Virtual Mentor
American Medical Association Journal of Ethics
August 2010, Volume 12, Number 8: 673-677.

MEDICINE AND SOCIETY

Proposed DSM-5 Revisions to Sexual and Gender Identity Disorder Criteria

Robert Marvin, MD

Psychiatry is a medical specialty that operates at the junction of the biological, psychological, and social sciences. As such, our definitions of illness and "disorders" reflect our understanding of these overlapping arenas. This is particularly evident in the areas of gender and sexual disorders, in which data are rapidly increasing and psychological and social paradigms are evolving.

The American Psychiatric Association (APA) has embarked on a major revision of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The most extensive revision in almost 20 years, DSM-5 has a projected publication date of 2013 [1]. As part of this process, APA has convened 13 work groups to propose revisions to the current diagnostic criteria. The Work Group on Sexual and Gender Identity Disorders (WGSGID) has announced the proposed revisions to the DSM-IV-TR diagnoses of gender identity disorder and paraphilias [2]. These changes reflect an extensive review of the current research, expert consensus from clinicians working in the field, and input from the community.

Revisions: Gender Identity Disorder

Under the proposed revision, what is currently called gender identity disorder (GID) in the DSM-IV-TR will be renamed "gender incongruence" in DSM-5. For adults and adolescents, the proposed criteria are:

> a marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by 2 or more of the following indicators:
>
> 1. a marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics)
> 2. a strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
> 3. a strong desire for the primary and/or secondary sex characteristics of the other gender
> 4. a strong desire to be of the other gender (or some alternative gender different from one's assigned gender)

5. a strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
6. a strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender) [3].

The two major changes to the criteria are: (1) framing of the disorder in terms of the incongruence between experienced gender and assigned gender, instead of a "cross-gender" identification and (2) the removal of distress or impairment as a requirement for diagnosis. These changes refine the criteria to be more reflective of the current clinical presentation of people with GID [4]. The criteria for gender incongruence in children are similarly revised, removing the distress or impairment criterion [5, 6].

Revisions: Paraphilias

The paraphilias comprise a broad range of atypical sexual behaviors that include exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, voyeurism, and "paraphilia not otherwise specified." The proposed changes to these criteria for the DSM-5 better reflect the range of presentations and degree of distress or disability found in this population [2]. For example, what is now called exhibitionism would be changed to "exhibitionistic disorder":

A. Over a period of at least six months, recurrent and intense sexual fantasies, sexual urges, or sexual behaviors involving the exposure of one's genitals to an unsuspecting stranger.
B. The person is distressed or impaired by these attractions, or has sought sexual stimulation from exposing the genitals to three or more unsuspecting strangers on separate occasions [7].

In these revised criteria, the paraphilia is defined in criterion A. To meet the definition of a "disorder," an individual would also have to meet criterion B, which includes both a distress component and an action component with specific numbers of incidents. This separation represents a major shift in the DSM, reflecting the current understanding of clinical presentations of these disorders and an attempt to measure the extent of the disorder by quantifying paraphilic behaviors. The proposed revisions for all the paraphilias are presented at the APA website and discussed in detail by several authors [2, 8-14].

Should These Still be Considered Disorders?

Currently, the DSM-IV-TR defines a mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significant increased risk of suffering death, pain, disability, or an important loss of freedom" [15]. The challenge presented with gender identity and sexual behaviors is that we lack a clear definition of "normal," from either a biological or psychological

standpoint. This generates a moving target for pathology, which is therefore in need of ongoing review and discussion.

With regard to gender identity disorder, a parallel to homosexuality has been used to argue for the elimination of this disorder from the DSM. Homosexuality was removed over the course of revisions to the DSM in the 1970s and ‘80s due to pressure from both inside and outside the APA. This reflected the growing research data that depathologized homosexuality and the development of a greater social consciousness within the organization. For further background, see Drescher’s comprehensive review of this parallel [16].

Similar arguments are being made for removing GID, namely that continued labeling of expressions of gender as pathological is discriminatory and perpetuates stigma, causing harm to transgender individuals [17]. There is growing evidence that the increased incidence of psychiatric problems in transsexual individuals is related to stigma and that many individuals have nonclinical levels of distress or impairment [18]. There is also concern over the lack of data to support the attribution of an “inherent distress” to gender incongruence [19]. A recent survey of organizations concerned with the welfare of transgender people found that a majority, 55.8 percent, believed that the diagnosis should be removed but that, if it were to be retained, the name and language should be revised to minimize stigma by better reflecting the experience of transgender people. [20].

One important argument in favor of keeping a gender identity disorder in the DSM is the concern that its removal would lead to denial of medical care for transgender individuals, hamper their ability to pursue discrimination claims, and deprive people, including children, with GID of the counseling and medical treatments demonstrated to be beneficial, which will likely continue to require a psychiatric assessment for justification [19].

There is less controversy about keeping the paraphilias in the DSM because, unlike GID, they can manifest with behaviors that harm the self or others—one major area in which the domain of the psychological overlaps the arena of the legal. The revised criteria distinguish between those whose actions towards others are invasive or harmful—those who would receive the diagnosis—from those who merely have atypical sexual fantasies, thoughts, and private or consensual behaviors, who formerly met the criteria for a disorder but now would not. The more precisely quantified behavioral criteria will also assist those working in forensics [8, 12-14].

So where does that leave us? These proposed revisions seek a balance between our growing understanding of these disorders and the changing societal and personal views of behavior, while attempting to meet the need to define conditions that benefit from intervention. Do they go far enough? I would argue yes. The paraphilias are likely to remain based on their association to legal consequences. With regard to GID, we are not ready for a complete removal of the diagnosis. Physicians and surgeons are likely to be uncomfortable prescribing treatments without confirmation

of the diagnosis from a psychiatrist or psychologist. I am hopeful that ongoing social, political, and insurance reform will one day allow for its removal. The APA's goal of making the DSM-5 a "living document," responsive to ongoing scientific discovery, will likely encourage such an adoption [21].

References

1. American Psychiatric Association. DSM-5 development timeline. http://www.dsm5.org/about/Pages/Timeline.aspx. Accessed June 6, 2010.
2. American Psychiatric Association. Sexual and gender identity disorders. http://www.dsm5.org/MeetUs/Pages/SexualandGenderIdentityDisorders.aspx. Accessed June 6, 2010.
3. American Psychiatric Association. Proposed revision: 302.85: gender identity disorder in adolescents or adults. http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=482. Accessed June 6, 2010.
4. Cohen-Kettenis PT, Pfafflin F. The DSM diagnostic criteria for gender identity disorder in adolescents and adults. *Arch Sex Behav*. 2010;39(2):499-513.
5. American Psychiatric Association. Proposed revision: 302:6: gender identity disorder (children). http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=192. Accessed June 6, 2010.
6. Zucker KJ. The DSM diagnostic criteria for gender identity disorder in children. *Arch Sex Behav*. 2010;39(2): 477-498.
7. American Psychiatric Association. Proposed revision: 302.4: exhibitionism. http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=62. Accessed June 6, 2010.
8. Blanchard R. The DSM diagnostic criteria for pedophilia. *Arch Sex Behav*. 2010;39(2):304-316.
9. Blanchard R. The DSM diagnostic criteria for transvestic fetishism. *Arch Sex Behav*. 2010;39(2):363-372.
10. Kafka MP. The DSM diagnostic criteria for paraphilia not otherwise specified. *Arch Sex Behav*. 2010;39(2):373-376.
11. Kafka MP. The DSM diagnostic criteria for fetishism. *Arch Sex Behav*. 2010;39(2):357-362.
12. Krueger RB. The DSM diagnostic criteria for sexual masochism. *Arch Sex Behav*. 2010;39(2):346-356.
13. Krueger RB. The DSM diagnostic criteria for sexual sadism. *Arch Sex Behav*. 2010;39(2):325-345.
14. Langstrom, N. The DSM diagnostic criteria for exhibitionism, voyeurism, and frotteurism. *Arch Sex Behav*. 2010;39(2):317-324.
15. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed revised. Washington, DC: American Psychiatric Association; 2000.

16. Drescher J. Queer diagnoses: parallels and contrasts in the history of homosexuality, gender variance, and the diagnostic and statistical manual. *Arch Sex Behav*. 2010;39(2):427-460.
17. Ault A, Brzuzy S. Removing gender identity disorder from the Diagnostic and Statistical Manual of Mental Disorders: a call for action. *Soc Work*. 2009;54(2):187-189.
18. Nuttbrock L, Hwahng S, Bockting W, et al. Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *J Sex Res*. 2010;47(1):12-23.
19. Meyer-Bahlburg HF. From mental disorder to iatrogenic hypogonadism: dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Arch Sex Behav*. 2010;39(2):461-476.
20. Vance SR, Cohen-Kettenis PT, Drescher J, Meyer-Bahlburg HFL, Pfafflin F, Zucker KJ. Opinions about the DSM gender identity disorder diagnosis: results from an international survey administered to organizations concerned with the welfare of transgender people. *Int J Transgenderism*. 2010;12(1):1-14.
21. APA modifies DSM naming convention to reflect publication changes [news release]. Arlington, VA: American Psychiatric Association; March 9, 2010. http://www.dsm5.org/Newsroom/Documents/DSM-Name-Change.pdf. Accessed July 20, 2010.

Robert Marvin, MD, is an associate professor of clinical psychiatry at the University of Illinois at Chicago College of Medicine, where he serves as the residency training director. His clinical interests include HIV psychiatry, psychotherapy, and first-episode psychosis.

Related in VM
Suppression of Puberty in Transgender Children, August 2010