

Gender incongruence in the latest International Classification of Diseases ICD-11

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ABSTRACT

Aim

The aim of this article is to discuss the ICD-11 with respect to the changes introduced in the classification of diagnoses related to gender identity.

Method

The text analyses and discusses briefly the changes concerning gender identity in the new classification of diseases with respect to the content and the language as well as to their practical implications and social dimension.

Results

The decision by the World Health Organisation to remove *transsexualism* and create a new category under the name of gender incongruence in the section other than mental illnesses and disorders had been long awaited most of all by those specialising in mental and sexual health but also by patients experiencing their gender in a way different than that assigned to them at birth.

Keywords: ICD-11, gender incongruence, gender dysphoria

Introduction

Among numerous changes introduced in the ICD classification 26 years after its previous edition, one attracted special attention of mental and sexual health specialists (WHO, 2018). Replacing the diagnosis of transsexualism with gender

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incongruence and transferring it to the chapter devoted to conditions related to sexual health was such a brave move by the World Health Organisation that it outshone to a certain extent the previous fame gained by the American Psychiatric Association for replacing gender identity disorder (DSM-IV-R) (APA, 2000) with gender dysphoria (DSM-5) (APA, 2013). The change in DSM was considered in the sexological circles as almost paradigmatic; and that was mostly because it put suffering as the axis of the diagnosis, rather than someone's non-cisgender identity, and also as it considered identities other than the binary one (DeCuyper, Knudson, & Bockting, 2010). And even though it undoubtedly initiated a formal depathologisation of people experiencing their gender identity differently to what would result from the sex assigned to them at birth, it was the WHO's decision that should be considered a real breakthrough (Dakic, 2020). A detailed analysis of the changes in classifications can be found in the text by Mijas and Koziara (2022), while, for the sake of this commentary, it is worth referring to 1977 when the diagnosis of transsexualism appeared in the ICD for the first time – back then in the group of sexual deviations and disorders (WHO, 1977). That marks the beginning of a 41-year-long process of localising diagnoses from the scope of gender diversity in the part of the classification related to mental diseases and disorders. In the light of the above, the change in ICD-11 is of a historic nature.

The aim of the analysis is to discuss the content of the new diagnosis and the implications for specialist practice that it entails. In order to obtain more clarity, the analysis has been divided into two sections: *Content and language* and *Practical application and social dimension*.

Content and Language

As noted above, the group that the diagnoses related with transsexualism have been moved to is called “Conditions related to sexual health”. It is a new group comprising, among others, sexual dysfunctions. However, such a location entails two drawbacks – the dimension of transsexualism is that of identity and not sexual; besides, it is a feature of a person and not a condition in which that person is; separating it from mental diseases and disorders translates into decreasing its social stigmatisation and internalised transphobia. The higher category is gender incongruence, defined as a marked and persistent incongruence between the sex assigned at birth and an individual's experienced gender. It is also stated that gender variant behaviours and preferences are not a basis for assigning the diagnosis. Therefore, the emphasis is put directly on experiencing gender in the aspect of identity and not on performing it, that is expressing it with one's dressing style, gestures or mannerisms stereotypically ascribed to a particular gender, as well as with one's name or pronouns used. This category is divided into three diagnoses: gender incongruence in adolescence or adulthood, gender incongruence in childhood and gender incongruence, unspecified.

Gender incongruence in adolescence or adulthood is characterised by

a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty (WHO, 2018).

The definition worded as above contains several essential elements. First of all, the word 'incongruence' does not imply any variant of gender identity; therefore, what is expected (by diagnosticians) is not any more the variant opposite to the sex assigned at birth, but simply a different one. Such a solution allows for inclusion of non-binary people, i.e. the people who experience their gender outside of the binary division; e.g. they experience themselves as having male and female features and at the same time feeling partly male and partly female. Secondly, the emphasis is put on the persistence and the markedness and not on the duration, which can be translated into limiting (and ultimately – abandoning) the use of the so-called real-life tests for patients, in which two years of functioning in accordance with one's identity gender are required before the patient is eligible to receive gender-affirming treatment. Such a condition – of living for 24 months in the gender role; however, without medications which would facilitate it, authenticate it socially and, many a time, make it safer, not only has nothing to do with real life but, most of all, in the author's opinion, is abusive. Thirdly, the word 'often' reflects the reality in which not all the people experiencing gender incongruence want to undertake transition. Finally, the word 'or' adequately reflects the diversity of transition-related needs. The degree to which people want to change their body is of very individual character and it is the role of a sexual health specialist to help them make the decision about possible further steps, without arbitrarily defining their number or order.

Gender incongruence in childhood covers people in the pre-pubertal period (note: it is not the age criterion that matters, but the fact of starting puberty) and it is characterised by

(...) a marked incongruence between an individual's experienced/expressed gender and the sex assigned at birth. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis (WHO, 2018).

Similarly to the case of adolescents and adults, there is also room for non-binary identities. Though the younger the person is, the smaller the probability of such experience (the understanding of being non-binary requires a certain level

of abstraction, which is not necessarily available to children), yet it may happen. It is also worth noting the importance of the desire that the body should look different / should have different sex characteristics. In DSM-5 it was characterised as a distress related to anticipated changes; however, those are different experiences in the qualitative sense. The experience of e.g. a child who feels like a girl and desires or imagines having breasts in the future differs from the experience of anxiety related to the fear of their voice breaking or the appearance of facial hair. Clinical practice shows that some pre-puberty patients do not express the symptoms of dysphoria, because instead of it they experience fantasies, bordering with conviction, about their bodies evolving by themselves in the future the way they would wish them to do. Hence, they do not experience fear about their body going through puberty in accordance with the assigned sex, but they are impatient, waiting for the changes of their dreams. One of the patients says: 'I felt like a girl and I knew that girls grow breasts, so it was obvious to me that I would too. I don't know what I thought would happen to my penis, but I might have subconsciously assumed that it would fall off.'

In the light of the above, ICD-11 is more clinically useful in this respect, as it comprises both variants. While the changes in ICD concerning adolescents and adults do not arouse much controversy, preserving and the wording of the diagnosis of gender incongruence in childhood was not positively received (Drescher, Cohen-Kettenis, & Reed, 2016; Winter et al., 2017). The opponents express their concerns about pathologising of non-normative expressions in pre-puberty-aged children as well as about misleading the patients and their parents: if there is a diagnosis, there is also a treatment – e.g. a hormonal one, while no medical interventions are possible before the onset of puberty. A very interesting suggestion for an alternative wording, with a detailed justification for that solution can be found in the standpoint of Global Action for Trans Equality (GATE, 2013)

Gender incongruence, unspecified has not been defined and it will most probably be playing the role of a diagnostic hypothesis in people remaining under observation.

Practical Application and a Social Dimension

The dispute between the supporters of leaving transgender-related diagnoses on the ICD and the opponents of that solution, advocating for their complete removal, similar to the disappearance of homosexuality from DSM in 1973, is still going on. The World Health Organisation has found a conciliatory solution, and assuming there can be any compromise between depathologisation and clinical utility, it was done tactfully. The official departure from transsexualism and the new terminology deprived of references to distress reflect the changing perception of gender identity variability and offer an opportunity to those in whose case the discomfort is non-existent, small or situational. Transferring it to another category does not close the door on conducting a differential diagnosis of people in whose case there are suspicions as to whether their gender incongruence might

have resulted from psychopathology, yet, it does not condition access to medical treatment on an obligatory psychiatric assessment, which has been the case so far. Thus, it allows sexologists who are doctors with base specialisations other than psychiatry to play the role of attending specialists e.g. in cases about legal gender recognition. What is more, in those countries which allow full or partial reimbursement of costs of gender affirmation interventions, the implementation of ICD-11 is not going to reverse that option.

Currently, the largest controversy surrounds preserving diagnoses referring to children. The voices against focus mostly on the unnecessary medicalisation of gender diversity at the age when no medical interventions that could require refund are applied anyway, so the diagnosis does not condition access to professional treatment. The relevance of preserving the diagnosis is justified by the necessity of providing professional support and education for the parents and the need to single out that subpopulation of gender non-normative children for whom it is not going to be a passing developmental variant and who do or will experience discomfort or suffering because of it (Drescher, Cohen-Kettenis, & Reed, 2016).

ICD-11 has been in force since January 2022, while Poland, just like other countries, has a 5-year transitional period to implement it and to prepare the national information system to use it fluently. Nevertheless, the clinical practice can employ the terminology included in it and shape the inclusive language usage. However, the question whether experiencing oneself in a way different than the sex assigned at birth should be perceived in diagnostic terms remains open.

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