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COMMENTARY ON WINTER ET AL. (2016)

ICD-11 and Gender Incongruence: Language is Important

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The World Health Organization (WHO) publishes the International Classification of Diseases and Related Health Problems (ICD), which currently is being revised. The ICD-11 is scheduled for completion in 2018 and the current Beta draft version is posted on the Internet to elicit commentary (WHO, 2016).

Winter, De Cuypere, Green, Kane, and Knudson (2016) discuss whether to include a diagnosis of gender incongruence of childhood in ICD-11 because these children "do not require 'medical' treatment" (Zucker, 2016, p. 1877). Strictly speaking, adults with gender incongruence do not always require medical treatment either. Some adults manage their gender dysphoria with dress, living in the desired role, and sheer force of will.

I will get to the question of the childhood diagnosis shortly, but first I want to contrast the terms used in the DSM-5 (American Psychiatric Association [APA], 2013) and the ICD-11. Cohen-Kettenis and Pfäfflin (2010) recommended the DSM-5 diagnostic label be changed from gender identity disorder to gender dysphoria. They contended that the new term would:

1. clearly express the heart of the problem, the discontent with one's physical sex characteristics and/or assigned gender, and not be applicable to gender variant individuals without this discontent;
2. be dimensional; it should be possible to have more or less complete forms of the condition;
3. allow fluctuations, i.e., increase as well as decrease over time, and, finally;
4. it should be acceptable and non-stigmatizing to those who fulfill…the revised diagnostic criteria (p. 506).

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I had proposed gender dysphoria as the new diagnostic label previously (see Moser, 2008). The concept of "gender dysphoria" satisfies the attributes enumerated above and has the advantage that it can be resolved. The DSM-5 gender dysphoria diagnostic criteria, unfortunately, do not satisfy those attributes.

After treatment (i.e., hormones, surgery, and/or support) an individual's gender dysphoria can dissipate. At that point, it is no longer necessary (or helpful) to label these individuals with that mental disorder. The DSM-5 does not allow for the resolution of gender dysphoria specifically, although there is a posttransition specifier to justify "continuing treatment procedures that serve to support the new gender assignment" (APA, 2013, p. 453).

The current ICD-11 proposal changes the diagnostic label from "gender dysphoria" to "gender incongruence." Gender incongruence is "characterized by a marked and persistent incongruence between an individual's experienced gender and the assigned sex" (World Health Organization, 2016). The DSM-5 used similar language in the diagnostic criteria for gender dysphoria: "A marked incongruence between one's experienced/expressed gender and assigned gender" (APA, 2013, p. 452). Changing the individuals' assigned gender so that it matches the experienced/expressed gender would appear to resolve their gender incongruence and the associated mental disorder. Transsexualism (i.e., gender identity disorder) was once characterized as a psychiatric disorder cured only by surgery. Now (at least in the U.S.) non-medical bureaucrats are responsible (albeit on the recommendation of a health-care provider) for "curing" the gender incongruence by legally changing the assigned gender to match the experienced/expressed gender.

Both the DSM-5 and the ICD-11 diagnostic criteria mostly ignore issues related to non-binary presentations of the gender dysphoria (e.g., those who identify as agender, both genders, a third gender). The legal classification system also has not been updated to allow for these possibilities.

Although gender dysphoria is categorized as a mental disorder in the DSM-5, the ICD-11 is considering classifying gender incongruence in a new category, that is, "Conditions related to sexual health."

The Gender Dysphoric Prepubescent

Prepubescent children (whether cis or trans) may need help in exploring their feelings about being male or female (or a different gender), and some will experience frank gender dysphoria/incongruence. Although some of these children will "outgrow" their gender dysphoria/incongruence and embrace their assigned gender, others will not.

There is a need for professional guidance in at least three areas for these minors with gender dysphoria/incongruence. The first issue entails the risks and benefits of pubertal hormone blockers, including questions of fertility, bone health, and reversibility. The second issue involves helping minors with gender dysphoria/incongruence deal with others who may attempt to bully or shame them. The third issue is to equip these minors with the vocabulary and concepts needed to explain their feelings and desires to others. Consideration of these issues and professional assistance for them should begin in the prepubertal period.

Diagnoses should not be introduced with the sole intent of coercing insurance companies and government agencies to pay for services. There are too many examples of psychiatry creating diagnoses which hurt precisely the people they were intended to help. "Socially deviant behavior…and conflicts that are primarily between the individual and society are not mental disorders" (APA, 2013, p. 20). As Confucius reportedly wrote, the beginning of wisdom is to call things by their proper name.

Resolution of Mental Disorders

The DSM-5 (APA, 2013) does not discuss the situation in which a diagnosis is no longer applicable or a disorder has been treated successfully. Some, but not all, DSM-5 diagnoses have an "in remission" specifier, but the disorders are not resolved formally. Some mental disorders may resolve with treatment or remit spontaneously (e.g., phobias, enuresis, sexual dysfunctions). Other psychiatric diagnoses are time-limited (e.g., substance intoxications, acute stress disorder) though they may evolve into new diagnoses (e.g., substance use disorders, PTSD). Gender incongruence of childhood refers only to prepubertal children. Once the child enters puberty (i.e., is no longer prepubertal), the diagnosis of gender incongruence of childhood no longer seems applicable. Gender incongruence of adolescence or adulthood (or at least the gender dysphoria) may resolve with treatment or possibly spontaneously.

Conclusions

1. Gender incongruence is not gender dysphoria. The nature of the disorder should be clarified.
2. To avoid the stigma of being diagnosed with a mental disorder, placing gender incongruence in the new "Conditions related to sexual health" section of the ICD-11 is wise.
3. Being a gender nonconforming individual or an individual with gender incongruence does not imply that gender dysphoria is present or that the individual needs treatment.
4. Not all gender dysphoric individuals require treatment; when professional intervention is needed, appropriate diagnostic codes should be available.
5. Gender dysphoria can be resolved and the criteria for resolution should be explicit.

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