Gendercare suggestions for a new Classification for gender dysphorias at ICD 11th. A contribution to the WPATH proposal.

First of all we would like to consider an Introduction to that subject, as a whole.

We suggest there is a Gender Spectrum – a near continuum spectrum between two poles – M and F.

There are MtF and FtM conditions.

The Usual Conditions are near the poles. All other conditions we may consider surely as UNUSUAL GENDER CONDITIONS.

So we suggest that term - UNUSUAL GENDER CONDITIONS as an umbrella term to consider all these possibilities inside the spectrum.

Among these conditions there are typologies we may classify as:

1. MILD CONDITIONS (need no body change)

   Among these we may consider:
   1.1 - Dual-Role Crossdressers
   1.2 - Fetishistic Crossdressers
   1.3 - Drag Crossdressers.

   All these conditions NEED NO BODY CHANGE, ARE ALWAYS REVERSIBLE, AND MILD.

   We suggest they need NO CLASSIFICATION at ICD, because they are not a disorder or disease, but only a question of taste and diversity. Sometimes a question of imagination and even art!

2. INTENSE CONDITIONS (need some body changes)

   These are intense, they need body changes, perhaps hormones, surely surgeries, implants. BUT NEVER A SRS SURGERY.

   These may be related to mental disorders OR NOT. Not a specific mental disorder.
These are RARE and are DISEASES, and need professional medical help.

They need a good place at ICD - we may name them as TRANSGENDERS. A place among RARE DISEASES, not mental disorders.

3. EXTREME CONDITIONS

These extreme conditions we may name TRANSSEXUALITIES, are RARE, are EXTREME, and are DISEASES, that need professional medical help.

Rarely they may be related to a mental disorder - not a specific one.

They need a good place also at ICD - as RARE DISEASES, not mental disorders.

All these conditions may be related - OR NOT to mental conditions, and when they need BODY CHANGES and IRREVERSIBLE CHANGES, they need a place inside ICD among the RARE DISEASES.

SUGGESTIONS REGARDING THE DIAGNOSES: F64.0
Transsexualism
(we suggest the elimination of the F classification for all unusual gender conditions)

All members agreed with the change of name to Gender Dysphoria
(Yes, when intense or extreme, when the patient needs a body change)

The group has not reached consensus on the diagnostic criteria put forth:

Gender Dysphoria:

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, and this distress or impairment is not solely due to external prejudice or discrimination. (Distress that asks for a body change)

Some members thought that a criterion of at least one to two years of persistence was necessary for the diagnosis (We suggest the body needs one to two years for a transition, BUT THAT TRANSITION MAY BE IN STEALTH MODE, to protect jobs, bullying and lives! The DIAGNOSIS need not so many time – 3 months is enough)

All members thought that it should move out of the current chapter to E or Q however the research evidence is not strong for inclusion in these chapters. (There is now a Committee at ICD for RARE DISEASES - they are suggesting a new classification. We suggest as IMPORTANT – and now there is enough good scientific evidence that gender dysphorias are RARE and are DISEASES - to contact them and suggest Gender Dysphorias among these! Not a mental but Rare condition.)

SUGGESTIONS REGARDING THE DIAGNOSIS: F64.2 Gender identity disorder of childhood

All members agreed with the change of name to Gender Dysphoria

Yes!

The group has not reached consensus on the diagnostic criteria put forth:

Gender Dysphoria in Pre-pubertal Children

A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, or with a significantly increased risk of suffering, such as distress or disability, as manifested by the following indicators (The presence of A or B indicators are required):

A. A strong desire to be of the other gender or an insistence that he or she is the other gender (or some alternative gender different from one's assigned gender)
B. A strong dislike of one's sexual anatomy and/or a strong desire for the primary and/or secondary sex characteristics that match one's experienced gender, when such gender is different from the assigned gender

C. A strong desire for various aspects of the other typical gender's role including clothing and grooming, roles in make-believe or fantasy play, toys, games, or activities and playmates, and/or a rejection of the typical behaviors of his/her assigned gender

Note: Pubertal and post-pubertal children are best classified under the adult Gender Dysphoria category

Yes, we agree!
We agree also that at pre-pubertal age, we may not surely classify the full INTENSITY, if INTENSE OR EXTREME. That we may do soon later!

All members should agree that it follow the placement of the adult diagnosis

From here on we suggest all IS NOT CONSIDERED AS DISEASE, and be out of ICD radically.

When there is NO BODY CHANGE, there is no disease or disorder, and so it may be out of ICD.

( end of Gendercare suggestions & comments)

SUGGESTIONS REGARDING THE DIAGNOSES of Dual Role Transvestism and Fetishistic Transvestism

The group has not reached consensus on these diagnoses

F64.1 Dual-role transvestism
The wearing of clothes of the opposite sex for part of the individual's existence in order to enjoy the temporary experience of membership of the opposite sex, but without any desire for a more permanent sex change or associated surgical reassignment, and without sexual excitement accompanying the cross-dressing. Gender identity disorder of adolescence or adulthood, nontranssexual type. Excludes Fetishistic transvestism.
F65.1 Fetishistic transvestism
The wearing of clothes of the opposite sex principally to obtain sexual excitement and to create the appearance of a person of the opposite sex. Fetishistic transvestism is distinguished from transsexual transvestism by its clear association with sexual arousal and the strong desire to remove the clothing once orgasm occurs and sexual arousal declines. It can occur as an earlier phase in the development of transsexualism.

Clinical background
These two conditions can on one hand been seen has part of a gender spectrum or on the other hand as a personal gender journey over time. Where some people seem to start in their teens or early adulthood practicing fetishistic transvestism and then proceed to Dual-role transvestism and then end up somehow developing a gender dysphoric condition and request some surgical or hormonal cross gender body modification and or sex reassignment later in life. How many who proceeds in a gender journey are unknown. Fetishistic transvestism can of course just be a paraphilia by itself and in that aspect not be a part of a gender spectrum. Persons with these diagnoses sometimes have a clinical significant distress, or disability. The distress is mostly related to the social and interrelation complications to the practice or due to time-consuming issues. In this case they might seek help to ease this distress.

How often are these diagnoses used?
A Pubmed search makes no hit on Dual-role transvestism, however more hits on Fetishistic transvestism. We have found only one population based study from Sweden which reported that 2.8 % of the men and 0.4% of women age 18-60 reported at least one episode of transvestic fetishism (Långström and Zucker 2005). A search in the Swedish open ward register and the hospital discharge register which both covers diagnoses of all open ward visits and hospital discharge diagnosis in Sweden (9 000 000 inhabitants) shows that patients seldom seek help for these conditions.
F64,1 2005-2010 was used at 12 open ward visits and 1 hospital discharge, not unique patients (the diagnosis has not been used since 2008).
F65.1 has not been used at all between 2005-2010.

Pros and cons for keeping them as diagnosis

Pros:
- Develop evidence based treatment
- Research in order to do that
- Access to health care for the ones in need of that
**Cons:**

- Pathologizing and stigmatizing human behavior, which doesn't harm any one
- Persons might be subject to harmful treatment
- They are both just two expressions for gender dysphoria among many other expressions and it makes no sense just to choose these two ones.

**Two suggestions**

A Exclude them from ICD 11 and suggest that;
Fetishistic transvestism could be included in the today F65.8 (Other paraphilias) if one add, with clinical significant distress.
Dual-role transvestism could be included in a new diagnosis named other specified gender variance, or if the new gender dysphoria diagnosis will be close to the DSM V diagnosis Dual-role transvestism will be cover by that diagnosis.

**OR**

B To modify the diagnosis so they include both significant clinical distress and impairment. See the next slides.

Rename F65.1 to Fetishistic transvestic disorder may be useful.

Specifier A. This refers to the general criteria F65 that are inherently problematic.

G1 Namely women's clothes are not 'unusual objects'. Further, the 'activity' of cross dressing is not unusual for individuals with gender dysphoria.

G2 in this section, there should be differentiation between internal distress (ego dystonic) and distress that follows from the stigma imposed by either the current diagnostic criteria (usually from the clinicians) or from society (including prejudice and intolerance). The latter forms of distress should not be diagnostic of disorder. Second, there should be a definition of impairment in addition to the existing 'markedly distressed'.

G1/G2 Consider combining sexual urges, fantasies or acts (behaviours) together rather than separately.

G3 The distress (and impairment) should be for at least 6 months and
the duration not assigned to the urge alone as the 'paraphilia' itself should not be considered a disorder. That is to say, the preference may be life long but not ego dystonic and rather a healthy expression of diversity.

65.1 B&C could be combined as this would then remove the current inference that cross dressing alone for any purpose or intent is pathological.

Specific problems.

A statement is required that sexual behaviours ascertained as paraphilias are distinct from psychiatric/mental disorders. This could be in the overview to F65. G1.

G1 defines unusual objects or activities and as such immediately pathologises difference and diversity from the majority experience. Some evidence would cite 40% of individuals enjoy fetishistic activity as part of their 'normal' sexual life - hardly a significant minority?

G2 pathologises 'acts on urges' and may be exclusive and without 'marked distress'. There is a need to define 'clinically significant distress'.

Currently there is no reference to impairment of interpersonal, social or occupational live and these should be considered. Please see comments on excluding effects of stigma and prejudice within any diagnosis if these specifiers are considered useful.

There is real concern that FT is wrongly ascribed to individuals with gender dysphoria and as such discussion about how to best achieve differentiation from both paraphilias and paraphilic disorder is essential.

We need to consider the proposals for DSM5 regarding transvestic disorder (note the reversal from TF). There is useful differentiation between ascertaining the presence of a paraphilia and actually diagnosing the disorder on the basis of distress and impairment. See also above. More contentious are adding the two specifiers (fetishism and autogynephilia). This should be considered along with the fetishism and partialism debate in our deliberations and discussion.

Ref

Transvestic fetishism in the general population: prevalence and correlates. Långström N, Zucker KJ. J Sex Marital Ther. 2005 Mar-Apr; 31(2):87-95
SUGGESTIONS REGARDING: F64.8 Other gender identity disorders and F64.9 Gender identity disorder, unspecified

Most group members support these suggestions

I there is a specific diagnosis for GID in DSM 5, which appears to be the case, then inevitably there will be people who meet clinical significance criteria for a disorder but who do not meet the criteria for GID, even though we do not yet know the final criteria set. Therefore, if there is GID (or some other name for what we now know as GID; I will use GID in this commentary recognizing that the nosology may change) then there needs to be GID unspecified/NOS.

I would advocate for ICD-11 being as close to, or identical to, DSM 5 in this section. Again, I am hampered by not knowing what DSM 5 terminology and criteria are.

The current systems (DSM and ICD) are flawed in that they offer no criteria whatsoever. This needs to change, as diagnoses are not useful to clinicians without some guidance in how to use them. To that end, the first recommendation is that GID Unspecified needs to have as a key criterion a clinical significance criterion that matches, word for word, the phraseology of the clinical significance criterion in other diagnoses in ICD. This important clinical significance criterion should be identical for GID NOS in ICD-11, assuming that all psychiatric diagnoses include a clinical significance criterion, which I strongly advocate for.

Second, there need to be specific criteria in addition to the clinical significance criterion, but I am unable to provide those specifics without seeing what will be used in the GID (or equivalent) section of ICD-11. GID NOS is a derivative diagnosis, based largely on what GID does not include. At a minimum, examples of non-GID clinically significant gender disorders need to be included.

SUGGESTIONS REGARDING: F66 PSYCHOLOGICAL AND BEHAVIOURAL DISORDERS ASSOCIATED WITH SEXUAL DEVELOPMENT AND ORIENTATION

Consensus reached for elimination of all the F66 diagnoses:
Excerpts:

**Psychosexual Development Disorders**

Psychosexual development was at the cornerstone of Freud’s first effort to articulate a theory of child development and mental functioning. Although psychoanalytical thinking about psychosexual development continues to play an important role in our contemporary theorizing as well as in our clinical work, these concepts are not easily translated into a modern, objective research tool, let alone into a clear diagnostic category. Hence, this is perhaps the main reason that this diagnosis lacks an adequate description in the ICD-10.

A literature search over the last 25 years in the Web of Knowledge of Thompson Reuter and Medline does not render any results for “psychosexual development disorder”, nor does this ‘diagnosis’ appear in any relevant major psychiatric textbook. This specific ‘diagnosis’ has clearly not been researched or specifically written about for decades! I think this is due to the fact that the study of psychosexual development has become part of the much broader research framework of sex and gender research with researchers and scholars which cut through the social, biological and medical sciences. Hence, I believe that this diagnosis should be omitted in the forthcoming ICD-11. The same arguments apply to F66.9.

I agree that "Psychosexual development disorder, unspecified" (F66.9) should be omitted from the ICD-11. My arguments are similar to those listed under F66.8. In fact, I think the whole Category F66 should be deleted. It's scientific validity and clinical utility is non-existent.

**Egodystonic Sexual Orientation**

I recommend that "Egodystonic sexual orientation" be removed from the ICD. The American Psychiatric Association removed Ego Dystonic Homosexuality from the DSM in 1987. The argument then was that gay and lesbian people often have a transient ego-dystonic phase to the formation of their identity as gay or lesbian, influenced by internalized societal homophobia. The primary use of the disorder, however, was not in helping gay and lesbian people with developing healthy gay and lesbian identities, but rather for "reparative" therapy to attempt to change sexual orientation. "Reparative" therapy has been condemned by major mental health organizations, including the American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers, as ineffective and potentially harmful.
For gender identity, similarly, there may be a period in identity formation in which the gender identity is questioned or not desired. Persistent Gender Dysphoria, needing treatment, would be covered under the Gender Dysphoria diagnosis.

**Sexual Maturation Disorder**

The diagnosis "sexual maturation disorder" in the current ICD-10 has little, if any scientific validity AND clinical utility. I searched The Web of Knowledge of Thomson Reuters as well as Medline from 1950 onwards (and had a look in major psychiatric textbooks and sexuality textbooks (Balon& Segraves, Bancroft, Leiblum & Rosen, Schiavi, etcetera)and found only one reference from a Russian paper entitled: Disorders in the psychosexual maturation of youths with residual organic insufficiency (1993) by Gur'eva V. A.;Burelov E. A.; Kuznetsov I. V.; et al. in the Journal of Russian and East European Psychiatry, 26(1),44-53. This article has never been cited since! Consequently I think we can safely conclude that this diagnosis is redundant and certainly not a focus for ongoing research or clinical utility.

In my view, the same argument can actually be made for the whole Category of F66 in the ICD-10.

**Sexual Relationship Disorder**

The diagnosis “F66.2 Sexual relationship disorder should not be included in the ICD-11, because it is not a primary diagnosis (in fact it is not a diagnosis at all), but rather a consequence of one or more than one factor which cause the relationship difficulties (The use of the term "sexual relationship disorder" is problematic in itself, I prefer the use of "sexual relationship" difficulties or problems, which in my view tends to be the responsibility of both (or more) partners within a relationship.) These factors include any or a combination of any somato-bio-psycho-social-sexual-religious-cultural-etcetera issues (e.g. cancer, ageing, MS, poor sex education, sexual boredom, strict religious beliefs, anxiety, sexual inexperience and, phimosis, etcetera)and clearly not only gender identity or "sexual preference abnormality", the latter being a totally inappropriate and politically incorrect term.