University of Sao Paulo - USP
Faculty of Philosophy, Literature and Human Sciences - FFLCH

Final work of the discipline
Anthropology and Gender

ESSAY ON THE BORDERS The Gendered Limits of Neurodivergence

Isabela Diniz Gonçalves Gualtieri - USP nº 8802990
Marina Nittolo Bagatini - USP nº 10763484
Professor Heloisa Buarque de Almeida

São Paulo
2022

ETIOLOGY

THIS PERSON (choose one option):

1. She is on a dangerous journey, from which we can learn a lot if she returns.

2. She is possessed (choose one option):

a. by the gods.
b. by God (i.e., by a prophet).
c. by evil spirits, demons or devils.
d. by devil.
and. It is a witch.
f. She is bewitched (variant of item 2).
g. She is bad and needs to be isolated and punished.
h. Is sick and needs to be isolated and treated by (choose one option):

i. of purgatives and leeches.
ii. removal of the uterus, if you have one.
iii. electric shocks to the brain.
iv. of sheets soaked in cold water, tied tightly around the body.

v. of Amplíctil or Stelazine.

7. You are sick and need to spend the next seven years talking about it.

8. He is a victim of social intolerance resulting from behaviors that deviate from the norm.

9. She is sane in an insane world.

10. You are undertaking a dangerous journey from which you may never return.

Girl, Interrupted
Susanna Kaysen
1993

INDEX

1. Introduction

Although supposedly based on an “exact” science, medicine is a large arena where the existence of a gender/sex system has visible and quantified results, even within its own standards. In addition to a biological determinism that is often found within scientific production and clinical care, perceptions of gender and traits considered “feminine” and “masculine” result in a differentiation in access to diagnoses and access to necessary care.

In emergency departments, studies show that patients' gender and race predict the amount of pain medication given to patients, with women and people of color receiving less pain medication than white men.[1], just as “feminine” personality traits imply less access to medical treatment for women who are heart patients[2]. In the case of diseases associated with women, the time for diagnosis is also substantial: the average time for diagnosis of endometriosis is seven years, between the first symptoms and the final diagnosis.[3], data in line with international averages.

In psychiatry, this differentiation continues. While some diseases are historically characterized as “feminine” diseases (such as hysteria, considered a disease of “feminine temperament turned neurotic”), with their diagnoses diluted over time among several diseases with their own gender differentiation mechanisms, some diseases are still considered to be typically feminine diseases. In the case of the diseases chosen here as the object of analysis, Borderline Personality Disorder is primarily diagnosed in women, who make up 3 out of every 4 diagnoses made. At the other extreme, Autism Spectrum Disorder is diagnosed four times more often in men, with part of the theoretical study around it pointing to autism as a condition resulting from an “extremely masculine brain” that does not understand the “feminine” traits of empathy and focus on maintaining social and family relationships.

With the creation of diagnostic models focused on traits associated with certain gender constructions, even if separated from the (also social) construction of the concept of sex and biological differences, there is a creation of “model patients” that affect the way diseases are diagnosed, researched and understood. While the model patient for autism is commonly seen as a white, cisgender, heterosexual man with above-average intelligence, the other subjects who occupy the same spaces in the medicalization of their experiences have diametrically opposed experiences. Although there is a

---

[1] WEISSE, Carol S, et al. Do Gender and Race Affect Decisions About Pain Management? **Journal of general internal medicine**, v. 16(4), p. 211-217, 2001.

[2] PELLETIER, Roxanne; HUMPHRIES, Karin H.; Shimony, Avi; *et al*. Sex-related differences in access to care among patients with premature acute coronary syndrome. **CMAJ: Canadian Medical Association Journal**, v. 186, no. 7, p. 497–504, 2014.

[3] ARRUDA, M. S.; PETTA, C. A.; *et al*. Time elapsed from onset of symptoms to diagnosis of endometriosis in a cohort study of Brazilian women. **Human Reproduction**, v. 18, no. 4, p. 756–759, 2003.

pointing out that the medicalization of their experiences does not necessarily coexist with appropriate support systems, the lack of formal diagnosis often excludes these subjects from the possible accessibility adaptations necessary for them to have a certain quality of life, a lack that can have serious consequences.

By the very terms that dictate scientific production in these areas, this analysis is bound to a certain degree of gender and cisgender binarism that does not consider the very existences lived within the reality of these diagnoses, which exist in a gray area around conformity and adherence to socially expected standards. Despite this limitation, this work seeks to be an entry point that allows for a fuller understanding of the ways in which medical diagnosis is affected by the constructions of the sex/gender system.

2. Forms of diagnosis

In this session the objective is to understand the evolution of diagnoses of hysteria, a disorder [4]borderline personality disorder, and autism spectrum disorder through changes in the concepts described in the DSM - The Diagnostic and Statistical Manual of Mental Disorders. Now in its 5th edition, the publication by the American Psychiatric Association (APA) is considered by many experts to be the "bible" of psychiatry, used not only by doctors and hospitals, but by the pharmaceutical industry, insurance companies and health plans, the legal system, and even in the production of public policies.

The evolution of the editions, from the first in 1952 to the most recent, in 2013, marks not only the evolution of medical concepts, but also social ones. Biology is part of the interpretative dilemmas and generic cultural studies, and theories of sexual difference have influenced the scientific process and the interpretation of its experimental results, in a way that is not essentially cultural. The body, and its diseases, are also a product of their specific historical and cultural moment - diseases and their form of diagnosis and lists of symptoms exist from the moment of their systematization and separation as an entity of their own, separate from the others. Over time, these elements of the diagnoses and their "solutions" are made part of the characteristics of sexual differentiation, becoming part of the codes belonging to "femininity and masculinity".[5].

2.1. Hysteria

Hysteria as a mental illness or disorder is not mentioned in any of the DSMs, however, there are references to it in the DSM-I, relating behaviors of that time with old "hysterical" diagnoses, and the mention of "histrionic behavior" as a

[4] LAQUEUR, Thomas:*Inventing Sex: Body and Gender from the Greeks to Freud*, Rio de Janeiro, Relume-Dumará, 2001

[5]See, for example, the listing of Prozac and Valium, medications used to treat anxiety, panic disorder and depression (among others) in the "semiotic-technical codes of white heterosexual femininity belonging to the post-war pharmacopornographic political ecology" in the work of Paul B. Preciado. Symptoms and methods of "cure" become constitutive elements of femininity.
PRECIADO, Paul B.: "Technogender" in: Testo Junkie, New York, N-1 Editions, 2018.

similar to hysteria in the DSM-II, from 1968 and DSM-III, from 1987. In the DSM-V there is the categorization of histrionic personality disorder, but this is no longer linked to the old hysteria.

Code No. 3rd Ed.	Code No. 4th Ed.	Code Supp. Term	Old Diagnosis	New Diagnosis
336–550	000–x03		Neurosis, incoordination of vocal cords	Conversion reaction
330–551	000–x03		Neurosis of larynx, hysteria	Conversion reaction
330–552	000–x03	902	Anesthesia of larynx	Conversion reaction
330–553	000–x03	905	Hyperesthesia	Conversion reaction
330–554	000–x03	907	Paresthesia	Conversion reaction
339–555	000–x03		Paralysis of larynx, hysteria	Conversion reaction
339–556	000–x03	9222	Spasm of larynx, hysteria	Conversion reaction
617–550	000–x03		Paralysis of uvula, hysteria	Conversion reaction
620–550	000–x03	610	Ptyalism, hysterical	Conversion reaction
631–552	000–x03	902	Anesthesia	Conversion reaction
631–553	000–x03	905	Hyperesthesia	Conversion reaction
631–554	000–x03	907	Paresthesia	Conversion reaction
672–550	000–x03	721	Incontinence, hysteria	Conversion reaction
x23–551	000–x03	x13	Amblyopia, hysteria	Conversion reaction
x23–552	000–x03	x12	Hysterical amaurosis	Conversion reaction
x30–555	000–x03		Asthenopia hysteria	Conversion reaction
x39–555	000–x03		Hysterical paralysis of accommodation	Conversion reaction
x70–551	000–x03	x06	Deafness, hysteria	Conversion reaction

Image 1: source-DSM-I, 1953

> 301.5 Hysterical personality (histrionic personality disorder)
> These behavior patterns are characterized by instability, overreactivity, and self-dramatization. This self-dramatization is always attentive and often seductive, whether or not the patient is aware of its purpose. These personalities are also immature, self-centered, often vain, and generally dependent on others.
> Source: DSM-II

> [...] They are prone to exaggeration and often act out a role, such as the "victim" or the "princess," without being aware of it. Behavior is overly reactive and intensely expressed. Minor stimuli give rise to emotional excitability, such as irrational, angry outbursts or temper tantrums. [...] In other classifications, this category is called Hysterical Personality. [...]
> Source: DSM-III

2.2. Borderline Personality Disorder (BPD)

The definition given today for this disorder according to the DSM-V is based on nine characteristics, with the minimum presence of five of them being necessary for the diagnosis to be considered a possibility.

> A pervasive pattern of unstable interpersonal relationships, self-image, and affects, and of marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following: 1. Frantic efforts to avoid real or imagined abandonment. 2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
> 3. Identity disturbance: marked and persistent instability of self-image or self-perception.
> 4. Impulsivity in at least two potentially self-destructive areas (e.g., spending, sex, substance abuse, reckless driving, binge eating).
> 5. Recurrence of suicidal behavior, gestures or threats or self-mutilating behavior.
> 6. Affective instability due to marked mood reactivity (e.g., episodic dysphoria, irritability, or intense anxiety lasting usually a few hours and only rarely more than a few days).
> 7. Chronic feelings of emptiness.
> 8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of irritation, constant anger, recurrent physical fights).
> 9. Transient paranoid ideation associated with stress or intense dissociative symptoms.

The term was first mentioned in the third edition of the DSM with some differences in characteristics, there were eight diagnosed traits. Before the term was coined, the equivalent diagnosis already present in the DSM I was “cyclothymic personality”, which also fits into the group of personality disorders. The idea of cyclothymia in general terms is the cyclical variation between mania and depression, but more rapidly and intensely than a bipolar disorder. The same classification was maintained in the DSM II.

> This pattern of behavior is manifested by recurring and alternating periods of depression and euphoria. Periods of euphoria may be marked by ambition, warmth, enthusiasm, optimism, and high energy. Periods of depression may be marked by worry, pessimism, low energy, and a sense of futility. These mood swings are not easily attributable to external circumstances. If possible, the diagnosis should specify whether the mood is characteristically depressed, hypomanic, or alternating.

2.3. Autism Spectrum Disorder (ASD)

The evolution of the diagnostic criteria for ASD, and even its nomenclature, is evident, since the first mention in the DSM-I, which only mentioned “autistic thought form” within the classification of “schizoid personality”, without its own categorization. In the DSM-III it first appeared as “childhood autism”, implying that there was no diagnosis, or the disease itself, in adulthood, as can be seen in the description below:

> A syndrome present from birth or beginning almost invariably in the first 30 months. Responses to auditory and sometimes visual stimuli are abnormal and there are usually severe problems in understanding spoken language.

> Speech is delayed and, if it develops, is characterized by echolalia, pronoun reversals, and the ability to use abstract terms. There is usually a deficiency in the use of verbal and sign language. Problems in social relationships are most severe before the age of five and include a deficiency in the development of eye contact, gaze, social bonding, and cooperative play. Ritualistic behavior includes abnormal routines, resistance to change, fixation on unfamiliar objects, and stereotyped behavior.
> patterns of play. The capacity for abstract or symbolic thought and for imaginative play is diminished. Intelligence ranges from severely subnormal to normal or above. Performance is generally better on tasks involving rote memory or visuospatial skills than on those requiring symbolic or linguistic skills.

The characterization of the disorder remained practically identical in the DSM-IV of 1994, with the difference in nomenclature: “Autistic Disorder”. There was still the reinforcement of early diagnosis, between the first months and three years of age, but it was only in the DSM-V that the disorder was understood as a spectrum:

> Diagnostic Criteria
> A. Persistent deficits in social communication and social interaction across multiple contexts
> B. Restricted and repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by previous history (examples are illustrative only and are not exhaustive; see text): 1. Stereotyped or repetitive motor movements, use of objects, or speech 2. Insisting on the same things, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior 3. Fixed and highly restricted interests that are abnormal in intensity or focus 4. Hyper- or hypo-reactivity to sensory stimuli or unusual interest in sensory aspects of the environment
> C. Symptoms must be present early in the developmental period (but may not become fully manifest until social demands exceed limited capacities or may be masked by strategies learned later in life). D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of functioning in the individual's life at the present time.

3. Analysis of disorders through the lens of gender theory

This section aims to analyze the diagnostic criteria of the three mental disorders in question from a gendered perspective, that is, to understand the boundary between what is pathological and what is social, in the nature x culture dichotomy.

3.1. Hysteria

Hysteria is, historically, a female disease. Not only a disease considered a women's disease, but also a disease of the “feminine temperament”, that is, a disease of the mannerisms considered socially as part of the personality.

expected of female subjects, elevated to a neurotic condition that removes the subject from the acceptable and leads him to “behavioral pathology”, as described by Laqueur.

As perhaps the most obvious and common example of a disease where there is a significant disparity in diagnosis between the sexes, its existence has been extensively studied. Since its emergence as a disease of the irregular movement of blood from the uterus to the brain as theorized by Hippocrates and demonstrated in its etymology (from the Greek “uterus”), several theories about its emergence and formation have been established, with the main proponents being the neurologist Jean-Martin Carchot (who focused his studies on the “Salpêtrière”, the public asylum for women which he considered a museum of pathologies to be recorded), and Sigmund Freud (whose studies around the “repressed memories” that cause hysteria would eventually give rise to psychoanalysis).

Neurosis, here explicitly feminine, served as a control mechanism: considered as a form of possession and witchcraft, an epidemic, a form of madness or a disease of suggestible people[6]. All of her traits are traits associated with traits constructed as feminine, and the theorized solutions to this affliction revolve around creating more feminine women, closer to what was expected of women of their time. The hysteric's body is seen as possessed by organic energies, which go beyond the limits established by neurology. This energy's existence is not necessarily seen as harmful – its limit is the feminine temperament that does not rise to neurosis, and when surpassed, it must be brought back to the limits of acceptability.

One of its forms of control is based on biological principles, linking the “feminine” temperament to the cisgender woman’s body, and treating her excesses as intrinsically linked to her reproductive organs. “Female castration” emerged as a way of curing the so-called flaws of femininity, with the removal of healthy ovaries being used from the 1870s onwards as an immediate cure for “behavioral pathologies”. This form constitutes, in Laqueur’s words, a sexual difference that is simultaneously incommensurable and not incommensurable: “female castration” is not seen as a form that brings about the social and psychological effects of castration, but rather as a final way of making the “woman more feminine”, removing the organic demons that gave rise to vulgar behavior.[7]. This effect would surpass the effects of surgery on secondary sexual characteristics and the cessation of menstruation (which would theoretically bring women closer to masculinity).

Similarly, hysteria in men continued to be seen as a trait of femininity. Charcot, who supposedly discovered “male hysteria,” does not present a single photograph of men in his extensive photographic records of hysteria, but he elevates a form of invention of sexuality that necessarily understands hysteria.

---

[6]DIDI-HUBERMAN, Georges.*Invention of Hysteria: Charcot and the Photographic Iconography of the Salpêtrière*. MIT Press, Cambridge, United States of America, 2003. 375 pp.

[7]LAQUEUR, Thomas:*Inventing Sex: Body and Gender from the Greeks to Freud*, Rio de Janeiro, Relume-Dumará, 2001

as a trait of femininity[8]. This characterization of hysteria as a form of "femininity where it shouldn't be, exacerbated into a form of neurosis" has continued throughout its history as an independent diagnosis. Even today, with the features of its diagnosis being diluted into other new terms (including the common features of anxiety and BPD), the term still carries a connection to the features of femininity, and is often used in the political and social characterization of women and people who identify with the features of so-called femininity.

3.2. Borderline Personality Disorder (BPD)

> Perhaps it is still not clear why I ended up here. [...] I did not mention that I had never seen this doctor before, nor that it took him fifteen minutes – or twenty, perhaps – to decide to commit myself. What was so insane about me that in less than half an hour a doctor sent me to the asylum? And he tricked me: he had said I would stay for a few weeks. I stayed for almost two years. I was 18 years old. [...] I was not a threat to society. Was I a threat to myself? [...]
>
> Look at it from the doctor's point of view. It was 1967. [...] What are these kids doing? And then, all of a sudden, one of these young women walks into his office, wearing a skirt the size of a napkin, sporting a bunch of pimples on her chin and speaking in monosyllables. She's high, he concludes. [...] He cannot, in good conscience, return her to this world, where she would be swept away by the substandard tide of society that now and then invades his office and throws others like her into it. A form of preventive medicine. (KAYSEN, 1993)

The etymology of borderline personality disorder (BPD) comes from the idea of limit, of frontier; a personality that alternates rapidly between mania (euphoria) and depression. The stereotype of a person with BPD is the one reported in 1993 by Susanna Kaysen, whose diary she wrote during the two years she was hospitalized in a psychiatric hospital in the 1960s became the film "Girl, Interrupted" in 1999: a young, "disturbed" girl. In her book, Kaysen reports that it took her more than 25 years to receive her diagnosis, and in a chapter about it she asks herself:

> When I went to the bookstore on the corner to look for my diagnosis in the Manual, it occurred to me that I might not find it anymore. The truth is that things are discarded. Homosexuality, for example. Until recently, many of my friends would have been documented in that book, just like me. Well, they disappeared from the book and I remained. Maybe in another 25 years I won't be in it either.
> "Instability of self-image, interpersonal relationships and state of mind... uncertainty regarding... long-term goals or career choices...". Isn't that a good description of adolescence? Moody, fickle, fashion-conscious, insecure. In other words, unbearable." (KAYSEN, 1993)

The goal here is not to make people believe that borderline personality disorder does not exist, but to what extent it is not used to silence women who run away from their beliefs.

[8]DIDI-HUBERMAN, Georges.*Invention of Hysteria: Charcot and the Photographic Iconography of the Salpêtrière*. MIT Press, Cambridge, United States of America, 2003. 375 pp.

social norms of behavior, whether through psychiatric hospitalization in the 1960s or through medication today. In all diagnostic criteria for BPD in DSMs III, IV and V there is a comment on the issue of gender: *"diagnosed predominantly (about 75%) in female individuals*.(DSM-V, 2013). One possible indication would be that the prevalence of the diagnosis in women is due to the descriptive criteria of the disorder itself, which are biased in terms of gender; the choice of words in the Manual itself is biased: "diagnosed", not "more common in women". Kaysen points out in the excerpt cited above how "uncertainties of self-image and long-term goals" could characterize the majority of young people, however, other items of the diagnosis are notable for directly referring to so-called feminine behaviors, such as compulsive shopping, shoplifting, uncontrolled appetite and "promiscuity". Regarding the latter, the author states:

> How many girls would a 17-year-old boy have to sleep with to be labeled "compulsively promiscuous"? Three? No. That's not enough. Six? I doubt it. Ten? It seems more likely. Probably between fifteen and twenty, my guess. That is, if they ever put that label on boys, which, if I remember correctly, they never did. What about 17-year-old girls? How many boys would that have to be with?
> (KAYSEN, 1993)

Based on the concept that gender is socially constructed, gender expectations are also socially constructed. It is possible that borderline diagnoses are more frequent in women not because they are biologically more prone to the disorder, but because what is expected of them in terms of behavior and social behavior is more evident. Once the norms are broken, the label is given. Is this a case of neurodivergence or socio-discordance?

3.3. Autism Spectrum Disorder (ASD)

The first studies on autism were carried out separately in the 1940s by two doctors, Leo Kanner in the United States and Hans Asperger in Germany, when analyzing the behavior of eleven children who presented similar behaviors that later indicated the elementary criteria for the diagnosis of ASD: "difficulties since childhood in social communication and interactions, repetitive behaviors or restricted interests".

According to the DSM and research in the area, ASD is diagnosed fifteen times more often in boys, and it was only in the 1980s that psychologists and psychiatrists began studying autism in girls (children). Four points were highlighted as to why women are diagnosed less frequently:

I. The "male brain" theory

Scientist Simon Baron-Cohen has proposed the hypothesis that "the male brain is 'wired' for systemizing, while the female brain is 'wired' for empathy." Since people with ASD have repetitive patterns of behavior and routine systemizing, it is like having an "extreme version of a male brain."

II. The difference in male and female phenotypes

Based on the theory that the female brain is more prone to empathy, gender expectations related to women are reinforced in these patterns; autistic women often force themselves to repeat the behavior that is expected of them and demonstrate fewer social difficulties than men, leading to under-diagnosis.

III. "Masking"

Researchers Tony Attwood and Judith Gould suggest that girls are more likely to engage in "social mimicry," that is, to repeat other people's mannerisms as a form of social integration, creating a behavioral "mask."

IV. Inappropriate questionnaires

Due to the stereotype of autistic people often reinforced by the media, many questionnaires do not take into account feminine traits, such as items II and III, and end up being inept at capturing ASD characteristics in women, who are often diagnosed only in adulthood and spend a large part of their lives in inadequate psychiatric treatments.

In the book "*Camouflage - The Secret Lives of Autistic Women*" (free translation) by Dr. Sarah Bargiela, one of her interviewees explains:

> "For me it was automatic, I would imitate what other people were doing or saying or their accents without realizing it. Sometimes I was conscious of trying to 'fit in'. I perfected a 'persona' that was lively and perhaps a little vague, because I had nothing to talk about. I cultivated an image that I brought to social situations that was not me. Later, I would get exhausted, it is such an effort to have to play someone else. I would have to lie down in a room alone to recover. Sometimes I was so good at acting neurotypical so convincingly that I wondered if I really had autism after all" (BARGIELA, 2019. free translation)

The stereotyping of ASD, the inadequacy of diagnosis, and the propensity for masking techniques not only create difficulties in treating the disorder but also reinforce social gender expectations. The creation of a "behavioral mask" reflects attitudes that are expected of women, and does not encourage the development of an identity that is far removed from these standards.

Conclusion

Some semiotic-technical codes of neurodivergent white femininity:

Electric shocks. Ice baths. A piece of wood between the teeth so as not to cut the tongue out during convulsions. Hiding sharp objects in the house, making them cook with plastic cutlery. Short hair, short skirts, high heels, loud voices. Distorted mirrors and screens on the windows. The smell of gas in the kitchen and the noise of lighters. Scars on the wrists, fine lines running down the arms. Fifty aspirins and a bottle of vodka. Imaginary friends in childhood. Obsessive interests in objects that are outside the norm. Masks. Saying no when you should say yes. Saying yes when you should say yes. Not knowing how to hide your tears. Not knowing how to muffle your screams. Shattering patterns. Throwing the shards out the window. The body too.

It is inspired by Paul's "semiotic-technical codes of femininity"

Preciado, in her text "Technogender," makes an allegorical amalgam of the stereotypes of the crazy woman. The dichotomy between nature and culture expands here into a spectrum of possible fragmentations of social codes, just as the diagnostic definitions themselves have expanded over the years. What is the boundary between what is in fact a psychiatric disorder or illness and what are deviant behaviors of women who deviate from the norms? Centuries of stereotyping and attempts at silencing have created a bonfire of antipsychotics, as if proposing a modern witch hunt. There is no shortage of examples in literature, and in life, of women who succumbed to social pressures and brutal medical procedures. In the end, if they are subjugated by society, the crazy women burn and ascend to heaven.

Bibliography

ARRUDA, M. S.; PETTA, C. A.;*et al*. Time elapsed from onset of symptoms to diagnosis of endometriosis in a cohort study of Brazilian women.**Human Reproduction**, v. 18, no. 4, p. 756–759, 2003.

BARGIELA, Sarah. Camouflage, The hidden lives of autistic women. London, Jessica Kingsley Publishers, 2019

DIDI-HUBERMAN, Georges.*Invention of Hysteria: Charcot and the Photographic Iconography of the Salpêtrière*. MIT Press, Cambridge, United States of America, 2003. 375 pp.

DSM First Edition - Diagnostic and Statistical Manual of Mental Disorders, Prepared by The Committee on Nomenclature and Statistics of the American Psychiatric Association Published By American Psychiatric Association, Washington DC, 1952

DSM Fourth Edition - Diagnostic and Statistical Manual of Mental Disorders, Prepared by The Committee on Nomenclature and Statistics of the American Psychiatric Association Published By American Psychiatric Association, Washington DC, 1994

DSM Fifth Edition - Diagnostic and Statistical Manual of Mental Disorders, Prepared by The Committee on Nomenclature and Statistics of the American Psychiatric Association Published By American Psychiatric Association, Washington DC, 2013

DSM Second Edition - Diagnostic and Statistical Manual of Mental Disorders, Prepared by The Committee on Nomenclature and Statistics of the American Psychiatric Association Published By American Psychiatric Association, Washington DC, 1968

DSM Third Edition - Diagnostic and Statistical Manual of Mental Disorders, Prepared by The Committee on Nomenclature and Statistics of the American Psychiatric Association Published By American Psychiatric Association, Washington DC, 1987

KAYSEN, Susanna. Girl, Interrupted; translated by Marcia Serra - New York: Routledge, 2013.

LAQUEUR, Thomas:*Inventing Sex: Body and Gender from the Greeks to Freud*, Rio de Janeiro, Relume-Dumará, 2001

PELLETIER, Roxanne; HUMPHRIES, Karin H.; Shimony, Avi;*et al*. Sex-related differences in access to care among patients with premature acute coronary syndrome. **CMAJ: Canadian Medical Association Journal**, v. 186, no. 7, p. 497–504, 2014.

PRECIADO, Paul B.: "Technogender" in: Testo Junkie, São Paulo, N-1 Editions, 2018

SANSONE, Randy A.; SANSONE, Lori A. Gender Patterns in Borderline Personality Disorder. **Innovations in Clinical Neuroscience**, v. 8, no. 5, p. 16–20, 2011.

WEISSE, Carol S,*et al*. Do Gender and Race Affect Decisions About Pain Management? **Journal of general internal medicine**, v. 16(4), p. 211-217, 2001.