cadernos pagu (62), 2021:e216219
ISSN 1809-4449

ARTICLE

Classificatory incongruities: an analysis of the discourses on ICD11 proposals in relation to trans experiences*

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Abstract

In this article, we investigate the discourses concerning the classification of trans experiences present on a website created by the World Health Organization during the formulation of the 11th International Classification of Diseases and Related Health Problems (ICD11). It is a qualitative study in which we analyze the statements of 16 participants, establishing four axes of discussion, which finally converge around the conception of "Gender Incongruence" as a "physical-moral disturbance". In this way, the social act of classifying as well as the possibilities of care for trans people outside the pathological frame are problematized.

Keywords: Transsexuality, Classifications, Health Care, Science.

* Received February 08, 2019, accepted April 30, 2020. Translated by Pedro Souza.

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http://dx.doi.org/10.1590/18094449202100620019

Introduction

Sexuality has been constituted, throughout history, as a fundamental element of the vicissitudes in the West. Understood as the embodiment of the "truth" of each one of us, its study may reveal some of the most significant social processes of modern societies, especially those that culminated in the conception of the individual and its forms of subjectivation (Russo, 2004). Such processes are engendered by power games that reveal, finally, that the efficiency of mechanisms to control bodies is not exactly due to repression, but the incitement to the production of discourses, practices and knowledges that subject individuals and produce subjectivities (Foucault,1999a; 2009).

In this dynamic, the hegemony of the medical-psychiatric discourse is remarkable, which, particularly since the 19th century, has strived to define normal, dysfunctional, and deviant sexual behaviors. Although any classification is an essentially human act — an act in which things and experiences of the sensitive world gain intelligibility from arbitrary decisions (Durkheim, Mauss, 1981) — its operationalization in the field of sexualities contributed to naturalize dichotomous categories that restrict ways of existing and being in the world.

When it comes to ways of life that do not fit the binary and heteronormative logic established by "gender norms" (Butler, 2003), this issue becomes evident. From sin to moral deviation, from paraphilias to brain injuries (Leite Jr., 2011), the field composed of a heterogeneity of experiences related to the sexual domain is marked by processes of disputes, negotiations, subjections and resistances that try, at all times, to make it socially intelligible and controllable. In this context, *trans*[1] experiences are paradigmatic.

Circumscribed by contours that vary according to the historical and social context, they highlight how practices and discourses regulate how individuals relate to themselves and to others (Borba, 2016). Harry Benjamin (1966) was one of the pioneers to describe the "transsexual phenomenon" in the medical environment, contributing to consolidate the hegemonic narrative that the transsexual person is one who, since childhood, demands to live and be accepted as a person of the opposite gender, which was hetero-designated. The condition would be accompanied by persistent discomfort with their own assigned sex, dislike of genital organs, and a tendency to depression and suicide.

Currently, criteria from diagnostic manuals — such as the International Statistical Classification of Diseases and Health Problems (ICD), organized by the World Health Organization (WHO) and adopted in Brazil — are part of the daily life of care services dedicated to *trans* people. This classificatory discourse sediments a regime of truth that integrates the "transsexuality device" (Bento, 2008). It is a network composed of "(...) discourses, institutions, architectural organizations, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral, philanthropic propositions" (Foucault, 2011:244) that ultimately promotes the essentialization of an imaginary transsexual identity for the purpose of regulating bodies and social space.

The non-recognition of forms of existence that escape the diagnostic framework functions as a symbolic violence that excludes the person from the very condition of being human. To pathologize is, in this sense, to confer intelligibility from a norm that invisibilizes the practices and all the humanity that exceeds it (Butler, 2004). Legal, political and social rights are thus denied, making precarious all those who remain at the margins of this network.

In Brazil, the Unified Health System (SUS) included, in 2008, the transsexualization process[2] in its list of procedures, establishing a strict protocol, guided by the conception of transsexuality as a mental disorder. This perspective, defended by medical diagnostic manuals, assumes that these

[1] In this article, we will use the term "*trans* experiences" - or simply the adjective *trans* - in an attempt to distance ourselves from the pathological framework of the medical-psychiatric discourse that, based on names such as transsexualism and transvestism, defines hegemonic ways of experiencing transsexualities.

[2] The transsexualization process can be understood as "a set of health care strategies involved in the process of transformation of sexual characteristics that transsexual individuals go through at a certain moment in their lives. It is not, therefore, the establishment of guidelines for comprehensive care in the strict sense, but of those actions necessary to ensure the right to health circumscribed to the transition to social living in gender in disagreement with the sex of birth" (Lionço, 2009:44).

experiences are diseases, whose treatments include not only psychotherapeutic interventions, but also interventions in the body to adapt it to the gender identity with which the person identifies. The sequence of pre-established procedures includes compulsory psychological monitoring, evidence that the subject lives well socially with the gender with which he or she identifies, ratification of the condition through medical-psychiatric reports, hormone treatments, surgical procedures, and bureaucratic procedures for changing the name and gender in documents (Arán; Murta; Lionço, 2009). In 2013, a new ordinance began to regulate this process[3], which, despite having been redefined and expanded, remained supported by the pathological framework (Souza; Braz, 2016). In other words, the right to autonomy and interventions on the body are still only possible if the person accepts to be treated as "sick" (Ávila, 2014).

On the contrary of this conception, social movements — such as *Stop Trans Pathologization,* for example — have been challenging, for over ten years, the hegemony of the biomedical discourse on *trans* experiences and the supposed psychopathology of this condition. A recurring question in this struggle is how to depathologize, while ensuring, at the same time, the access of this population to comprehensive health care (Almeida; Murta, 2013; Prado, 2018). Such an inquiry has no pre-established solution and requires discussions that must be located according to the reality of each location (Bento, 2018).

In the national scene, researchers and activists are engaged in this cause, opening possibilities for the construction of new care formats for *trans* people (Almeida; Murta, 2013; Bento; Pelúcio, 2012; Lionço, 2009). Some services have already put in place forms of care that subvert hegemonic classifications and hierarchies, thus respecting the uniqueness of each person (Prado, 2018:50). In this process, the protagonism of psychology councils is notable, which, unlike medical institutions, tension diverse perspectives and destabilize the medical-psychiatric domain in this field (Pacheco; Rasera; Prado; Teixeira, 2017). However, as the medical diagnosis remains as the legal means to regulate the access to specific procedures, it is necessary to keep alive the problematization of nosological categories to advance the debate regarding depathologization.

In order to foster this discussion, in this article, we propose to investigate the "transsexuality device" based on the analysis of the speeches present in a website created by the WHO at the time of the formulation of the ICD 11. This virtual space was established to support a public debate, open to those interested about all the diagnostic categories proposed by the manual, including not only the organic diseases and psychiatric conditions, but also the codifications of contact with health services and the various procedures that may be performed. In this investigation, we focused on the contents related to transsexualities, which, according to the ICD 11 proposal, will be named "Gender Incongruence"[4], in a category dissociated from mental disorders. Given the diversity of the participants and their different perspectives, we understand that this material constitutes a privileged object for an analysis that gives us indications of how disputes and negotiations occur in the regulation of *trans* bodies and experiences today. After all, the classificatory reiteration is part of the pathologization of transsexualities, which, in turn, "is a question of power" (Prado, 2018:53). In Brazil, this discussion becomes especially important considering that health services and professionals use, with a greater or lesser degree of criticality, the ICD codifications in their daily practices.

[3] From that time on, transvestite people and trans men were allowed to take advantage of the services offered.

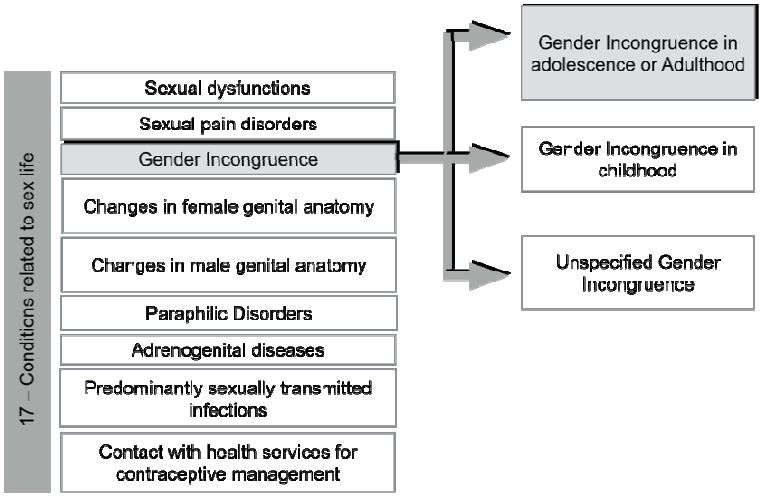
[4] According to ICD 11, "Gender Incongruence" is characterized by marked and persistent incongruence between an individual's experienced gender and his or her assigned sex. Generally, people with this condition exhibit aversion to or discomfort with primary and secondary sexual characters of the assigned sex and a strong desire to have primary and secondary sexual characters of the experienced gender. Establishing congruence may include hormone treatments, surgery, or other health care that allows the body to align with the experienced gender according to the individual's desire.

Methodological journey

This is a qualitative study whose object was the speeches extracted from the website[5] created by the WHO with the objective of fostering the debate on diagnostic categories proposed by ICD 11. This stage (beta phase) of formulation of the manual was preceded by another (alpha phase) in which 24 groups, composed of specialists, revised categories and diagnostic criteria of ICD 10, removing, altering, and adding new elements. The website contained the results of such interventions, and it was opened between 2012 and 2017 for any interested parties, upon prior registration, to make comments and suggestions. The expectation was that the analysis of these considerations could contribute to greater stability of the manual.

Given the objective of our investigation, we focused on the speeches recorded between 20/12/2012 and 31/01/2016 that were related to the diagnostic group named, in the alpha phase, as "Conditions related to sexual health", more specifically on those related to the general category "Gender Incongruence" and the subcategory "Gender Incongruence in adolescence or adulthood[6]" (figure 1). To access the website, one of the researchers signed up and joined, participating most of the time as an observer.

Figure 1: Chapter 17, entitled "Conditions related to sexual health", and its subdivisions, as proposed by the ICD11



Source: Made by the authors.

Sixteen people were involved in these discussions. To preserve anonymity, each participant was defined by the acronym of some Brazilian state. They were all identified according to nationality and, when possible, in the way they presented themselves (table 1). We analyzed a total of 64 speeches, 12 of which referred to the name "Gender Incongruence" and 52, to the definition of the condition itself. The last two were from the principal researcher of this investigation.

[5] The ICD-11 beta phase website (ICD-11 BETA DRAFT) can be found at: http://apps.who.int/classifications/icd11/browse/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f90875286

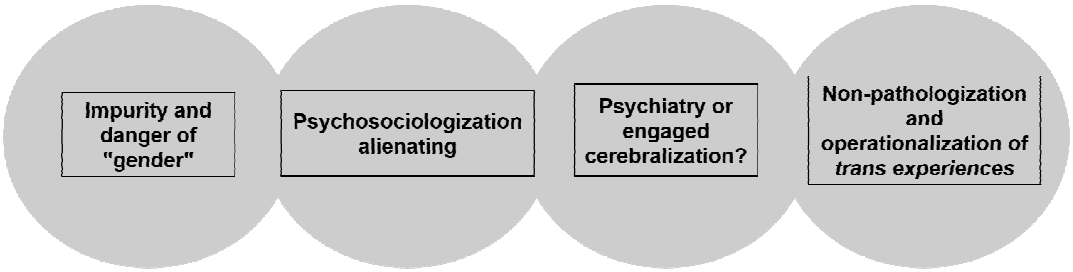
[6] Due to the specifics of this thematic in childhood, we chose not to include the category "Gender Incongruence in childhood" in this study.

Table 1 - Specification of the participants and the content of their comments						
Participants			Gender Incongruence		Gender Incongruence in adolescence or adulthood	
Identification	Form of presentation	Nationality	Comments on the title	Comments on the definition	Comments on the title	Comments on the definition
AM	linked to the university	Germany	1	6	4	12
MG	linked to the university	Brazil	0	0	0	3
RS	-	Russia	1	2	0	0
IF	radical feminist	United States	1	0	1	0
BA	linked to the university	Pakistan	1	0	0	0
GO	-	New Zealand	1	2	1	4
SP	-	United States	0	3	0	4
PI	linked to the university trans woman	United Kingdom	0	0	0	4
AL	linked to the university	Venezuela	0	0	0	2
DF	-	Canada	0	0	0	1
RR	*trans* woman	Germany	0	0	0	5
MA	-	Australia	0	0	0	1
RO	student	United Kingdom	0	0	0	1
PB	linked to the university	United States	0	0	0	1
ES	-	United States	0	0	0	1
SC	-	United States	0	0	1	0

The analysis had as reference the proposal by Foucault (2008) that the discourse, beyond the signs that refer to contents or representations, is constituted with "practices that systematically form the objects of which they speak" (2008:55). Following this indication, we strived to describe them, locating who and how to declare them, as well as the socio-historical context in which they were inscribed. As much as possible, we tried to evidence the rules that governed the conditions of exercise of the enunciative function (Foucault, 1999b), keeping, at the same time, the incoherencies, contradictions, and mismatches between the various speeches, which we translated, freely, from English to Portuguese.

To operationalize our work, we separated four axes of analysis and discussion (figure 2) that were highlighted from the tension between the perceptions and interpretations of each of the researchers, after an exhaustive reading of the material. We kept this division in the presentation and discussion of results, supported by the critical dialogue between our work group and the literature related to the field of health, humanities, and social sciences.

Figure 2: Axes of analysis and discussion



Source: Made by the authors.

Results and discussion

Impurity and danger of "gender"

The *trans experiences* have been named in several ways in the manuals that determine the diagnostic criteria of the conditions that make up the medical nosology. In the specific case of the Diagnostic and Statistical Manual of Mental Disorders (DSM)[7], supported by the American Psychiatric Association, there was some gradation: what was defined as "Transsexualism" became "Gender Identity Disorder", which, in turn, more recently became recognized as "Gender Dysphoria". On the other hand, the proposed transition is more direct in the IDC: from "Transsexualism", a subcategory of a subgroup of psychiatric disorders known as "Sexual Identity Disorders", to "Gender Incongruence", a subcategory of a non-psychiatric group named as "Conditions Related to Sexual Health" (figure 3).

Figure 3: Historical line of the ICD[8]

ICD 7 (1955)
V. Mental, Psychoneurotic, and Personality Disorders
Character, behavior and intelligence disorders
320 Pathological personality
302.0 Schizoid personality
320.1 Paranoid personality
320.2 Cyclothymic personality
302.3 Inadequate personality
302.4 Antisocial Personality
302.5 Asocial personality
302.6 Sexual Deviancy: *Exhibitionism; Feitichism; Homosexuality; Pathological Sexuality; Sadism; Sexual Deviancy*
302.7 Pathological personality not specified

ICD 8 (1965)
V. Mental, Psychoneurotic, and Personality Disorders
Neurotic disorders, personality disorders and other non-psychotic mental disorders
302 Sexual deviance
302.0 Homosexuality
302.1 Fetishism
302.2 Pedophilia
302.3 **Transvestism**
302.4 Exhibitionism
302.5 Voyeurism
302.6 Sadism
302.7 Masochism
302.8 Other
302.9 Unspecified

[7] It is worth remembering that the DSM, although widely used in the biomedical literature, is not the reference for psychiatric notifications in Brazil. Adopting it as a "universal truth" implies disregarding the particularities of our health system, whose construction, unlike the US model, relies on the participation of social movements and the State (Bento, 2018).

[8] Psychiatric disorders started to be part of the ICD as of its sixth edition in 1948. Given its similarity with ICD 7, in this figure we start from this version to highlight that, until 1955, transsexualities were encompassed within the "sexual deviation" named as "homosexualism". In ICD 8, "transvestism" was incorporated and, as of ICD 9, transsexualities gained their own nomination.

ICD 9 (1979)
V. Mental Disorders
Neurotic disorders, personality disorders and other non-psychotic mental disorders
302 Sexual deviance and sexual disorders
302.0 Homosexuality
302.1 Bestiality
302.2 Pedophilia
302.3 Transvestism
302.4 Exhibitionism
302.5 **Transsexualism**
302.6 Psychosexual identity disorder
302.7 Frigidity and powerlessness
302.8 Other
302.9 Unspecified

ICD 10 (1989)
V. Mental and Behavioral Disorders
Personality and behavior disorders in adults
F64 Sexual identity disorder
F64.0 **Transsexualism**
F64.1 Ambivalent transvestism
F64.2 Childhood sexual identity disorder
F64.8 Other gender identity disorders
F64.9 Sexual identity disorder not otherwise specified

Source: Made by the authors.

These new classifications reveal the trend toward including the word "gender" in current diagnostic appointments. This term, however, was questioned by several participants: "This section would be better titled 'Biological Sexual Dysphoria' because the underlying issue for transgender people is a disconnect between their biological truth and a mental fiction about their biology" (GO); "[the idea of] (...) gender roles is what often causes mental health problems and gender dysphoria (...)" (DF).

Such considerations seem to be supported in the very history of the formulation of gender's concept. In the 1950s, John Money, a New Zealand sexologist, appropriated this notion to solve the impasse regarding the diagnosis and therapy of intersex bodies, that is, bodies whose anatomies did not fit within the binary male-female logic. By supporting a determinism of social and environmental influences, the focus of the approach to reconcile sex and gender became centered on the matrix of body anatomy. This type of conduct, shortly after, was established by Harry Benjamin as a form of "treatment" of transgender people (Cyrino, 2013). The requirement of a coherence between sex and gender, in an essentialist perspective, became the basis of the heterosexual matrix in Western thought (Butler, 2003).

In this sense, it seems that the speeches of the participants emphasized "gender", because it is a concept linked to the idea of a psychosocial construction without a fixed support (biological), which is something unstable and problematic. It is as if the creation of this shifting category, by opening a range of possibilities for bodily interventions, produced by itself the psychic illness known as "transsexuality". Following Mary Douglas' (1991) perspective, gender was understood by many as an "impure" and "dangerous" concept that should be eliminated for the sake of "health" and social order:

> In addition, since the parallel issue concerning the social construction of 'gender' is detrimental to the mental health of all people — men and women — it is better that the underlying issue of the patient's body dysphoria be the focus and not the 'gender', which is something that should be abolished for the good of all (GO).

This draws our attention to the proximity of discourses with those around in Brazil through the auspices of the expression "gender ideology", used by right-wing political segments linked to conservative sectors of the Catholic and neo-Pentecostal churches, caught our attention. This maneuver follows the logic of a system of accusation that represents "a more or less conscious strategy to manipulate power and organize emotions, delimiting borders" (Velho, 2008:59). Such an attack has been directed at anyone who defends women's rights or the LGBT population, expressing a worldview, not of an explanatory purpose, but of a moral order (Miskolci, 2018).

In our investigation, the fight against the threat of "gender" could be verified in several proposals for "purifying" this category. All of them settle on the idea that there is a natural essence to the sexuality of human beings. Duarte (1999) clarifies that the conception of "human nature" was sedimented by physicalism, an ideological movement that appeared, between the XVII and XVIII centuries, due to the radical separation between body and soul. On this basis, corporality came to be conceived as a material substratum endowed with its own logic capable of exhausting the explanation of the human "essence". There are, in this direction, different strands that sustain this type of universalistic rationality in contemporary Western civilization.

Among them, the one "enlightened" by the biomedical discourse stands out, which, centered on anatomical and physiological aspects of the human body, started to rule truth regimes of modern science. The radicalism of this kind of proposition made the body, in its most organic sense, the center of all human experience, culminating, finally, in a physicalist reductionism (Duarte, 2004). This is evident, for example, in the first speech presented, whose suggestion is that the emphasis of *trans* experiences should focus on the body – and not on gender – from the insignia "Biological Sexual Dysphoria". In the same way, another participant pointed out, "It is not about 'gender', it's about 'unadjusted' body parts that have developed in discordance with sex (in a broader sense). 'Transsexual' describes this body-related variation (...)" (RR).

There is therefore a clear reference to bodily aspects in detriment of gender stereotypes. We should, in this context, ask ourselves: which biology would carry the "truth" of sex? Would it be the genitals? The hormones? The chromosomes?

According to Duarte (1994), this type of biomedical determinism, throughout the 20th century, suffered some attacks that took two distinct forms: "psychologicism" and "sociologism"[9]. The first one maintains the existence of a specific internal reality governed by proposals, named psychological, psychic, or unconscious, that are detached from strict corporality. The second holds that human experience stems exclusively from the conditioning promoted by the social field. These two currents seem to meet again, more contemporarily, in the idea of "psychosocial determinants", which, although it promotes some vacillation in the physicalist reductionism, it ends up assuming an equally essentialist tone supported by the conception of "human nature". Furthermore, the "somatic turn" that marks our times contributes to all these perspectives to mix, taking on different nuances marked by the prominence of the body (Russo, 2017).

This aspect was evident in the speech of one participant:

> I argue that no one knows what gender really is, and people are just fooling themselves if they think otherwise. The only reason most people are unfamiliar with radical feminism's view on gender is due to the fact transgender activists have managed to silence women's thinking through *bullying* and intimidation tactics. (…) Radical feminists are critical of gender per se. We are not gender reformers —we are gender abolitionists. Without the socially constructed gender roles that form the basis of patriarchy, all people would be free to dress, behave, and love others any way they wanted, no matter what their body type. (...) Radical feminists also believe that women have the right to define their boundaries and decide who is allowed in their spaces (SE).

This criticism is based on the idea that the concept of gender has been appropriated in order to reproduce the power relations between men and women. Gender thus becomes a way to indicate the social constructions of the ideals of "roles"[10] proper to men and women, finally constituting itself as a rigid social category that imposes a certain hierarchy on sexed bodies (de Santana, 2016). Although this speech seems to indicate a defense of the circulation of bodies, regardless of any socially produced subjective identity, it ends up reifying some separation from biology. After all, what would be the "women" that this participant refers to? This question seems to be clarified in

[9] We emphasize that the author does not take a critical position towards all the knowledge constructions that have taken place in the fields of psychology and sociology, but to those anchored in an essentialized, naturalized, and, consequently, pathologizing perspective of the relations of human beings with their psychism or social surroundings.

[10] We will always put the concept of "role" in quotation marks due to its conceptual and analytical limitation, as it carries a sense of fixity. This idea has been gradually replaced by the notion of "performativity" (Butler, 2002, 2003, 2004), which does not ignore the materiality of bodies, but moves away from any essentialist rancor.

another speech: "The basis of female oppression comes from biology. The existence of intersex people does not deny this since it is also based on the biology of the body and not on the abstract identity adopted by any particular individual" (RO).

This defense, despite presenting a political-social appeal, leads us, once again, in the reaffirmation of the essentialism of sexed bodies supported by physicalism. A physicalism that, although it is sustained in imminently organic aspects, seems to acquire a slightly less reductionist perspective when contemplating the interaction of bodies with the social environment (Russo, 2017). In the following analyses, we will verify how the physical and moral elements are mixing with each other in order to outline more or less impure thematic axes, never homogeneous and always imperfect.

What is this "psychosociologization"?

As noted, Harry Benjamin was one of the pioneers to describe what he called the "transsexual phenomenon", contributing decisively to these experiences becoming the target of the medical-psychiatric discourse. This doctor assured there were different types of "sexes", ranging from genetic to social. Although he believed in the existence of a "psychological sex", even attributing to it a certain autonomy to the point of being able to disagree with the others, he claimed that this expression was a direct result of hormonal influences. His thesis, with a clear physicalist orientation, defended that this disagreement could assume different stages: pseudo-transvestite; fetishist transvestite; true transvestite; non-surgical transsexual; moderate intensity transsexual; high intensity transsexual. Benjamin was incisive about the importance of differentiating these categories considering that, in his view, only those people who were in the last three stages would benefit from surgical interventions. Transsexualities, from this point, began to gain clear contours, standing out from homosexualities, transvestites and intersexualities (Santos, 2011). This trend ended up being adopted by psychiatric manuals that, since the 1980s, began to classify each of these entities separately from one another. In practice, as we shall see, this issue still causes an impasse.

Soon after, the psychosocial reading of Money, by emphasizing the importance of socialization and learning in establishing gender "roles" and identities, as well as sexual orientation, expanded, on the one hand, the field of research on the subject. On the other hand, however, it ended up being used much more to justify behavioral interventions in order to produce a coherence between sex, gender and sexual orientation based on heteronormative binarism than to expand the possibilities of welcoming sexual diversities (Santos, 2011).

In the same way, another exponent in the history of the "transsexuality device" —the psychoanalyst Robert Stoller — established his studies by working with several boys whose parents considered them "effeminate". His objective was to understand how, and which socialization processes could lead to a gender identity divergent with the biological sex. Supported by Freudian theories, at the time already appropriated in questionable ways in the United States, the psychoanalyst argued that this disharmony stemmed from a dysfunctional relationship with the parents, especially with the mother. For him, a family dynamic marked by a domineering mother and an absent father would create a propitious environment to the development of a "true transsexual". Following this thesis, Stoller recommended early interventions by the therapist in order to create a "therapeutically induced Oedipus complex" that would allow the child to disidentify from the mother and identify with elements attributed to the male gender. The psychoanalyst, thus, unlike Benjamin and Money, was against sexual reassignment surgeries, betting exclusively on psychotherapeutic interventions (Santos, 2011; Borba, 2016).

All these elaborations, which include from the idea of a "psychological sex" (even if biologically determined), to the aspect of learning from interpersonal relationships in childhood or the normative idea of a functional Oedipus, point, in some way, to elements that do not coincide exactly with the organic viscerality of bodies. Such perspectives, however, although they seem to give another coloring to more radical physicalist theories —sometimes causing a certain vacillation —carry an equally essentialist, determinist and moralizing tone. Following this track, based on the

speeches we analyzed, we established "*psychosociologization*"[11] as the axis of discussion. In general, the speeches described here refer to the psychic and social aspects involved in certain conceptions of transsexualities that refer to the elaborations of Benjamin, Money and Stoller.

The insistence on keeping *trans experiences* linked to mental health was frequent. This is the case, for example, of a participant who questioned the proposal to place "Gender Incongruence" in a separate category from the psychiatric pictures ("Conditions related to Sexual Health"), justifying that the absence of a brain substrate brings it closer to other established mental sufferings. He further added that:

> (...) these definitions are applicable to all people with "Gender Incongruence", including Fetishistic Transvestites (and this definition has now been mysteriously deleted from the ICD). For many, perhaps for most men who transition late to become transsexuals, Fetishistic Transvestism is the first stage (SP).

In his speech, he contested the proposal to suppress the subcategory "Fetishistic Transvestism" — which in the ICD 10 is part of the subgroup "Sexual Preference Disorders" – emphasizing that this condition constitutes one of the stages of transsexualities. It is curious that, despite the understanding that these manifestations constitute a psychic entity, the participant makes a clear reference to the "natural history" model of organic diseases, locating the "Fetishistic Transvestism" as a kind of "pre-morbid state" of transsexuality. This idea of a *continuum*, coined by Benjamin, seems to corroborate certain ideals of "treatment" that sometimes meet and sometimes distance themselves:

> Male and female transsexuals are people who have a mental perception of their biology that is at odds with their biological reality. For them, the dysphoria is so significant and intractable that the only solution is cosmetic surgery to make their body look less like their biological truth and more like their mental fiction. (...) Transgender male and female people generally have no significant body issues, other than a fetishistic desire to present themselves using mannerisms and behaviors that society usually expects of people of the opposite sex. They want to use bathrooms, changing rooms, and other facilities reserved for the opposite sex. They are usually heterosexual. In my opinion, fetishism should be treated and not encouraged (GO).

Another participant, although she agreed with this differentiation between "transsexuals" and "transgenders" —a common distinction among Americans that have not been sedimented in Brazil — stressed that none of these conditions imply a particular sexual orientation. It should be remembered that until the 1970s, despite Benjamin's efforts to establish a differential diagnosis, "transsexualism" and "homosexualism" received similar medical-psychological approaches. It was only in 1973, when homosexualities were no longer considered pathological pictures by the American Psychiatric Association (see figure 3 for how this trend was incorporated by the ICD), that transsexualities were grouped into a category of their own (Dunker; Kyrillos Neto, 2010). However, in common sense, as well as in certain studies and practices, an association between both conditions is still observed.

The same participant, besides clarifying the difference between gender and sexual orientation, was incisive in refuting the need for treatment of "transgenders" without the consent of the people so classified:

> If a transgender person voluntarily seeks treatment, in general the behavior should be neither encouraged nor discouraged. Instead, psychotherapy requires individual decisions by the therapist about how each individual should be helped (AM).

[11] The term "psychosociologization" does not disregard the importance of the elaborations and actions of sociology and psychology that have contributed (and contribute) to break the physicalist and classifying logic, but intends to problematize discourses that, although they may be referred to these fields, remain anchored in anachronistic perspectives that, like those of Benjamin, Money, and Stoller, have done little to destabilize the norms that govern bodies and subjectivities in the West.

Despite the above punctuation, the previous speech protagonist insisted, "The two most relevant classes for most cases are 1) transsexuality: highly effeminate gay men; 2) transgenderism: straight men with a narcissistic fetish for looking and behaving in stereotypically feminine ways" (GO).

Although it is not clear what would be the form of "treatment" he advocates for the case of transgenders, it is inevitable to refer his idea of "highly effeminate gay men" to the approach proposal coined by Stoller. There is, in this sense, a tendency to adopt a pedagogical procedure of correction in detriment of an intervention that requires the authorization and the engagement of the subject in a creative process of construction of an authentic way of life, independently of any standardization. Not far from what has been contemporarily named as "gay cure" (Dunker; Kyrillos Neto, 2010).

We could also think of a psychosocial approach with a strongly humanistic verve, which moves toward a kind of self-acceptance and social "tolerance": "It would be a much healthier path if you simply recognized that you are a man who has a strong desire to 'be' a woman, to mimic stereotypes of the 'female' ('gender') sex role, and to seek 'validation' from society (...)" (BP).

It is observed that, in both cases, the attempt to operationalize a rationality focused on psychosocial aspects often culminates in a nominalistic maneuver, which universalizes experiences and demarcates what is socially acceptable and what should be eradicated, reversed, or cured. This kind of discursive homogenization, as we will see, is part of the logic of contemporary medical-psychiatric textbooks, which, by establishing stable categories with an apparent scientific validity, influence psychotherapeutic practices, which become focused on the social adaptation of the supposed patients. The subjective forms become, thus, pathological pictures that, from moral dispositions and conduct guidelines, guide professionals, subjects, and the entire social fabric around a pre-established norm (Dunker; Kyrillos Neto, 2010).

Psychiatrization or engaged cerebralization?

The debate about the pathologization of *trans experiences* has divided the opinion of many, including within the social movements themselves. In the speeches analyzed, the tendency to maintain transsexualities as psychiatric conditions is evident:

> (...) transsexualism causes suffering in itself and it is therefore a disorder that requires a medical and scientific naming appropriate to the professional field, and not a harmful or politically correct terminology, as may be used in social debates on the subject (...) Transsexualism is not a perversion, it does not deserve stigma, but it is a disorder (...) (AM).

This participant used the term "transsexualism"[12] and the argument that keeping *trans experiences* as a "psychiatric disorder" would ensure the advancement of scientific research on the topic and the access of these people to adequate care. It is observed, in this case, that the reference moves from the concept of "disease" — that is, a condition with a well-defined etiology (cause) and pathophysiology (pathological physiological changes) —to the idea of "disorder" —an established translation of the term *disorder*, which ultimately refers to a "clinically" significant psychic and social dysfunction. This reflects the discussion sedimented in the psychiatric field in 1980 with the release of the DSM III that culminated in the establishment of objective, stable, descriptive categories based on supposedly atheoretical empirical studies. Since psychiatry is unaware of the etiology and pathological process of the pictures addressed to it, it was necessary to establish this new category — "disorder" —which, detached from any etiological discussion, would provide a common language among professionals and researchers, legitimating their fields of intervention (Aguiar, 2004).

Therefore, in this sense, the participant advocated that understanding transsexualities as a "disorder" would allow operationalizing a universally valid scientific knowledge and an effective technical approach. Such a claim was somehow configured in the very empirical *corpus* we

[12] The term stopped being adopted after DSM IV, but it is still used in more conservative medical-scientific discourses and practices. At the same time, it is a term totally rejected by the LGBT movement and by scientific productions that problematize the essentialization of identities.

analyzed. The fact that we did not locate any speeches about trans-masculinities, for example, besides indicating an understanding of trans experiences as something associated exclusively with the feminine, seemed to us to reiterate the belief in the stability of a category valid for everyone, regardless of the specificities of gender, sexuality, age, race, and social class.

The same participant also claimed that the biomedical view would contribute so that this type of experience would not be interpreted as a voluntary choice, reducing the guilt and social stigma of individuals. To better understand this point, it is important we question ourselves about the atheoretical claim of the notion of "disorder". Now, we know that the empirical objectivity adopted in this conception is ideally close to the empirical objectivity of the physiological and organic substrate. This trend became even clearer with the release of DSM V, which defined categories based not only on statistical tests, but also on speculations from recent research in genetics and neuroimaging. We can thus say that the so-called "a-theoricism" is nothing more than the adoption of a physicalist view of mental disorder (Russo, 2004).

It is common, in this context, the argument that bringing psychiatric pictures closer to organic diseases would contribute to the reduction of prejudice and social isolation experienced by these people. Studies reveal, however, that despite the efforts of scientific discourse to make society aware of this issue, in practice, what has happened is just the opposite. There is, in fact, a growing tendency to wish to distance oneself from individuals with psychiatric disorders such as, for example, schizophrenia. The idea that this syndrome is a "mental illness", in the biomedical sense, seems to reinforce the conception that subjects with these manifestations have an organic, permanent, and irreversible abnormality. This makes them "dangerous" and "unpredictable", a situation that reinforces social isolation (Watters, 2010).

When it comes to *trans experiences*, the diagnosis contributes to these people not being recognized as subjects capable of speaking and deciding for themselves. The idea that these subjects are "trans", in this case, undermines the autonomy for each one to build a singular narrative of their identity and decide on the form of care that best suits them (Borba, 2016).

The prominence of physicalist logic in this field becomes even more evident in the speech of a *trans* woman, corroborated by other participants:

> I am a patient suffering from this pathology (...) it is not about social constructs, gender or political agenda; it is about biology, how we feel from birth and how we can fix ourselves to feel better. (...) it is clear there are two different sexes. People like me who do not agree with the sex they were assigned when they were born are not rebelling against anything, but to match their sexual body to their brain, which determines which sex they belong to (IP).

The brain, in this context, becomes the great protagonist in defining the bodies and the forms of subjectivation of each one. This is part of a very contemporary trend, authorized by a proliferation of technologies, practices, and discourses that blur the boundaries between the brain organ and the less materializable ideas concerning the mental. Identities thus become determined by the neurological functioning that, ultimately, embodies the "nature" of each one (Azize, 2008).

This kind of reasoning promotes a new form of social organization, named by Nikolas Rose (2013) as "neurochemical citizenship". That is, new patterns of biological activism around a physicalist understanding of individuals that controls and docilizes the bodies from what the author called "neuropolitics". In other words, although, apparently, we are facing a certain engagement —a true "brain engagement" —that opens the possibility for people to undertake their autonomy, there is a tacit exercise of power that produces discourses, practices, and knowledge with domination purposes.

One of the participants, however, questioned the validity of the thesis that "brain sex" is the main determinant of human sexuality, citing several studies that compare the brain aspects of *trans* people with cisgender people:

> (...) from the point of view of assessing the quality of evidence using the GRADE system[13] (...), all evidence on 'brain sex' is useless because of the serious problems of imprecision: very small samples, often indirectly obtained (e.g. in post-mortem studies) and possibly other types of biases (SP).

It is curious how the findings of this type of study are taken as scientific evidence, even when they are supported by questionable methodologies. It seems to us, there is actually a "pseudo-scientificism", which produces exaggerated claims without any opening to refutation and construction of new perspectives. This is the path that, according to Hacking (2005), sets the imperatives of biopower in the contemporary. For him, what is at stake in this process is: counting and correlating data; quantifying; medicalizing; normalizing; biologizing; making genetic; bureaucratizing and, finally, taking possession of the identity that is thus manufactured. Here, especially, we are in the field of the "let's biologize" imperative. In this logic, several mental disorders —even those that are intended to depathologize, as is the case of sexualities —have their explanation going through the brain and its neurochemistry, based on a scientific-like maneuver that acquires the effect of absolute and immutable truth.

And, in this direction, we cannot leave aside the role of hormones in the formulation of this discourse. As Rohden (2008) points out

> It is becoming increasingly common to come across articles in scientific journals and books, or even in mainstream newspapers, and television programs dedicated to dealing with the importance of hormones in the well-being and health of individuals and in determining certain behaviors. The more current the story is, the more likely it is that it will also deal with the connection between the brain and hormones, and that it will present the innate and unbridgeable differences between the sexes. The idea that hormones determine everything, even our intelligence and our behavior towards the opposite sex, seems to gain more and more supporters. There is also talk of hormonal intelligence. We witness the empire of a "hormonal body" that seems to override any other current biomedical conception, at least if we consider the success of its acceptance among an increasingly broad public (Rohden, 2008:134).

The immutable "nature of being", therefore, can draw on a vast technological arsenal of interventions on the body to be transformed and improved, not only in order to restore good health, but also with the aim of perfecting one's performance. This phenomenon is very much in line with the consumer logic of contemporary capitalism in which the human body becomes a commodity. A democratic commodity whose quality is governed by moral values that determine certain ideals of the Western human being. There is, in this sense, the junction between a subjective moral and a physicalist vision focused on brain functioning, so that the second ends up encompassing the first (Azize, 2008). Here is a form of power exercise verified in the "transsexuality device" that finally erases singularities and scratches the destinies of bodies. Given this, what are the possible ways out to operationalize the diversity of demands and desires that involve *trans* experiences?

Non-pathologizing and operationalizing trans experiences

In general, the central issue of the debate about the pathologization of *trans* experiences is that, if on the one hand assuming a medical diagnosis contributes to the medicalization of non-hegemonic ways of life, on the other hand, the absence of a classification legitimized by contemporary manuals can make the bureaucratic procedures of health systems unviable, making it (even more) difficult for these people to access the various forms of care, including bodily interventions for those who want them (Bento, 2018).

As we have observed, there are various discursive strategies that support the non-pathologization of these experiences:

[13] The Grading of Recommendations, Assessment, Development and Evaluation (GRADE) system aims to standardize the criteria used to define scientific evidence that can guide clinical practice.

> Yes, there is a need to help transgender people, but a diagnosis must be based on human rights. And that is accepting the knowledge that people have about their own sex. If a girl knows she is a girl, she should be treated as a girl by doctors. And so, being transsexual cannot be a "gender dysphoria" ... it is a body variation (RR).

This *trans* woman seems to agree with the psychosociological view of Stoller, who established the concept of "gender identity" to highlight that the definition of gender, contrary to what was advocated by Money, depended more on one's feelings than on the behavior exhibited by the individual (Cyrino, 2013). The self-determination of one's own identity would be, in this sense, the most appropriate way to know one's gender. The act of speaking for oneself, however, is affected by different perspectives: "I was born a girl with masculinized body parts. Why are there so many people who think they have the right to speak in our names?" (RR).

One notices that, in this case, the participant, while legitimating the knowledge of each one about their own gender, reinforced that this determination has, at its base, something of the body's organicity. Regardless of this paradox, she opens an important question about the issue: if gender is exactly this individual feeling of belonging to a certain socially established group, how to talk about gender "dysphoria" or "incongruence"? This problematization becomes even more pressing when we adopt Butler's (2002; 2003; 2009) idea that gender is an ongoing performative exercise that not only reproduces and naturalizes intelligible binary norms, but also destabilizes them, making room for new creations. Now, to the extent that gender refers to a performativity, which involves not only collective ways of being in the world but also singular forms of appropriation, terms like "deviation", "dysphoria", "deception", "incongruity", or "inadequacy" should indeed be outlawed.

In practice, however, stereotypical repetition is privileged to the detriment of creative and singular constructions. This is what often happens in health services in which the intimate truth of each person ends up being overshadowed by an ideal type of transsexuality, emerging as a hegemonic narrative that must be repeated to professionals in order to ensure institutional authorization and access to bodily interventions (Borba, 2016).

But how to guarantee the access of these people not by a medical-evaluative model, but by "a model based on autonomy and shared decision, in which *trans* people have decision centrality and narrative openness to intervene in the clinical encounter" (Borba, 2016:51)? In our study, there was a single speech that seemed to us to indicate this path:

> The name "gender incongruence" is stigmatizing and driven by transphobic beliefs that cisgender identities are better than trans identities. Trans issues should not be considered diseases. The only reason to keep them in the ICD is to enable trans people to make body modifications, such as hormone treatment or surgery. It should be noted that not all trans people want this transition. These modifications change the biological sex and have nothing to do with "gender", which is a social construct. I propose to rename this category "Body Modifications Related to Secondary Sex Characteristics" to keep the focus on the medical interventions that trans people may or may not desire, and not on their identities or gender, which should be kept out of medical discourse. The proposed category (...) should be moved to Section 24, "Conditions Associated with Interventions", as this will describe (...) not the reason for the treatment, but the treatment itself (SR).

Perhaps, this alternative would allow a co-participation and co-responsibility of *trans* people from the "rupture of a device that has as its foundation the impediment of the recognition of the other as a subject capable of saying and deciding for herself/himself" (Teixeira, 2013:285). It seems, however, that this proposal is far from being adopted by institutions that determine the classifications of diseases in contemporary times, but it is on the agenda of activists, academics and services that bet on depathologization (Prado, 2018).

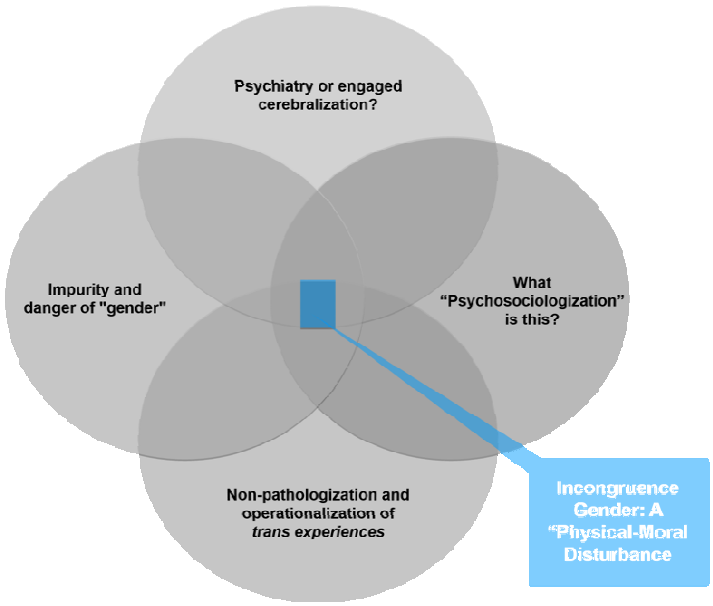
But, after all, where is the incongruity?

Throughout this work, we noticed that the speeches about the classification proposals of *trans* experiences focus on a point marked by the "unwavering tension" between romanticism and enlightenment that characterizes the universe of values of the Western world (Duarte, 1994; 2004).

If, on the one hand, there are some more constructionist discourses that point to the centrality of the subjects, their experiences, and their relations in the definition of sexualities and genders, on the other hand, there are those more illuminist ones that focus on the biology and physiology of the bodies. Regardless of the perspective, there is always a crossing of moral aspects, which are not always evident.

In practice, as we review each of the axes we have forged throughout our analysis, we realize that they mix up, so that their boundaries become uneven and imprecise (figure 4). When we discuss, for example, the rise of the brain sustained by contemporary medical-psychiatric discourse regarding transsexualities, it is inevitable not to turn to psychosociological categories to understand, finally, how this body assumes the materiality of these shifting elements in order to stabilize them as a concrete and unshakable truth (Duarte, 2018).

Figure 4: Intersections between the axis of analysis and discussion



Source: Made by the authors.

This notion of shifting, non-linear categories that contradict or confuse the ideal classes, brings us back to post-structuralist discussions about classifications. In fact, especially when we focus on complex objects — as occurs in the experiences related to sexualities and genders — there is always a residue that resists any attempt to establish a clear delimitation between different categories. In our study, we delimit the very conception of "gender" as this "polluting element" (Douglas, 1991). In the face of what escapes, there is a permanent effort to reintegrate a certain order from the notion that there is a human "nature" independent of "culture". This perspective is anchored in a dualistic paradigm that, by upholding the existence of a fixed and unchanging nature upon which countless culturally determined sayings and non-sayings are drawn, disregards the hybrid elements that cut across the very domains of nature and culture that we artificially establish (Strathern, 2014). Such elements are, to some extent, "purified" from discursive strategies that, by naming and categorizing them, create a kind of essence that makes us take them as concrete or natural objects. This is the case of *trans* experiences that, when classified as "Gender Incongruence", even if apparently dissociated from psychiatric conditions through their allocation to "Conditions related to sexual health", continue to be understood as fixed, trans-historical and universal psychopathological phenomena.

Following this reasoning, it is worth returning to the critique by Strathern (2014) about the binary categories – nature-culture, male-female, wild-domesticated, etc. — that are part of Western rationality. The anthropologist, when studying the ideas of the Hagen people, highlights that the impure elements, which challenge the aprioristic Western dichotomous classifications, are

fundamental to the establishment of the mobility of the social fabric. This is the case of gender, which, by placing itself between nature and culture, tenses the social fabric in a way that allows interactions and processes of construction and reconstruction to take place. This is precisely why Strathern is emphatic in designating gender as the "operator of culture," that is, that which makes society interact, move, and transform itself.

In the West, this element — as well as all those that deny the purity of classes — are managed from a binary logic that works as a powerful "persuasive fiction". This elaboration is especially valid in our investigation, which finally demonstrates that what is pathological, problematic, dysphoric, or incongruous, in fact, is not the gender, but the practices, the discourses, the said and the unsaid that try, all the time, to classify, purify, delegitimize, and invisibilize it.

We rescued, in this sense, the idea of "physical-moral disturbance" (Duarte, 1998) as a point of convergence between our axes of analysis (figure 4). The term "disturbance" refers to situations that are considered "pathological" in our Western culture and "regular" in other contexts, thus evidencing that suffering is not intrinsic to the condition itself, but determined by social, historical, and cultural aspects. The qualitative "physical-moral", in turn, emphasizes the "linking or mediating character that these phenomena have in the relations between the corporality and all other dimensions of social life, including, and eventually, the spiritual or transcendental" (Duarte, 1998:22). This perspective clarifies that the socially authorized practices and discourses that make up the "device of transsexuality", although they seem to be based on objective aspects of corporalities, carry with them a moral dimension that includes evaluative elements about a certain Western ideal. This is the way that we locate, in most of the speeches, a veiled consensus about unquestionable "natural" and essentialist assumptions due to the "all-encompassing" effect of the physicalist vision on the romantic vision of (trans)sexualities (Azize,2008). This union is essential to legitimize discourses that come to have a status of "scientific truth", supporting a binary, heterosexual and pathologizing logic of *trans* experiences.

Discussing such issues from the investigated *corpus* is especially important considering that it is the ICD codes that appear in our country's official health statistics. Even though the removal of the category "Gender Incongruence" from the chapter on mental disorders meant a victory for depathologizing movements, the access of trans people to health care remains problematic. The new codes created remain, to some extent, pathologizing and restricting the contact of this population with health services, fostering inequities and exclusions.

In this process, as we highlighted in the last speech, the need for a care of singular bodies is put in parentheses by a homogeneous discourse that values more the universal classification of an ideal identity than the interventions desired by each one. Yet, "how to declassify and care at the same time? How to declassify and use the biomedical order to care?" (Prado, 2018:51).

It seems to us that, beyond any classificatory change, there must be a true ethical engagement of professionals in order to respect and recognize that the demands of *trans* may not be related to an attempt to reach "normality", but to find a better way to inhabit and live in the world. Perhaps, this is the way for the *setting of* "treatment" to move away from the pathologizing framework, becoming a *setting of* "care" (Butler, 2011). That is, a place where a real encounter between the subject and the professional takes place in order to support unique constructions and open new possibilities for social bonding.

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