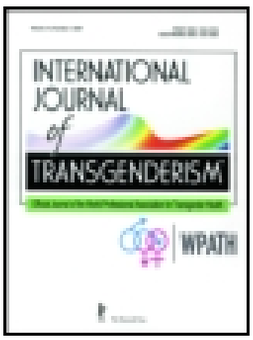

International Journal of Transgenderism

ISSN: 1553-2739 (Print) 1434-4599 (Online) Journal homepage: https://www.tandfonline.com/loi/wijt20

Recommendations for Revision of the *DSM* Diagnoses of Gender Identity Disorders: Consensus Statement of the World Professional Association for Transgender Health

Gail Knudson , Griet De Cuypere & Walter Bockting

To cite this article: Gail Knudson , Griet De Cuypere & Walter Bockting (2010) Recommendations for Revision of the *DSM* Diagnoses of Gender Identity Disorders: Consensus Statement of the World Professional Association for Transgender Health, International Journal of Transgenderism, 12:2, 115-118, DOI: 10.1080/15532739.2010.509215

To link to this article: https://doi.org/10.1080/15532739.2010.509215

Published online: 17 Sep 2010.

International Journal of Transgenderism, 12:115–118, 2010

ISSN: 1553-2739 print / 1434-4599 online
DOI: 10.1080/15532739.2010.509215

Routledge
Taylor & Francis Group

EXECUTIVE SUMMARY

Recommendations for Revision of the *DSM* Diagnoses of Gender Identity Disorders: Consensus Statement of the World Professional Association for Transgender Health

Gail Knudson
Griet De Cuypere
Walter Bockting

ABSTRACT. This consensus statement is an executive summary of several papers resulting from a 2009 consensus process comprising nine work groups and 37 members of the World Professional Association for Transgender Health (WPATH). The purpose of this group was to put forth recommendations for the upcoming revision of the *DSM* with respect to the Gender Identity Disorder diagnoses. The consensus process was collaborative, interdisciplinary, and evidence based. A majority (but not all) of the participants believed that a diagnosis related to Gender Identity Disorder should remain in the *DSM*, and many advocated changes in name, diagnostic criteria, and placement within the *DSM*. The proposed name is Gender Dysphoria, and the diagnostic criteria should be distress based. Placement should be outside the chapter on Sexual Disorders and possibly within Psychiatric Disorders Related to a Medical Condition. If there were to be a diagnostic category for childhood, there should also be separate categories for adults and adolescents. A Not Otherwise Specified category should be retained, and Disorders of Sex Development should not be an exclusionary criterion for Gender Dysphoria.

KEYWORDS. Transgender, transsexualism, gender identity disorder, *DSM 5*

This consensus statement is an executive summary of several papers resulting from a 2009 consensus process comprising nine work groups and 37 members of the World Professional

Gail Knudson, MD, is a psychiatrist and clinical associate professor in the Department of Sexual Medicine, University of British Columbia, and medical director of the Transgender Health Program, Vancouver Coastal Health, Vancouver, British Columbia, Canada. Griet De Cuypere, MD, is a psychiatrist and the gender team coordinator in the Department of Sexology and Gender Problems, University Hospital, Ghent, Belgium. Walter Bockting, PhD, is a psychologist and coordinator of Transgender Health Services and associate professor at the Program in Human Sexuality, Department of Family Medicine and Community Health, University of Minnesota Medical School, Minneapolis, Minnesota, USA.

Address correspondence to Dr. Gail Knudson, University of British Columbia, Department of Sexual Medicine, Echelon 5, 855 West 12th Avenue, Vancouver, British Columbia, Canada V5Z 1M9. E-mail: gail.knudson@vch.ca

Association for Transgender Health (Richter-Appelt & Sandberg, 2010/this issue; Bouman, Bauer, Richards, & Coleman, 2010/this issue; Corneil, Botzer, & Eisfeld, 2010/this issue; Ehrbar, 2010/this issue; Fraser, Karasic, Meyer, & Wylie, 2010/this issue; Green, McGowan, Levi, Wallbank, & Whittle, in press; Haraldsen, Ehrbar, Gorton, & Menvielle, 2010/this issue; Rachlin, Dhejne, & Brown 2010/this issue).

PROCESS

The process around the consensus statement is described in more detail elsewhere (Knudson, DeCuypere, & Bockting, 2010/this issue). Briefly, the process was collaborative, interdisciplinary, and evidence based. The nature of the evidence the WPATH work groups considered varied from empirical research with large samples to qualitative research and case reports. Where evidence seemed inadequate, it was augmented with consensus based on collective clinical experience. The consensus-building process took the form of face-to-face meetings, phone conferences, online meetings of work groups and a half-day collective consensus meeting followed by presentation and discussion with the attendees of the 2009 WPATH Biennial Symposium in Oslo, Norway. Ultimately, the consensus group arrived at recommendations for revision of the Gender Identity Disorder diagnoses to the *DSM 5* Work Group on Sexual and Gender Identity Disorders (WGSGID) of the American Psychiatric Association.

QUESTIONS

The following questions were posed to the WPATH work groups:

Should the Diagnosis of Gender Identity Disorder Be Removed or Retained?

The consensus participants could not reach consensus on whether GID should remain in *DSM 5*. While the majority believed that it should remain in the *DSM*, many advocated changes in name, diagnostic criteria, and placement within the *DSM*. We had an extensive discussion of the pros and the cons of a diagnosis and these are detailed in Ehrbar (2010/this issue) and Knudson, DeCuypere, and Bockting, (2010/this issue).

The consensus group did agree that gender variance is not in and of itself reflective of pathology and having a cross- or transgender identity is not a psychiatric disorder. Therefore, any gender-related disorder should represent distress—not identity—and the psychiatric consequences of this distress.

If the Diagnosis Is Retained, What Should Be the Primary Criteria to Qualify as a Disorder?

As noted already, any diagnosis should be based on the experience of distress resulting from an individual's gender identity conflict (e.g., distress related to a conflict between gender identity and sex assigned at birth, primary and/or secondary sex characteristics, or gender role). As such, the disorder would be more appropriately labeled *gender dysphoria* or *gender dysphoric disorder* and not *gender identity disorder*. The diagnostic criteria should focus on distress, not identity.

DIAGNOSTIC CATEGORIES

The current definition of *DSM-IV-TR* includes two diagnostic categories, one for children and the other for adolescents and adults. The WPATH work groups recommend that there be separate diagnostic criteria for children, for adolescents, and for adults in *DSM 5*.

Children

The child work group did not reach a consensus, but their overall recommendation was that the GID diagnosis for children was not appropriate and, therefore, should not be included in *DSM 5*. However, if a child gender identity disorder is to be retained, the work group recommends the following:

Proposed name: *Gender Dysphoria in Childhood*
Proposed diagnostic criteria: Extreme cross-gender behavior *and* wishes, accompanied by persistent and severe internal dysphoria with birth-assigned gender.
Proposed specifiers: None suggested.
Proposed placement: Remove from Sexual Disorders section and place within Childhood-Onset Disorders

Adolescents

Given the significant difference between young children, adolescents, and adults with regard to gender identity, WPATH work groups further separated adolescents from both child and adult disorders and gave them their own specification:

Proposed name: *Gender Dysphoria in Adolescents*
Proposed diagnostic criteria:

1A. Clinically significant persistent distress with current or anticipated physical sex characteristics, or ascribed social gender role that is incongruent with persistent gender identity.
1B. Clinically significant stress or stress that causes impairment in social, occupational, or other important areas of functioning and that is not solely due to external influences such as prejudice, discrimination, or social pressures or benefits.
1C. The symptoms are not better accounted for by another medical condition or mental disorder.

Rule outs:

- Symptoms are 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).
- Symptoms not simply gender nonconformity or difficulty with cultural norms or desire to conform to social expectations from peers, parents, social networks.

Proposed specifiers: None suggested.

Proposed placement: We recommend a separate diagnostic category. If classified with adults, substantial supporting text about adolescent issues is needed.

Adults

As described above, if a gender-related disorder is included in *DSM 5*, it should be designated as *dender dysphoria* not *gender identity disorder.*

Proposed diagnostic criteria for *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. Clinically significant stress 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.

- Consistent with virtually all other *DSM* disorders, the consensus group recommends the retention of the Not Otherwise Specified (NOS) category.
- Disorders of sex development should not be an exclusionary criterion for gender dysphoria. Some individuals with disorders of sex development may experience discomfort with the sex they were assigned at birth and suffer from gender dysphoria.

Proposed specifiers:

- The work groups agreed that the diagnosis should not apply to all gender variant individuals but only to those who are currently experiencing distress. For

many individuals with gender variant identities, distress associated with their gender may subside (with or without the assistance of psychotherapeutic or medical interventions) as individuals find comfort with their gender identity and expression, their bodies and their social role. Thus, the distress for many is not lifelong. Therefore, we recommend inclusion of the specifier "in remission." A diagnosis of Gender Dysphoria in remission could then also be used for individuals continuing hormone therapy after resolution of gender dysphoria.

- We recommend that the specifiers related to sexual orientation not be included in the *DSM 5*. Since the new diagnosis is focused on distress rather than identity, such specifiers are not relevant.
- We recommend that the term autogynephilia not be added as a specifier as the validity of this specifier is yet to be determined (Moser, 2009).

Proposed placement: The diagnoses related to gender dysphoria should be located in a chapter elsewhere (e.g., Psychiatric Disorders Related to a Medical Condition) as they are not sexual disorders.

CONCLUSION

Gender variance is not in and of itself a psychiatric disorder and, therefore, the label of *gender identity disorder* as a mental illness/mental disorder is not appropriate. Such labeling may undermine human rights in that it undermines legitimacy of identity and creates and sustains social stigma and cultural prejudice against individuals and significant others with gender variant identities. It could also call into question the mental competence or capacity to consent to treatment, limiting personal autonomy and access to care (Green et al., in press). Therefore, if retained in *DSM 5*, the name change from Gender Identity Disorder to Gender Dysphoria is essential.

REFERENCES

Bouman, W. P., Bauer, G. R., Richards, C., & Coleman, E. (2010/this issue). World Professional Association for Transgender Health consensus statement on considerations of the role of distress (Criterion D) in the *DSM* diagnosis of Gender Identity Disorder. *International Journal of Transgenderism, 12*, 100–106.

Corneil, T. A., Eisfeld, J. H., & Botzer, M. (2010/this issue). Proposed changes to diagnoses related to gender identity in the *DSM*: A World Professional Association for Transgender Health consensus paper regarding the potential impact on access to health care for transgender persons. *International Journal of Transgenderism, 12*, 107–114.

Ehrbar, R. D. (2010/this issue). Consensus from differences: Lack of professional consensus on the retention of the Gender Identity Disorder diagnosis. *International Journal of Transgenderism, 12*, 60–74.

Fraser, L., Karasic, D. H., Meyer, W. J., III, & Wylie, K. (2010). Recommendations for revision of the *DSM* diagnosis of Gender Identity Disorder in Adults. *International Journal of Transgenderism, 12*, 80–85.

Green, J., McGowan, S., Levi, J., Wallbank, R., & Whittle, S. (in press). Human rights implications of the GID diagnosis. *International Journal of Transgenderism*.

Haraldsen, I., Ehrbar, R. D., Gorton, R. N., & Menvielle, E. (2010/this issue). Recommendations for revision of the *DSM* Diagnosis for Gender Identity Disorder in Adolescents. *International Journal of Transgenderism, 12*, 75–79.

Knudson, G. A., De Cuypere, G., & Bockting, W. (2010/this issue). Process toward consensus on recommendations for revisions of the *DSM* diagnoses of Gender Identity Disorders by the World Professional Association for Transgender Health. *International Journal of Transgenderism, 12*, 54–59.

Moser, C. (2009). Autogynephilia in women. *Journal of Homosexuality, 56*, 539–547.

Rachlin, K., Dhejne, C., & Brown, G. R. (2010/this issue). The future of GID NOS in the *DSM-5*: Report of the GID NOS Working Group of a consensus process conducted by the World Professional Association for Transgender Health. *International Journal of Transgenderism, 12*, 86–93.

Richter-Appelt, H., & Sandberg, D. E. (2010/this issue). Should disorders of sex development be an exclusion criterion for gender identity disorder in *DSM-5*? *International Journal of Transgenderism, 12*, 94–99.