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NEW PERSPECTIVES ON TRANSGENDER HEALTH IN THE FORTHCOMING 11TH REVISION OF THE INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS: AN OVERVIEW OF GENDER INCONGRUENCE - DEPATHOLOGIZATION, CONSIDERATIONS AND RECOMMENDATIONS FOR PRACTITIONERS

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SUMMARY

On June 18th, 2018, the World Health Organization officially released its new International Classification of Diseases (ICD-11) for preview; it was presented on World Health Assembly in May 2019 for adoption by Member States. Since ICD 11 is planned to come into effect and be officially used as from January 1st, 2022, this early sneak peek allows health care professionals enough time to prepare for the new classification and all the changes it brings along. ICD 11 moves away from stigmatizing practices of psychiatrization of transgender persons and finally excludes issues of gender identity from the chapter on mental and behavioral disorders. This reconceptualization consequently sets the stage for different roles of psychiatrists in meeting transgender patients' health care needs. This article addresses the most important changes to the ICD related to Gender incongruence, a new nosological entity formerly known as Gender Identity Disorder or Gender Dysphoria. The paper offers an overview of the current and future positions of transgender health issues through contemporary medical conceptualization and classification. It aims to eliminate barriers to quality care for transgender patients, by attending to the recognized knowledge gaps and by providing recommendations for psychiatrists and other health care professionals who commonly receive low levels of exposure to transgender content in their education.

Key words: *ICD-11 - gender incongruence - gender dysphoria - transgender - depathologization*

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INTRODUCTION

Numerous controversies that took place in the history of mental health and the plethora of debates about psychopathology that followed have led to the evolution of conceptions and definitions related to gender identity. Much of the terminology that was traditionally used to describe transgender persons and their mental health is now considered to be outdated, discriminatory and offensive (Moliero & Pinto 2015). A plentiful corpus of research on mental health and transgender health has largely contributed to advancing knowledge on these matters and significantly influenced social attitudes, policies, laws and standards of human rights (Reed et al. 2016). Current evidence suggests that gender variance is not a mental disorder, and that the language previously used, such as "gender identity disorder", in the 10th and earlier revisions of International Statistical Classification of Diseases and Related Health Problems (hereinafter International Classification of Diseases - ICD) (World Health Organization 1992) has caused great stigmatization of transgender persons. The latest 11th revision of ICD (ICD 11) finally excludes issues of gender identity from the chapter on mental and behavioral disorders (World Health Organization 2018a). However, due to the significant need for health services, as well as the need for more accessible and improved health care, the matters of transgender health are not completely omitted from ICD 11. The condition presently recognized as Gender Incongruence will now be encoded in the newly added chapter on conditions related to sexual health (World Health Organization 2018b).

The aim of this paper is to aid mental health care professionals in their transition to the upcoming ICD 11 and offer guidance that will assist them in providing the highest level of professionally and culturally competent health care. A significant body of topical literature suggests that psychiatrists, physicians in general and professionals from related disciplines demonstrate low levels of exposure to transgender content in their education, significant knowledge deficits and report feelings of under-preparedness for working with gender nonconforming patients (Snelgrove et al. 2012, Beagan et al. 2015, McPhail et al. 2016, Hill & Shapiro 2017, Acker 2017). The major goal of this narrative review is to provide an overview of the current and future position of transgender issues through contemporary medical conceptualization and classification, by attending to the recognized knowledge gaps in order to eliminate barriers to quality care for transgender patients.

CURRENT AND UPCOMING NOSOLOGICAL CATEGORIES

In 1993 World Health Organization (WHO) published the ICD 10, which has been in use to this very day. The section on Gender identity disorders is itemized in the fifth chapter of ICD 10 that contains clinical descriptions and diagnostic guidelines for Mental and Behavioral Disorders, under the subdivision on Disorders of adult personality and behavior (World Health Organization 1992). However, the rationale for this classification of gender identity within the group of mental disorders remains unclear to this date. It appears that such placement was merely a matter of circumstance and quite arbitrary, given that ICD 10 simply continued the trend established in ICD-8 (1965) and ICD-9 (1975) in which transgender and transsexual matters were classified as "sexual deviations", as a subgroup of mental disorders. Quite peculiarly, since the leading opinions of that time, which were based more on social attitudes than the scientific evidence, emphasized that the underlying cause of transsexuality was a "hormonal imbalance", it remains unclear how it came to chance that transgender and transsexual issues were not instituted in the group of metabolic or endocrine disorders; instead they were buried among mental disorders, as a deviation of gender identity. Given the fact that there are yet no established, scientifically based criteria for assessing "normal" and "pathological" gender identity, all further discussions on the subject of justification of former classification of transsexuality as a mental disorder remain solely in the domain of theoretical speculations (Dresher et al. 2012).

The 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM V) that was published by the American Psychiatric Association in 2013 retains certain categories related to gender identity as part of the classification of mental disorders. They use the term *Gender dysphoria*, that was readily embraced by the mental health professionals upon its introduction, as it was perceived more illustrative and less stigmatizing than the former "Gender Identity Disorder". Gender dysphoria, as defined in DSM-V (American Psychiatric Association 2013), is a descriptive term related to the affective or cognitive discontent a person experiences as a result of the gender assigned to them at birth as a reflection of their natal sex. When used as a diagnostic category, gender dysphoria is more precisely defined and specifically refers to distress that may accompany the incongruence between one's experienced/ expressed gender and gender assigned at birth. Although not all persons will experience distress as a result of this incongruence, many are truly distressed, especially if they are denied medical interventions such as hormonal or surgical therapy. Thus, although DSM V still uses a diagnosis for gender-related issues, it has moved them out of the sexual disorders category and into a category of its own that does not problematize gender identity per se; instead, DSM V focuses strictly on dysphoria as a clinical problem, while at the same time providing access to the necessary health care services for gender-related issues.

The forthcoming WHO classification of diseases and related health problems reconceptualizes the subject of transgender health. It replaces the formerly used terms *Gender identity disorder* and *Gender dysphoria* with the term *Gender Incongruence* and introduces it under the category of *Conditions related to sexual health*. Unlike DSM V, ICD 11 diagnostic criteria emphasize that distress and dysphoria are not necessary for diagnosing gender incongruence. The aim of current conceptualization was to deflect from the scientifically unsupported psychopathologization of transgender persons that originates from the outdated notions on sexual deviations from the 1940's. ICD-11 is based on a model that reflects the attitudes of contemporary medicine based on scientific evidence and good practice guidelines, a model that is more open to the needs, experience and human rights of transgender persons, and a model that will support greater availability and better quality of health care (Reed et al. 2016, Drecher et al. 2012, European Parliament 2011).

As defined in the ICD 11, *"Gender incongruence of adolescence and adulthood is characterized by a marked and persistent incongruence between an individual's experienced gender and the assigned sex, as manifested by at least two of the following:*

- *a strong dislike or discomfort with the one's primary or secondary sex characteristics (in adolescents, anticipated secondary sex characteristics) due to their incongruity with the experienced gender;*
- *a strong desire to be rid of some or all of one's primary and/or secondary sex characteristics (in adolescents, anticipated secondary sex characteristics) due to their incongruity with the experienced gender;*
- *a strong desire to have the primary and/or secondary sex characteristics of the experienced gender.*

The individual experiences a strong desire to be treated (to live and be accepted) as a person of the experienced gender. The experienced gender incongruence must have been continuously present for at least several months. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis." (World Health Organization 2018c).

Furthermore, recognizing that gender identity and gender variances present differently in prepubertal children than in adolescents and adults, and that their different presentations implicate different needs and different clinical approach ("What does ICD-11 mean for child health professionals?" 2018) ICD 11 introduces the category *Gender incongruence of childhood*, which *"is characterized by a marked incongruence*

between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. 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." (World Health Organization 2018d).

ROLES OF THE MENTAL HEALTH PROFESSIONALS

Throughout much of the history, psychiatrists were positioned as the "gatekeepers" of the health care system and the primary obstacle between transgender persons and health care services they needed (Reed 2016, Drescher & Byne 2017). In many countries, transgender persons who sought transition or gender reassignment treatment were required to fulfill burdensome requests to provide evidence of their "true transsexuality", absence of another psychiatric condition, substantiate that they had lived in their desired gender role for a sufficient amount of time, or undergo long-lasting psychotherapy requirements before they could qualify for necessary health care services. What we know today confirms the wrongness of such approach; since many transgender persons who seek medical help do not suffer from mental disorders, insisting on long-term psychiatric evaluation and treatment was an unnecessary and oppressive request (Drescher & Byne 2017, Selvaggi et al. 2012, World Professional Association for Transgender Health 2011). Reconceptualization of gender issues in the upcoming ICD 11 and deflection from stigmatizing practices of psychiatrization of transgender health may bring about new roles for psychiatrists in meeting transgender patients' health care needs.

The health care professional's approach to transgender, transsexual and gender non-conforming patients must be based on the individual patient's assessment and tailored to his or her needs. It would be wrong to assume that there is a pattern of typical presentation of individuals seeking health care for gender incongruence. For example, a person whose gender expression is not consistent with socially established concepts may not necessarily self-identify as transgender or desire hormonal therapy or surgical interventions in order to adjust their gender expression (Dacić et al. 2015). Health care professionals must also understand that there are many transgender persons who have already been living with gender incongruence and/or gender dysphoria for years or even decades, before they were sufficiently empowered (or it could be that they were just now given the opportunity) to contact an expert with the desire to help them adjust their gender expression or begin the process of medical transition. Others may have already socially adjusted their gender expression, and now present themselves in the desired gender role during their first encounter with a psychiatrist, or perhaps they have already started hormonal therapy, or have undergone some of the surgical procedures. There are also those patients who may prefer not to express their experienced gender identity before undergoing months or even years of hormone therapy (Royal College of Psychiatrists 2013). All these differences must be recognized and individual circumstances adequately considered in the overall treatment plan. Implementation of the transition plan will depend on the patient's needs, their life circumstances, the steps that have been taken up to that moment, and the estimates of how successful they were in consolidating their gender role. The role of a psychiatrist in transgender health must never again be oppressive, but a supportive and an affirmative one.

RECOMMENDATIONS AND GUIDELINES FOR PSYCHIATRISTS AND OTHER HEALTH CARE PROFESSIONALS

In order to meet the diverse health care needs of transgender, transsexual and gender nonconforming persons, tasks of a psychiatrist or any other physician may vary, depending on the individual patient's needs. Once the reasons for seeking health care are established, the psychiatrists may find themselves in the role of a diagnostician and the one who refers the patient to further medical interventions of feminization or masculinization; their task may be psychotherapeutic, in the form of providing patient assistance to investigate his or her gender identity and expression; their role may be to support a patient in their coming out process or provide support to their partners or family members; they may also play a part in the psychotherapeutic or pharmacotherapeutic treatment of other mental health problems unrelated to gender, or provide any other professional service from the opus of their professional activity (World Professional Association for Transgender Health 2011). Although in-depth exploration of different roles of psychiatrists and other health care professionals is well beyond the scope of this paper, it may be useful to provide some examples.

The Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (hereinafter Standards of Care - SOC), which are based on the best available science and expert professional consensus, are the most well-known and most widely used good practice guidelines for clinicians working with transgender, transsexual and gender non-conforming individuals (World Professional Association for Transgender Health 2011).

Standards of Care propose the "Informed consent" model of care that offers greater accessibility of hormone and surgical treatment, which can be initiated without the formerly established exclusive referral from the psychiatrist. For example, any qualified health professional that is a part of multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy may refer a patient, after a psychosocial assessment is conducted and informed consent is obtained from the patient. The informed consent model rests upon the notion that the decision about hormonal therapy, as well as any other decision regarding one's health and body, is first and foremost an exclusive decision of the patients themselves. However, the roles of psychiatrists are still vital in this process, as they are the ones who are most competent to inform the patient adequately and prepare for further steps, so that their decisions about gender expression and the treatment of gender incongruence may be informed and thoughtfully and recurrently considered. The psychiatrist should approach the patient in a way that affirms patient's experienced gender identity and their health care needs, while informing them about the benefits and risks of different treatment options for gender incongruence and/or dysphoria. Psychiatrist should also play the role of a primary facilitator of access to the appropriate health care, given that studies have shown that the use of hormonal therapy in transgender patients is associated with a lower degree of anxiety and depression, and can affect the improvement of psychiatric status and overall quality of life (Schulz 2018, Gorin-Lazard et al. 2013, Gomez-Gil et al. 2012).

Although Standards of care enable more accessible health care for the transgender community, they rely on the DSM V classification and insist on thus proposed diagnostic criteria for the diagnosis of gender dysphoria. In light of the emerging ICD 11, I recommend that gender dysphoria need not be considered a necessary prerequisite for further referral to hormonal and/or surgical interventions (Dakić 2018). Gender non-conforming persons present in a wide range of diverse manners, and do not necessarily suffer from gender dysphoria (Royal College of Psychiatrists 2013, World Professional Association for Transgender Health 2011). If a person feels a strong incongruence between their experienced gender and gender assigned at birth, has a strong need to be treated (to live and be accepted) as a person of the experienced gender, but there is no evidence of clinically significant distress that interferes with their social, professional or other important areas of functioning (according to DSM-V criteria), it does not mean that this individual should be denied services that could enable them to achieve personal comfort and improve their health and overall wellbeing in accordance with their inner feelings and self-identification. Bearing in mind the emerging need to evaluate transgender identity outside the box of medical pathologization, while also being aware of the possible negative consequences of minority stress on transgender individuals, it is understandable that mental health care professionals must consider and explore the potential evidence of gender dysphoria. However, the model proposed here does not insist on dysphoria as a prerequisite for referral to other medical services. Instead, it suggests that the proposed criteria for further referral should involve evidence of gender incongruence, in accordance with the criteria laid out in the ICD 11, in addition to standard requirements for assessment of patient's decision-making competence (Dakić 2018). Accordingly, the criteria for referral for hormone therapy, as proposed in the Standards of Care and adapted to the new ICD 11 based model should be as follows:

- Persistent, well-documented gender incongruence or dysphoria;
- Capacity to make a fully informed decision and to consent to treatment;
- Age of majority in a given country (if younger, a permission from parent or a guardian);
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

For more good practice guidelines in working with transsexual, transgender, and gender nonconforming patients, mental and other health professionals should refer to the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, making sure that they adjust thus proposed standards to the principles presented in the ICD 11.

CONCLUDING REMARKS

Transgender individuals have historically been exposed to a large amount of chronic stress due to marked social stigmatization, marginalization, discrimination and victimization (Institute of Medicine 2011). As a result of psychopathologization, inaccessibility of health care, as well as poorly trained and insufficiently knowledgeable health care professionals, these individuals have been additionally marginalized and stigmatized in the medical context, as well (American Psychiatric Association 2013). Among the most prominent examples of controversial practices in the past were the attempts to change and convert a person's gender identity to match their natal sex (Gelder & Marks 1969). Such attempts were massively unsuccessful and hurtful for the patients involved, and are presently considered unacceptable and extremely unethical (Drescher & Byne 2017, World Professional Association for Transgender Health 2011). Contemporary approach to gender incongruence and/or gender dysphoria is dedicated to exploration and affirmation of one's gender experience. It is focused on the ways that harmonize gender expression and social adjustment of a person with their experienced gender and their personal needs, with the goal to alleviate the socially induced stress and its consequences, and improve a person's overall wellbeing.

While it is understood that psychiatrists and other health care professionals must still observe the stigmatizing and discriminatory terminology of the ICD 10 in their daily practice, I propose that they do so only to the degree necessary (Dakić 2018). Outside the official diagnosis which is an indispensable criterion for the exercise of the patients' right to health care, physicians should refrain from the abusive and stigmatizing vocabulary of the ICD 10 (eg. gender identity disorder), and begin to endorse the language and principles of the upcoming ICD 11. Personal and medical histories as well as all the findings in medical reports of transgender and gender non-conforming patients should only contain the affirmative and non-discriminatory terms such as gender incongruence, as required by ICD 11, or, where appropriate, gender dysphoria, in accordance with DSM-V criteria.

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