

# DSM V and ICD 11: Current Controversies and Implications

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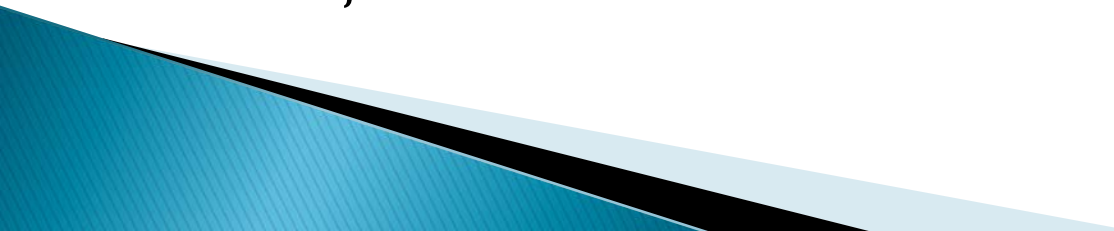


Co-Chairs DeCuyper, Knudson, & Bockting of the WPATH consensus process on revision of the DSM diagnoses of GID and TF

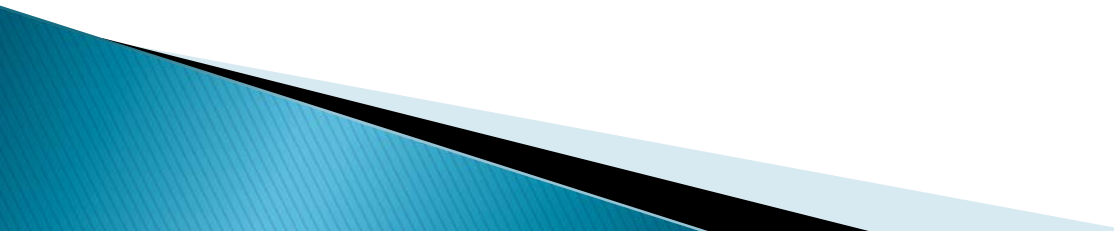
# History of the GID diagnosis

- ▶ Included since DSM III (1980)
- ▶ To legitimize the condition
- ▶ To facilitate treatment and research
- ▶ Increasingly controversial since the 1990s
- ▶ Recently denounced by such countries as Sweden and France
- ▶ Currently under revision
- ▶ WPATH conducted a consensus process for recommended removal or reform
- ▶ APA's proposed revision at [www.dsm5.org](http://www.dsm5.org)
- ▶ WPATH's reaction at [www.wpath.org](http://www.wpath.org)

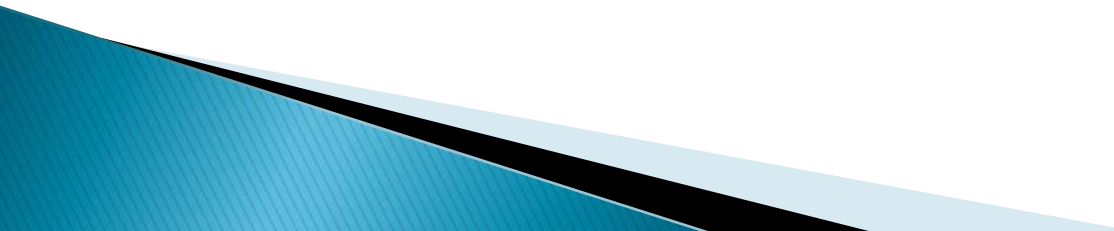
# Gender Identity Disorder (DSM IV TR)

- ▶ A. A strong and persistent cross-gender identification
  - ▶ B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex
  - ▶ C. The disturbance is not concurrent with a physical intersex condition
  - ▶ D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
  - ▶ Specify “Sexually Attracted to Males, Females, Both, or Neither”
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# Transsexualism and other Gender Identity Disorders (ICD 10)

- ▶ A desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment
  - ▶ The transsexual identity has been present persistently for at least two years
  - ▶ The disorder is not a symptom of another mental disorder or a chromosomal abnormality
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# Transvestic Fetishism (DSM IV TR)


- ▶ A. Over a period of at least 6 months, in a heterosexual male, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing
  - ▶ B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
  - ▶ Specify “With Gender Dysphoria” if the person has persistent discomfort with gender role or identity
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# Fetishistic Transvestism and Dual-role Transvestism

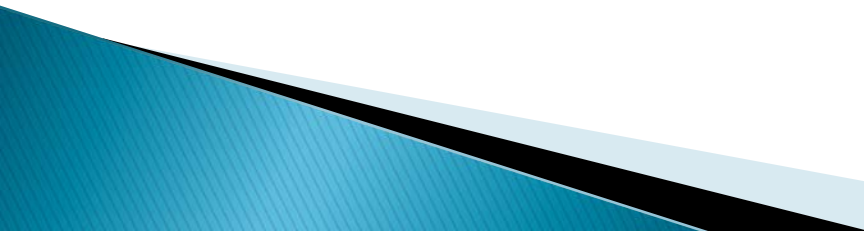
## Fetishistic Transvestism:

- ▶ The wearing of clothes of the opposite sex principally to obtain sexual excitement

## Dual-role Transvestism:

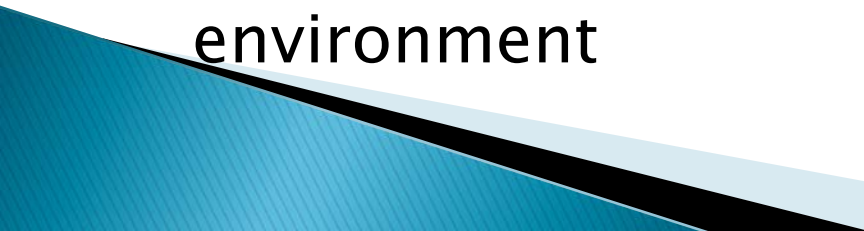
- ▶ The individual wears clothes of the opposite sex in order to experience temporary membership in the opposite sex
  - ▶ There is no sexual motivation for the cross-dressing
  - ▶ The individual has no desire for a permanent change to the opposite sex
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# Common criticism of the DSM IV and ICD 10 diagnoses


- ▶ Whose disorder is it, the transgender individual's, the parents', or a disorder of society? Is the distress inherent or stemming from social stigma?
  - ▶ The diagnoses perpetuate stigma
  - ▶ The diagnosis for children conflates gender dysphoria with gender role nonconformity
  - ▶ The diagnoses reflect homophobia and sexism, and facilitate reparative therapy
  - ▶ Should the diagnosis be limited to those who seek hormone therapy and surgery?
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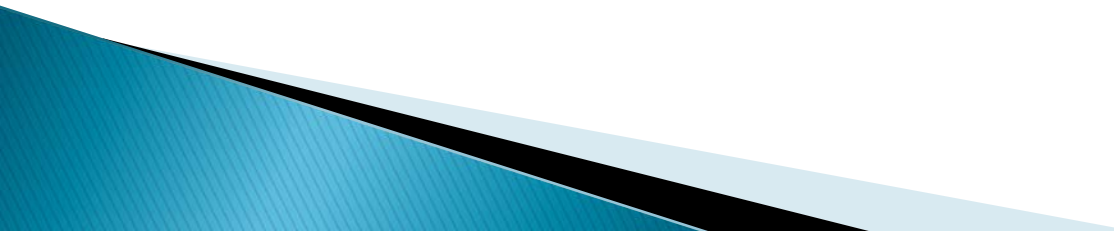
# Whose disorder is it?

- ▶ Intrapsychic problem of the individual, family system problem, or a consequence of society's gender and sex role stereotypes?
  - ▶ Parental psychopathology and family dysfunction have been associated with GID in children and adolescents, yet unclear whether this is cause or effect
  - ▶ Social stigma has been associated with symptoms of anxiety and depression
  - ▶ Is what appears to be inherent distress also a result of binary gender norms and social stigma?
  - ▶ Interventions increasingly focus on the environment
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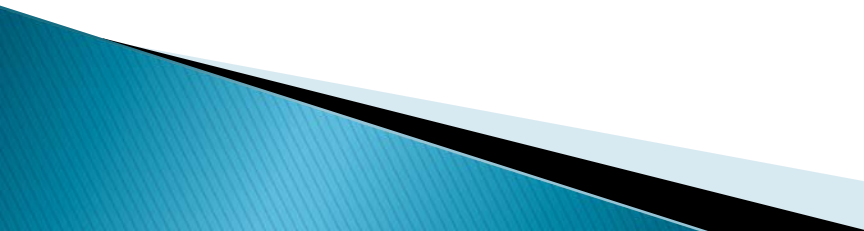
# The diagnoses perpetuate stigma

- ▶ Studies have demonstrated stigma associated with such mental disorders as Schizophrenia and Borderline Personality Disorder, yet the stigmatizing effects of GID have not been adequately assessed
  - ▶ Tied to the SOC requirement of a psychological or psychiatric evaluation prior to hormones or surgery
  - ▶ On the other hand, the GID diagnosis facilitates access to care
  - ▶ While some argue the diagnosis limits legal and civil rights (e.g., child custody), others argue that removal might undermine existing rights (e.g., recognition as member of preferred sex)
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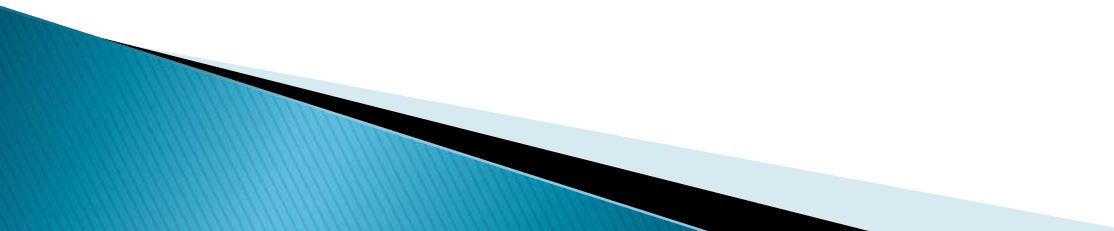
# Gender dysphoria vs. gender role nonconformity

- ▶ This diagnosis for children conflates gender dysphoria with gender role nonconformity
  - ▶ Indeed, criterion A(1) “repeatedly stated desire to be, or insistence that he or she is, the other sex” is not required to receive the diagnosis
  - ▶ Gender identity and gender role behavior are separate components of sexual identity
  - ▶ This may explain the fact that only a minority of children meeting criteria for GID grow up to be transgender
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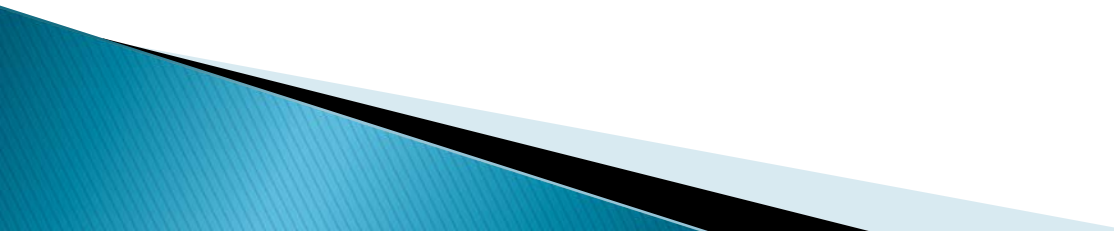
# Homophobia, sexism, and reparative therapy

- ▶ Transvestic Fetishism only applies to heterosexual males; what about women and gay men? Yet paraphilia implies compulsivity
  - ▶ The differences based on sexual orientation and autogynephilia might be better explained as stigma management based on level of childhood gender role nonconformity
  - ▶ The diagnosis pathologizes gender variance and justifies reparative therapy; the goal should be exploration and comfort rather than a particular gender or sexual orientation outcome
  - ▶ A clinician judgment study showed that clinicians under- rather than over-diagnose GID in children
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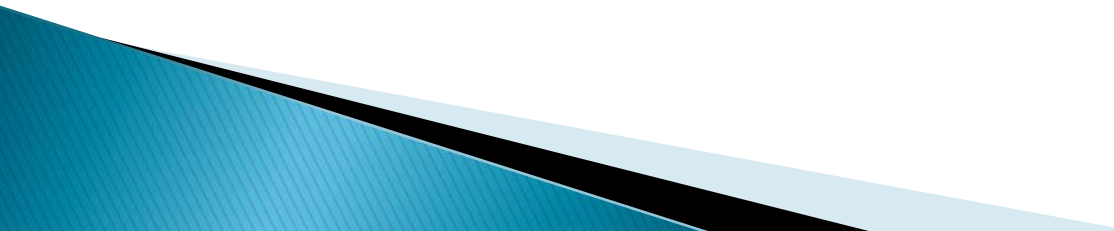
# Limit to those who seek hormone therapy and surgery?

- ▶ The diagnosis facilitates access to hormones and surgery
  - ▶ Code on Axis III?
  - ▶ Yet medical interventions are only a few of the available therapeutic tools to alleviate gender dysphoria
  - ▶ Is anyone who desires medical interventions distressed?
  - ▶ Need for an “exit clause”
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# Gender Incongruence (proposed for DSM V by APA)

- ▶ A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration
  - ▶ For children, the A(1) criterion “a strong desire to be of the other gender or an insistence that he or she is the other gender” is now required
  - ▶ Specify: “With or Without a Disorder of Sex Development”
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# Transvestic Disorder (proposed for DSM V by APA)


- ▶ A. Over a period of at least six months, in a male, recurrent and intense sexual fantasies, sexual urges, or sexual behaviors involving crossdressing
  - ▶ B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
  - ▶ Specify if: “With Fetishism” or “With Autogynephilia”
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# Rationale and reaction to Transvestic Disorder

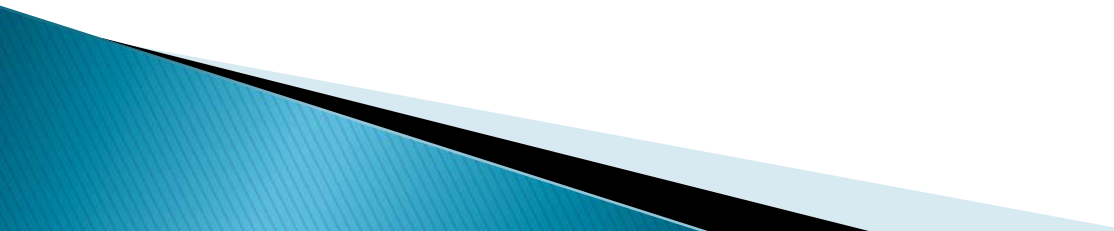
- ▶ A distinction is proposed between the nature of the interest (paraphilia) and potential associated distress (paraphilic disorder)
  - ▶ “Heterosexual” was removed
  - ▶ Specifiers were added, most notably “With Autogynephilia”
  - ▶ Specifier “With Gender Dysphoria” was removed, which is now subsumed under “With Autogynephilia”
  - ▶ Autogynephilia remains controversial; it will be particularly important what the text will say
- 



# WPATH's reaction to Gender Incongruence: On the plus side


- ▶ The change in name is an improvement, *identity* no longer disordered
  - ▶ The criteria reflect a less binary, broader spectrum of gender diversity (e.g., A(4) “a strong desire to be of the other gender (or some alternative gender different from one’s assigned gender)”) )
  - ▶ The requirement of A(1) for children addresses, at least in part, concerns about pathologizing gender role nonconformity and facilitating reparative therapy
  - ▶ Intersex no longer excluded
  - ▶ The sexual orientation specifier has been removed
  - ▶ An exit clause is implied; once incongruence has been alleviated, the diagnosis no longer applies
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# WPATH's reaction to Gender Incongruence: Five points of critique

- ▶ 1. Removal of reform?
  - ▶ 2. Broad versus distress based criteria
  - ▶ 3. Separate or combined diagnoses for adolescents and adults
  - ▶ 4. Name of the diagnosis
  - ▶ 5. Location of the diagnoses within the DSM
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# 1. Removal or reform?

## Continuum of positions

- ▶ Remove from DSM, ICD, or any other way to describe as disease
  - ▶ Remove from DSM, code as a non-mental health disease in ICD
  - ▶ Pragmatic: Already in DSM, change to make it better
  - ▶ Gender dysphoria is a mental disorder, but we can change the DSM diagnosis to make it better
  - ▶ It's perfect just the way it is in the DSM. Don't change a thing!
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# 1. Removal or reform? Pros and cons

- Gender variant people who experience gender dysphoria related distress can be diagnosed
- A diagnosis reflects that treatment is necessary
- Gives a framework for assessment
- Creates greater access to care, especially in countries with socialized medicine
- Creates the opportunity for competent care
- A name for one's experience or condition can be empowering
- Facilitates research
- Having a "mental disorder" doesn't mean being "mentally ill"
- Basis for change in identification documents
- Gender variance and gender variant identities are not mental disorders
- The diagnosis pathologizes such variance, and perpetuates stigma and discrimination
- Diminishes autonomy in making personal decision about one's body and gender expression
- May push individuals unnecessarily into treatment
- Places label on a child who does not experience distress
- Medicalizes the "condition"

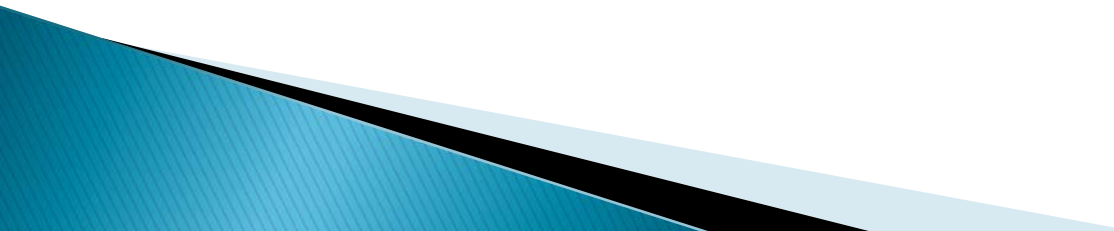
Pros

Cons

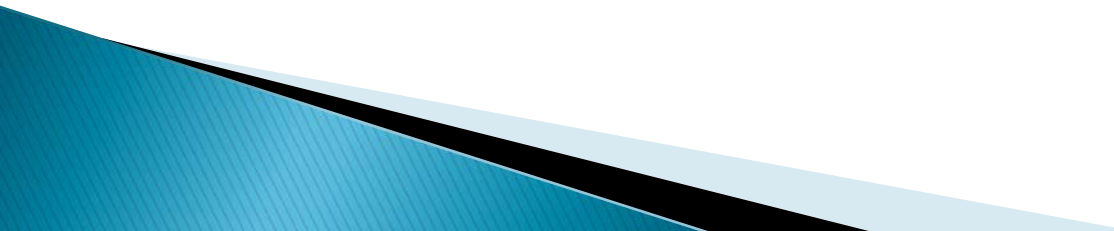
## 2. Broad vs. distress based criteria

- ▶ The attempt to be inclusive of a wide spectrum of gender diversity and to facilitate access to hormones and surgery for those with no impairment and little distress, seems to have led to any type of gender variance being diagnosable
- ▶ E.g., if one meets criteria A(5) “a strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender)” and A(6) “a strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender),” one is eligible for the diagnosis
- ▶ If there is no suffering and no treatment is desired, why do we need a diagnosis?
- ▶ Instead, WPATH recommends a narrowing of the criteria to focus only on those who experience “distress” (with or without impairment). The diagnosis should only apply to some transgender individuals at some point in their lives when they are in distress and need assistance

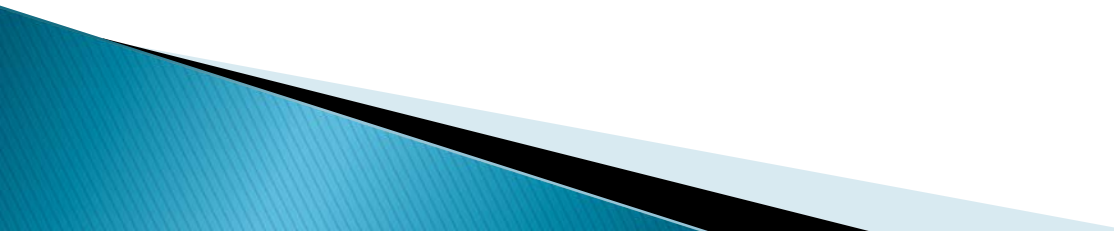
### 3. Separate or combined diagnoses for adolescents and adults

- ▶ Adolescents are not small adults or large children
  - ▶ They have unique challenges and treatment options (e.g., puberty delaying hormones)
  - ▶ Therefore, WPATH recommends separate diagnoses for adolescents and adults
  - ▶ If they remain combined, the text should clearly speak to the unique issues of adolescents
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# 4. Name of the diagnosis

- ▶ “Incongruence” implies that congruence is the norm and that anything other is problematic
  - ▶ A person can be comfortable with variance among different components of sexual identity (e.g., between gender identity and social sex role or gender role expression)
  - ▶ Consistent with recommending a focus on distress, WPATH favors Gender Dysphoria over Gender Incongruence
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# 5. Location of the diagnoses within DSM

- ▶ Location has not been decided
  - ▶ With “Other Conditions that May be a Focus of Clinical Attention” as advocated by Meyer–Bahlburg is an option as long as it does not endanger health care coverage
  - ▶ WPATH recommends NOT with sexual disorders
  - ▶ WPATH offered two alternatives: with “Psychiatric Disorders Related to a Medical Condition” or in a chapter on childhood–onset disorders
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# WPATH's consensus: Children

## Gender Dysphoria in Children

- ▶ The diagnosis should only be applied for extreme cross-gender behavior and wishes, accompanied by persistent and severe internal dysphoria with birth-assigned gender

# WPATH's consensus: Adolescents

## Gender Dysphoria in Adolescents

- ▶ A. Clinically significant persistent distress with current or anticipated physical sex characteristics and ascribed social gender role that is incongruent with persistent gender identity
- ▶ B. The distress is clinically significant or causes impairment in social, occupational, or other important areas of functioning that is not solely due to external influences such as prejudice, discrimination, or social pressures or benefits
- ▶ C. The symptoms are not better accounted for by another medical condition or mental disorder

## Articulated “rule outs:”

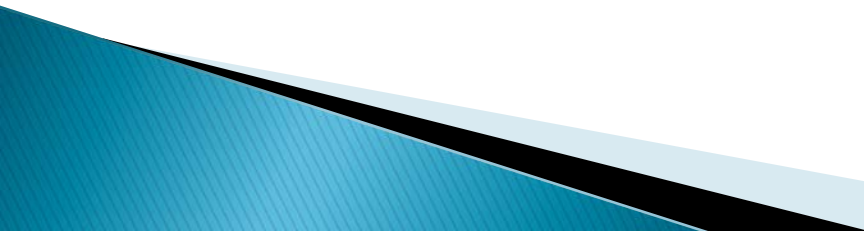
- ▶ Not better accounted for by another medical or mental health condition such as Asperger's Disorder, Pervasive Developmental Disorder, Borderline Personality Disorder, Schizophrenia, Body Dysmorphic Disorder (although these can be co-morbid conditions)
- ▶ Not simply gender nonconformity or difficulty with cultural norms or desire to conform to social expectations from peers, parents, social networks

# WPATH consensus: Adults

## Gender Dysphoria in Adults

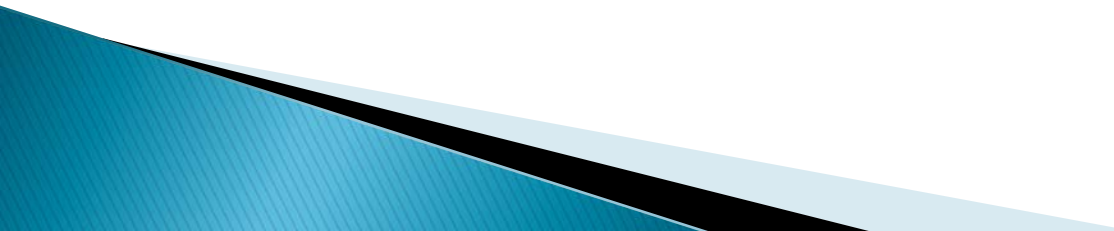
- ▶ A. Strong and persistent distress with physical sex characteristics or ascribed social gender role, that is incongruent with persistent gender identity
- ▶ B. The distress is clinically significant or causes impairment in social, occupational, or other important areas of functioning, when this distress or impairment is not primarily due to external prejudice or discrimination

### Specifiers:

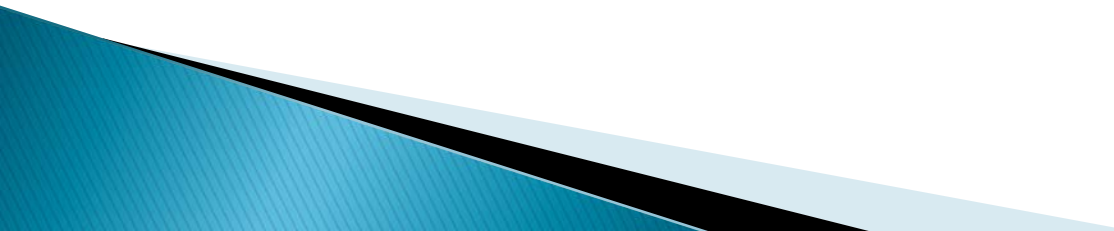
- ▶ Sexual orientation and autogynephilia should not be specifiers
  - ▶ To indicate severity, use specifiers for Major Depression as a model
  - ▶ “In Remission” to facilitate ongoing treatment
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# WPATH's statement on gender variance

“The WPATH Board of Directors strongly urges the de-psychopathologization of gender variance worldwide. The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon which should not be judged as inherently pathological or negative. Psychopathologizing gender variance reinforces stigma, rendering transgender and transsexual people more vulnerable to social and legal marginalization and exclusion, and increasing risks to mental and physical well-being. WPATH urges governmental and medical professional organizations to review their policies and practices to eliminate stigma toward gender-variant people.”



# Extending the paradigm shift: Toward further depathologization

- ▶ Paradigm shift from “sex change” to “coming out”
  - ▶ Gender diversity
  - ▶ America’s rediscovery of transgender identity and sexuality
  - ▶ Is there any distress aside from the internalization of society’s gender norms and expectations?
  - ▶ Discussion
- 

# Further reading

- ▶ wpath.org
- ▶ DSM5.org
- ▶ Special issue of the International Journal of Transgenderism, 12(2)
- ▶ Bockting, W.O., & Ehrbar, R. (2005). Commentary: Gender variance, dissonance, or identity disorder. *Journal of Psychology and Human Sexuality, 17*(3/4), 125–134
- ▶ Bockting, W. (2009). Are gender identity disorders mental disorders? Recommendations for revision of the World Professional Association of Transgender Health's Standards of Care. *International Journal of Transgenderism, 11*(1), 53–62.
- ▶ Bockting, W. (2008). From gender dichotomy to gender diversity: Implications for psychotherapy and the Real Life Experience. *Sexologies, 17*, 211–224.
- ▶ Ehrbar, R. D., Witty, M. C., Ehrbar, H. G. & Bockting, W. O. (2008). Clinician judgment in the Diagnosis of Gender Identity Disorder in Children. *Journal of Sex & Marital Therapy, 34*, 385–412.
- ▶ Meyer-Bahlburg, H. F. L. (2010). From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Archives of Sexual Behavior, 35*(2), 461–476