

Comments on the Proposed Revision to 302.6 Gender Identity Disorder in Children

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Kelley Winters, PhD
GID Reform Advocates
www.gidreform.org
kelly@gidreform.org

Summary

The current Gender Identity Disorder diagnosis imposes harmful stigma of mental illness and sexual disorder on gender variant and nonconforming children, regardless of the presence of gender dysphoria. Simultaneously, it poses barriers to social transition and access to puberty blocking or hormonal transition treatment at a later age, by describing transition itself as symptomatic of pathology. The proposed nomenclature for Gender Incongruence in Children for the DSM-5 contains a number of improvements in the title and diagnostic criteria intended to address both issues. However, these revisions fall short of clarifying that social or medical transition and other nonconformity to a birth- assigned gender do not in themselves constitute mental illness. These revisions obfuscate the clinically significant distress that may result from physical sex characteristics or an assigned social gender role that are incompatible with experienced gender identity: distress that may require medical attention. If there is a specific diagnostic category or criteria set for children in the DSM-5, it should be explicitly based on distress of anatomical or gender role dysphoria and not on gender role nonconformity.

Positive Aspects of the Proposed Revisions

- **Title:** The proposed title of Gender Incongruence is intended to be more descriptive and less stigmatizing than the previous title of Gender Identity Disorder, which implied a “disorder” of experienced gender identity (Winters 2005).
- **Diagnostic Focus:** The subcommittee stated their intent to shift the diagnostic focus away from gender identities that differ from assigned birth gender: “We have proposed a change in conceptualization of the defining features by emphasizing the phenomenon of 'gender incongruence' in contrast to cross-gender identification per se.” This is a significant positive departure from the prior DSM editions.
- **Evidence of Gender Dysphoria:** Under the current GID criteria in the DSM-IV-TR, children may be diagnosed strictly on the basis of nonconforming gender expression with no evidence of distress or dissatisfaction with their birth-assigned gender roles or natal sex characteristics. The proposed DSM-5 criteria partially address this issue by requiring subcriterion A1, “a strong desire to be of the other gender or an insistence that he or she is the other gender.”
- **Facets of Gender Dysphoria:** The proposed subcriteria A7 and A8 recognize that children may articulate anatomic dysphoria (distress with physical sex characteristics) in different ways. Some may verbalize distress their natal or anticipated pubertal characteristics, while others are concerned with their lack of physical characteristics

that match their experienced gender identities.

- **Diagnostic Exit:** The subcommittee stated an intent “for individuals who have successfully transitioned to 'lose' the diagnosis after satisfactory treatment.” In the proposed diagnostic criteria, “sex” (in reference to natal sex) was replaced by “gender” (current social gender role) to partially reduce false-positive diagnosis in previous DSM editions for transitioned individuals no longer distressed by their sex characteristics or current gender roles (Winters 2008).
- **Removal of Sexual Orientation Subtyping:** The subcommittee eliminated the following specifiers from the current GID diagnosis, “Sexually Attracted to Males, Sexually Attracted to Females, Sexually Attracted to Both, and Sexually Attracted to Neither.” Sexual orientation has no bearing on the legitimacy of an individual's experienced gender identity, nor is it relevant to classification of mental disorder.

Shortcomings of the Proposed Revisions, and Recommendations

- **Incongruence Undefined:** Incongruence, in the proposed title and diagnostic criteria, is not sufficiently clear. It may be easily inferred to mean difference or nonconformity to social expectations of birth-assigned gender. A title of Gender Dysphoria would better describe the often painful nature of a problem that may eventually require medically necessary care. If Incongruence is retained in the title and diagnostic criteria, it should be clearly defined as a distressing sense of incongruence experienced by the child and not gender expression that is nonconforming to social stereotypes associated with natal sex (Lev, et al. 2010A).
- **Gender Dysphoria Defocused:** All references to distress and discomfort in the diagnostic criteria have been replaced by less descriptive, euphemistic terms, such as “preference,” “dislike,” “rejection” and “desire” (next item). For gender dysphoric youth who are extremely distressed by impending pubertal changes to their bodies, this language would fail to acknowledge any problem that merits attention. This wording would pose unintended barriers to access puberty-delaying medical treatment for those who need it. Any diagnostic category or criteria set for children in the DSM-5 should be explicitly based on distress of anatomical or gender role dysphoria (Winters, Ehrbar 2009), not on mere nonconformity of *likes* and *dislikes* to stereotypes of natal sex or assigned gender role.
- **Desire for Congruence Pathologized:** Subcriteria A1 and A8 describe a “desire” for social gender expression or physical sex characteristics that are congruent with experienced gender identity as symptomatic of mental disorder. In truth, all people desire harmony and congruence in their lives, and all people with medical conditions desire effective treatment. This language inadvertently implies that desire for transition is in itself pathological and contradicts treatment for gender dysphoria. “Deprivation” (Vitale 2001) is a much clearer term than “desire” to describe distress or discomfort caused by a lack of physical sex characteristics or social gender expression that are congruent with experienced gender identity.
- **Clinical Insignificance:** The removal of the clinical significance criterion further confuses the purpose of the diagnosis and opens it to false-positive ensnarement of children who meet no definition of mental disorder. A second criterion requiring clinically significant distress or impairment, should be restored to the diagnosis. It is

crucial, however, that a clinical significance criterion should exclude distress or impairment that is caused by societal prejudice or discrimination. To cast victimization as symptomatic of mental illness would inflict further harm upon victims of prejudice (Ehrbar, Winters, Gorton 2009).

- **Nonconformity Pathologized:** Unfortunately, the proposed diagnostic criteria retain much of the anachronistic language of gender stereotyping from prior DSM editions. Five of eight subcriteria, A2 through A6, describe simple nonconformity to outmoded, sexist, binary gender stereotypes as symptomatic of mental illness. These subcriteria should be removed entirely from the diagnosis.
- **False-negative Exclusion of Anatomic Dysphoria:** The subcommittee is correct to require evidence of gender dysphoria for diagnosis (subcriterion A1). However, ambiguous language inadvertently excludes youth who have transitioned to affirmed social gender roles (and no longer meet A1) but remain painfully distressed by their physical sex characteristics. These youth may be denied access to puberty delaying medical treatment by this oversight. Criterion A should be corrected to require evidence of social gender role dysphoria or anatomic dysphoria or both, rather than social role dysphoria alone.
- **Maligning Language:** Children who have transitioned into affirmed gender roles congruent with their experienced gender identities are maligned by pronouns and terms (such as “girls” and “boys”) of their natal sex. This language should be removed from the diagnostic criteria and supporting text.
- **Placement in the DSM:** Classification of Gender Incongruence in Children in the DSM section with sexual disorders is inaccurate, misleading and brutally stigmatizing to young children and their families. The subworkgroup is correct in questioning the current placement of the childhood diagnosis.
- **Intersex Condition Terminology:** The term “Disorder of Sex Development” is used to describe children with intersex conditions in proposed diagnostic specifiers. This term is highly offensive to many in the intersex community (Hinkle 2007), and the relevance and utility of such a specifier to this diagnosis are questionable (Lev, et al. 2010A).
- **Dimensional Diagnosis:** The proposed diagnosis includes a dimensional diagnosis assessment questionnaire that is focused on arcane, sexist gender stereotypes that have little relevance to access to medical transition or puberty-delaying treatment. The draft dimensional questions throughout the DSM-5 proposal have been criticized as “remarkably ad hoc, idiosyncratic, and cumbersome” (Frances 2010)

Suggested Diagnostic Criteria for Gender Dysphoria of Childhood: (Lev, et al. 2010A)

A. A distressing sense of incongruence in childhood between the child’s persistent experienced or expressed gender and current physical sex characteristics or assigned gender role, as manifested by the child’s self-report or documentable observation of at least one of the following indicators for a duration of at least 3 months. Incongruence, for this purpose, does not mean gender expression that is nonconforming to social stereotypes of assigned gender role or natal sex.

1. A distress or discomfort with living in the present gender or being perceived by others as the present gender, which is distinct from the experiences of discrimination or the societal expectations associated with that gender.

2. A distress or discomfort caused by deprivation of gender expression congruent with persistent experienced gender or insistence that one has a gender that differs from the present gender. Experienced gender may include alternative gender identities beyond binary stereotypes.

3. A distress or discomfort with one's current (and/or anticipated) primary or secondary sex characteristics that are incongruent with persistent experienced gender.

4. A distress or discomfort caused by deprivation of primary or secondary sex characteristics that are congruent with persistent experienced gender (including anticipated post-pubertal characteristics).

B. Distress or discomfort is clinically significant or causes impairment in social, educational or other important areas of functioning, and is not due to external prejudice or discrimination.

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About Me

Kelley Winters is the author of *Gender Madness in American Psychiatry: Essays from the Struggle for Dignity* and a community advocate on issues of gender diversity in medical and public policy. She is the founder of GID Reform Advocates and an Advisory Board Member for the Matthew Shepard Foundation and TransYouth Family Allies. Kelley has presented papers on the psychiatric classification of gender diversity at annual conventions of the American Psychiatric Association, the American Psychological Association, the American Counseling Association and the Association of Women in Psychology. Kelley is a transsexual woman and proud member of the transgender community.

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