

Anatomy of 'Ze' Delusion

Boris Vatel, M.D.

I end a conversation with one of my patients [details changed to protect confidentiality] by saying, "Have a good day, sir."

He replies, "Don't call me sir; call me Baron."

In addition to his preference for being so addressed, my patient also believes that the FBI has inserted a computer into his head in order to manipulate his thoughts. He spends his days producing numerous meticulously executed but entirely nonsensical drawings that he says represent a novel computer language of his own invention. He also expresses his ideas in words he has made up by combining bits of other words. This otherwise highly intelligent and articulate man carries the diagnosis of chronic paranoid schizophrenia and is under a court order to receive antipsychotic medications. Those of us who provide psychiatric treatment to this patient refer to his ideas of being a Baron, of having a computer inside his head, and to his inventions (which also include a time machine) as delusions and consider the new words he makes up to be neologisms.

Stedman's Medical Dictionary defines a delusion as "a false belief or wrong judgment held with conviction despite incontrovertible evidence to the contrary."¹ In psychiatry we often deal with individuals whose beliefs about themselves and the world differ from that body of consistent, collective, and commonly shared observations to which we refer as reality. For example, another one of our patients says that he is the hospital superintendent, and we call that a delusion because everyone knows who the real superintendent is. Yet another patient, a woman now deceased, insisted at times that she was actually a man, would start to speak in a lower voice, and affected masculine mannerisms. Since there was ample evidence to the contrary, no one believed that this woman was a man, or referred to her using a male pronoun, any more than anyone believed another patient who maintained that she was related to the Queen of England, evidence for this also being scant.

Dealing with psychotic individuals means having to distinguish between a subjective reality that exists only in the mind of the patient, and the objective reality in which the rest of the world lives. After all, there must be a philosophical, linguistic, and physical basis on which a belief can be labeled as wrong. To say that the patient claiming to be the superintendent is experiencing a delusion, we need to have an idea of what a superintendent is, use a word that consistently refers to this idea, and know an actual person who fulfills this function. The superintendent cannot be someone whose primary duty is to mop the floor, or someone who is a psychiatric patient in the very institution he is supposed to administer. Similarly, we could not have a stable idea of the superintendent's function if its very definition were arbitrary or changed daily. That an external, verifiable, and commonly experienced reality can be described in stable words and concepts allows all of us to function in the world and enables those who treat psychiatric patients to distinguish delusions from facts.

These ideas, in themselves ordinary and noncontroversial, are strangely absent in any discussion about people who claim a different sexual identity from the one which their anatomy incontrovertibly demonstrates. From the viewpoint of someone who treats psychiatric patients this seems rather odd. Although the man claiming to be the hospital superintendent believes himself to be one, acts like one, and insists on being treated as one, we call him delusional. However, the man who claims to be a woman, dresses like one, and wants a surgeon to castrate him, is increasingly considered normal. The beliefs of the man in the first example have resulted in his having been placed under a court-ordered psychiatric treatment. In contrast, calling the beliefs of the man in the second example delusional represents "discrimination on the basis of gender identity" and carries a hefty fine, according the latest statement by the New York City Commission on Human Rights.

The NYC Commission says that gender identity is "one's internal deeply held sense of one's gender which may be the same or different from one's sex assigned at birth."² Leaving aside the false assertion that, except in cases of ambiguous genitalia, anatomical sex is "assigned" at birth, the fact that one's beliefs are "deeply held" does not make them any more correct or closer to objective reality than if they were held but lightly. In fact, the hallmark of a delusion is precisely that it is a deeply held and unshakable belief despite evidence to the contrary. Yet, the NYC Commission says that evidence to the contrary, i.e. anatomical sex, is no impediment to "gender identity," which may be "male, female, neither or both, e.g., non-binary."² Presumably the evidence that one is a human being ought to be no impediment to developing the identity of, say, a reptile, providing that such an identity should be "deeply held."

In a section entitled "Failing to Use an Individual's Preferred Name or Pronoun" the NYC Commission "requires employers and covered entities to use an individual's preferred name, pronoun, and title regardless of the individual's sex assigned [*sic*] at birth... or the sex indicated on the individual's identification." Such pronouns may include "ze/hir."² Of course, as far as neologisms go, such pronouns are not as clever as the ones produced by my patient "the Baron." Still, using the commission's logic, it should be reasonable to call the information technology department when my patient says that his thoughts have been stopped by the FBI-run computer in his head.

People who claim more than one psychological identity are considered to be suffering from dissociative identity disorder. People who identify with being obese even though in reality they are underweight are treated for an eating disorder. A white person claiming to be black (or vice versa) for reasons other than a secondary gain would certainly be considered delusional, as would a person who claimed a non-human identity. The logic on which each of these subjective beliefs is considered to be a departure from reality is inconsistent with the notion that men who claim to be women, women who claim to be men, or people who claim no sexual identity at all

are psychiatrically normal. In fact, as psychiatrists we can adopt the kind of language now required by the NYC Commission on Human Rights only by abandoning the kind of reasoning that allows us to consider anyone delusional at all.

Unless we have a basis for determining whether an idiosyncratic subjective idea, no matter how deeply held, is grounded in objective reality, we have no business calling something a delusion. Our field relies on ideas, words, and physical objects for its nosology, diagnosis, and treatment. Saying that external reality does not matter, that ideas are entirely subjective, and that words can be changed at will not only renders the very idea of psychiatric disorder invalid, it is a line of thinking that is itself ultimately psychotic in nature. There is no psychiatric basis for considering the "internal [and] deeply held" beliefs about one's gender to be normal when such beliefs are contradicted by the external reality of one's anatomical sex. The discomfort with and dis-ease in one's own sexual anatomy that causes a person to assume an identity of someone of the opposite sex, no sex at all, or a non-human identity for that matter, is not psychiatrically normal unless we abandon the very notion that there is such a thing as normality. Individuals experiencing such discomfort deserve psychiatric treatment no less than other individuals whose false beliefs cause emotional and functional impairment. That the NYC Commission on Human Rights finds it necessary to change how society functions around such individuals ironically speaks to how much functional impairment they experience in normal everyday life as a result of their false beliefs. The only way to normalize them as the NYC Commission is trying to do is to paint reality itself as pathological or irrelevant.

The language we use has a great deal to do with how honestly and consistently we think about the world. The kind of language change recently mandated about "transgender persons" in New York City represents a fundamental loss of honesty and consistency with which we view reality and treat our patients. We cannot embrace the delusions of some while prescribing treatment to target the delusions of others. To put it simply, we cannot start telling lies to others without also lying to ourselves. And so, despite his having drawn the copyright logo on his time-machine drawings, we are not planning to submit my patient's work for actual publication. Calling him "Baron" might work in favor of sustaining a therapeutic alliance, but such an allowance is understood to be a treatment intervention as opposed to a validation of an alternate identity. Fortunately for me, the "superintendent" administrates only in his own head—after all, he has fired me many times.

Boris Vatel, M.D., is a psychiatrist practicing in Evansville, Ind. Contact: baskakov55@gmail.com.

REFERENCES

1. *Stedman's Pocket Medical Dictionary*. Williams and Wilkins; 1987.
2. NYC Commission on Human Rights Legal Enforcement Guidance on the Discrimination on the Basis of Gender Identity or Expression: Local Law No. 3 (2002); N.Y.C. Admin. Code § 8-102(23). Available at: http://www.nyc.gov/html/cchr/downloads/pdf/publications/GenderID_InterpretiveGuide_2015.pdf. Accessed Feb 23, 2016.

Subscribe now!

Journal of American Physicians and Surgeons

Please enter my subscription to the *Journal of American Physicians and Surgeons*.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

E-mail: _____ Degree: _____ Specialty: _____

I wish to join AAPS.

M.D., D.O. (\$350)

Associate (\$95)

Subscription only:

Individual (\$75)

Sponsored (\$75)

Institution (\$125)

Send a Subscription with my compliments to: _____

Check enclosed Please charge \$ _____ to my Visa, MasterCard, AmEx # _____ Exp. _____

Signature: _____ →

Mail to: AAPS, 1601 N. Tucson Blvd. Suite 9, Tucson, AZ 85716
or FAX to 520-325-4230.