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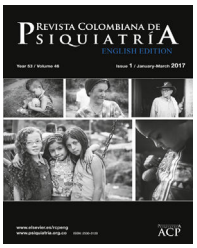

Letter to the Editor

Gender incongruence or dysphoria: More of the same in ICD-11 and DSM-5-TR

Disforia o incongruencia de género: más de lo mismo en la CIE-11 y el DSM-5-TR

Dear Editor,

In 2013, the American Psychiatric Association (APA) published the fifth edition of its Diagnostic and Statistical Manual (DSM-5) with some innovations in terms of sexual behaviours and identities.[1] Some of the most notable are the separation of sexual dysfunctions from paraphilic disorders, and the inclusion of a rather controversial category: gender dysphoria.[2]

Activists consider that opinions have been imposed on gender incongruence or dysphoria that correspond more to legal arguments, in an attempt to regulate sexual behaviour in the private lives of citizens.[3] This perspective ignores the diversity of human sexuality from a cultural perspective.[2] On the other hand, the disorder concept is a normative view of disease, which links identity with a distancing from what is socially desirable.[4]

In 2018, after several delays, the World Health Organization (WHO) released the eleventh revision of its International Classification of Diseases (ICD-11). Like the APA, the WHO made changes to its classification of sexual behaviours and identities.[5]

The ICD-11 is completely harmonised with the DSM-5-TR, published in 2022. Both classifications include three major categories covering sexual behaviours.[1,5] The ICD-11 includes the diagnostic possibility of "gender incongruence," coded as HA60 for adolescents and adults and HA61 for gender incongruence of childhood. This replaces the previous classification of transsexualism in the ICD-10[6] and is equivalent to "gender dysphoria" in the DSM-5[1] and the DSM-5-TR.[7] It is unclear whether the diagnosis of "gender incongruence" persists following complete transition, given that "post-transition" should be specified.[8]

The DSM-5 and the DSM-5-TR have kept the criteria for gender dysphoria almost unchanged,[1,7] except that the DSM-5-TR uses more inclusive or culturally sensitive language in defining the criteria, even without having the official translation in Spanish; for example, "expressed gender" was changed to "experienced gender" and "gender reassignment surgery" was changed to "gender confirmation surgery".[7] The advantages of this language are based on the fact that they refer more to the lived experience, are more accurate, and use more fluid terms, for example, changing the expression "expressed gender" to "experienced gender" or the expression "male or female at birth" to better indicate "male or female assigned at birth." However, there are disadvantages associated with softening the terms, which does not necessarily imply stigma-discrimination; on the contrary, the same characteristics of exclusion are perpetuated.[9]

Furthermore, this view that pathologises experiences of everyday life and suggests that the diagnosis of "gender incongruence" goes against the transitions that are typical of childhood and adolescence, the best times for an identity search. Likewise, this category not only discriminates against the search for alternative gender identities, but is also accompanied by serious mental health conditions: stigma-discrimination, body dissatisfaction, high levels of anxiety or depression, substance abuse and a greater risk of self-harm or suicide.[10–14] The normative bias for sexuality thus persists, since it becomes evident that a natural sexual difference is, in reality, a reading of the body screened for culturally situated meanings and values that help generate a gender-politics distribution of the bodies.[15]

Sexual diversity activist sectors thought that gender incongruence would be excluded from the ICD-11, just as they thought that gender dysphoria would be omitted from the next revision of the DSM, due to the lack of evidence for its diagnosis[16] and because it is clear that the characteristics observed in people with gender dysphoria or incongruence are more the product of the objectification of the disorder in response to the stigma-discrimination complex due to non-hegemonic sexual identity.[17] In line with the above, Heylens

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et al.[8] observed that signs of distress decrease as the necessary actions are taken to reassign sexual identity. However, despite these movements, a significant number of healthcare professionals still treat these populations as if they were sick, and even prefer to avoid treating them, especially when the stigma of sexuality is superimposed on other stigmas.[18]

The continued medicalisation of gender dysphoria or incongruence confirms the existence of a normative bias in the classification of so-called mental disorders.[3,4] Normative bias undermines the validity of this diagnostic category since it describes as a mental disorder condition what is only socially undesirable or disapproved.[4,17]

It is necessary to bear in mind that both psychiatry and psychology, in their short existence, have been instruments of political domination or control and have become the most effective way to discipline the plurality of human behaviour.[19] This is linked to deficiencies in the formation of cultural competences in the treatment of diverse populations, common deficiencies linked to the expectation of working with populations that adhere to regulatory limits. Likewise, these professions, with a very limited vision, have denied natural variety, the possibilities of gender diversity, as constructions that flow over time, are continually changing and bring together biological and cultural elements.[19–23]

Therefore, it is imperative that future editions of the classifications of mental disorders, ICD and DSM, eliminate the label of mental disorder from all signs of human sexual diversity that imply an exercise of autonomy and thereby promote respect for the rights of other fellow citizens.[3] In the same way, these classifications are obliged to avoid changes in residual titles and categories based on normative principles that ignore the fluidity of sexual identity.[2,5,17,19,20,24] It is clear that atypical is not synonymous with abnormal, sick or disordered.[25]

Finally, mental health professionals must accept the consensuses of the discipline and avoid the connotation of mental disorder in different aspects of sexual diversity, today excluded from manuals but not from personal ideologies, and desist from psychotherapeutic treatments to restore hegemonic sexual identities, despite the ineffectiveness and negative emotional effects of these "therapies".[26,27] Likewise, disciplinary interventions tend to simplify the treatment and ignore the relevance of the social experience, the congruence of the perception of the body with gender satisfaction, and insist on excluding the importance of stress suffered during and after gender affirmation surgery.[28]

Mental health classifications have many positive aspects for the construction of knowledge. However, to date, the categorisation of sexual behaviours and identities is based, in several aspects, on normative foundations that must be considered and, therefore, dismissed or discarded for the construction of clinical diagnoses. To summarise, the argument supports the idea of restoring the diagnosis beyond classification as a holistic task that involves knowledge of aetiology, epidemiology, course, treatment and prognosis of any potential "illness".[29,30] However, "gender incongruence" or "gender dysphoria" is still a debate that remains valid and proves, in other words, to be more of the same, in these new classifications.

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Conflicts of interest

The authors declare that they have no conflicts of interest.

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Adalberto Campo-Arias*, Mónica Reyes-Rojas
Universidad del Magdalena, Santa Marta, Colombia

*Corresponding author.
E-mail address: acampoa@unimagdalena.edu.co
(A. Campo-Arias).
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