielenkäyttäjän ideologiat vaikuttavat näihin representaatioihin, voidaan representaatioita analysoimalla saada kuva kielenkäyttäjän ideologioista.

TUTKIMUSKYSYMYKSET, AINEISTO JA METODIT

Tässä tutkimuksessa tarkastellaan DSM-5 manuaalin 'Gender Dysphoria' – kappaleessa käytetyn kielen ideologisia heijastumia ja niiden sosiaalisia vaikutuksia kolmen tutkimuskysymyksen avulla: 1) Minkälainen representaatio diagnosoidusta yksilöstä muodostuu tekstissä? 2) Kuinka tekstissä rakennetaan representaatiota sukupuolidysforiasta mielenterveyshäiriönä? 3) Miten analyysin tulokset saattavat vaikuttaa käsitykseen sukupuolen yhteydestä mielenterveyteen ja sukupuolidysforian diagnosoimiseen. Tutkimuskysymykset limittyvät toisiinsa, sillä sukupuolidysforian representaatio vaikuttaa myös yksilön representaatioon. Koska keskeisenä tarkoituksena on kuitenkin selvittää, minkälaisen kuvan kirjoittajat luovat diagnosoidusta yksilöstä, aineisto on rajattu vain niihin lauseisiin (*clause*), jota sisältävät yksilön yhtenä prosessin osallistujista tai joissa yksilö on sisällytetty olosuhteisiin. Sukupuolidysforian representaatiota mielenterveyshäiriönä analysoidaan siis yksilön näkökulmasta, mutta keskusteluosuudessa otetaan huomioon myös ne (suhteessa vähäiset) lauseet Gender Dypshoria – kappaleessa joissa sukupuolidysforia on yksi prosessin osallistujista mutta yksilö ei. Lisäksi aineisto on rajattu sisältämään vain lauseet, jotka sisältävät prosesseja; verbittömät listat jäävät siis aineiston ulkopuolelle. Tämä perustellaan sillä, että transitiivisuusanalyysi keskittyy prosesseihin, eikä täten huomioi merkityksiä jotka muodostetaan ilman prosesseja. Nämä listat, kuten diagnoosikriteerit, ovat kuitenkin ilmaistu myös prosessien avulla aineistossa.

Analyysissä käytetään metodina pääasiassa M. A. K. Hallidayn transitiivisuusteoriaa, mutta myös joitakin muita osia systeemis-funktionaalisesta kieliopista. Näihin muihin osiin kuuluvat *ergatiivisuus,* joka keskittyy syys-seuraussuhteisiin prosessin ja sen osallistujien välillä sekä *modalisaatio,* jonka avulla kirjoittajat laskevat prosessien toteutumiseen liittyvää todennäköisyyttä ja siten pienentävät vastuutaan ilmaistusta asiasta (Halliday 2004). Analyysissä keskitytään valintoihin, joita kirjoittajat tekevät kuvatessaan oireelliseksi luokiteltua käyttäytymistä. Analyysissä merkityksellisiä ovat valinnat erilaisten *prosessityyppien* välillä, joiden avulla voidaan muuttaa sävyjä ilmaistun asian merkityksessä. Analyysissä näin tapahtuu muun muassa valinnassa *verbaalisten* ja *relationaalisten* prosessien välillä. Verbaaliset prosessit viittaavat jonkin asian ilmaisemi-

seen, kun taas relationaalisilla prosesseilla voidaan ilmaista esimerkiksi omistussuhteita. Kirjoittajat käyttävät molempia prosesseja tunteisiin ja mielihaluihin liittyen: tytöt usein ilmaisevat tunteita ja mielihaluja, kun taas pojilla kuvataan olevan niitä. Näiden kahden valinnan nälillä on merkitysero, joka vaikuttaa poikien ja tyttöjen representaatioihin. Merkityksellistä on myös, ketkä tai mitkä osallistuvat mihinkin prosesseihin ja ovatko osallistujat prosesseja toteuttavassa asemassa vai prosessien kohteita.

Analyysi paljasti, että sukupuolidysforia esitetään mielenterveysongelmana erottamalla se yksilöstä erilliseksi toimijaksi, joka suorittaa erilaisia prosesseja yksilön sisällä. Sukupuolidysforia ja sen oireet kuvattiin myös omistussuhteena yksilön ja sukupuolidysforian tai oireen välillä. Yksilö sisällytetään usein prosessien olosuhteisiin tavalla, joka ilmaisee sukupuolidysforian suorittamien prosessien tapahtuvan heidän sisällään. Yksilö myös kuvataan ’omistamassa’ tunteita ja ’osoittamassa’ tietynlaisia käyttäytymismalleja. Näistä kaikista seuraa se, että yksilöllä on niukasti valtaa suhteessa sukupuolidysforiaan ja diagnoosi ei perustu suoraan ilmaistuihin henkilökohtaisiin kokemuksiin sukupuoli-identiteetistä.

Yksilöistä erityisesti lapset esitetään tekstissä voimakkaasti perinteisiin sukupuolirooleihin pohjautuvan ideologian valossa. Heidän oireensa perustuvat psykiatrin tarkkailemiin käytösmalleihin ja tunteiden osoituksiin. Nämä oireelliset käytösmallit taas perustuvat perinteisiin sukupuolistereotypioihin. Oireiden kuvaukset antavat ymmärtää, että niiden havaitsemiseen tarvitaan tietoa kolmannelta osapuolelta. Analyysi osoittaa lisäksi logiikkaongelmia lasten oireiden kuvailussa, jotka johtavat ristiriitoihin oireiden ja mielenterveysongelman yhteydessä ja täten kumoavat perusteet, joiden pohjalta lapset diagnosoidaan. Näistä suurimmat ongelmat liittyvät väitteeseen, että henkinen pahoinvointi, joka on edellytys diagnoosille, on lähtöisin mielenterveysongelmasta. Aineistossa henkisen pahoinvoinnin lähteenä prosesseissa toimivat perhe ja ympäristö.

Tulosten valossa tutkimuksessa todetaan, että aineistosta heijastuu kirjoittajien voimakas ideologia kaksijakoisen, biologiseen sukupuoleen perustuvan sukupuoli-identiteetin oikeellisuudesta. Loppupäätelmänä on, että vaikka sukupuolidysforian

diagnoosissa korostetaan edellytystä henkisestä pahoinvoinnista, aineistossa ei osoitetta henkisen pahoinvoinnin syyseurausyhteyttä sukupuolidysforiaan. Diagnoosikategorian lähtökohtana on siis, erityisesti lasten kohdalla, että biologisesta sukupuolesta poikkeavan sukupuoli-identiteetti itsessään on mielenterveysongelma. Tutkimuksen lopussa ehdotetaan, että sukupuolidysforiaan liittyvien diagnoosiohjeiden ja – kriteerien perusteita muokataan yleisesti sukupuoli-identiteetin itsemääräämisoikeuteen pohjautuvaksi. Lasten osalta tekstiin tulisi sisällyttää mahdollisia tieteellisiä perusteluja, jotka kumoaisivat diagnoosiohjeiden nykymuodossaan sisältämät ristiriidat ja perustelisivat lasten diagnosoinnin oikeellisuuden.